



Executive Summary: CMS 2018 IPPS Proposed Rule

Key Financial and Operational Impacts from the Proposed 2018 Inpatient Prospective Payment System (IPPS) Proposed Rule:

The fiscal year 2018 (FY18) IPPS proposed rule was made available on April 14, 2017. A detailed summary of the rule will be available on the [HFMA Regulatory Resources](#) page shortly.

- 1) **Base Operating Rate:** The proposed base operating rate is increased by approximately 1.6% for hospitals that successfully participate in the Inpatient Quality Reporting Program (IQR) and are meaningful users of electronic health records (EHRs).

FY18 PROPOSED RULE TABLES 1A-1D

	Standardized Operating Amounts Wage Index > 1		Standardized Operating Amounts Wage Index < 1	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User	\$3,822.07	\$ 1,773.93	\$3,469.52	\$2,126.48
Did Not Submit Quality Data and Is a Meaningful User	\$3,794.84	\$1,761.29	\$3,444.80	\$2,111.33
Submitted Quality Data and Is Not a Meaningful User	\$3,740.37	\$1,736.01	\$3,395.36	\$2,081.02
Did Not Submit Quality Data and Is a Not Meaningful User	\$3,713.14	\$1,723.37	\$3,370.64	\$2,065.87
Puerto Rico	N/A	N/A	\$3,469.52	\$2,126.48

Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013, and will continue until 2024, absent new legislation.

- 2) **National Capital Rate:** The proposed national capital rate for FY18 is \$451.37, up from the FY17 final rate of \$446.81.
- 3) **DSH:** The proposed rule makes two significant changes to “uncompensated care” (UC) Disproportionate Share (DSH) payments. First, CMS changes the source of “factor 2” – used to calculate the percentage change in the uninsured since before the Affordable Care Act coverage expansion began (2013). CMS proposes using estimates of all uninsured produced by the Census Bureau instead of estimates of the uninsured for those under 65 produced by the Congressional Budget Office. This change is projected to increase DSH payments by approximately \$1.3B or a 1.2% of total projected operating payments. Assuming CMS does not change data sources

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frequently, the shift in data source will only be a one-time impact on UC DSH dollars available for distribution.

Second, CMS proposes incorporating uncompensated care data (defined as charity care and bad debt) from cost report worksheet S-10 into the calculation of “Factor 3” in the UC DSH formula. Factor 3 is the percentage of uncompensated care a DSH eligible hospital provides relative to all other DSH eligible hospitals, and is used to allocate UC DSH dollars to individual hospitals. Currently, factor 3 is calculated as a three-year average of Medicaid and Supplemental Security Income (SSI) days. The rule proposes using one year of data from the S-10 and two years of data Medicaid and SSI days.

Once S-10 data is fully incorporated the impact will likely be redistributive. Previous analysis suggests large hospitals (>300 beds) will see UC DSH funds redistributed to medium and small hospitals. For-profit and not-for-profit facilities unaffiliated with a religious order will lose UC DSH funds to governmental hospitals¹.

CMS provides a comparison of FY17 UC DSH payments to proposed FY18 in the proposed rule data [files](#).

- 4) **Outlier Threshold:** The proposed fixed loss outlier threshold increases to \$26,713 (compared to the FY17 final threshold of \$23,570), which will decrease outlier payments.
- 5) **Documentation and Coding:** CMS begins a 6-year add-back of related prior year documentation and coding reductions by increasing operating payments by .4588%.
- 6) **Reversal of Two-Midnight Related Payment Increase:** CMS decreased FY18 operating payments by .6% to remove the cumulative increase in payments related to its unjustified .2% payment cut for FYs 2014 - 2017 related to the two-midnight policy.
- 7) **Hospital Readmissions Reduction Penalty (HRRP):** Hospitals with higher than expected readmissions rates will be subject to a maximum 3% penalty. The proposed rule estimates that in FY18 2,591 hospitals will be subject to the HRRP. This will result in \$564 million in savings to the program.

The payment adjustment factors are available [here](#).

The 21st Century Cures Act instructs CMS to adjust the HRRP by comparing a hospital’s readmission rate to a peer group based on the volume of dually eligible patients. This will be used as a socio-economic factor risk adjustment proxy while CMS develops a better methodology. The proposed rule defines the formula for calculating the percentage of dual-eligible patients, assigning hospitals to peer groups, and adjusting the HRRP using the comparator groups.

¹ <https://www.hfma.org/Content.aspx?id=48243##>

Executive Summary: CMS 2018 IPPS Proposed Rule

- 8) **Value Based Purchasing (VBP) Program:** The proposed FY18 IPPS rule will redistribute approximately \$1.9B in operating payments through the VBP program. All hospitals will be subject to a 2% reduction in base operating diagnosis-related group payments. The rule proposes the following changes to the VBP measures:
 - a. Remove the current 8 indicator PSI-90 measure from the safety domain in 2019, and replace it with the modified 10 indicator PSI-10 measure in 2023.
 - b. Incorporate the 30-day pneumonia episode cost measure into the efficiency and cost reduction domain beginning in FY22.
 - c. Beginning in 2021, the Medicare Spend Per Beneficiary (MSPB) measure will account for 50% of the Efficiency and Cost Reduction domain, and the other condition-specific payment measures, weighed equally, will comprise the remaining 50% of a hospital's domain score.
- 9) **HAC:** Approximately 771 hospitals will be penalized 1% of their IPPS payments resulting from the hospital-acquired condition (HAC) penalty. The proposed rule solicits feedback on questions related to future measures and socio-economic risk adjustment of the HAC measures.
- 10) **Long-Term Care Hospital (LTCH) PPS Standard Federal Rate:** CMS proposes to update the standard federal rate by %.
- 11) **Impact of LTCH Payment Policy Changes:** Despite the 1% increase to the standard federal rate, the cumulative impact of changes in LTCH payment policy will reduce LTCH PPS payments by 3.75% or \$173 million. The negative impact is the result of the continued implementation of the site neutral payment policy, which is projected to impact 42% of cases in FY18.
- 12) **LTCH 25% Rule:** The proposed rule delays implementation of the "25% rule" for an additional year. Instead of taking effect on 10/1/17, the proposed rule implements it on 10/1/18.