Overview and Resources

On August 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released the final federal fiscal year (FFY) 2018 payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, this final rule includes:

- The adopted rate increase amount (+0.4588%) for the Coding Offset adjustment;
- Expiration of the Medicare Dependent Hospital and expanded Low-Volume Hospital programs at the end of FFY 2017;
- Updates to the program rules for the Value-Based Purchasing (VBP) and Hospital-Acquired Condition (HAC) programs;
- Updates to the payment penalties for non-compliance with the Hospital IQR and Electronic Health Record (EHR) Incentive Programs; and
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies.

Program changes are effective for discharges on or after October 1, 2017 unless otherwise noted.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html.

On August 14, 2017, an online version of the rule will be available at https://www.federalregister.gov/d/2017-16434.

A brief summary of the major hospital provisions of the IPPS final rule is provided below.

IPPS Payment Rates

The table below lists the federal operating and capital rates adopted for FFY 2018 compared to the rates currently in effect for FFY 2017. These rates include all marketbasket increases and reductions as well as the application of an annual budget neutrality factor. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2017</th>
<th>Final FFY 2018</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$5,516.14</td>
<td>$5,574.11</td>
<td>+1.05%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(proposed at $5,596.00)</td>
<td>(proposed at 1.45%)</td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$446.79</td>
<td>$453.97</td>
<td>+1.61%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(proposed at $451.37)</td>
<td>(proposed at 1.03%)</td>
</tr>
</tbody>
</table>
The table below provides details for the adopted annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2018.

<table>
<thead>
<tr>
<th></th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update/Capital Input Price Index</td>
<td>+2.7% (proposed at 2.9%)</td>
<td></td>
<td>+1.3% (proposed at +1.2%)</td>
</tr>
<tr>
<td>ACA-Mandated Reductions</td>
<td></td>
<td>-1.35 PPT</td>
<td>-</td>
</tr>
<tr>
<td>21st Century Cures Act-Mandated Retrospective Documentation and Coding Adjustment</td>
<td>+0.4588%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2-Midnight Rule Temporary Retrospective Adjustment</td>
<td>-0.60%</td>
<td>-</td>
<td>-0.60%</td>
</tr>
<tr>
<td>Annual Budget Neutrality Adjustment</td>
<td>-0.15%</td>
<td>-0.59%</td>
<td>+0.90% (proposed at +0.43%)</td>
</tr>
</tbody>
</table>

- Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs ([FR pages 720-727]): Beginning in FFY 2015, the IQR MB penalty changed from -2.0 percentage points to a 25% reduction to the full MB, and the EHR Meaningful Use (MU) penalty began its phase-in over three years, starting at 25% of the full MB. Beginning FFY 2017, the EHR MU penalty is capped at 75% of the MB; hence the full MB update will be at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2018 is below:

<table>
<thead>
<tr>
<th></th>
<th>Neither Penalty</th>
<th>IQR Penalty</th>
<th>EHR MU Penalty</th>
<th>Both Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.9%)</td>
<td>-</td>
<td>-0.675 PPT</td>
<td>-</td>
<td>-0.675 PPT</td>
</tr>
<tr>
<td>Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.9%)</td>
<td>-</td>
<td>-</td>
<td>-2.025 PPT</td>
<td>-2.025 PPT</td>
</tr>
<tr>
<td>Adjusted Net Rate Update (prior to ATRA and 2-Midnight)</td>
<td>+1.35%</td>
<td>+0.675%</td>
<td>-0.675%</td>
<td>-1.35%</td>
</tr>
</tbody>
</table>

- Retrospective Coding Adjustment ([DISPLAY page 103-105]): CMS will apply a retrospective coding adjustment of +0.4588% to the federal operating rate in FFY 2018. The coding offset rate increase was authorized as part of the American Taxpayer Relief Act of 2012 (ATRA), which required inpatient payments to be reduced by $11 billion (or -9.3%) over a 4-year period. To meet the ATRA recoupment requirement of $11 billion, CMS applied -0.8% coding adjustments in FFYs 2014 through 2016 and a -1.5% adjustment in FFY 2017. Under ATRA, once the full recoupment had been accomplished, the base amount was to be restored.

