Medicare Inpatient Prospective Payment System
Final Rule Impact Analysis
Federal Fiscal Year 2018

-Version 1, August 2017-

Analysis Description

The federal fiscal year (FFY) 2018 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments will change from FFY 2017 to FFY 2018 based on the policies set forth in the FFY 2018 IPPS final rule. The analysis compares the year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes, including:

- potential payment penalties under the Inpatient Quality Reporting (IQR) and electronic health record (EHR) Incentive Programs;
- impact of the expiration of the Medicare Dependent Hospital (MDH) and expanded Low Volume Hospital Adjustment (LVA) programs;
- quality-based payment adjustments;
- Disproportionate Share Hospital (DSH) uncompensated care (UCC) payments; and
- CMS' transitioning to the use of Medicare Cost Report Worksheet S-10 for UCC payments for FFY 2018.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2018 IPPS Final Rule Changes Modeled in this Analysis:

- Provider Type Changes: Changes to inpatient payments resulting from a change in provider type. This includes adjustments to both hospital specific rate (if received) and changes to the traditional, rate-based DSH payment calculation for hospitals that change special status. Impacts provided here are due primarily to the expiration of the MDH program, but also include the effects of a small number of hospitals obtaining Rural Referral Center (RRC) status.

- Marketbasket Update: 2.7% operating marketbasket increase and 1.3% capital marketbasket increase; plus additional adjustments for budget neutrality.

- ACA Mandated Marketbasket Reductions: Combined 0.6 percentage point (PPT) productivity reduction and 0.75 PPT pre-determined reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.

- 21st Century Cures Act-Mandated Coding Adjustment Reduction: 0.4588% increase to the federal operating rate authorized by the 21st Century Cures Act to prospectively increase the rate after the American Taxpayer Relief Act (ATRA) of 2012 retrospectively recouped/adjusted for what CMS claimed to be over-payments due to coding improvements.

- 2-Midnight Rule Adjustment: In response to the outcome of Shands Jacksonville Medical Center, Inc. v. Burwell, CMS is applying a 0.6% decrease to the federal operating and capital rates to remove the effects of the temporary 0.6% increase applied for FFY 2017.

- Wage Index/GAF: Updated wage index and capital geographic adjustment factor (GAF) values; including any impact due to new wage data; reclassifications; and other adjustments to the wage indexes.

- DSH–UCC Payment Changes: Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2018 final rule DSH Supplemental File. Changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2018 DSH supplemental file. The impacts also consider year-to-year changes in hospital-specific UCC payment factors (factor 3) for these hospitals.

  Impacts of the adopted methodology change for the calculation of Factor 3 values for distribution of the uncompensated care pool are provided on page 5 of the report. For FFY 2018 and subsequent years, Factor 3 will be determined utilizing the average of three years of data to phase in the use of Medicare Cost Report Worksheet S-10. Although CMS has not yet finalized plans for FFYs 2019-2020, this analysis assumes that S-10 will replace the proxy Low-Income Days data over those three years.

- Change in Hospital Specific Rate: Reflects the impact to special status hospitals (Sole-Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs), or Essential Access Community Hospitals (EACHs)) where there is a change in payment status (hospital-specific vs federal) or where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments.

- MS-DRG Updates: Changes due to updates to the DRG groupings and weights. The impact shown is the case-mix change resulting from running the FFY 2016 Medicare claims data through the two DRG Grouper software programs (Grouper Version 34.0 for FFY 2017 and Grouper Version 35.0 for FFY 2018) and assigning the respective MS-DRG weights for each year.

- Quality-Based Payment Adjustments: Year-to-year change in hospital-specific quality performance and subsequent adjustments under the Value Based Purchasing (VBP), Readmissions Reduction, and Hospital Acquired Condition (HAC) Reduction programs.

