Medicare Inpatient Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2019

Overview and Resources

On August 2, 2018, the Centers for Medicare and Medicaid Services (CMS) released the display version of the final federal fiscal year (FFY) 2019 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 rule includes:

- A rate increase amount (+0.5%) for the Coding Offset adjustment;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies;
- Continuance of the Medicare Dependent Hospital and expanded Low-Volume Hospital programs;
- Addition of hospice transfers to the Post-Acute Care Transfer Policy;
- Elimination of 18 measures, and a de-duplication of an additional 21 measures from the IPPS quality programs;
- Updates to the program rules for the Value-Based Purchasing (VBP) and Hospital-Acquired Condition (HAC) programs; and
- Updates to the payment penalties for non-compliance with the Hospital IQR and Electronic Health Record (EHR) Incentive Programs.

Program changes are effective for discharges on or after October 1, 2018 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/FY2019-IPPS-Final-Rule-Home-Page.html.

An online version of the rule will be available at https://www.federalregister.gov/d/2018-16766 on August 17, 2018.

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

IPPS Payment Rates

DISPLAY pages 57 – 63, 941 – 950, 1,408 – 1,411, and 2,274-2,360

The table below lists the federal operating and capital rates adopted for FFY 2019 compared to the rates currently in effect for FFY 2018. 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.).

	Final FFY 2018	Final FFY 2019	Percent Change
Federal Operating Rate	**$5,572.53**	**$5,649.52**	**+1.38%**
Federal Capital Rate	**$453.95**	**$459.72**	**+1.27%**

The table below provides details for the final annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2019.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	**+2.9%** (proposed at +2.8%)		**+1.4%** (proposed at +1.2%)
ACA-Mandated Reductions 0.8 percentage point (PPT) productivity reduction and 0.75 PPT pre-determined reduction	**-1.55 PPT** (as proposed)		—
MACRA-Mandated Retrospective Documentation and Coding Adjustment	**+0.5%**	—	—
Annual Budget Neutrality Adjustment	**-0.47%**		**-0.13%**
Net Rate Update	***+1.38%***	***+0.88%***	***+1.27%***

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** ***(DISPLAY pages 941 – 949)***: 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 has capped at 75% of the MB; hence the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2019 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Marketbasket Update (2.9% MB less 0.8 PPT productivity and 0.75 PPT predetermined)	**+1.35%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.9%)	—	**-0.725 PPT**	—	**-0.725 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.9%)	—	—	**-2.175 PPT**	**-2.175 PPT**
Adjusted Net Marketbasket Update (prior to other adjustments)	***+1.35%***	***+0.625%***	***-0.825%***	***-1.55%***

- **Retrospective Coding Adjustment** ***(DISPLAY pages 57 – 63)*****:** CMS will apply a retrospective coding adjustment of +0.5% to the federal operating rate in FFY 2019 as part of the second year of rate increases (of six) tied to the American Taxpayer Relief Act (ATRA). The coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by $11 billion over a 4-year period, resulting in a cumulative rate offset of approximately -3.2%.
- **Outlier Payments** ***(DISPLAY pages 2,295 – 2,332)*****:** To maintain outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of $25,769 for FFY 2019. The proposed threshold is 2.89% lower than the current (FFY 2018) outlier threshold of $26,537.

Wage Index

DISPLAY pages 807 – 926

For FFY 2019, CMS is finalizing several changes that would affect the wage index and wage index-related policies, including:

- **Inclusion of Other Wage-Related Costs** ***(DISPLAY pages 823 – 837)*****:** Due to an inadvertent omission of Worksheet S-3, Part II, Line 15 (Home Office Part A Administrator) from the denominator in the instructions for the 1-percent test, CMS is proposing to clarify its inclusion as part of the test in the calculation of Worksheet S-3, Part III, Line 4.

  CMS states that only 8 out of over 3,000 hospitals reporting "Other wage-related costs" on Line 18 of Cost Report Worksheet S-3 Part II for the FFY 2019 wage index actually meet the 1% test for inclusion on that line (costs must

exceed 1% of the total adjusted salaries net of excluded areas). As a result, for the FFY 2020 wage index and subsequent years, CMS will include only the wage-related costs on the core list in the calculation of the wage index. No other wage-related costs would be considered. CMS believes that this will help ensure a more consistent and accurate wage index.

