Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1677-F)

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On August 1, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare payment and polices when patients are discharged from hospitals from October 1, 2017, to September 30, 2018. The final rule relieves regulatory burdens for providers; supports the patient-doctor relationship in healthcare; and promotes transparency, flexibility, and innovation in the delivery of care.

This fact sheet discusses major payment and policy provisions of the final rule, including the changes to termination notices for certain providers and the extension of the Rural Community Hospital Demonstration. The final rule (CMS-1677-F) can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection.

Changes and Updates in the FY 2018 Medicare Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Policies

Background on the IPPS and LTCH PPS
CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS sets base payment rates prospectively for inpatient stays based on the patient's characteristics, including diagnosis and severity of illness. A hospital receives a single payment for the case based on the payment classification – Medicare Severity Diagnosis-Related Groups (MS-DRGs) under the IPPS and Medicare Severity Long-Term Care Diagnosis-Related Groups (MS-LTC-DRGs) under the LTCH PPS – assigned at discharge.

By law, CMS is required to update payment rates for IPPS hospitals annually and to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital "market basket." The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and

the cost of hospital labor in the hospital's geographic area. Payment rates to LTCHs are typically updated annually according to a separate market basket based on LTCH-specific goods and services.

The changes, which will apply to approximately 3,330 acute care hospitals and approximately 420 LTCHs, will affect discharges occurring on or after October 1, 2017.

Changes to Payment Rates under IPPS

The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 1.2 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by a -0.6 percentage point required for productivity. This also reflects a -0.6 percent adjustment to remove the one-time adjustment of 0.6 percent made in FY 2017 for the FYs 2014–2016 effect of the adjustment to offset the estimated costs of the two midnight policy, a +0.4588 percentage point adjustment required by the 21st Century Cures Act, and the -0.75 percentage point adjustment to the update required by the Affordable Care Act.

CMS projects that the rate increase, together with other changes to IPPS payment policies, will increase IPPS operating payments by approximately 1.3 percent and that changes in uncompensated care payments will increase IPPS operating payments by an additional 0.7 percent. Other additional payment adjustments will include continued penalties for excess readmissions, a continued 1 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued upward and downward adjustments under the Hospital Value-Based Purchasing Program. CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $2.4 billion in FY 2018.

Medicare Uncompensated Care Payments

CMS distributes a prospectively determined amount to Medicare disproportionate share hospitals based on their relative share of uncompensated care. As required under law, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured individuals and other factors. In this rule, CMS is distributing roughly $6.8 billion in uncompensated care payments in FY 2018, an increase of approximately $800 million from the FY 2017 amount. This change reflects CMS' finalized proposal to incorporate data from its National Health Expenditure Accounts into its estimate the percent change in the rate of uninsurance, which is used in calculating the total amount of uncompensated care payments available to be distributed.

For FY 2018, CMS is finalizing its proposal to begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report in the methodology for distributing these funds. Specifically, for FY 2018, CMS will use Worksheet S-10 data from FY 2014 cost reports in combination with Medicare and Medicaid low income days data from the two preceding cost reporting periods to determine the distribution of uncompensated care payments.

In response to commenters' concerns relating to the instructions for Worksheet S-10, in this final rule CMS provided some additional clarification about discounts given to uninsured patients who meet the hospital's charity care policy. CMS also indicated that it will continue to work with stakeholders to address their concerns through provider education and refinement of the instructions for the Worksheet S-10. Additionally, in order to further ensure accurate Worksheet S-10 data are available for potential use in calculating FY 2019 uncompensated care payment amounts, CMS is providing hospitals with an opportunity to resubmit certain Worksheet S-10 data to their Medicare Administrative Contractors by September 30, 2017.

Imputed Floor

The imputed floor policy establishes a minimum wage index for hospitals in all-urban states (New Jersey, Rhode Island, and Delaware). This policy was set to expire at the end of FY 2017, and CMS proposed not to extend it. However, after consideration of public comments, CMS is not finalizing that proposal and will continue the imputed floor policy for an additional year, through FY 2018, while it continues to consider the issue.

Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes

Nationwide, most inpatients are treated in acute care hospitals, but some are admitted to LTCHs. In this final rule, CMS is updating the LTCH PPS standard Federal payment rate by 1 percent, consistent with the provisions of the Medicare Access and CHIP Reauthorization Act of 2015. This is the payment rate applicable to LTCH patients that meet certain clinical criteria under the dual rate LTCH PPS payment system required by the Pathway for SGR Reform Act of 2013. Overall, under the changes included in this final rule, CMS projects that LTCH PPS payments will decrease by approximately 2.4 percent, or $110 million in FY 2018, which is due in large part to the continued phase in of the dual payment rate system.

In addition, CMS is continuing to evaluate if the 25-percent threshold policy is still needed. For FY 2018, CMS is finalizing its proposal to implement a regulatory moratorium on the implementation of the 25-percent threshold policy for FY 2018 while it conducts the evaluation. CMS is also revising its short-stay outlier payment adjustment and implementing various provisions of the 21st Century Cures Act that affect LTCHs.

Notice Regarding Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement

For inpatient CAH services to be payable under Medicare Part A, the statute requires that a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Based on feedback from stakeholders, CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. In this final rule, CMS is reiterating the notification provided in the proposed rule that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017. This means that absent concerns of probable fraud, waste, or abuse, CAHs should not expect to receive medical record requests from QIOs, MACs, RACs, or the SRMC related to the 96-hour certification requirement.

Changes for Indian Health Service (IHS) and Tribal Facilities and Hospital-within-Hospitals (HwHs)
As part of its effort to reduce regulatory burden, CMS is making changes to the provider-based regulations as they relate to IHS and Tribal facilities and separately, is also revising certain HwH requirements, which are regulations governing payment when hospitals are co-located.

Hospital-Acquired Conditions (HAC) Reduction Program
The HAC Reduction Program helps to encourage hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to impose a payment reduction of one percent for applicable hospitals that rank in the worst-performing quartile. In the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing two changes to existing HAC Reduction Program policies:

1. Specifying the dates of the data period used to calculate hospital performance for the FY 2020 HAC Reduction Program; and

2. Updating the Extraordinary Circumstance Exception policy.

In addition, CMS is also responding to comments received on adoption of additional measures, accounting for social risk factors, and inclusion of disability and medical complexity in the CDC NHSN measures.

Hospital Readmissions Reduction Program (HRRP)
The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions associated with selected applicable conditions. For the FY 2018 IPPS/LTCH PPS final rule, CMS is implementing changes to the payment adjustment factor in accordance with the 21st Century Cures Act. CMS will 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. Specifically, CMS is finalizing the following:

1. Defining the proportion of full benefit dual-eligible beneficiaries as the proportion of dual-eligible patients among all Medicare fee-for-service and Medicare Advantage stays during the 3-year period that corresponds to the performance period;

2. Stratifying hospitals into five peer groupings; and

3. Adopting a change to the payment adjustment formula calculation methodology.

In addition, CMS is specifying the applicable time period and the methodology for the calculation of aggregate payments for excess readmissions for FY 2018 and updating the program's Extraordinary Circumstance Exception policy.

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Eligible Hospitals, Critical Access Hospitals (CAHs), and Eligible Professionals (EPs)
In 2011, the Medicare and Medicaid EHR Incentive Programs were established to encourage eligible professionals, eligible hospitals, and CAHs to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology (CEHRT).

Changes to Clinical Quality Measures (CQMs)

In the FY 2018 IPPS/LTCH PPS final rule, for eligible hospitals and CAHs that report CQMs electronically for the EHR Incentive Programs, CMS is finalizing the following policies:

- For Calendar Year (CY) 2017:

a. Reporting period: For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2017 or that have demonstrated meaningful use in any year prior to 2017, the reporting period will be one self-selected quarter of CQM data in CY 2017.

b. CQMs: If an eligible hospital or CAH is only participating in the EHR Incentive Program or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH will report on at least four (self-selected) of the available CQMs.

