



Special Bulletin

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CMS RELEASES FY 2018 HOSPITAL INPATIENT PPS FINAL RULE

This bulletin is eight pages.

The Centers for Medicare & Medicaid Services (CMS) August 2 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS [final rule](#) for fiscal year (FY) 2018. Select highlights of the final rule related to the inpatient PPS follow; highlights of the final rule related to the LTCH PPS are covered in a separate Special Bulletin.

CMS's rule could impact hospitals' ability to provide services for patients who rely on them for care. The AHA continues to have concerns related to the accuracy and consistency of the "Worksheet S-10" data CMS will begin using to determine the cost of treating uninsured patients beginning in FY 2018. We are disappointed CMS chose to implement its use for FY 2018 without ensuring additional protections for hospitals. However, the AHA is pleased that CMS finalized some of its proposals intended to reduce regulatory barriers for hospitals. This includes the agency's proposals to allow hospitals and critical access hospitals (CAHs) to report meaningful use modified Stage 2 in 2018, as well as the implementation of a 90-day meaningful use reporting period in FY 2018. In addition, we are pleased the agency recognized that the existing "96-hour" condition of payment for CAHs stands in the way of promoting essential, and often lifesaving, health care services to rural America.

HIGHLIGHTS

Inpatient PPS Payment Update. The final rule will increase inpatient PPS rates by 1.2 percent in FY 2018, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.7 percent, less 0.6 percentage points for productivity, 0.75 percentage points mandated by the Affordable Care Act (ACA), and 0.6 percentage points to remove the one-time, temporary adjustment that it made in FY 2017 to restore the unlawfully instituted two-midnight policy payment cuts from FYs 2014-2016. In addition, CMS finalizes an increase of 0.4588 percentage points to partially restore cuts made as a result of the American Taxpayer Relief Act (ATRA) requirement that the agency recoup what it claims is the effect of documentation and coding changes from FYs 2010-2012, which CMS says do

not reflect real changes in case mix. Table 1 below details the factors CMS includes in its estimate.

Table 1: Impacts of FY 2018 CMS Final Policies

Policy	Average Impact on Payments
Market-basket update	2.7%
Productivity cut mandated by the ACA	- 0.6%
Additional cut mandated by ACA	- 0.75%
Two-midnight policy adjustments	- 0.6%
Partial restoration of documentation and coding cut for FYs 2010, 2011 and 2012 mandated by ATRA	+ 0.4588%
Total	+1.2%

The ACA, two-midnight policy and ATRA adjustments will be applied to all hospitals. Additionally, hospitals not submitting quality data will be subject to a one-quarter reduction of the initial market basket (for a new market-basket rate of 2.025 percent), and, thus, will receive an update of 0.5 percent. Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2016 will be subject to a three-quarter reduction of the initial market basket (for a new market-basket rate of 0.675 percent), and, thus, will receive an update of -0.8 percent. Hospitals that fail to meet both of these requirements will be subject to a full reduction of the initial market-basket rate (for a new market-basket rate of 0 percent), thus, receiving an update of -1.5 percent.

Regarding the two-midnight policy, in FY 2017, CMS instituted two adjustments to reverse the effects of the 0.2 percent cut it unlawfully instituted when implementing the policy in FY 2014. Specifically, the agency implemented a permanent adjustment of approximately 0.2 percent to remove the cut prospectively for FYs 2017 and onward. It also instituted a *temporary* adjustment of 0.6 percent to address the retroactive impacts of this cut for FYs 2014-2016. It now finalizes its proposal to remove this 0.6 percent temporary adjustment from the inpatient PPS rates.

With respect to ATRA, the law requires CMS to recoup \$11 billion for what the agency claims is the effect of documentation and coding changes from FYs 2010-2012 that CMS says do not reflect real changes in case mix. The agency instituted these cuts in FYs 2014-2017. The Medicare Access and CHIP Reauthorization Act (MACRA) and the 21st Century Cures Act then required CMS to restore most of these cuts over a six-year period, beginning with a 0.4588 percentage point increase in FY 2018.