- **Policies Regarding Special Status for Multicampus Hospitals** ***(DISPLAY pages 837 – 859)*****:** For hospitals with a main campus and at least one remote location under a single provider agreement for services billed under the IPPS and meeting the criteria of a multicampus hospital, CMS has adopted its proposal that a main campus of a hospital cannot obtain an SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s), and vice versa. CMS deems this policy appropriate as all campuses would share the same provider number, and thus would share the same status/reclassification. In addition, it would not be administratively feasible for CMS and the MACs to track every hospital with remote locations within the same CBSA and to assign different statuses to each.

  To qualify for SCH, RRC, or MDH status, CMS has finalized that the combined data for all of a hospital's campuses must satisfy the relevant qualifying criteria.

- **Imputed Rural Floor** ***(DISPLAY pages 867 – 882)*****:** The imputed rural floor policy will expire on September 30, 2018. CMS is not adopting 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.

- **Wage Index Development Timetable for FFY 2020** ***(DISPLAY pages 911 - 923)*****:** Applications for FFY 2020 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 4, 2018.

- **Reclassification Requirements for Single-Hospital MSAs** ***(DISPLAY page 890 – 897)*****:** CMS is finalizing that, for FFY 2021 and subsequent reclassification applications, a hospital would provide the wage index data from the current year's IPPS final rule to demonstrate that it is the only hospital in its labor market area with wage data listed within the three-year period considered by the MGCRB.

- **Outmigration Adjustment** ***(DISPLAY pages 900 – 903)*****:** For FFY 2019, CMS will continue to use commuting microdata sourced from the American Community Survey (ACS) utilizing data from 2008 through 2012. CMS is not making any changes to the methodology of the calculation at this time.

- **Urban to Rural Reclassification Lock-In Date** ***(DISPLAY pages 903 - 911)*****:** Currently, hospitals wishing to reclassify from urban to rural must file their applications at least 70 days prior to the second Monday in June of the current FFY, and the application must then be approved by the CMS Regional Office. For FFY 2019, in order to change the lock-in date to allow for additional time in the ratesetting process and to match the lock-in date with another existing deadline; CMS has finalized that rural reclassification applications must be approved by the CMS Regional Office no later than 60 days after the public display date of the IPPS proposed rule, which aligns the deadline for applications with that for comments on the rule. Due to this change, the 70-day requirement would be rescinded, however CMS still believes this timeframe to be useful as a guideline.

- **Labor-Related Share** ***(DISPLAY pages 923 – 926)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2019, CMS will continue applying a labor-related share of 68.3% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

A complete list of the adopted wage indexes for payment in FFY 2019 is available on Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-Tables-2-3-4.zip.