- For CY 2018:

a. Reporting period: For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2018 or that have demonstrated meaningful use in any year prior to 2018, the reporting period will be one self-selected quarter of CQM data in CY 2018. For the Medicare EHR Incentive Program only, the submission period for reporting CQMs electronically will be the two months following the close of the calendar year, ending February 28, 2019.

b. CQMs: For eligible hospitals and CAHs participating only in the EHR Incentive Program or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH will report on at least four (self-selected) of the available CQMs.

c. For eligible hospitals and CAHs that report CQMs by attestation under the Medicare EHR Incentive Program as a result of electronic reporting not being feasible and for eligible hospitals and CAHs that report CQMs by attestation under their State's Medicaid EHR Incentive Program, they are required to report on all 16 available CQMs for the full CY 2018 (consisting of four quarterly data reporting periods). We also established an exception to this full-year reporting period for eligible hospitals and CAHs demonstrating meaningful use for the first time under their State's Medicaid EHR Incentive Program. Under this exception, the CQM reporting period is any continuous 90-day period within CY 2018.

Additionally, in the final rule, for the eligible professionals (EPs) in the Medicaid EHR Incentive Program, CMS is finalizing the following changes:

1. Reporting Periods: For 2017, CMS is modifying the CQM reporting period for EPs in the Medicaid EHR Incentive Program to be a minimum of a continuous 90-day period during calendar year 2017.

2. CQMs: For 2017, CMS is aligning the specific CQMs available to EPs participating in the Medicaid EHR Incentive Program with those available to professionals participating in the Merit-based Incentive Payment System.

Changes to the Medicare and Medicaid EHR Incentive Programs

For 2018, CMS is finalizing the modification to the EHR reporting periods for new and returning participants attesting to CMS or their state Medicaid agency from the full year to a minimum of any continuous 90-day period during the calendar year.

CMS is finalizing the addition of a new exception from the Medicare payment adjustments for EPs, eligible hospitals, and CAHs that demonstrate through an application process that compliance with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.

CMS is also finalizing an exception to the 2017 and 2018 Medicare payment adjustments for ambulatory surgical center (ASC)-based EPs and defining ACS-based EPs as those who furnishes 75 percent or more of their covered professional services in an ASC, using Place of Service (POS) code 24 to identify services furnished in an ASC.

CMS is adopting final policies to allow healthcare providers to use either 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT, for an EHR reporting period in 2018. This policy is based on the ongoing monitoring of progress on the deployment and implementation status of EHR technology certified to the 2015 Edition, as well as feedback by stakeholders expressing the need for more time and resources are needed for the transition process.

Hospital Inpatient Quality Reporting (IQR) Program
In the FY 2018 IPPS/LTCH PPS final rule, CMS is refining two previously adopted measures as follows:

1. Replacing the pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey to focus on the hospital's communications with patients about the patients' pain during the hospital stay beginning with surveys administered in January 2018. In response to stakeholder feedback, public display of hospital performance data on these refined questions will be delayed for one year so that hospitals may gain more experience with the refined questions.

2. Updating the risk adjustment methodology used in the Stroke 30-Day Mortality measure to include the use of stroke severity codes (based on the NIH Stroke Scale).

CMS is adopting the Hospital-Wide All-Cause Unplanned Readmission Hybrid Measure as a voluntary measure for the CY 2018 reporting period that uses both claims and electronic health record data for measure calculation. Furthermore, CMS received public comments on potential new quality measures for future inclusion in the Hospital IQR Program, accounting for social risk factors in the program and confidential and public reporting of measure rates for certain measures stratified by patients' dual eligibility status, which are being taken under consideration for development of policies and future rulemaking.

In addition, CMS is finalizing a number of changes in relation to the reporting of electronic clinical quality measures (eCQMs):

1. Modifying, by further reducing what was proposed, the previously finalized eCQM reporting requirements for the CY 2017 reporting period/FY 2019 payment determination and the CY 2018 reporting period/FY 2020 payment determination, such that hospitals would be required to select and submit four of the available eCQMs included in the Hospital IQR Program measure set and provide one, self-selected calendar quarter of data, in alignment with the electronic reporting requirements for CQMs in the EHR Incentive Program for hospitals.

2. Increasing flexibility for eCQM certification requirements such that for the CY 2018 reporting period/FY 2020 payment determination, hospitals will be able to use: (1) the 2014 Edition of CEHRT, (2) the 2015 Edition of CEHRT, or (3) a combination of both the 2014 and 2015 Editions of CEHRT.