- 2-Midnight Policy Adjustment ([Display pages 1165-1169]): In the FFY 2014 IPPS final rule, CMS adopted its 2-midnight policy for inpatient admissions and implemented a 0.2% prospective reduction to the IPPS rate to offset a predicted increase in expenditures resulting from this policy. The industry challenged the validity of CMS’ reasoning for the reduction and in Shands Jacksonville Medical Center, Inc. v. Burwell, the Court ordered that the policy be remanded back to the Secretary “to correct certain procedural deficiencies in the promulgation of the 0.2 percent reduction and reconsider the adjustment.” In response to the Court’s decision, CMS will rescind the prospective adjustment - increasing the IPPS rates by 0.2% - and will restore the money previously recouped in FFYs 2014, 2015 and 2016 by applying a single-year increase of 0.6%. For FFY 2018 CMS will end the single-year component of the adjustment by applying a reduction of 0.6% to the IPPS rates.
• **Rebasing and Revision of the Acute Care Hospital Marketbasket** *(DISPLAY pages 649-696):* CMS rebases the IPPS marketbasket every four years by updating the costs and input price indexes used in the calculation. In addition, CMS may revise the marketbasket by changing the data sources for price proxies used in the input price index. The last update to the marketbasket was implemented in FFY 2014 using 2010 data as the base period for the construction of the marketbasket costs.

For FFY 2018, CMS will rebase the hospital marketbasket cost weights using FFY 2014 Medicare cost report data and the 2007 Benchmark Input-Output (I-O) “Use Tables/Before Redefinitions/Purchaser Value” tables published by the Bureau of Economic Analysis (BEA) which are available publicly at [https://www.bea.gov/industry/io_annual.htm](https://www.bea.gov/industry/io_annual.htm). Data taken from the BEA file are derived from the 2007 Economic Census, and will be inflated to 2014 values by CMS. In addition, CMS will revise several of the price proxies using Bureau of Labor Statistics (BLS) data.

As a result, CMS will apply a marketbasket update of 2.7% for FFY 2018 which CMS shows would be the same as if rebasing were not done.

• **Rebasing and Revision of the Capital Input Price Index (CIPI)** *(DISPLAY pages 698-713):* As with the IPPS marketbasket, CMS rebases the CIPI in a similar fashion every four years.

For FFY 2018, CMS will rebase the CIPI cost weights using FFY 2014 Medicare cost report data, BEA, and BLS data.

As a result, CMS will apply a capital update of 1.3% for FFY 2018 which CMS states is 0.1 percentage points less than if rebasing was not done.

**Wage Index** *(DISPLAY pages 527-648)*

For FFY 2018, CMS has finalized several changes that will affect the wage index and wage index-related policies, including:

• **County Code Revisions** *(DISPLAY pages 530-532):* As the Social Security Administration (SSA) county codes are no longer being updated, CMS has adopted its proposal for FFY 2018 to transition to the use of the Federal Information Processing Standard (FIPS) county codes for crosswalking to CBSAs. Coinciding with this, the Census Bureau has made the following updates to the FIPS codes:
  1. Petersburg Borough, AK (FIPS 02195) created from part of former Petersburg Census Area (FIPS 02195) and part of the Hoonah-Angoon Census Area (FIPS 02105).
  2. The name of La Salle Parish, LA (FIPS 22059) is renamed to LaSalle Parish, LA (FIPS 22059).
  3. The name of Shannon County, SD (FIPS 46113) is renamed to Oglala Lakota County, SD (FIPS 46102).

• **Imputed Rural Floor** *(DISPLAY pages 565-582):* The imputed rural floor policy is set to expire on September 30, 2017. CMS stated in the proposed rule that it was not proposing an additional extension to this policy, in part because it disadvantages those states whose urban areas are unaffected by the rural floor due to the budget neutral aspect of the policy. As a result, the imputed rural floor would no longer be considered a factor in the national budget neutrality adjustment. However, due to comments received, CMS has extended the imputed rural floor through September 30, 2018.

• **Submission Deadline for SCH and RRC Classification Status to the MGCRB** *(DISPLAY pages 591-605, 621-625):* CMS is did not finalize the proposal to establish a deadline of the first business day after January 1 for hospitals to submit documentation for SCH or RRC status approvals to the MGCRB. However, CMS did adopt its proposal that, in order for a hospital to qualify for the special rules and exceptions applicable to a SCH or RRC, that hospital must have been approved for RRC or SCH status (regardless of the effective date) on the date of the MGCRB’s review.

CMS clarifies that this would not apply to an RRC seeking an urban-to-rural reclassification, and that RRCs may continue to submit these applications at any time.
Changes to the 45-Day Notification Rule (DISPLAY pages 585-590, 607-616): Currently, hospitals have 45 days from publication of the IPPS proposed rule to notify CMS or the MGCRB of changes regarding reclassification/redesignation and outmigration requests, such as withdrawal or termination of an application. CMS adopted a change that requires written notification to be provided to CMS or the MGCRB (as applicable) within 45 days of the date of public display of the annual IPPS proposed rule for hospitals that wish to withdraw outmigration applications, and for LUGAR hospitals that wish to drop their outmigration adjustment and/or return to a “deemed urban” status. CMS did not adopt this change or wage index reclassifications.

