# 2018 IPPS Proposed Rule

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**Inpatient Hospital Rates**

The proposed 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 1.6 percent. The 1.6 percent is equal to the Market basket rate increase of 2.9%, less the Productivity adjustment of -0.4%, less cuts under the ACA -0.75%, less adjustment for two-midnight rule -0.6%, plus adjustment to restore cuts under ATRA of 2012 0.4588%. The market basket change is proposing to shift 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 proposed 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 proposes to remove 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 has proposed to 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 has proposed to increase the UCC Pool to $6,962,310,946. 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 expects that Worksheet S-10 will be subject to review beginning in 2017.

**Long-Term Care Hospitals**

The PPS based payment rate increased 0.4% with site neutral based payments decreasing 22%. The overall payments decrease is 3.75% which equates to $173M. CMS proposed 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.

**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 proposed rule and Minnesota was removed. There is a gap noted between end of first 5 years and start of second 5 years, so may be an issue for hospitals already in the program. The second 5 years begins with first

cost reporting period on/after October 1, 2017. Solicitation methodology and application expected to be announced in April 2017, with a 30 day completion and submission deadline.

**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 two 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 the first 3 quarters of 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 6 self-selected clinical quality measures. For 2018, CMS is proposing 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 is not proposing to extend the imputed floor policy. CMS is proposing to 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 is proposing to apply the WI to a proposed labor related share of 68.3% of the national standardized amount. CMS proposing to 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 is proposing 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 proposed a change in 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.

**Cost Report Submission**

Effective FY 2018 providers 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.