However, in FY 2017, when completing its final ATRA recoupment, CMS finalized a cut that was almost two times what it had planned and lawmakers had expected. Yet, the agency did not propose to correct for this discrepancy when instituting this year's

restoration. As a result, hospitals are now be left with a larger permanent cut than Congress intended when legislating the MACRA restorations.

We are disappointed that CMS decided not to restore last year's excess cut to reimbursement rates for hospital services. While a reduction to the hospital update factor was mandated by law in 2012, CMS ignored Congress' intent by imposing a cut that was nearly two times what Congress specified.

Disproportionate Share Hospital (DSH) Payment Changes. The ACA required changes to the way in which DSH payments are made to hospitals, beginning in FY 2014. Under the new payment formula, hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool will be adjusted as the percentage of uninsured changes and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

In FY 2018, CMS will increase the amount of the 75-percent pool to reflect adjustments in the percentage of uninsured. Specifically, the agency will increase uncompensated care Medicare DSH payments by about \$800 million in FY 2018 compared to FY 2017. This increase is due to changes in the percentage of uninsured as well as CMS's finalized change to the data source it uses to calculate the uninsured rate from the Congressional Budget Office to its National Health Expenditures Account.

In addition, CMS finalizes its proposal to, in FY 2018, begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments. CMS will continue to use data from a rolling three-year period to estimate uncompensated care costs. Specifically, for FY 2018, CMS will use Worksheet S-10 data on uncompensated care costs from FY 2014 cost reports in combination with inpatient days of Medicaid patients plus inpatient days of Medicare Supplemental Security Income (SSI) patients from the two preceding periods – Medicaid days from FY 2012 and 2013 cost reports and FY 2014 and 2015 SSI ratios – to determine the distribution of uncompensated care payments.

In response to concerns from AHA and the field, CMS indicated that it will continue to work with stakeholders to address issues related to the accuracy and consistency of the S-10 data through provider education and refinement of the instructions for the Worksheet S-10. In addition, CMS indicates that it will attempt to address commenters' concerns in future cost report clarifications to ensure that Worksheet S-10 is an appropriate instrument to collect the information necessary to implement section 3133 of the ACA.

CMS also states that it continues to develop a process for auditing the S-10 data, and such instructions will be provided to the Medicare Administrative Contractors (MACs) as soon as possible and in advance of any audit. In the proposed rule, the agency indicated its expectation that cost reports beginning in FY 2017 would be the first cost reports for which the Worksheet S-10 data will be subject to a desk review. In addition to FY 2017 cost reports, the agency indicates that cost reports for FYs 2014, 2015 and 2016 also will receive further scrutiny. Additionally, CMS will be providing hospitals with an opportunity to resubmit certain Worksheet S-10 data to their MACs by Sept. 30, 2017.

The AHA had urged a one-year delay in the use of the Worksheet S-10 to allow CMS to further educate hospitals about how to accurately and consistently complete it. AHA also urged the agency to implement an audit process and a stop-loss policy to protect hospitals that lose more than 10 percent in any given year as a result of transitioning to the Worksheet S-10. We are disappointed CMS chose to implement the Worksheet S-10 data in FY 2018, and that the agency did not provide these additional protections for hospitals. We will continue to communicate and work with CMS on steps the agency may take to improve the quality of these data.

CAH 96-hour Certification Requirement. As a condition of payment for inpatient services provided at a CAH, the statute requires that a physician certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. In this rule, CMS states that it reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. As a result, the agency states that it will direct Quality Improvement Organizations (QIOs), MACs, the Supplemental Medical Review Contractor (SMRC) and Recovery Audit Contractors (RACs) to make the requirement a low priority for medical record reviews conducted on or after Oct. 1, 2017. **This means that, absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will *not* conduct medical record reviews to determine compliance with the CAH 96-hour certification requirement.**

The AHA commends CMS for recognizing that this condition of payment should not be enforced so that CAHs may continue to provide essential, and often life-saving health care services to rural America. The AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs.