Labor-Related Share (DISPLAY pages 643-648 and 683-696): The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2018, as CMS is rebasing and revising the IPPS market basket from a FFY 2010-baseline to FFY 2014, it will also update the wage index labor share, in a budget neutral manner. CMS will apply a labor-related share of 68.3% for hospitals with a wage index of 1.0 or more. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

Inclusion of Other Wage-Related Costs (DISPLAY pages 541-558): As 80 out of 3,320 hospitals reporting “Other wage-related costs” on Line 18 of Cost Report Worksheet S-3 Part II actually meet the 1% test for inclusion on that line (costs must exceed 1% of the total adjusted salaries net of excluded areas), CMS believes that costs reported on this line might not constitute an appropriate part of wage costs in a labor market area. As a result, CMS is clarifying that in order to be included on Line 18 of Cost Report Worksheet S-3 Part II, a cost must match the IRS’s description of a fringe benefit, and must be reported to the IRS on employees’ or contractors’ W-2 or 1099 forms as taxable income.

CY 2016 Occupational Mix Survey (DISPLAY page 560): CMS states that the FFY 2019 wage index calculation will utilize the CY 2016 Occupational Mix Survey. Hospitals were required to submit their completed 2016 surveys to their MACs by July 3, 2017. The preliminary, unaudited survey data was posted to the CMS website in mid-July 2017 for review and verification. The deadline for corrections to these data is September 1, 2017.

Wage Index Development Timetable for FFY 2019 (DISPLAY pages 625-643): Applications for FFY 2019 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 1, 2017. CMS has adopted its proposal that, beginning with wage index revision requests due to the MACs in April 2018, a hospital seeking to challenge the MAC’s handling of wage data would be required to request (via mail or email) that CMS intervene by the date in April specified as the deadline for hospitals to appeal MAC determinations in cases where the hospital disagrees with the MAC’s determination. CMS will also move forward with its plans to use existing appeal deadlines for hospitals to dispute CMS corrections made after the posting of the January wage index public use file (PUF) that do not arise from a hospital data revision request. Starting with the April 2018 appeal deadline, hospitals would use the earliest available appeal deadline to dispute any adjustments made by CMS unless the hospital were notified of said adjustment within 14 days of an appeal deadline. In such cases, the hospital would have until the following deadline to dispute any adjustments.

A complete list of the final wage indexes for payment in FFY 2018 is available on Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-2-3.zip.

DSH Payments
DISPLAY pages 65-66, 771-901

The ACA mandates the implementation of new Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds, referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is to be distributed to hospitals based on each hospital’s proportion of UCC relative to the total UCC for all DSH-eligible hospitals.
The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2017 to FFY 2018:

1. Project list of DSH-eligible hospitals (15% DSH percentage or more) and project total DSH payments for the nation using traditional per-discharge formula
   - $15.553 B (FFY 2018); [$14.397 B (FFY 2017); $13.411 B (FFY 2016)]
   - Includes adjustments for inflation, utilization, and case mix changes

2. Continue to pay 25% at traditional DSH value
   - $3.888 B (FFY 2018); [$3.599 B (FFY 2017); $3.353 B (FFY 2016)]
   - Paid on per-discharge basis as an add-on factor to the federal amount

3a. FACTOR 1: Calculate 75% of total projected DSH payments to fund UCC pool
   - $11.665 B (FFY 2018); [$10.797 B (FFY 2017); $10.058 B (FFY 2016)]

3b. FACTOR 2: Adjust Factor 1 to reflect impact of ACA insurance expansion
   - Based on latest CBO projections of insurance expansion
   - 41.99% reduction (FFY 2018); 44.64% (FFY 2017); 36.3% (FFY 2016)
   - $6.767 B to be distributed.

