Hello and thank you for listening. Today we will be going over DataGen's Inpatient Prospective Payment System impact model that you receive through your State Hospital Association or corporate health system. For those who are not familiar, DataGen is a for-profit subsidiary of the Healthcare Association of New York State that analyzes Medicare fee-for-service reimbursement for providers throughout the country.

Each year, usually in early April, the Centers for Medicare and Medicaid Services, known as CMS, releases a **proposed** rule for the Inpatient Prospective Payment System, or IPPS for short. This rule outlines potential changes to the hospital inpatient payment setting for the upcoming fiscal year. The industry has 60 days from the release of the proposed rule to submit comments on CMS' plans. Then, in early August of the same year, CMS releases a **final** rule responding to those comments and making the industry aware of what will be adopted for the upcoming year.

The proposed rule IPPS impact analysis is for advocacy purposes and is meant to bring attention to which proposed policies may be worth advocating for or against through CMS' comment process. It is also an opportunity to review the data from CMS to ensure that it is as expected. For example, if your hospital is paid at a hospital-specific rate and you do not see that breakdown in the Hospital Payments tab, you should contact your Medicare Administrative Contractor.

The final rule IPPS impact analysis is intended for budgeting purposes. At this point, CMS has adopted changes to the payment setting for the upcoming year, though some of these may differ from what was proposed based on comments received. This is an additional opportunity to verify that your hospital's payment characteristics look correct, and if not, contact your Medicare Administrative Contractor.

We are aware that many hospitals have fiscal years that do not align with a federal fiscal year and that these hospitals often use the proposed rule for budgeting purposes, as it is the best data available at the time that hospital budgets are being developed. These budgets are often adjusted once the final rule is released.

The Hospital Report tab includes a high level summary of the year-over-year Operating and Capital revenue changes, as well as an impact details section that shows how each changing line-item may affect the Medicare fee-for-service revenue for your hospital compared to the previous year. These impacts are based on historic data provided by CMS in tables released along with the rule.

Within the impact details section, you typically see lines for the Market Basket update, ACA-mandated productivity adjustment, budget neutrality adjustments, wage index

changes, disproportionate share uncompensated care cost changes, and quality based payment adjustments. The budget neutrality and wage index adjustments vary depending on what CMS is changing for the year under study. Some line items may also be influenced by either a piece of legislation or an administration policy change (i.e. advocacy dependent). Others, such as the market basket and aca-mandated productivity adjustments, are standard changes each year that change as a result of updated data inputs. Any line item that is greyed out, italicized, and with an arrow next to it is a breakout or subset of the non-greyed out and non-italicized line item above it. The check boxes on the lefthand side can be used to select individual changes to display. All percent changes are calculated based on the change relative to the prior year revenue total. The changes are broken down into operating changes, capital changes, and then summed in the last column as total changes.

The impact details section is followed by an estimate of the currently mandated 2 percent sequestration reduction, as it is applied to final Medicare payments and is not factored into CMS' estimates. Also provided is the potential penalty due to insufficient inpatient quality reporting and electronic health reporting **if** the provider was indeed subject to that penalty. These estimates do not indicate whether or not the provider actually met reporting requirements or not.

The following tab of the analysis is the Hospital Summary tab. This tab removes the granular breakouts of individual changes and provides just the high-level components of the provider details from the previous tab.

The two Hospital Payments tabs, provide all payment components that were used to estimate the annual Medicare inpatient fee-for-service revenue provided in this analysis, as well as how each of those pieces are expected to change between the two years under study. With this, the detailed calculations of rates for each year under study are represented with corresponding letters. This section includes changes to the inpatient federal operating and capital rates and labor-related share which are typically the same for all hospitals. It also includes hospital-specific characteristics for each year, such as the IPPS wage index value published by CMS, indirect medical education adjustments, disproportionate share adjustments, quality program adjustments, case-mix, etc. Overall inpatient fee-for-service payment estimates in the Hospital Report will match those calculated here unless otherwise noted.

On the bottom of the Hospital Payments (continued) tab there is detail about wage index and reclassifications over the two years under study.

Some lines within the two Hospital Payments tabs include formulas which can be used to recreate calculations, therefore include extra decimal points for accuracy.

The next tab of the analysis looks at a hospital's top 25 Medicare severity diagnosis-related groups, otherwise known as MS-DRGs, ranked by the absolute value of their payment impact. This information can be used to estimate which inpatient diagnoses could see the most payment impact . Volumes used to populate this table are sourced from CMS' most recently available 100% Inpatient Standard Analytic File Limited Data Set. DRGs with case counts less than 11 have been removed due to CMS' privacy rules.

The last tab of the analysis provides you with definitions for each abbreviation used throughout the analysis, data sources used, and detail each change modeled in the analysis. These bullet points are described more depth in the analysis description which accompanies the analysis.

Please be aware that the IPPS analysis was developed to measure the impact of fee-for-service Medicare inpatient policy changes only. Hospital volume and patient mix are held constant between the two years under study. The analysis also does not include payment estimates for services provided to Medicare Advantage patients, or modifications in fee-for-service payments resulting from provider participation in new payment models being tested under Medicare demonstration or pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations due to differences in the source data and analytic methods used.

If you have any questions, please reach out to your State Hospital Association or system representative. Thank you and have a great day.