- Low Volume Adjustment Changes: Reflects the change in overall payments made as a result of the Low Volume Hospital (LVH) Adjustment program. The LVH adjustment factors are from FFY 2017 final rule Table 14. Distance eligibility was determined using the most recent 3 years of cost report data (2014, 2015, and 2016). If a hospital reported low volume payments in their most recent cost report, or had reported in its most recent year that the distance requirement had been met on Worksheet S-2, it is assumed that the hospital had met the distance requirement of the low volume adjustment.
  The new requirements for receiving an LVH adjustment are that a hospital must have fewer than 200 total discharges (Medicare and Non-Medicare) during the fiscal year and must be located more than 25 road miles away from another hospital. Whereas a small number of hospitals may meet these more stringent requirements; due to the lack of distance measurements at the hospital level, impacts presented in this analysis make the assumption that no hospital will receive an LVH adjustment.

Data Sources

Estimated FFYs 2017 and 2018 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2018 IPPS final rule Impact File and data from CMS' DSH Supplemental files. These files are available on CMS' website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html.

The inpatient federal operating and capital rates are from the FFYs 2017 and 2018 final rules, as published in the *Federal Register*.

Medicare cases and case-mix indices are from the CMS FFY 2018 final rule Impact File and include cases, case-mix indices, and transfer-adjusted cases resulting from running the FFY 2016 Medicare claims data through the two DRG Grouper software programs (Grouper Version 34.0 for FFY 2017 and Grouper Version 35.0 for FFY 2018).

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFYs 2017 and 2018 final rule Impact Files and the wage index tables in the *Federal Register*.

The DSH impact estimates are based on the Impact and DSH Supplemental files published with the final FFY 2017 and 2018 IPPS rules. The DSH Supplemental file includes: an indicator of DSH-eligible hospitals for FFY 2018 (CMS is projecting that 2,427 hospitals will be eligible for DSH payments and paid as such in FFY 2018), the national UCC pool dollars, and hospital-specific UCC factors/payment amounts.

The impact of the quality-based payment adjustments are based on the following: The readmissions adjustment factors used to calculate impacts for FFY 2018 are from IPPS final rule Table 15, and were calculated by applying the FFY 2018 excess readmission ratios to claims data for the period July 1, 2013 to June 30, 2016. The list of hospitals that could potentially be subject to the HAC Reduction Program penalty used to calculate impacts for FFY 2018 is estimated based on hospital quality data available from Hospital Compare as CMS did not release penalty flags with the final rule. Although CMS has stated that no more than 25% of hospitals will be penalized under the HAC program, this analysis assumes that all hospitals at-or-over the 75th percentile breakpoint will receive a penalty. As a result, HAC penalties may be overstated. The VBP adjustment factor for FFY 2018 is estimated based on hospital quality data available from Hospital Compare as CMS' VBP proxy adjustment factors from final rule Table 16 are not considered reliable. The quality adjustment factors used to calculate FFY 2017 impacts are from the FFY 2017 IPPS final rule correction notice. Please note that quality adjustments that have been estimated are based on CMS' 2nd Quarter 2017 update of the data available on the Hospital Compare website.

Note: This analysis was developed to measure the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, DSH eligibility, factors used to calculate the DSH and IME adjustments and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2018 final rule Impact File and DSH Supplemental File. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating FFY 2017 payments. Estimated FFY 2017 payments reflect the wage index, labor-share, DSH, IME and quality-adjusted federal payment amount (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated FFY 2017 payments, the adopted policy changes to the IPPS payment rates are applied. Then, the effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are calculated by substituting FFY 2017 values with FFY 2018 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the marketbasket update is applied to estimated FFY 2017 payments. Then, the change in the ACA-mandated marketbasket reductions are applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. marketbasket, ACA, etc.).

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeroes due to rounding.

Hospitals with Special Status

SCH status and federal/hospital-specific payment determinations for SCHs are based on the status predicted by CMS in its FFY 2018 final rule DSH Supplemental File. Former MDHs eligible for special IPPS payment rates during FFY 2017 are identified based upon their provider status in the CMS FFY 2017 final rule Impact Files. If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, IME, and transfer adjustments), payments based on the hospital-specific rate are used in this analysis.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the hospital-specific rate is more beneficial, these hospitals are paid at 100% of the hospital-specific rate. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate.