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2018 Final Inpatient Prospective Payment System (IPPS) Rule Focused on Quality

by Steve Kowske

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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The Centers for Medicare and Medicaid Services (CMS) has released the final 2018 inpatient prospective payment system (IPPS) rule, which covers acute care hospitals, psychiatric hospitals and units, cancer hospitals, critical access hospitals (CAH), certain rural hospitals, and long-term care hospitals (LTCH). The rule is effective for discharges on or after October 1, 2017.

With this rule, CMS estimates that payments will increase by 1.3 percent overall, which is equivalent to $2.4 billion for IPPS hospitals. CMS continues to focus on quality reporting, reducing readmissions, hospital-acquired conditions, and increasing payments for disproportionate share hospitals (DSH) that still experience high uncompensated care costs. Uncompensated care payments will increase by $789 million to $6.766 billion.

Operating rate increase

The final rule will result in a net increase to IPPS hospitals' rates of 1.2 percent. This includes the following:

- 2.7 percent inflationary increase
- -0.6 percent productivity increase
- -0.75 percent decrease mandated by the Affordable Care Act
- -0.6 percent decrease to account for the sunsetting of the two-midnight adjustment
- 0.4588 percent increase required by the 21st Century Cures Act

Should a provider not submit quality data and meaningful use data, they will receive a 1.2 percent decrease in their update to the IPPS rate.

Capital rate increase

Capital rates will increase by 1.3 percent. Standardized rates are as follows:

Standarized Rates (Wage Index Greater Than One; 68.3 Percent Labor Share)							
Hospital Submitted Quality Data and Is Meaningful EHR User		Hospital Submitted Quality Data and Is NOT Meaningful EHR User		Hospital did NOT Submit Quality Data and Is a Meaningful EHR User		Hospital did NOT Submit Quality Data and Is NOT a Meaningful EHR User	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3807.12	$1766.99	$3731.05	$1731.69	$3781.76	$1755.22	$3705.7	$1719.92

Standarized Rates (Wage Index Less Than/Equal to One; 62 Percent Labor Share)							
Hospital Submitted Quality Data and Is Meaningful EHR User		Hospital Submitted Quality Data and Is NOT Meaningful EHR User		Hospital did NOT Submit Quality Data and Is a Meaningful EHR User		Hospital did NOT Submit Quality Data and Is NOT a Meaningful EHR User	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3455.95	$2118.16	$3386.90	$2075.84	$3432.93	$2104.05	$3363.88	$2061.74

It is estimated that payments will increase by 1.3 percent overall, which is equivalent to $2.4 billion in additional payments to IPPS hospitals. The national capital standard rate will be $453.97.

Outlier threshold

An additional payment takes effect when the cost of a case exceeds the payment by more than $26,600 (which includes indirect medical education [IME], DSH, uncompensated care payments, and add-on payments for new technology, but excludes value-based purchasing [VBP] or readmission adjustments). Medicare will make an extra payment equal to 80 percent of the difference between the total cost of the case and the outlier threshold. The outlier threshold in 2017 was $23,573.

Disproportionate share payments

Due to the Affordable Care Act, CMS was mandated to change the way DSH payments are made to eligible hospitals. DSH payments were previously reduced by 75 percent, and 58 percent of that reduction will be returned to DSH hospitals in 2018. This will be based upon the amount of uncompensated care each individual hospital declares on Worksheet S-10 of the Medicare Cost Report, as a percentage of uncompensated care calculated from the cost reports for all DSH hospitals.

Prior to 2018, these payments were given back to hospitals based upon Medicaid patient days as a percent of total DSH eligible patient days. This put states that chose to expand Medicaid via the Affordable Care Act at an advantage for the uncompensated care payments compared to states who chose not to expand Medicaid. Due to the overall increase in the number of uninsured and Medicaid/supplemental security income (SSI) patient days, the uncompensated care payments that will be returned to hospitals increased by $789 Million to $6.766 Billion. The 58 percent add-back factor increased from 55.36 percent in 2017 due to this increase in Medicaid/SSI patient days.

Wage index

In 2018, the wage index has been adjusted to account for the difference between average wages in each Metropolitan Statistical Area in urban and rural areas. In 222 urban areas and 23 rural areas wage indexes increased. In 184 urban areas and 24 rural areas wage indexes decreased.

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Frontier states

States that have at least 50 percent of counties with a population density of six residents per square mile or less are considered frontier states. Certain counties in these frontier states may be eligible for a wage index of one:

- Montana
- Wyoming
- Nevada
- North Dakota
- South Dakota

Counties in these states eligible for the wage index of one must have a high percentage of nurses working outside of the counties they reside in. Hospitals in these counties will be eligible for the higher wage index. This provision is not budget neutral and costs Medicare an additional $65 million.

Readmission penalty

Hospitals are penalized if their readmissions are more than what their average readmissions have been in previous years. For 2018, it is estimated that 2,577 hospitals will be affected by this penalty, costing them $556 million.

Beginning in 2019, CMS will adjust the penalty for excess readmissions based on the hospital's socioeconomic status, as mandated by the 21st Century Cures Act. Hospitals will be grouped with peers with similar proportions of dual eligible patients (those that qualify for both Medicare/Medicaid). This ensures that hospitals will not be disadvantaged by having a high Medicaid patient load, which could lead higher readmissions. The readmission penalty reductions apply to the following conditions:

- Acute myocardial infarctions (AMI)
- Heart failure (HF)
- Pneumonia
- Total hip or knee replacement (THA or TKA)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery bypass graft (CABG)

The penalty range (from zero to negative 3 percent) for Medicare-fee-for-service inpatient payments depends on how many readmissions the hospital has for their Medicare fee-for-service patients, 65 and older, compared to their three-year average.

The all-cause, hospital-wide readmission measure being implemented in 2018 will include only patients enrolled in Medicare Part A, 65 and older, and will exclude patients with a psychiatric diagnosis.

Hospital-acquired conditions (HAC) penalty

Hospitals whose performance places them in the lowest quartile for patients acquiring certain conditions relative to the national average will have 1 percent of their base Medicare payments reduced. CMS is also considering how to incorporate socioeconomic factors in determining whether a hospital should have the reduction applied. For 2018, it is estimated 3,233 hospitals will have the reduction applied to their payments. CMS did not provide an estimate on the effect of this reduction.

Value-based purchasing (VBP) program

The 2,955 hospitals participating in the VBP program will have a 2 percent reduction applied to their base diagnosis-related group (DRG) payments for 2018 to support this budget neutral program. These participating hospitals will be required to report on 19 measures. The pool of money available to be redistributed is $1.9 billion. CMS indicates that more hospitals will receive an increase in their base DRG payments (a return of the two percent withheld plus incentive payments) based on their outcomes than those facing a decrease (that will not receive the full two percent withheld). High DSH hospitals do not receive their 2 percent back.

CMS is also considering altering the scoring on these measures due to socioeconomic factors and is seeking comments on how to implement changes into this program.

Beginning in 2019, CMS is proposing to remove the eight Patient Safety and Adverse Events Composite (PSI 90) measures from the patient safety domain. CMS will replace this measure with a 10-measure composite patient safety and adverse events measure, but not until 2023. In 2022, CMS is also proposing to add one measure to their efficiency and cost domain: a hospital level risk standardized payment associated with a 30-day episode of care for pneumonia.

Hospital inpatient quality reporting program

Hospitals must report to the quality reporting program or have a 2 percent reduction applied to their inpatient inflationary update. Starting in 2020, CMS will be changing the pain management portion of the Hospital Consumer

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Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey will now focus on pain management while in the hospital, rather than the overall pain the patient is presently experiencing. In 2017, CMS had proposed to remove 15 measures in FY 2019 due to those measures having no room for improvement. This did not change in the 2018 rule.

From 62 measures, providers choose to report on six (down from eight), and they must report for two selected quarters (down from reporting on the full fiscal year). The measures hospitals report on in 2018 and, their improvement in those measures, will affect their 2019 payment.