3. Requiring that a hospital using EHR technology certified to the 2014 Edition or 2015 Edition, or a combination thereof, have its EHR technology certified to all 15 eCQMs that are available to report in the Hospital IQR Program; requiring use of the most recent version of the eCQM electronic specifications; and specifying that eCQMs would not need to be recertified each time it is updated to a more recent version. These policy changes are being made in alignment with the CQM electronic reporting policies for the Medicare and Medicaid EHR Incentive Programs.

4. Modifying the previously finalized validation process for eCQM data to reduce the number of cases required to be submitted and to include additional policies related to the exclusion criteria for hospital and case selection and the data submission requirements for participating hospitals; requiring submission of at least 75 percent of sampled eCQM measure medical records in a timely and complete manner.

5. Formalizing the educational review process for chart abstracted measures and using this process to correct quarterly scores for any of the first three quarters of validation in order to compute final confidence intervals.

Lastly, CMS is aligning its Extraordinary Circumstances Exceptions (ECE) policy with other quality reporting programs and is making conforming updates to 42 CFR 412.140(c)(2).

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. In the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing its proposals to implement updates to the Hospital VBP Program, including the removal of one measure and adoption of two measures. Specifically, CMS is finalizing its proposals to:

1. Remove the current 8-indicator Patient Safety for Selected Indicators measure from the Safety domain beginning with the FY 2019 program year and replace it with the 10-indicator Patient Safety and Adverse Events Composite measure, which is a modified version of the removed measure beginning with the FY 2023 program;

2. Adopt a payment measure associated with 30-day episodes of care for pneumonia patients for the Efficiency and Cost Reduction domain beginning with the FY 2022 program year; and

3. Update the weighting of measures in the Efficiency and Cost Reduction domain to reflect the addition of the new condition-specific payment measures along with the overall Medicare Spending per Beneficiary measure beginning with the FY 2021 program year.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
The PCHQR Program collects and publishes data on an announced set of quality measures. In the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing its proposals to adopt four new measures, remove three previously-adopted measures, and implement revisions to the PCHQR Extraordinary Circumstances Exceptions (ECE) Policy. Specifically, CMS is adopting four measures that assess end-of-life care:

1. Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210);

2. Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213);

3. Proportion of Patients Who Died from Cancer Not Admitted to Hospice (NQF #0215); and

4. Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days (NQF #0216).

CMS is also removing three cancer-specific, chart-abstracted process measures:

1. Adjuvant Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer (NQF #0223);

2. Combination Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer (NQF #0559); and

3. Adjuvant Hormonal Therapy (NQF #0220).

Inpatient Psychiatric Facility Quality Reporting Quality Reporting (IPFQR) Program
In the final rule, CMS is not finalizing the Medication Continuation following Inpatient Psychiatric Discharge measure. CMS is updating the IPFQR Program's extraordinary circumstances exception (ECE) policy to align with other CMS programs' ECE provisions. CMS is also changing the annual data submission timeframes for Notices of Participation (NOP) and withdrawals from the Program and its policy to provide precise dates defining the end of the data submission period. Finally, CMS is adopting factors by which it would evaluate measures to be removed from or retained in the IPFQR Program.

Long Term Care Hospital Quality Reporting Program (LTCH QRP)
Under the LTCH QRP, the applicable annual update for any LTCH that does not submit the required data to CMS is reduced by 2 percentage points with respect to that fiscal year.

In this FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing the replacement of the current pressure ulcer measure with an updated version of that measure, as well as adopting two new companion measures (one process and one outcome) related to ventilator weaning, beginning with the FY 2020 LTCH QRP. These finalized measures are:

1. Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

2. Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay

3. Ventilator Liberation Rate

Further, CMS is finalizing the removal of two currently adopted measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512). CMS is also finalizing the public display of six new quality measures on the LTCH Compare website by fall 2018 and the public display of one new quality measure on the LTCH Compare website by fall 2020.