3c. FACTOR 3: Distribute UCC payments based on hospital’s ratio of UCC relative to the total UCC for DSH-eligible hospitals
   \[ \text{UCC Factor} = \frac{\text{Low Income Patient Days}_{\text{ds}, \text{hospital}}}{\text{Low Income Patient Days}_{\text{ds}, \text{hospital}}} + \frac{\text{Low Income Patient Days}_{\text{sis}, \text{hospital}}}{\text{Low Income Patient Days}_{\text{sis}, \text{hospital}}} + \frac{\text{Uncompensated Care}_{\text{ds}, \text{hospital}}}{\text{Uncompensated Care}_{\text{ds}, \text{hospital}}} + \frac{\text{Uncompensated Care}_{\text{sis}, \text{hospital}}}{\text{Uncompensated Care}_{\text{sis}, \text{hospital}}} \]
   - Based on averaged 2012 and 2013 Cost Report Medicaid data; 2014 and 2015 SSI ratios; and 2014 Cost Report Uncompensated Care data
   - Paid on per-discharge basis as an add-on factor to the federal amount

4. Determine actual DSH eligibility at cost report settlement
   - No update to national UCC pool amount or hospital-specific UCC factors (unless merger occurs)
   - Recoup both 25% traditional DSH payment and UCC payment if determined to be ineligible at settlement
   - Pay both 25% traditional DSH payment and UCC payment determined to be DSH-eligible at settlement, but not prior

The DSH dollars available to hospitals under the ACA’s payment formula will increase in FFY 2018 due to a change in the data source used by CMS for determination of the reduction factor.

Eligibility for FFY 2018 DSH Payments (DISPLAY pages 777-782): CMS is projecting that 2,427 hospitals will be eligible for DSH payments in FFY 2018. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2018. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-18.zip.

According to the tables provided in this final rule, 91 hospitals that were not eligible for DSH in FFY 2017 are projected to receive DSH payments in FFY 2018; while 69 are projected to lose eligibility due to changes in their Medicare and Medicaid days, or likelihood of being paid at their hospital-specific rate.

Adjustment to Factor 2 Determination (DISPLAY pages 803-815): For FFYs 2014-2017, CMS used the ratio of “Insured Share of the Nonelderly Population Including All Residents,” as reported by the CBO in March of each year, in calculation of Factor 2, the amount by which the UCC pool is reduced each year. For FFY 2018, CMS will change its source to the uninsured estimates produced by CMS’ Office of the Actuary (OACT) as part of the
development of the National Health Expenditure Accounts (NHEA), which is used to estimate national levels of healthcare spending.

- **Adjustment to Factor 3 Determination (DISPLAY pages 815-901):** CMS has been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014, due to concerns regarding data variability and lack of reporting experience with Worksheet S-10. However, CMS has again stated in that it has been seeing an improving correlation between Factor 3 values calculated using data on uncompensated care from Worksheet S-10 and those calculated using data from the IRS Form 990. CMS will phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the UCC payment factor (Factor 3), starting with FFY 2014 cost reports for DSH payments in FFY 2018.

The Worksheet S-10 data will be phased-in as part of the three year averaging process for Factor 3; i.e. an average of 2 years of proxy data (2012 and 2013 Medicaid days, 2014 and 2015 Medicare SSI days) and 1 year of S-10 data (2014) for FFY 2018 DSH payments. Due to reporting requirements, CMS will not be utilizing Worksheet S-10 for the calculation of Factor 3 for Puerto Rico, IHS/Tribal, or all-inclusive rate hospitals. Instead, Factor 3s for these providers will be calculated by applying a double-weight to the FFY 2013 data due to the effects of Medicaid expansion on data reported for FFY 2014.

CMS had stated in the proposed rule that if, in the future, they were to propose to continue this transition using a similar methodology for FFYs 2019 and 2020, the data used would be 1 year of proxy data (2013 Medicaid days, 2015 Medicare SSI days) and 2 years of S-10 data (2014, 2015) for FFY 2019 DSH payments, and 3 years of S-10 data for FFY 2020 DSH payments and thereafter. In the final rule, CMS states that as it gradually incorporates cost report data, they will be leaving the door open for the future inclusion of proxies based on blends of Worksheet S-10 data, low-income insured days, or other sources.

In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS has adopted a trimming methodology targeting the cost to charge ratio (CCR). The adopted methodology may be found on pages 888-891 of the display copy of the final rule. In addition to the trimming methodology, in cases where the ratio of uncompensated care costs relative to total operating costs exceeds 50% for a hospital’s 2014 cost report, the ratio will instead be determined utilizing that hospital’s 2015 cost report and then applied to the 2014 operating costs before determining Factor 3 for FFY 2018.

Additionally, CMS will annualize cost report data used in the calculation of Factor 3 so as to not unfairly penalize short-period filers, nor award those with cost reports spanning a period of longer than 12 months. Finally, when calculating the 3-year average factor 3 values, CMS is adopting its proposal to add a scaling factor to account for national UCC distributions of other than 100% of the pool amount resulting from hospitals with one or more years excluded from their 3-year average.

CMS also stated that, contrary to the proposed rule, it will work with stakeholders through provider education and further refinement of the instructions regarding completion of Worksheet S-10. Finally, CMS is developing audit protocols for Worksheet S-10 data for use in future rulemaking as the S-10 data will be subject to a desk review beginning with FFY 2017 cost reports. For the FFYs 2014 and 2015 cost reports, amended S-10s can be submitted to the MAC by September 30, 2017 for use in FFY 2019 distributions.

**GME Payments**

*DISPLAY page 770-771*

CMS did not adopt any major changes to the direct GME payment policies for FFY 2018. The Indirect Medical Education (IME) adjustment factor will remain at 1.35 for FFY 2018.

**Updates to the MS-DRGs**

*DISPLAY pages 105-526*

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes finalized for the
FFY 2018 MS-DRGs will decrease the number of payable DRGs from 757 to 754. Sixty-eight percent of DRG weights will change by less than +/- 5%. Of those MS-DRGs with weights changing by more than this, the top five are:

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>FFY 2017 Weight</th>
<th>FFY 2018 Weight</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS-DRG 950: Aftercare w/o CC/MCC</td>
<td>0.5660</td>
<td>0.8045</td>
<td>+42.14%</td>
</tr>
<tr>
<td>MS-DRG 080: Nontraumatic Stupor &amp; Coma w/ MCC</td>
<td>1.2566</td>
<td>1.7369</td>
<td>+38.22%</td>
</tr>
<tr>
<td>MS-DRG 782: Other Antepartum Diagnoses w/o Medical Complications</td>
<td>0.4711</td>
<td>0.6116</td>
<td>+29.82%</td>
</tr>
<tr>
<td>MS-DRG 941: O.R. Proc w/ Diagnoses of Other Contact w/ Health Services w/o CC/MCC</td>
<td>1.4341</td>
<td>1.8577</td>
<td>+29.54%</td>
</tr>
<tr>
<td>MS-DRG 886: Behavioral &amp; Developmental Disorders</td>
<td>0.8339</td>
<td>1.0674</td>
<td>+28.00%</td>
</tr>
</tbody>
</table>

Of particular note, in response to several recommendations regarding the inclusion of Total Ankle Replacement (TAR) procedures in MS-DRGs 469 and 470, CMS will move the following ICD-10-PCS TAR procedure codes from MS-DRG 470 to the more intensive MS-DRG 469, even if no MCC is reported:

- 0SRF0J9: Replacement of Right Ankle Joint with Synthetic Substitute, Cemented, Open Approach;
- 0SRF0JA: Replacement of Right Ankle Joint with Synthetic Substitute, Uncemented, Open Approach;
- 0SRF0IZ: Replacement of Right Ankle Joint with Synthetic Substitute, Open Approach;
- 0SRG0J9: Replacement of Left Ankle Joint with Synthetic Substitute, Cemented, Open Approach;
- 0SRG0JA: Replacement of Left Ankle Joint with Synthetic Substitute, Uncemented, Open Approach; and
- 0SRG0IZ: Replacement of Left Ankle Joint with Synthetic Substitute, Open Approach.

The full list of adopted FFY 2018 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-5.zip](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-5.zip).

For comparison purposes, the FFY 2017 DRGs are available in Table 5 on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-5.zip](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-5.zip).

**New Technology**

*DISPLAY pages 419-526*

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. In this final rule, CMS:

- discontinued add-on payments for five medical services/technologies;
- continued new technology add-on payments for four technologies; and
- implemented add-on payments for four technologies.

**Changes to the MS-DRG Postacute Care Transfer and Special Payment Policies**

*DISPLAY pages 714-720*

When a patient is transferred from an acute care facility to a post-acute care setting, the transferring hospital receives a per diem payment, with a total payment capped at the full MS-DRG amount. For MS-DRGs subject to the post-acute care transfer policy that CMS deems to be high cost, CMS applies a special payment methodology so that the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with total payment capped at the full MS-DRG amount. Each year CMS, using established criteria, reviews the lists of MS-DRGs subject to the post-acute care transfer policy and special payment policy status.

Effective FFY 2018, CMS will add three MS-DRGs to the list of those subject to the special payment transfer policy:

- MS-DRG 987: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC
- MS-DRG 988: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC
- MS-DRG 989: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis without MCC/CC
Outlier Payments  
*DISPLAY pages 2162-2189*

To maintain outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of $26,601 for FFY 2018. The adopted threshold is 12.86% higher than the current (FFY 2017) outlier threshold of $23,570.