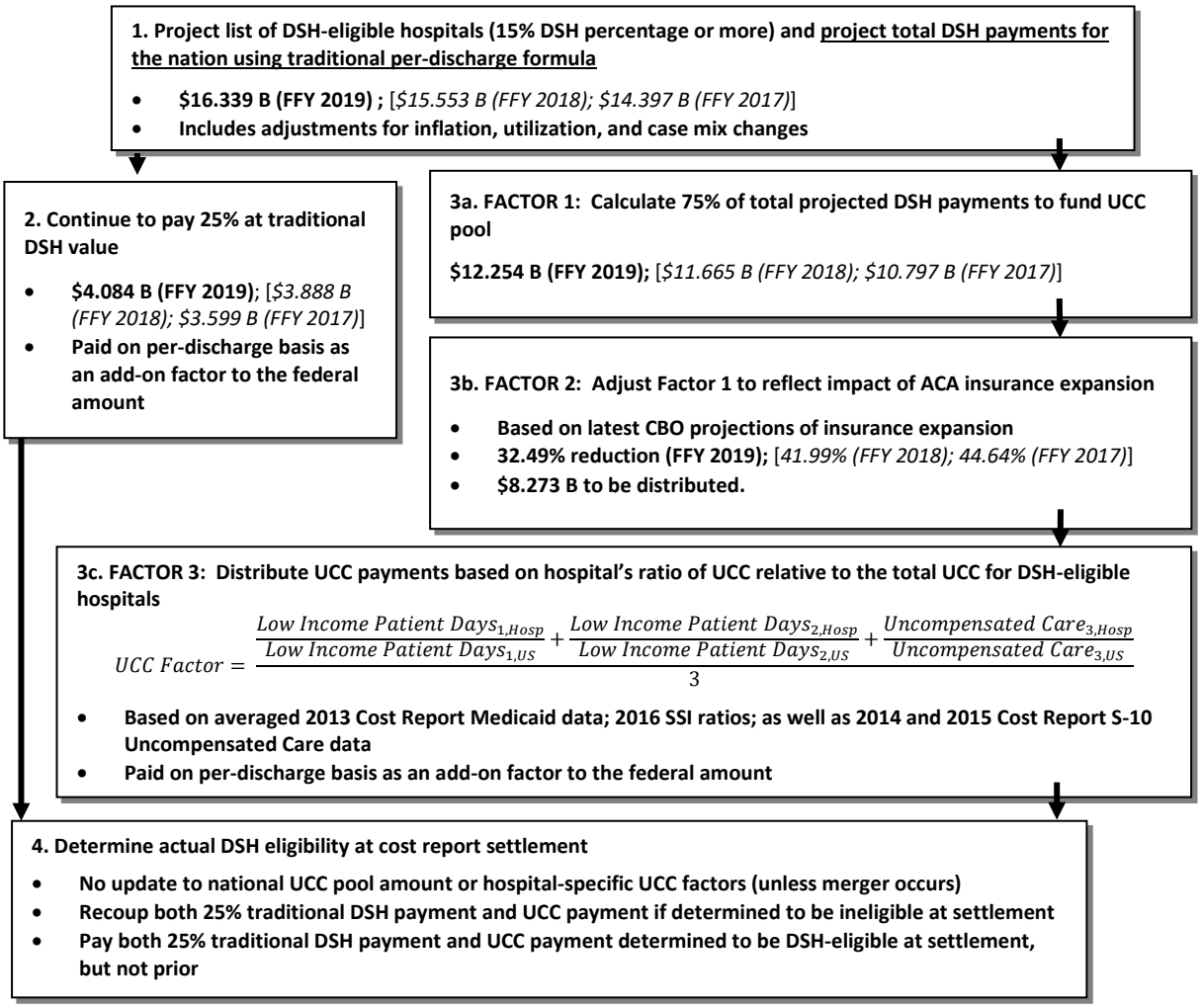
DSH Payments

DISPLAY pages 969 – 1,084

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.

- **DSH Payment Methodology for FFY 2019** ***(DISPLAY pages 981 – 1,084)*****:**
  The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2018 to FFY 2019:



The DSH dollars available to hospitals under the ACA's payment formula will increase by $1.5 billion in FFY 2019 due to an increase in the projected percentage of uninsured individuals.

- **Eligibility for FFY 2019 DSH Payments** ***(DISPLAY pages 974 - 979)*****:** CMS is projecting that 2,448 hospitals will be eligible for DSH payments in FFY 2019. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2019. 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/FY2019-CMS-1694-FR-DSH.zip.

  According to the tables provided in this final rule, 101 hospitals that were not eligible for DSH in FFY 2018 are projected to receive DSH payments in FFY 2019; while 73 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 3 Determination** ***(DISPLAY pages 1,006 – 1,084)*****:** CMS had 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, in the FFY 2018 IPPS final rule, CMS again stated 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 began to 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.

  For FFY 2019, CMS will continue the Worksheet S-10 data phase-in as part of the three year averaging process for Factor 3; i.e. an average of 1 year of proxy data (2013 Medicaid days, 2016 Medicare SSI days) and 2 years of S-10 data (2014 and 2015) for FFY 2019 DSH payments. Due to reporting requirements, CMS will continue to not utilize 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 triple-weight to the FFY 2013 data due to the effects of Medicaid expansion on data reported for FFYs 2014 and 2015. CMS has not yet stated how it will develop Factor 3 values for FFY 2020.

  Due to the policy finalized in FFY 2018 to annualize hospital data under S-10, CMS will also discontinue the policy concerning multiple cost reports beginning in the same fiscal year as the FFY 2018 methodology appears to adequately address the issue. Under this policy CMS would first combine data across the multiple cost reports before determining the difference between the start and end dates to determine if annualization is needed. As a result, CMS will utilize data from the cost report that is equal to 12 months, or to annualize the cost report that is closest to 12 months if none exists. For instances in which a hospital's cost reporting period may have started towards the end of a given FFY but covers the duration of the next FFY, CMS will use the data as the latter year.

  In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS will continue its FFY 2018 trimming methodology targeting the cost to charge ratio (CCR). 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 2019. CMS will also utilize this process for aberrant 2015 data using the 2016 cost report.