Rural Community Health (RCH) Demonstration Program. The 21st Century Cures Act extended the RCH Demonstration for an additional five years and expanded the program to rural areas in all states. This program, which allows rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement, was

established under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The ACA extended the program an additional five years, increased the maximum number of participating hospitals from 15 to 30, and expanded the eligible sites to rural areas in 20 states with low-population densities. Under law, the ACA limit for the maximum number of participating hospitals – 30 – would remain in place.

Solicitation of New Participants. CMS issued requests for applications in the spring. CMS has not yet finalized the selection of additional participants to participate in the demonstration, and the start dates for the five-year extension period for the additional hospitals will be announced after selections are announced.

Existing Hospitals. CMS proposed to align the periods of performance for both previously participating hospitals and newly selected hospitals during the extension period such that the performance periods for any of the hospitals would start with a hospital's first cost reporting period beginning on or after Oct. 1, 2017 following the announcement of the selection of the additional hospitals. This proposal would have resulted in a gap in the reasonable cost payment methodology paid to RCH demonstration hospitals that previously participated in the program. In the final rule, in response to concerns from the AHA and the hospital field, CMS modified this proposal so that there is no gap – the performance period for previously participating hospitals will begin immediately after the date the period of performance under the first five-year extension period ended. **We are pleased that CMS implemented this alternate proposal, which will allow these hospitals to continue delivering essential health care services to their communities.**

Inpatient Quality Reporting (IQR) Program. For the IQR program, CMS finalizes its proposals to decrease the number of electronic clinical quality measures (eCQMs) and decrease the number of calendar quarters for which hospitals are required to submit data.

For the FY 2019 IQR program, hospitals will report at least four self-selected eCQMs, a decrease from CMS's proposal of six and the FY 2017 inpatient PPS final rule requirement to report eight. CMS also finalizes that hospitals submit one self-selected quarter of eCQM data from calendar year (CY) 2017, a decrease in the CMS proposal to report two self-selected quarters of data and the FY 2017 inpatient PPS final rule requirement to report one full calendar year of data. CMS states the finalized requirements will provide hospitals additional time to plan for data processing, report quality data to CMS, and focus on system upgrades, data mapping and staff training. CMS states they will continue to monitor the progress of hospitals implementing the eCQM reporting requirements and to engage hospitals regarding their experiences as the agency develops future eCQM policy. **The AHA is pleased that CMS reduced its burdensome reporting requirements.**

For the FY 2020 payment determination, CMS also finalizes its proposal to reduce the eCQM reporting requirements. Hospitals will report at least four self-selected eCQMs, a decrease from the CMS proposal to report at least six eCQMs and the FY 2017 inpatient PPS final rule requirement to report eight eCQMs. CMS also finalizes that hospitals submit one self-selected quarter of eCQM data from CY 2018, a decrease from the CMS proposal to report data for Q1, Q2 and Q3 of CY 2018. The FY 2017 inpatient PPS final rule required hospitals to report one calendar year of data. CMS states that having the same reporting requirements for the 2016 through 2018 reporting years provides consistency requested by stakeholders and allow hospitals and their health IT vendors to improve CQM reporting capabilities. **The AHA strongly supports the finalized eCQM CY 2018 reporting requirements.**

CMS will align the electronic eCQM reporting requirements of the Medicare EHR Incentive Program for eligible hospitals and CAHs and the Hospital IQR electronic eCQM requirements for the CY 2017 and CY 2018 reporting periods. CMS also aligns the eCQMs available for eligible professional (EP) reporting in the Medicaid EHR Incentive Program with the eCQMs available for EPs to report if participating in the Merit-based Incentive Payment System. In addition, the agency finalizes a reporting period for EPs in the Medicaid EHR Incentive Program of any continuous 90 days during CY 2017.

Finally, the agency finalizes its proposal to update the pain management questions in the HCAHPS in an effort to reduce the emphasis on using pharmacotherapy – including opiates – to manage pain. The new questions will be implemented with surveys starting Jan. 1, 2018. However, CMS will delay publicly reporting the results by one year (i.e., until October 2020). CMS also adopts a voluntary “hybrid” hospital-wide 30-day readmission measure in which hospitals will submit certain data elements from EHRs to supplement the claims data used to calculate the readmission measure.