Expiration of the More Inclusive Low-Volume Adjustment Criteria  
*DISPLAY pages 751-770*

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. MACRA had extended the relaxed low volume adjustment criteria (15-mile/ <1,600 discharges) for an additional 30 months, through the end of FFY 2017. However, as no further legislation has been put into place, beginning October 1, 2017 the criteria for the low-volume hospital adjustment will return to the more restrictive pre-ACA levels. In order to receive a low-volume adjustment, subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status, including for those currently assigned low-volume status, its MAC must receive a written request by September 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for the 25% add-on beginning the October 1 that immediately follows the request. This written request must include supporting documentation that the hospital meets the updated mileage and discharge criteria. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Additionally, CMS is adopting its proposal to adjust the mileage criterion with regards to Indian Health Services (IHS) and Tribal hospitals. Specifically, the mileage criterion would be relaxed such that IHS/Tribal hospitals and non-IHS/Tribal hospitals do not affect the proximity requirement of low-volume eligibility for hospitals belonging to the other group.

Medicare Dependent Hospitals (MDH)  
*DISPLAY pages 901-906*

The Medicare-Dependent Hospital (MDH) program has been extended several times by Congressional legislative action. Most recently, MACRA extended this program by an additional 30 months, through the end of FFY 2017.

Absent legislation, beginning October 1, 2017, the MDH program will expire, and hospitals that qualified for the MDH program in prior years would be paid based on the IPPS Federal rate. Hospitals that will lose MDH status that intend to apply for SCH status for FFY 2018 must do so by September 1, 2017, and must also request that, if approved, SCH status would be effective with the expiration of the MDH program. Hospitals that do not meet this deadline will have an effective date, if approved, for SCH classification beginning 30 days after the date of CMS’ written notification of approval.

Volume Decrease Adjustment for SCHs and MDHs  
*DISPLAY pages 729-745*

Payments made to SCHs and MDHs (if the MDH program is extended) are adjusted as necessary to fully compensate the hospital for the fixed costs incurred in providing inpatient services when it experiences a decrease in inpatient discharges of more than 5% due to circumstances beyond its control.

Beginning FFY 2018, in order to ensure that hospitals qualifying for a volume decrease adjustment are fully compensated for fixed costs, CMS will prospectively estimate the fixed portion of a hospital’s Medicare revenue by applying the ratio of the hospital’s fixed costs to total costs to the hospital’s total Medicare revenue for a given
cost report period. As this calculation would never exceed the difference between a hospital’s inpatient operating costs and total DRG revenue, CMS will also eliminate the volume decrease adjustment cap for FFYs 2018 and future years.

In addition, as it is to be expected that a hospital would adjust their staff totals if revenue were to decrease, CMS is modifying the volume decrease process to no longer require that a hospital demonstrate that it adjusted the number of staff in inpatient areas based on the decrease in number of inpatient days, and will no longer require MACs to adjust the volume decrease adjustment payment amount for excess staffing.

**RRC Status**
*DISPLAY pages 745-751*

Hospitals that meet certain case-mix and discharge criteria may be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and special treatment with respect to geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The finalized FFY 2018 minimum case-mix and discharge values are available on the pages listed above.

**Indian Health Services and Tribal Facilities**
*DISPLAY pages 1169-1175*

In the April 7, 2000 OPPS final rule, so as to not jeopardize the Medicare participation of IHS and Tribal facilities providing outpatient services, CMS adopted a policy under which IHS or Tribal facilities would be considered as “Departments of hospitals operated by the IHS or Tribes,” and thus grandfathered from application of the provider-based rules, if they furnished only services that were billed as if they had been furnished by a department of an IHS or Tribal hospital on or before April 7, 2000 and that they are:

1) Owned and operated by the IHS;
2) Owned by the Tribe, but leased from the Tribe by the IHS under the Indian Self-Determination and Education Assistance Act; or
3) Owned by the IHS but leased and operated by the Tribe under the Indian Self-Determination and Education Assistance Act.

CMS states that as IHS policies and procedures regarding the planning, operation, and funding of such facilities are resulting in appropriate payments, it will remove the date limitation that restricts the grandfathering provision to IHS or Tribal facilities furnishing services on or prior to April 7, 2000. In addition, CMS will make a technical change to the billing reference by replacing “were billed” with “are billed using the CCN of the main provider and with the consent of the main provider.”

**Changes to Instructions for the Review of the CAH 96-Hour Certification Requirement**
*DISPLAY pages 1202-1211*

In an effort to reduce burden on providers, CMS is providing notice that will direct Quality Improvement Organizations, Medicare Administrative Contractors and the Supplemental Medicare Review Contractor, and Recovery Audit Contracts to make the CAH 96-hour physician certification requirement that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to a CAH a low priority for medical record reviews conducted on or after October 1, 2017.