  Finally, CMS is adopting a HCRIS cutoff of June 30 for data used in the calculation of the FFY 2019 uncompensated care pool distribution factors.

GME Payments

DISPLAY pages 967 – 969 and 1,329 – 1,357

Hospitals that are part of the same Medicare GME affiliated group are permitted to apply their IME and direct GME FTE caps on an aggregate basis, and to temporarily adjust each hospital's caps to reflect the rotation of residents among affiliated hospitals during an academic year. For a new urban teaching hospital that qualifies for an adjustment to its FTE cap, this hospital may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase to its direct GME and IME FTE caps. In order to promote flexibility, CMS will revise the regulations to specify that new urban teaching hospitals may form a Medicare GME affiliated group and therefore be

eligible to receive both decreases and increases to their FTE caps, beginning with affiliation agreements entered into for the July 1, 2019 – June 30, 2020 residency training year.

However, an agreement resulting in a decrease will only be allowed if it results from a Medicare GME affiliated group consisting solely of two or more new urban teaching hospitals. In addition, effective for Medicare GME affiliation agreements entered into on or after July 1, 2019, a new urban teaching hospital may participate in a Medicare GME affiliated group with an existing teaching hospital and receive an adjustment that is a decrease to the urban hospital's FTE caps. This is provided that the agreement is effective with a July 1 date that is at least five years after the start of the new urban teaching hospital's cost reporting period coinciding with, or following, the start of the sixth program year of the first new program.

The Indirect Medical Education (IME) adjustment factor will remain at 1.35 for FFY 2019.

Notice of Teaching Hospital Closure and Opportunity to Apply for Available Slots

DISPLAY pages 1,357 – 1,360

The ACA authorizes the redistribution of residency slots after a hospital that trained residents in an approved medical residency program closes. This final rule is being used to notify hospitals of one such closure, and the opportunity to obtain additional residency slots. Hospitals that wish to apply for these slots must submit their applications by October 31, 2018. The closed teaching hospital is:

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap (including +/- MMA Sec. 422 and ACA Sec. 5503 Adjustments	Direct GME FTE Resident Cap (including +/- MMA Sec. 422 and ACA Sec. 5503 Adjustments
410001	Memorial Hospital of Rhode Island	Pawtucket, RI	39300	1/31/2018	73.66	72.62

Updates to the MS-DRGs

DISPLAY pages 57 – 447

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 adopted for the FFY 2019 MS-DRGs will increase the number of payable DRGs from 754 to 761. Seventy-seven 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:

MS-DRG	FFY 2018 Weight	FFY 2019 Weight	Percent Change
MS-DRG 770: Abortion w D&C, Aspiration Curettage or Hysterotomy	0.7878	1.0679	+35.54%
MS-DRG 295: Deep Vein Thrombophlebitis w/o CC/MCC	0.7855	0.5513	-29.82%
MS-DRG 573: Skin Graft for Skin Ulcer or Cellulitis w MCC	4.0635	5.2515	+29.24%
MS-DRG 661: Kidney & Ureter Procedures for Non-Neoplasm w/o CC/MCC	1.454	1.0728	-26.22%
MS-DRG 756: Malignancy, Female Reproductive System w/o CC/MCC	0.6352	0.7801	+22.81%

The full list of finalized FFY 2019 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/FY2019-CMS-1694-FR-Table-5.zip.
For comparison purposes, the FFY 2018 DRGs 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.

New Technology

DISPLAY pages 448 – 806

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 will:

- discontinue add-on payments for five medical services/technologies;
- continued new technology add-on payments for three technologies; and
- Implement add-on payments for 10 technologies.

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

DISPLAY pages 927 – 941

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.

Due to the enactment of the Bipartisan Budget Act of 2018, CMS is making conforming changes to the regulations in order to apply the postacute care transfer policy to those individuals transferred to hospice care, effective October 1, 2018. Due to this change, hospital bills with a Patient Discharge Status code of 50 (Discharges/Transferred to Hospice – Routine or Continuous Home Care) or 51 (Discharged/Transferred to Hospice, General Inpatient Care or Inpatient Respite) will be subject to the postacute care transfer policy.

Effective FFY 2019, CMS has adopted changes to a number of MS-DRGs affected by these policies, including:

- Assign CAR-T therapy procedure codes to MS-DRG 016 (Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy);
- Delete MS-DRG 685 (Admit for Renal Dialysis) and reassign diagnosis codes to MS-DRGs 698, 699, and 700 (Other Kidney and Urinary Tract Diagnoses with MCC, with CC, and without CC/MCC, respectively);
- Delete 10 MS-DRGs (MS-DRGs 765-767, 774, 775, 777, 778, and 780-782) and create 18 new MS-DRGs relating to Pregnancy, Childbirth and the Puerperium (MS-DRGs 783-788, 794, 796, 798, 805-807, 817-819, and 831-833);
- Assign two additional diagnosis codes to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator). This DRG is also proposed to become subject to the special payment methodology in addition to MS-DRG 024;
- Reassign 12 ICD-10-PCS procedure codes from MS-DRGs 329-331 (Major Small and Large Bowel Procedures with MCC, with CC, and without cc/MCC, respectively) to MS-DRGs 344-346 (Minor Small and Large Bowel Procedures with MCC, with CC, and without cc/MCC, respectively); and
- Reassign ICD-10-CM diagnosis codes R65.10 and R65.11 from MS-DRGs 870-872 (Septicemia or Severe Sepsis with and without Mechanical Ventilation >96 Hours with and without MCC, respectively) to MS-DRG 864 (Fever and Inflammatory Conditions).

Low-Volume Hospital Adjustment

DISPLAY pages 956 – 967

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. The Bipartisan Budget Act of 2018 had extended the relaxed low volume adjustment criteria (>15-mile/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 <u>total</u> discharges

(rather than 1,600 Medicare discharges). The new payment adjustment formula for hospitals with between 500 and 3,800 total discharges will be:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

Beginning with FFY 2023, the criteria for the low-volume hospital adjustment will return to the more restrictive levels. At that point, in order to receive a low-volume adjustment, subsection (d) hospitals would 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 for FFY 2019, including for those currently assigned low-volume status, and consistent with historical practice, CMS will require that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria. The MAC must receive a written request by September 1, 2018 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2018. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Under this process, a hospital receiving the adjustment for FFY 2018 may continue to receive it without reapplying if it continues to meet the mileage and (newly modified) discharge criteria.

Medicare Dependent Hospitals (MDH)

DISPLAY pages 1,086 – 1,097

The Medicare-Dependent Hospital (MDH) program has been extended several times by Congressional legislative action. Most recently, the Bipartisan Budget Act of 2018 extended this program through FFY 2022.

As a result of the legislation, and consistent with prior extensions, hospitals that were classified as an MDH as of September 30, 2017 were reinstated as an MDH effective October 1, 2017, with no need to reapply. However, for an MDH that classified as an SCH or cancelled its rural classification effective on or after October 1, 2017, the effective date of MDH status may not be retroactive back to October 1, 2017.

Effective Dates of Change to SCH and MDH Classification Status

DISPLAY pages 1,090 – 1,097

Currently, the effective date for MDH and SCH classification is set for 30 days following the date of CMS' written notification of approval, at which point the hospital will begin to receive the relevant payment adjustment.

In order to minimize the lag between the effective date of a hospital's rural reclassification, and the effective date for MDH/SCH status, CMS is adopting an effective date for MDH/SCH classification and for the payment adjustment that would be the date that the MAC receives the complete MDH/SCH application, effective for those applications received on or after October 1, 2018.

RRC Status

DISPLAY pages 950 - 956

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 2019 minimum case-mix and discharge values are available on the pages listed above.

Medicare Part A Hospital Inpatient Admission Orders Documentation

DISPLAY pages 1,390 – 1,407

In the FFY 2014 IPPS final rule, CMS adopted a set of policies that are commonly referred to as the "2-midnight" rule. Amongst them, the policy that a beneficiary becomes a hospital inpatient if they are formally admitted following a physician's (or other qualified practitioner's) order, in accordance with the hospital conditions of participation. Additionally, CMS requires that a written inpatient admission order by present in the medical record as a specific condition of Medicare Part A payment.

CMS has found that, despite the discretion granted to medical reviewers to determine that admission order information taken from the medical record satisfies the written hospital inpatient admission order requirement, medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders. These discrepancies include missing practitioner admission signatures, missing co-signatures, and signatures occurring after discharge; and have occasionally become a primary reason for payment denial.

CMS will revise the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment. Specifically, a written inpatient admission order (including physician admission and progress notes) will no longer be required to be present in the medical record as a specific condition of Medicare Part A payment. This does not change the requirement that a patient is considered an inpatient if they have been formally admitted under an order for inpatient admission.

Quality-Based Payment Adjustments

DISPLAY pages 1098-1328

For FFY 2019, 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 2019 programs and payment adjustment factors are below (future program year program changes are addressed at the end of this Brief):

- **VBP Adjustment *(DISPLAY pages 1134 -1252)*:** The FFY 2019 program will include hospital quality data for 19 measures in 4 domains: safety of care; clinical care; person and community engagement; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2019 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 2019 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the current year's (FFY 2018) program. Hospitals should use caution in reviewing these factors as they do not reflect performance on new measures for FFY 2019, 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/FY2019-CMS-1694-FR-Table-16.zip

  Effective with the FFY 2019 VBP program, CMS will remove the Patient Safety Indicator (PSI)-90 composite measure from the safety of care domain.

  CMS anticipates making actual FFY 2019 VBP adjustment factors available in the Fall of 2018. Details and information on the program currently in place for FFY 2018 and FFY 2019 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 1098-1133)*:** The FFY 2019 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%.

Beginning in FFY 2019, hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare Fee-For-Service and Medicare Advantage patients during the same 3-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the 6 measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

The data applicable to the FFY 2019 RRP program is still being reviewed and corrected by hospitals, and therefore CMS did not yet post final factors for the FFY 2019 program in Table 15. CMS has stated that it expects to release the final FFY 2019 RRP factors in the Fall of 2018

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 1253-1328)*:** The FFY 2019 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 2019 in Fall of 2018.

  For FFY 2019, 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 2020 and Beyond

For FFYs 2020 and beyond, CMS is adopting new policies and measures for its quality-based payment programs. CMS is also considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

- **VBP Program–FFYs 2020 through 2024 *(DISPLAY pages 1134-1252)*:** CMS has already adopted VBP program rules through FFY 2020 and some program policies and rules beyond FFY 2020. CMS is adopting further program updates for FFYs 2020-2024, which include:
  - New measure removal criteria that closely resembles measure removal criteria for IQR;
  - Removal of the requirement that a measure must remain in IQR if it is currently in VBP;
  - Removing 4 measures from the program in order to reduce cost, complexity, and burden while continuing to incentivize improvement in quality:
    - Beginning FFY 2019 (due to inclusion finalized for after FFY 2021+): AMI Payment, HF Payment, PN Payment; and
    - Beginning FFY 2021: PC-01
  - National performance standards for a subset of the FFY 2021 and FFY 2024 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking); and

- Renaming of Clinical Care domain to Clinical Outcomes.

CMS also proposed to remove CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA, C.diff, and PSI-90 from the VBP program beginning FFY 2021. In response to public comments, CMS did not finalize the removal of these measures because they are critically important to quality improvement and patient safety and therefore provide appropriate incentives for hospitals to avoid them through inclusion in more than one program.

If all of the measures within the Safety of Care domain were finalized for removal from the VBP program, CMS had also proposed to remove the Safety of Care domain entirely beginning FFY 2021 because there would not be any measures left in the domain. However, since CMS is not removing all of the Safety of Care domain measures from the VBP program, CMS will maintain the domain.

Additionally, CMS proposed to weight the Clinical Outcomes domain at 50% of the Total Performance Score and leave Person and Community Engagement and Efficiency and Cost Reduction domains each at the current 25% beginning FFY 2021. Since CMS is maintaining the Safety of Care domain in the VBP program, CMS is also maintaining the current VBP domain weights of 25% to each of the four domains.

Details and tables on the final measure removals, collection time periods, performance standards, and measure weighting are available on the pages listed above.

- **Readmissions Reduction Program** ***(DISPLAY pages 1098-1133)*****:** CMS is adopting its proposal to continue the FFY 2019 socio-demographic status adjustment to the readmission program in subsequent years. CMS also adopted 3-year performance periods for FFYS 2019, 2020, and 2021.

  HAC Reduction Program–FFY 2020 ***(DISPLAY pages 1253-1328)*****:** CMS has already adopted program specifications through FFY 2020. CMS is adopting specifications for the FFY 2021 program such as time periods used to calculate performance scores. In the proposed rule, CMS requested comments on measures for inclusion in future program years. Specifically, CMS asked for feedback on the inclusion of electronic clinical quality measures (eCQMs). Those comments can be found on pages 1321 – 1328.

