Executive Summary: CMS 2018 IPPS Final Rule
Key Financial and Operational Impacts from the Final 2018 IPPS Rule

The 2018 IPPS (Inpatient Prospective Payment System) Final Rule was made available on Aug. 2, 2017. A detailed summary of the rule will be available on the HFMA Regulatory Summary Page shortly.

1) **Base Operating Rate**: The final base operating rate is increased by approximately 1.35 percent for hospitals that successfully participate in the Inpatient Quality Reporting Program (IQR) and are meaningful users of electronic health records (EHRs).

FY 2018 FINAL RULE TABLES 1A-1C

	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	$3,807.12	$1,766.99	$3,455.95	$2,118.16
Did Not Submit Quality Data and Is a Meaningful User	$3,781.76	$1,755.22	$3,432.93	$2,104.05
Submitted Quality Data and Is Not a Meaningful User	$3,731.05	$1,731.69	$3,386.90	$2,075.84
Did Not Submit Quality Data and Is Not a Meaningful User	$3,705.70	$1,719.92	$3,363.88	$2,061.74
Puerto Rico	N/A	N/A	$3,455.95	$2,118.16

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

2) **National Capital Rate**: The final national capital rate for FY2018 is $453.97, up from the FY2017 final rate of $446.81.

3) **Disproportionate Share Hospitals (DSH)**: The final rule makes two significant changes to "uncompensated care" (UC) DSH payments. First, CMS changes the source of "factor 2" – used to calculate the percentage change in the uninsured since before the ACA coverage expansion began (2013). CMS finalizes using estimates of all uninsured produced by the U.S. 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 $800 million or 1.0 percent of total projected operating payments. Assuming CMS does not change data sources frequently, the shift in data source will have only a one-time impact on UC DSH dollars available for distribution.

Second, CMS finalizes incorporating uncompensated care data (defined as charity care and bad debt) from cost report worksheet S-10 from FY2014 cost reports 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 finalizes using one year of data from the S-10 and two years of data for Medicaid and SSI days.

Once S-10 data is fully incorporated, the impact will likely be redistributive. Previous analysis suggests that 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 hospitals.[1]

CMS provides a comparison of FY2017 UC DSH payments to final FY2018 in the final rule data files.

4) **Outlier Threshold**: The final fixed loss outlier threshold increases to $26,601 (compared to the FY2017 final threshold of $23,570), which will decrease outlier payments.

5) **Documentation and Coding**: CMS begins a six-year add-back related to prior year documentation and coding reductions by increasing operating payments by .4588 percent.

6) **Reversal of Two-Midnight-Related Payment Increase**: CMS decreased FY2018 operating payments by .6 percent to remove the cumulative increase in payments related to its unjustified .2 percent payment cut for FYs 2014 - 2017 related to the two-midnight policy. This is a one-time reduction.

7) **Hospital Readmissions Reduction Penalty (HRRP)**: Hospitals with higher-than-expected readmissions rates will be subject to a maximum 3 percent penalty. The final rule estimates that in FY2018 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 assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid. CMS will stratify HRRP performance into five cohorts based on the percentage of dual eligibles. This will be used as a socioeconomic factor risk adjustment proxy while CMS develops a better methodology. The final 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##

8) **Value Based Purchasing (VBP) Program**: The final FY2018 IPPS rule will redistribute approximately $1.9B in operating payments through the VBP program. All hospitals will be subject to a 2 percent reduction in base operating DRG payments. The rule finalizes the following changes to the VBP measures:
    a. Remove the current eight-indicator PSI-90 measure from the safety domain in 2019 and replace it with the modified ten-indicator PSI-10 measure in 2023.
    b. Incorporate the 30-day pneumonia episode cost measure into the efficiency and cost reduction domain, beginning in FY2022.
    c. Beginning in 2021, the Medicare Spend per Beneficiary (MSPB) measure will account for 50 percent of the Efficiency and Cost Reduction domain and the other condition-specific payment measures, weighed equally, comprise the remaining 50 percent of a hospital's domain score.

9) **Hospital-acquired conditions (HAC):** Approximately 808 hospitals will be penalized 1 percent of their IPPS payments resulting from the HAC penalty.

10) **Long-Term Care Hospital (LTCH) PPS Standard Federal Rate:** CMS finalizes an update of the standard federal rate by 1 percent.

11) **Impact of LTCH Payment Policy Changes**: Despite the 1 percent increase to the standard federal rate, the cumulative impact of changes in LTCH payment policy will reduce LTCH PPS payments by 2.4 percent, or $110 million. The negative impact is a result of the continued implementation of the site-neutral payment policy, which is projected to impact 42 percent of cases in FY2018.

12) **LTCH 25 Percent Rule**: The final rule delays implementation of the "25Percent rule" for an additional year. Instead of taking effect on Oct. 1, 2017, the final rule implements it on Oct. 1, 2018.