**Rural Community Hospital Demonstration Program**
*DISPLAY pages 1125-1165*

Originally enacted by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the Rural Community Hospital Demonstration has been extended multiple times, most recently by the 21st Century Cures Act for an additional five years, beginning December 13, 2016. This demonstration pays rural community hospitals...
under a reasonable cost-based methodology for covered inpatient services furnished to Medicare beneficiaries; this payment methodology is budget neutral within the IPPS. A maximum of 30 hospitals are allowed to participate in the program, in addition to being located in one of the 20 states with the lowest population density these facilities must:

- Be located in a rural area, or in an area treated as rural by its State;
- have fewer than 51 beds as reported in its most recent cost report (excludes distinct psychiatric and rehabilitation units);
- provide 24-hour emergency care services; and
- not be designated as, or eligible for CAH status.

The extension of the program implemented by the 21st Century Cures Act did not account for the potential gap between the end of each hospital’s participation in the first five-year extension period (implemented by the ACA), and the enactment of the new five-year extension on December 13, 2016. CMS adopted an approach that each previously participating hospital that chooses to continue with the demo would begin the second five years on the date immediately after the date that the previous performance period ended.

CMS has not yet finalized the selection of additional participants in the demonstration.

### Quality-Based Payment Adjustments

**DISPLAY pages 907 -1124**

For FFY 2018, IPPS payments to hospitals will be adjusted for quality performance under the Value Based Purchasing (VBP) Program, Readmissions Reduction Program (RRP), and the Hospital-Acquired Conditions (HAC) Reduction Program. Detail on the FFY 2018 programs and payment adjustment factors are below (future program year program changes are addressed at the end of this Brief):

- **VBP Adjustment (DISPLAY pages 980 - 1091):** The FFY 2018 program will include hospital quality data for 19 measures in 4 domains: safety of care; clinical care; patient experience of care; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2018 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.9 billion). Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0% reduction.

  While the data applicable to the FFY 2018 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the current year’s (FFY 2017) program. Hospitals should use caution in reviewing these factors as they do not reflect performance on new measures for FFY 2018, changes to domain weights, updated performance periods/standards, nor changes to hospital eligibility.

  The proxy factors published with the final rule are available in Table 16A on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-16A.zip.

  Effective with the FFY 2018 VBP program, CMS will remove the pain management measure from the patient experience domain.

  CMS anticipates making actual FFY 2018 VBP adjustment factors available in October 2017. Details and information on the program currently in place for FFY 2017 and FFY 2018 program are available on CMS’ QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

- **Readmissions Reduction Program (RRP) (DISPLAY pages 907 - 979):** The FFY 2018 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) (expanded in FFY 2017 to include diagnoses of sepsis with a secondary diagnosis of pneumonia, and aspiration pneumonia), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.
The final FFY 2018 RRP factors are published with the final rule in Table 15 and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-CMS-1677-FR-Table-15.zip.

Details and information on the RRP currently are available on CMS’ QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.

HAC Reduction Program (DISPLAY pages 1092 - 1124): The FFY 2018 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. CMS has stated that it expects to release the list of hospitals subject to the HAC penalty for FFY 2018 in October 2017.

For FFY 2018, CMS previously adopted a continuous program z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS’ QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166.

Quality-Based Payment Policies—FFYs 2019 and Beyond

For FFYs 2019 and beyond, CMS is finalizing new policies and measures for its quality-based payment programs as follows:

- VBP Program—FFYs 2019 through 2023 (DISPLAY pages 980 - 1091): CMS has already adopted VBP program rules through FFY 2019 and some program policies and rules beyond FFY 2019. CMS is adopting further program updates for FFYs 2019-2023, which include:
  - Removing the PSI-90 measure beginning with the FFY 2019 program year;
  - New data collection time periods (baseline/performance periods) for the FFY 2019-2023 program years;
  - National performance standards for a subset of the FFY 2020-FFY 2023 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking);
  - Addition of Hospital-Level Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment) measure for the FFY 2022 program year;
  - Addition of modified PSI-90 measure: Patient Safety and Adverse Events (Composite) for the FFY 2023 program year;
  - Changing the minimum number of measure scores a hospital must receive in order to be eligible for the Safety of Care domain from three measures to two measures and addition that a hospital must receive a minimum of one measure within the Efficiency and Cost Reduction domain;
  - New minimum case count criteria for new measures.