In addition to the new policies to quality measures and public reporting, CMS is finalizing that beginning with the FY 2019 LTCH QRP, the data that LTCHs report on the measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) meet the definition of standardized patient assessment data, and beginning with the FY 2020 LTCH QRP, the data that LTCHs report on the measures, Changes to Skin Integrity Post-Acute Care: Pressure Ulcer/Injury and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), meet the definition of standardized patient assessment data. However, in response to the comments received on the proposed rule, for the FY 2020 program year, CMS is not finalizing the additional proposed standardized data elements.

Lastly, CMS is finalizing its proposals with respect to the applicability of current procedural requirements.

Changes to the Application and Re-Application Procedures for National Accrediting Organizations (AOs)

In the proposed rule, CMS proposed to revise the application and re-application process for Accrediting Organizations (AOs), specifically related to transparency by requiring AOs to post provider/supplier survey reports and plans of corrections from CMS-approved accreditation programs on their public-facing websites. AOs currently do not make their survey reports and acceptable PoCs from their CMS-approved accreditation programs publicly available.

After consideration of the public comments received, CMS decided that it would be best if the proposal was not finalized and instead, the proposal was withdrawn. CMS is committed to

ensuring that patients have the ability to review the findings used to determine that a facility meets the health and safety standards required for Medicare participation. However, we believe further review, consideration, and refinement of this proposal is necessary to ensure that CMS establishes requirements, consistent with our statutory authority, that will inform patients and continue to support high quality care.

Changes to Termination Notices

In the proposed rule, CMS proposed to eliminate newspaper notices for the Medicare termination of Ambulatory Surgical Centers (ASCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Organ Procurement Organizations (OPOs). Newspapers have become an outdated means of communication for these notices. The existing regulations for the majority of providers and suppliers require CMS to notify the public of Medicare terminations. Previously, the public notice of termination for ASCs, FQHCs, RHCs, and OPOs had to be published in one or more local newspapers. We proposed to change the requirement for ASCs, FQHCs, RHCs, and OPOs in order to be consistent with the regulatory language for other provider and suppliers' public notification requirements.

After consideration of the public comments received, CMS is finalizing the proposal to eliminate newspaper notices for the Medicare termination of ASCs, FQHCs, RHCs, and OPOs.

Rural Community Hospital Demonstration Extension

Section 15003 of the 21st Century Cures Act requires an extension of the Rural Community Hospital Demonstration for an additional 5-year period. The demonstration was authorized originally for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), and it was extended for another 5-year period by sections 3123 and 10313 of the Affordable Care Act.

The 21st Century Cures Act allows for hospitals that were participating in the demonstration as of the last day of the initial 5-year period, or as of December 30, 2014, to participate in this second extension period unless the hospital makes an election to discontinue participation. The statute also requires that no later than 120 days after enactment of the law, a request for applications be issued for additional hospitals to participate in the demonstration program for the second 5-year extension period, so long as the maximum number of 30 hospitals stipulated by the Affordable Care Act is not exceeded.

The MMA requires the demonstration to be budget neutral. In prior years, CMS has adjusted the national IPPS rates by an amount sufficient to account for the added costs of this demonstration program, thus applying budget neutrality across the payment system as a whole rather than merely across the participants in the demonstration program.

In the proposed rule, CMS proposed to align the periods of performance for both previously participating hospitals and newly selected hospitals during the second 5-year 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 October 1, 2017, following upon the announcement of the selection of the additional hospitals.

Responding to concerns expressed by commenters that adopting this approach would create financial hardship for some of the previously participating hospitals, in the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing an alternative approach whereby the performance period for previously participating hospitals that choose to participate would begin immediately after the date the period of performance under the first 5-year extension period ended. CMS has not yet finalized the selection of additional participants to participate in the demonstration, and the start dates for the 5-year extension period for the additional hospitals will be announced after selections are announced.

In addition, CMS is finalizing a budget neutrality methodology similar to that of previous years by adjusting the national IPPS rates to account for the added costs of the demonstration for the second extension period. As the additional participants for the second extension period have not been selected, CMS is finalizing the proposal to include the estimated costs of the demonstration for all participating hospitals for FY 2018 in the budget neutrality offset amount to be calculated in the FY 2019 IPPS/LTCH PPS proposed and final rules.

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