Hospital Readmissions Reduction Program (HRRP). The HRRP imposes penalties of up to 3 percent of base inpatient PPS payments for having “excess” readmissions rates for selected conditions when compared to expected rates. For the FY 2019 HRRP, CMS finalizes its proposal to implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act. CMS will place hospitals into one of five peer groups (quintiles) based on their proportion of dual-eligible Medicare fee-for-service (FFS) and Medicare Advantage patients. Hospitals will have their performance compared to others within their quintile. As required by statute, the peer grouping approach will be implemented in a budget-neutral manner.

Value-based Purchasing (VBP) Program. As required by the ACA, CMS will fund the FY 2018 VBP program by reducing base operating diagnosis related group payment amounts to participating hospitals by 2.0 percent. For the FY 2019 VBP program, CMS will remove the current version of the claims-based patient safety indicator (PSI)

composite because it does not have the software to calculate it in ICD-10. The agency will reintroduce a revised version of the PSI composite based on ICD-10 data as part of the FY 2023 VBP program. CMS also will add an episode-based payment measure for pneumonia to the FY 2022 VBP program.

Other Quality Reporting Programs. The final rule also adopts several policy updates for the Inpatient Psychiatric Facility Quality Reporting Program, Hospital Acquired Condition Reduction Program, and PPS-exempt Cancer Hospital Quality Reporting Program.

Medicare and Medicaid EHR Incentive Programs CY 2018 Reporting Period. For CY 2018, CMS finalizes its proposal to revise the EHR reporting period to a minimum of any continuous 90-day period within CY 2018 for new and returning participants attesting to the Medicare or Medicaid EHR Incentive Programs. This is a reduction from the previous requirement of a full-year reporting period. CMS states that the 90-day EHR reporting period will allow eligible hospitals, CAHs and EPs additional time for testing and implementation of the 2015 Edition, including the new application programming interface functionality requirement for stage 3. **The AHA appreciates the finalized 90-day reporting period for CY 2018.**

CMS also finalizes policy to allow health care providers in the Medicare or Medicaid EHR Incentive Programs flexibility in their choice of certified EHR technology for the CY 2018 reporting period. As a result, hospitals, CAHs and EPs can attest to modified stage 2 objectives and measures or they can attest to stage 3 objectives and measures in CY 2018. CMS states that additional flexibility is in response to several stakeholder concerns about the inability to fully implement the 2015 Edition certified HER, including issues related to time constraints, implementation of new functionalities and testing new workflows to support the technology. **The AHA strongly recommended the availability of modified stage 2 reporting in CY 2018. We are pleased that CMS finalized this reporting option and flexibility in the choice of certified technology available for CY 2018 reporting.**

Survey and Certification Requirements. In the proposed rule, CMS had indicated that it planned to require accrediting organizations, such as The Joint Commission and DNV, to publish the results of any triennial, complaint, or other survey they conducted and the hospital or other provider organization's corrective action plans. The accrediting organizations were to publish the surveys and corrective action plans on their websites. The AHA and others objected to this proposal because it likely would interfere with the relationship of trust between the hospital and its accreditor, which is essential to a productive relationship of quality and safety improvement, and because it appeared to

circumvent the law that prohibits CMS from publishing such survey results. In the final rule, CMS withdrew its proposal.¹

NEXT STEPS

The final rule will be published in the Aug. 14 Federal Register and provisions generally take effect Oct. 1. Watch for a more detailed analysis of the proposed rule in the coming weeks.

If you have further questions, contact Priya Bathija, AHA senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.

¹ Please note that the regulatory language appears to still require publication of citations related to Medicare Conditions of Participation, but the AHA has confirmed with CMS that this regulatory language is in error; CMS is withdrawing the proposal in its entirety, and will focus on other means of promoting transparency around quality.