OMFS Update for Inpatient Hospital Services (Effective for discharges occurring on or after December 1, 2017)

1. Data Sources
    a. The Medicare FY18 update to the inpatient prospective payment system was published on August 14, 2017 in the Federal Register (Vol. 82 FR 37990) and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Services and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices" (CMS-1677-F). Corrections to the final rule were published on October 4, 2017, in the Federal Register (Vol. 82 FR 46138, CMS-1677-CN – Final rule; correction). These documents are available at http://www.cms.hhs.gov/AcuteInpatientPPS/.

    b. The factors to determine composite rates are available on the CMS website at http://www.cms.hhs.gov/AcuteInpatientPPS/. The public use file used to calculate the composite rates is entitled "FY 18 Final Rule Impact File (Final Rule and Correction Notice)". The file contains wage data posted on the CMS website.

2. Composite Rate Calculation

    a. Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare FY2018 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the 2017 OMFS rates for dates of discharge effective, December 1, 2017.

    b. OMFS rate for operating costs
        i. Based on the Medicare Hospital Inpatient Prospective Payment System, all hospitals are paid the same standard rate for operating costs (based on the rate for hospitals located in large urban areas). The 2017 rate was $6,439.11. The estimated increase in the market basket is 2.7%. The 2018 standard rate under the OMFS is $6,612.97 ($6,439.11 x 1.027).
        ii. The Medicare Hospital Inpatient Prospective Payment System provides that if a hospital's wage index is less than or equal to 1.0, the labor-related share is .62 of the standard rate. If the wage index

is greater than 1.0, the labor-related share is .683. The wage-adjusted standard rate is determined as follows:

a. For discharges occurring on or after December 1, 2017, use FY 2018 wage index, which can be found in the Impact File for FY 2018

b. If FY 2018 wage index >1.0, wage-adjusted rate = $6,612.97 x (.683 x FY 2018 wage index + .317)

c. If FY 2018 wage index <=1.0, wage-adjusted rate = $6,612.97 x (.62 x FY 2018 wage index + .38)

iii. The wage-adjusted operating rate is further adjusted for any additional payments for teaching and serving a disproportionate share of low-income patients.

1. OMFS operating DSH adjustment factor equals the sum of a) the Medicare DSH operating adjustment and b) 3 * the Medicare DSH operating adjustment * the Uncompensated Care adjustment).
2. Adjusted operating rate = wage-adjusted standard rate x (1 + TCHOP + DSHOPP *4*DSH adjustment factor). The DSH adjustment factor for 2018 is 0.685 (75%*Medicare DSH factor 2 which is 58.01% +25)/100.

c. OMFS rate for capital-related costs

i. The estimated increase in the capital market basket is 1.3%. The 2018 capital standard federal payment rate is $489.51 ($483.23 x 1.013).

ii. The capital standard federal payment rate is adjusted for the capital geographic adjustment factor, teaching, and for serving low-income patients.

iii. For discharges occurring on or after December 1, 2017, use FY 2018 GAF, which can be found in the Impact file for FY 2018:

1. Adjusted capital standard federal payment rate = $489.51 x FY 2018 GAF x (1+ DSHCPG + TCHCP).

d. The standard composite rate is the sum of the OMFS rate for operating costs and the OMFS rate for capital-related costs.

e. Sole community hospitals (PTYPE = 16 or 17) receive the higher of the standard composite rate or a composite rate based on a hospital-specific rate for operating costs plus the OMFS rate for capital-related costs. When the hospital-specific composite rate (FY 18 HSP Rate) is higher than the standard composite rate, the amount is shown in italics. The FY 18 HSP Rate is the FY 1982/1987/1996/2006 Hospital Specific Payment (HSP) Rate updated to FY 2018 for SCH providers.

3. Cost-to-charge ratio (CCR) used to determine an outlier payment is the sum of the operating and capital cost-to-charge ratios. CCR = Operating CCR + Capital CCR

4. Hospital-specific outlier factor

    a. The fixed loss cost outlier threshold is $26,537.
    b. The fixed loss cost outlier threshold is allocated to operating and capital components and adjusted for geographic location as follows:
        i. For discharges occurring on or after December 1, 2017, use FY 2018 wage index, which can be found in the Impact File for FY 2018:
            1. If FY 2018 wage index > 1.0, operating outlier factor = $26,537 x Operating CCR/CCR x (FY 2018 wage index x .683 +. 317)
            2. If FY 2018 wage index < =1.0, operating outlier factor = $26,537 x Operating CCR/CCR x (FY 2018 wage index x .62 + .38)
        ii. For discharges occurring on or after December 1, 2017, use FY 2018 GAF, which can be found in the Impact File for FY 2018:
            1. Capital outlier factor = $26,537 x Capital CCR/CCR x FY 2018 GAF
        iii. Hospital-specific outlier factor = operating outlier factor + capital outlier factor

5. DRG Relative Weights: Revised DRG relative weights is entitled "Table 5 (Final Rule and Correction Notice) – Table 5. - List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay – FY 2018 Correction Notice." This document is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending. Section 9789.24, Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay is revised to reflect these changes effective with discharges occurring on or after December 1, 2017.

6. Maximum Allowable Fees: To determine the standard payment rate, the hospital-specific composite rate would be multiplied by the DRG relative weight and 1.20 multiplier. Additional payments will be made for high cost outlier cases and for certain pass-through costs in accordance with the regulations.

7. Acute Care Transfers: Section 9789.22(j)(2)(A) is amended to conform to Medicare's updates to the qualifying Medicare Severity DRGs when an acute care patient is discharged to a post-acute care provider, which were indicated in the August 14, 2017 Federal Register (Vol. 82 FR 37990; CMS-1677-F) and correction notice of October 4, 2017 Federal Register (Vol. 82 FR 46138; CMS-1677-CN). This document is available at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp. Table 5 lists how the

transfer policy will apply when an acute care patient in a particular MS-DRG is discharged to a post-acute care provider.

8. Section 9789.22(j)(2)(B) is amended to conform to Medicare's updates to Medicare-Severity DRGs subject to payment under this subsection which are indicated with a "yes", in the "FY2018 Final Special Pay DRG" column, listed in Table 5, which was indicated in the August 14, 2017 Federal Register (Vol. 82 FR 37990; CMS-1677-F) and correction notice of October 4, 2017 Federal Register (Vol. 82 FR 46138; CMS-1677-CN). This document is available at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp.

9. Sections 9789.20 through 9789.25 are further amended by Order of the Acting Administrative Director as described in paragraph 10, below. In particular, the subsections which reference the Federal Register or Code of Federal Regulations are amended to incorporate by reference the Federal Register (Vol. 82 FR 37990) and is entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Services and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices" (CMS-1677-F) and corrections to the final rule published on October 4, 2017, in the Federal Register (Vol. 82 FR 46138, CMS-1677-CN – Final rule; correction), to be applied to discharges occurring on or after December 1, 2017.

10. Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers' Compensation orders that to the extent references to the Federal Register or Code of Federal Regulations are made in any sections starting from section 9789.20 through 9789.25 of Title 8 of the California Code of Regulations, said section is hereby amended to incorporate by reference the applicable Federal Register final rule (including correction notices and revisions) and Federal Regulations in effect as of the date the Order becomes effective, to be applied to discharges occurring on or after December 1, 2017.