Beginning in FFY 2021, with the additional of new measures for the Efficiency and Cost Reduction domain, the Medicare Spending per Beneficiary (MSPB) measure will be weighted at 50% of the Efficiency and Cost Reduction domain, leaving 50% of the domain weight to the other measures.
Details and tables on the adopted measures, collection time periods, performance standards, and measure weighting are available on the pages listed above.

- **Readmissions Reduction Program (DISPLAY pages 907 -979):** The 21st Century Cures Act requires the development of a transitional methodology for the program that accounts for the percentage of full-benefit dual eligible patients treated by a hospital, as a proxy for social risk factors, to determine a hospital’s payment adjustment factor beginning in FFY 2019. In order to do this, hospitals will be assigned into peer groups (quintiles) and compared separately within these groups. The adjustment to the methodology must be budget neutral.

CMS will identify full-benefit dual eligible patients using the State Medicare Modernization Act (MMA) file of dual eligibility and will group hospitals based on the ratio of full-benefit dual eligible patients and total Medicare patients into quintiles. CMS will define the total number of Medicare patients, using MedPar data, as all Medicare FFS and Medicare Advantage stays and will identify full-dual eligible patients during the same 3-year period as the program performance period (July 1, 2013- June 30, 2016 for FFY 2019).

CMS will then compare hospitals to those within their quintile by replacing the comparison “1” in the payment adjustment formula with the median excess readmission ratio for the hospital’s peer group. CMS will calculate a budget neutral program by applying a uniform modifier to maintain budget neutrality. The calculation of impacts for FFY 2019 is as below:

\[
\text{Excess Readmission Ratio (ERR) (by condition)} = \frac{\text{Predicted Readmission Rate}}{\text{Expected Readmission Rate}}
\]

\[
\text{Total Excess Readmission Revenue} = \sum \left(\text{ERR (by condition)} - \text{Peer Group Median ERR (by condition)}\right) \times \text{Condition Specific Base Operating Revenue}
\]

\[
\text{RRP Adjustment Factor} = [1 - \text{Budget Neutrality Modifier} \times \left(\frac{\text{Total Excess Readmission Revenue}}{\text{Total Inpatient Operating Revenue}}\right)]
\]

\[
\text{Annual Program Impact} = [\text{IPPS Base Operating Dollars} \times \text{RRP Adjustment Factor} - \text{IPPS Base Operating Dollars}]
\]

CMS also adopted extraordinary circumstance policy updates.

**HAC Reduction Program–FFY 2020 (DISPLAY pages 1092 - 1124):** CMS has already adopted program specifications through FFY 2019. CMS adopted specifications for the FFY 2020 program such as time periods used to calculate performance scores. CMS also listed measures that they are considering proposing in the future for the CDC program. In addition, CMS solicited comments on inclusion of disability and medical complexity for CDC measures. A discussion on these comments can be found on DISPLAY pages 1118 – 1119. Lastly, CMS adopted extraordinary circumstance policy updates.

CMS also reviewed how to account for social risk factors in all three programs. A discussion of the comments received for each program can be found on the following DISPLAY pages:

- **Value Based Purchasing:** pages 988 - 990
- **Readmissions Reduction Program:** pages 971 - 975
- **Hospital Acquired Condition Reduction Program:** pages 1112 - 1116

**Updates to the IQR Program and Electronic Reporting Under the Program (DISPLAY pages 1320 - 1677)**

CMS is adopting one new voluntary measure for the CY 2018 reporting period. CMS is also refining one previously adopted measure for the Hospital IQR program beginning in FFY 2020 and one previously adopted measure beginning in FFY 2023. Public display of hospital performance data for the FFY 2020 measure refinement will be delayed a year until FFY 2020, rather than the proposed FFY 2019.
CMS is also adopting two changes to the electronic clinical quality measures (eCQMs) with modifications from what was proposed. For the calendar year (CY) 2017 reporting period/FFY 2019 payment determination, CMS is decreasing the number of eCQMs for which hospitals must report data on from 8 to 4 (proposed at 6) and decreasing the length of submission from a full calendar year to one (proposed at two) self-selected calendar quarter of CY 2017 data. For CY 2018 reporting period/FFY 2020 payment determination, CMS is finalizing the same requirements as the CY 2017 reporting period, as opposed to the proposed 6 eCQM submissions with the submission of the first three calendar quarters of CY 2018 data.

CMS is also solicited comment on potential options to adjust for social factors in the IQR program. A discussion of these comments can be found on DISPLAY pages 1328 – 1333.

A table on DISPLAY pages 1416-1421 of the final rule outlines the previously adopted Hospital IQR Program measure set with adopted refinements to measures for the FFY 2020 payment determination and subsequent years.

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