Electronic health records (EHR) incentive program

Providers participating in the EHR incentive payments program will have their data reporting requirements reduced from a full year to any continuous 90-day period. Due to the time and expense it takes to convert to a newer version of the EHR program, providers have the option of reporting via the 2014 or 2015 reporting version. Eligible hospitals and CAHs must report on 4 of the 16 available clinical quality measures. CMS indicated that 103 hospitals are not meaningful EHR users, meaning that they chose not to be in the program or failed the data submission process.

Eligible practitioners (EPs) who perform at least 75 percent of their services in an ambulatory surgery center (ASC) are exempt from the reporting requirements for the EHR program.

Critical access hospitals

Critical access hospitals are currently expected to abide by the requirement that overall patient length of stay cannot exceed 96 hours before the patient must be transferred. In 2018, this requirement will have a low priority for compliance by Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), supplemental Medical Review Contractors (SMRC), and Recovery Audit Contractors (RACs). Contractors will not conduct medical reviews for the 96-hour requirement for CAH certification unless there are concerns of fraud, waste, or abuse.

Long-term care hospitals

As mandated by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), LTCHs will be limited to a 1 percent increase in payment for FY 2018. LTCHs are paid under the same DRGs as acute care hospitals, adjusted for case mix and standardized amount. The wage index affects 66.2 percent of the payment. The standardized amount for FY 2018 is $41,430.56. When the cost of the case exceeds the payment by more than $27,382, an outlier payment will be made in which Medicare will pay 80 percent of the difference between the threshold and the cost of the case. The cost of the case is established from the cost to charge ratio (from the cost report) multiplied by billed charges.

Beginning in 2018, CMS is implementing a moratorium on the current rule for hospitals that receive 25 percent or more of their referrals from the same hospital.

Long-term care hospital quality reporting requirements

LTCHs are subject to the same quality reporting requirements as other care facilities starting in 2020. If an LTCH does not report, they are subject to a 2 percent reduction to their annual update to the federal rate. LTCHs must report on 17 measures quarterly. Providers are concerned that socioeconomic factors may distort their reporting results, which are made publicly available. CMS is evaluating how to adjust the results due to these factors.

Electronic cost report signature

CMS finalized their proposal to allow an electronic signature on the certification statement that contains the first and last name of the provider’s administrator or chief financial officer. The signature may be an electronic stamp of the signing official’s signature or a typed signature. An electronic signature checkbox on the certification page must be checked if an electronic signature is used. The electronically signed certification page may now also be submitted electronically with the cost report.

How we can help

Clearly, the 2018 IPPS regulations and changes are complex, and are both difficult to understand and implement. CliftonLarsonAllen professionals have served in many health care field from medical records to finance. We can help you understand the impact of these regulations and guide you as you implement any necessary changes.

Author

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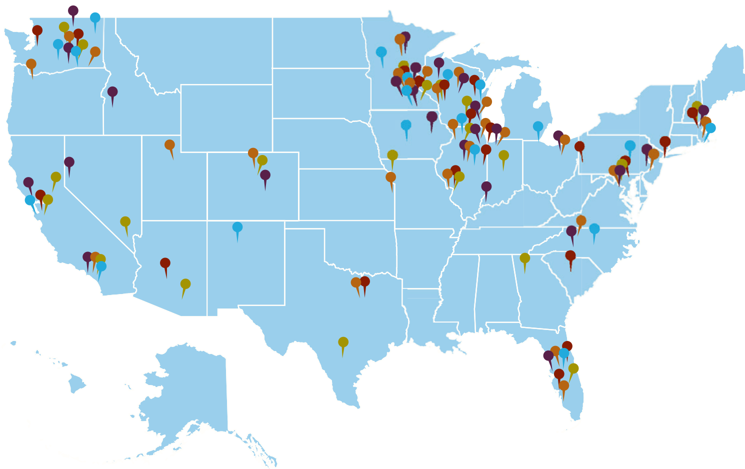

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