  Beginning FFY 2020, CMS is adopting a change to the domain weighting scheme in Total HAC score calculations that removes domains entirely and applies an equal weight to each measure for which a hospital has a measure.

Updates to the IQR Program and Electronic Reporting Under the Program

DISPLAY pages 1526-1813

CMS is finalizing the removal of 39 measures from the Hospital IQR Program across FFYs 2020, 2021, 2022 and 2023, 18 of which were previously adopted and topped out, no longer relevant or the burden outweighs the contribution where 21 are to de-duplicate and simplify measures across programs. These measure span the following measure types: structural patient safety, safe surgery checklist use, patient safety, claims-based readmission, claims based mortality, hip/knee complications, Medicare Spending per Beneficiary, chart-abstracted clinical process of care, eCQMs, and clinical episode-based payment.

A full list of the measures removed from IQR is found in the Display copy of the final rule on pages 1686-1693.

CMS solicited comments on two potential measures for inclusion in the future (pages 1713 – 1729):

- Claims-Only, Hospital-Wide, All-Cause, Risk-Standardized Mortality measure; and
- Hybrid Hospital-Wide, All-Cause, Risk-Standardized Mortality Measure.

Lastly, CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs. CMS plans to eventually make stratified data publically available on *Hospital Compare* to allow consumers and other stakeholders to view critical information about the care and outcomes of subgroups of patients with social risk factors.

CMS is also adopting changes to the eCQMs. For the calendar year (CY) 2019 reporting period (FFY 2021 payment determination), CMS is extending the same eCQM reporting and submission requirements as the CY 2018 reporting period (FFY 2020 payment determination), such that hospital would be required to report one, self-selected calendar

quarter of data for four self-selected eCQMs. CMS is also adopting its proposal to require hospitals to use only the 2015 Edition certification criteria for reporting beginning with the CY 2019/FFY 2021 payment determination, in contrast to the CY 2018/FFY 2020 payment determination where hospitals were allowed to use either the 2014 Edition certification criteria, the 2015 Edition certification criteria, or a combination of both.

CMS is adopting an additional factor to consider when evaluating measures for removal from the Hospital IQR Program measure set: the costs associated with a measure outweigh the benefit of its continued use in the program.

Tables in the Display copy of the final rule on pages 1690 - 1697 outline the previously adopted Hospital IQR Program measure set with finalized refinements to measures for the FFYs 2020 – 2022 payment determination and subsequent years.

IPPS-Excluded Hospital Policies

DISPLAY pages 1,412 – 1,413

Certain hospitals excluded from the inpatient prospective payment system, including children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico receive payment for inpatient hospital services they furnish on the basis of reasonable costs, subject to a rate-of-increase ceiling. A per-discharge limit is set for each hospital based on the hospital's own cost experience in its base year, and updated annually. For FFY 2019, CMS is making the following policy changes that would affect hospitals excluded from the IPPS:

- **FFY 2019 Payment Rate of Increase for Excluded Hospitals *(DISPLAY pages 1,412 – 1,416)*:** For each cost reporting period, an excluded hospital's updated target amount is multiplied by total Medicare discharges during that period and applied as an aggregate upper limit of Medicare reimbursement for total inpatient operating costs for a hospital's cost reporting period. CMS uses the percentage increase in the IPPS operating market basket to update the target amounts for children's hospitals, cancer hospitals, and RNHCIs.

  CMS will, for cost reporting periods starting during FFY 2019, set the update to the target amount for long-term care neoplastic disease hospitals is 2.8 percent.

- **Satellite Facilities *(DISPLAY pages 1,416 – 1,421)*:** In FFY 2017, CMS adopted a change to its hospital-within-hospital (HwH) regulations to only require that IPPS-excluded HwHs that are co-located with IPPS hospitals comply with the separateness and control requirements in those regulations, to which there were public comments requesting a similar change be made to the rules governing satellite facilities. CMS states that there are significant similarities between the definition of a satellite facility and the definition of an HwH as those definitions relate to their co-location with host hospitals, and are each premised on many of the same concerns.

