2018 IPPS Final Rule

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Inpatient Hospital Rates

The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 1.2 percent. The 1.6 percent is equal to the Market basket rate increase of 2.7%, less the Productivity adjustment of -0.6%, less cuts under the ACA -0.75%, less adjustment for two-midnight rule -0.6%, plus adjustment to restore cuts under ATRA of 2012 0.45%. The market basket change is shifting the base year cost structure for the IPPS hospital index from FY 2010 to 2014. Providers that are not EHR users and or do not participate in the IQR program will receive additional deductions.

Hospital Value-Based Purchasing

The VBP applicable percentage is 2.0% with approximately $1.9 billion available. The adjustment factors by hospital, will be posted this fall, after hospitals have a chance to review and correct their TPSs. 1 measure will be removed in 2019 and 1 measure each added for 2022 and 2023. CMS is removing PSI 90 in 2019 from safety domain and adopt a composite PSI 90 in safety and adverse events domain in 2023. In 2022, CMS will adopt a hospital-level risk-standardized payment associated with a 30 day episode of care for pneumonia to be included in the efficiency and cost reduction domain.

Hospital Readmissions Reduction Program

For FY 2018, the "applicable period" is the three years of July 1, 2013 through June 30, 2016. CMS will implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act for FY 2019 which assesses penalties based on relative performance to other hospitals with similar proportions of dual-eligible patients.

Disproportionate Share Hospital

CMS is changing the source of the percent change in the rate of uninsurance from the Congressional Budget Office to the National Health Expenditure Accounts. This change will increase the UCC pool by approximately $800 million in FFY 2018. In addition, Worksheet S-10 data to be used for purposes of calculating Factor 3 beginning in FY 2018. The methodology of using three cost reporting periods will effectively transition this in to 100% by 2020, with a corresponding phase out by FY 2020. CMS is not proposing at this time to implement a wage index style review of the S-10 data. However, they plan on creating a work group of MACs, hospitals and consultants to discuss this issue further. Hospitals have until September 30, 2017 to refile their FFY 2014 and FFY 2015 cost reports for only S-10 changes. Hospitals must refile (i.e., they cannot just submit proposed changes to the MAC) and the MACs have been instructed to accept them and upload them to the HCRIS database.

Long-Term Care Hospitals

The PPS based payment rate increased 0.4% with site neutral based payments decreasing 22%. The overall payments decrease is 2.4% which equates to $110M. CMS has implemented a graduated payment scale that will be introduced in FY18 to allow for greater short stay outlier payment to incentivize delays in discharges. In FY 2020 new quality measures will be introduced, some QMs will be deleted, and a revised data collection program will be implemented.

Medicare Dependent Hospitals

The MDH program is terminating for cost reporting periods beginning on/after October 1, 2017 (unless extended again beyond September 30, 2017).

Low Volume Hospitals

Qualification returns to less than 200 total discharges and more than 25 road miles from another hospital (unless extended again beyond September 30, 2017).

Critical Access Hospitals

CMS is instructing the CAH 96-hour certification requirement as a low priority for medical record reviews for MACs, QIOs, RACs, and SMRCs. Under the revised instructions to contractors, CAHs will not receive any medical record requests from MACs, RACs, QIO, or SMRCs related to the 96-hour certification unless CMS or its contractors find evidence of gaming or a failure to comply with CMS' provider screening and revalidation requirements. CMS estimates the FCHIP payment recoupment would be no greater than 0.03 percent of CAHs' total Medicare payments within one fiscal year and will be adjusted on a 3 year period begging in 2020.

Rural Demonstration Program

The 21st Century Cures Act approved solicitation for applications for 5 year period (second 5 years of 10 year extension) with a maximum of 30 hospitals able to participate. A hospital in any state can apply to participate but preference given to the 20 most sparsely populated states. Vermont and Maine (in our service area) are both on the list of most sparsely populated states. Vermont was added in this rule and Minnesota was removed. CMS had anticipated announcing the hospitals that were being admitted to the program in June 2017. However, they have pushed that deadline back until early fall 2017. In the final rule, CMS clarified that hospitals that had been in the program would be starting back up in the program (unless they opt out) at the same point in time as when the last 5 year period ended. This is a change from the proposed rule in which CMS was going to restart their 5 year window with the newly announced hospitals.

Electronic Health Records

For eligible hospitals and CAHs reporting for the first time in 2017 or that have demonstrated MU in any year prior to 2017, the reporting would be one self-selected quarters in CY 2017. For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2018 or that have demonstrated meaningful use in any year prior to 2018, the reporting period would be one self-selected quarter in CY 2018 and the submission period is the 2 months following the close of the calendar year, ending February 28, 2019. These providers will report on at least 4 self-selected clinical quality measures. For 2018, CMS is going to modify the EHR reporting periods for new and returning participants attesting to CMS or their state Medicaid agency from the full year to a minimum of any continuous 90-day period during the calendar year. Attestation alone will no longer be an option beginning in CY 2018 (with exceptions).

Wage Index

Other wage related costs associated with contract labor and home office personnel should be included in the 1% test. CMS intends to clarify hospital cost report instructions to reflect that these salaries should be added to the subtotal of salaries on WS S3, III Line 3 Column 4 for purposes of performing the 1% test. The imputed floor will expire on 10/1/2017 and CMS will continue to extend the imputed floor policy. CMS will apply the wage index to a labor related share of 62% of national standardized amount for hospitals whose WI is <= 1.000. For those hospitals whose WI is > 1.000 CMS will apply the WI to a proposed labor related share of 68.3% of the national standardized amount. CMS will discontinue the use of SSA county codes (no longer being maintained or updated) and begin using only the FIPS county codes. FIPS codes will be updated to incorporate all changes included in the most recent list from Census Bureau. For other wage related costs CMS this must be a fringe benefit as described by the IRS and must be reported to the IRS on employee's or contractor's W-2 or 1099 as taxable income in order to be on S3, II LN 18.

Volume Decrease Adjustments

CMS will change its methodology prospectively to cost reporting periods beginning on/after October 1, 2017. The changes are to remove the peer group comparisons and adjustments, remove the comparison to inflated PY cost for a cap, and to apply the fixed cost percentage to both cost and revenue. CMS, despite many comments to the contrary, refused to budge on the calculations and approach for VDAs prior to this date.

Cost Report Submission

Providers with fiscal year ends on or after 12/13/2017 can submit electronic signature and do not need a hard copy mailed into MACs. The process will be optional and if they submit electronically providers would be required to check a box off stating the CFO/Administrator signed off on the report.