  CMS is finalizing that, effective on or after October 1, 2018, a satellite facility that is part of an IPPS-excluded hospital that provides inpatient services in a building also used by an IPPS-excluded hospital, or in one or more entire buildings located on the same campus as buildings used by an IPPS-excluded hospital, is not required to meet the criteria in §412.22(h)(2)(iii)(A)(1) through (3) in order to be excluded from the IPPS. Further, a satellite facility that is part of an IPPS-excluded hospital which is located in a building also used by an IPPS hospital, or in one or more entire buildings located on the same campus as buildings used by an IPPS hospital, is still required to meet those same criteria in order to be excluded from the IPPS.

  Additionally, CMS adopted its proposal that for cost reporting periods beginning on or after October 1, 2019, an IPPS excluded hospital would no longer be precluded from having an excluded psychiatric and/or rehabilitation unit, and therefore would not have to comply with the separateness and control requirements as long as the satellite of the excluded unit is not co-located with an IPPS hospital.

- **Excluded Units of Hospitals *(DISPLAY page 1,421 – 1,430)*:** CMS is finalizing that, effective with cost reporting periods beginning on or after October 1, 2019, an IPPS-excluded hospital would be permitted to have an excluded psychiatric and/or rehabilitation unit. In addition, CMS is also specifying that an IPPS-excluded hospital may not have an IPPS-excluded unit of the same type (psychiatric or rehabilitation) as the hospital.

Medicare Electronic Health Record (EHR) Incentive Program

DISPLAY pages 1916-2098

Beginning CY 2019, CMS is adopting an updated EHR Incentive program performance-based scoring methodology for eligible hospitals and Critical Access Hospitals (CAHs), as opposed to the current Stage 3 methodology. CMS believes the new scoring methodology will reduce burden on health care providers, EHR developers and vendors, as well as allow for flexibility on scoring.

The new program has fewer measures and moves away from the threshold-based methodology currently in use. It applies to eligible hospitals and CAHs that submit an attestation to CMS under the Medicare EHR program beginning in CY 2019.

The adopted methodology groups measures into four objectives as opposed to the current 6 objectives and scores hospitals and CAHs based on performance and participation, rather than the threshold-based methodology currently in use.

The smaller set of objectives in the adopted methodology are: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. Each measure is scored individually based on the eligible hospital or CAH's performance for that measure, except for the Public Health and Clinical Data Exchange objective, which requires a yes/no attestation. The scores for each measure are added together to calculate a total Promoting Interoperability (PI) score, 100 points being the max. A total score of 50 points or more satisfies the requirement to report on the objectives and measures of meaningful use and therefore either receive an incentive payment and/or avoid a payment reduction.

CMS is reducing the overall number of required measures in the program from 16 to 6. In addition, CMS is adopting two new opioid measures and one new health information exchange measure.

Adopted Performance-Based Scoring Methodology Beginning with EHR Reporting Periods in CYs 2019 and 2020:

Objectives	Measures	2019: Maximum Points	2020: Maximum Points
e-Prescribing	e-Prescribing	10 points	5 points
	Query of Prescription Drug Monitoring Program (PDMP)	5 point (bonus)	5 points (required)
	Verify Opioid Treatment Agreement	5 point bonus (bonus)	5 points (proposed as required, finalized as bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Heath Information	20 points	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	40 points (proposed at 35 points)
Public Health and Clinical Data Exchange	<u>Choose two measures:</u> Syndromic Surveillance Reporting (proposed as required but finalized as optional) Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points	10 points

Lastly, CMS is adopting its proposal to rename the current EHR Incentive Program to the Promoting Interoperability Program which reflects the finalized scoring and measurement policies for CYs 2019 and 2020 which focus on interoperability and improving patient access to health information.

Online Posting of Standard Hospital Charges

DISPLAY pages 2,135 – 2,142

Effective January 1, 2019, CMS is updating its guidelines to require hospitals to make a list of their current standard charges available via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate. This could take the form of the chargemaster itself, or another form of the hospital's choice, as long as the information is in a machine readable format.

In order to further its objective of hospital price transparency, in the proposed rule CMS sought public comment on a number of topics, including:

- The definition of "standard charges";
- The types of information most beneficial to patients, how hospitals can best enable patients to use charge and cost information, and how CMS and providers can help third parties create patient-friendly interfaces for this data;
- Requirements for providers to inform patients of their out-of-pocket costs prior to performing a service, improvements to patient out-of-pocket cost transparency; and
- Requirements for providers to provide patients with information on what Medicare pays for a given service.

After consideration of comments received, CMS does not believe that there is a need for further updates to the guidelines beyond those that are currently effective as of January 1, 2019.

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