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An Analysis and Commentary on Federal Health Care Issues
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Final FY 2019 Medicare IPPS and LTCH Update Issued

The Centers for Medicare and Medicaid Services (CMS) have released a final rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2019 – for discharges beginning October 1, 2018.

The document is currently on public display at the ***Federal Register*** office and is scheduled for publication August 17th. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16766.pdf.

The IPPS tables for this rule are available through the Internet on the CMS website at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2019 IPPS Final Rule Home Page" or "Acute Inpatient—Files for Download."

The LTCH PPS tables are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1694-F.

Comment

CMS projects that "the rate increase, together with other changes to IPPS payment policies, will increase Medicare spending on inpatient hospital services in FY 2019 by approximately $4.8 billion, including an increase in new technology add-on payments of $0.2 billion. Other additional payment adjustments will include continued penalties for excess readmissions, a continued 1.0 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."

This is a huge rule. Its long, perhaps too long at 2,593 pages. It could be the longest rule ever issued in the Medicare program. Much material still repeats old history.

CMS still fails, to provide any help with page numbering. As we have said on many occasions, if the agency wants to truly assist the reader in locating pertinent information and reduce burden, page numbers would be very helpful. It is not hard to do. The table of contents only refers to major headings. No subheads/ sections are identified. When CMS refers the reader to a particular section, it is extremely difficult to locate.

To assist those with a particular subject interest page numbers corresponding to the material in the **display copy** of the rule are provided. Note, these numbers will change upon the rule's official publication. Also, there are instances in which a particular item can be discussed in more than one area. Not all such area page listings are identified.

Note: CMS' page numbering is inaccurate. It skips 17 pages. [Acrobat Pro has been used to read the document.] The Secretary and Administrator signed off on the rule on page 2,249. This is the same page count that Adobe Acrobat notes. However, the next page in the long document, the start of the Addendum, CMS says is page 2,267. Adobe says the page is 2,250. Adobe is not skipping any pages. Therefore, our references are to the Adobe count since that is how one would find the information.

For many payment issues, the rule's Addendum **(beginning on Adobe Page 2,250)** contains much concise and extremely helpful information, especially those items related to payment subjects.

The rule contains an extremely long Regulatory Impact analysis (**Page 2,403).** The analysis is helpful in understanding many of the payment changes being made. The regulatory section amplifies CMS cited increase in payments above. It says that "the applicable percentage increase to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule, will result in an estimated $4.8 billion increase in FY 2019 payments, primarily driven by a combined $4.4 billion increase in FY 2019 operating payments and uncompensated care payments, and a combined $0.4 billion increase in FY 2019 capital payments, new technology add-on payments, and low-volume hospital payments." Please note that the uncompensated care costs – Disproportionate Hospital Payments (DSH) – will increase $1.5 billion because the number of uninsured patients is increasing.

In addition, CMS says that LTCHs are expected to experience an increase in payments by $39 million in FY 2019 relative to FY 2018.

As of July 2018, CMS says there were 3,256 IPPS acute care hospitals included in its analysis. This represents approximately 54 percent of all Medicare-participating hospitals. There also are approximately 1,398 CAHs.

The material that follows is a section-by-section analysis of major components based. It does not necessarily follow the organization contained in the rulemaking.

I. CHANGES TO PAYMENT RATES UNDER IPPS (Page 941 and Addendum Page 2,250)

The final increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users will be approximately 1.85 percent. This reflects a projected hospital market basket update of 2.9 percent (up from a proposed amount of 2.8) reduced by a 0.8 percentage point multi-factor productivity (MFP) adjustment. This also reflects a proposed +0.5 percentage point adjustment required by Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MARCA) for documentation and coding, and a negative 0.75 percentage point adjustment required by the ***Affordable Care Act*** (ACA).

CMS displays four applicable percentage increases to the standardized amount for FY 2019, as specified in the following table **(Page 2254)**. Note: the +0.5 percent documentation and coding adjustment cited above is not included in the table.

FY 2019 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS				
FY 2019	**Hospital Submitted Quality Data and is a Meaningful EHR User**	**Hospital Submitted Quality Data and is NOT a 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**
Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.725	-0.725
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.175	0	-2.175
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.8	-0.8	-0.8	-0.8
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	**1.35**	**-0.825**	**0.625**	**-1.55**

Standardized Payment Rates

CMS has calculated the following FY 2019 standardized payment amounts. **(Page 2,401)**

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.85 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.550Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.55 Percent)	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,858.62	**$1,790.90**	**$3,775.81**	**$1,752.47**	**$3,831.02**	**$1,778.09**	**$3,748.21**	**$1,739.66**
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,502.70	**$2,146.82**	**$3,427.43**	**$2,100.75**	**$3,477.65**	**$2,131.46**	**$3,402.48**	**$2,085.39**

The **labor-related** portion for areas with wage indexes greater than 1.0000 will continue at **68.3** percent. Areas with wage index values equal to or less than 1.000 will remain at **62.0.** **(Page 924 and Page 2,258)**

The total labor/nonlabor amount for the full update (2 left columns) (hospitals that submit quality data and are meaningful EHR users) is $5,649.52 for both wage index areas – those greater than 1.0000 and those with values equal to or less than 1.0000.

The current (FY 2018) large urban labor rate is $3,806.04 and the non-labor rate is $1,766.49 for a total of $5,572.53. The other area labor rate is $3,454.97 and the non-labor component is $2,117.56 for a total of $5,572.53.

The following table **(Pages 2,317-2,318)** illustrates the changes from the FY 2018 national standardized amount to the final FY 2019 national standardized amount. The total FY 2018 rates for both urban areas (large and other) is $5,572.53. These amounts are adjusted by the outlier and geographic reclassification factors as shown. The result is a total labor/ non-labor amount of $5,943.43.

Changes from FY 2018 Standardized Amounts to the FY 2019 Standardized Amounts

	Hospital Submitted Quality Data and is a Meaningful EHR User	**Hospital Submitted Quality Data and is NOT a 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**
FY 2018 Base Rate after removing: 1. FY 2018 Geographic Reclassification Budget Neutrality **(0.987985)** 2. FY 2018 Operating Outlier Offset **(0.948998)**	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor = $5,943.43)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor = $5,943.43)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor = $5,943.43)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7% $1,884.07 *(Combined labor and nonlabor = $5,943.43)*
	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*
Final FY 2019 Update Factor	1.0135	0.99175	1.0062	0.9845
FY 2019 MS-DRG Recalibration Budget Neutrality Factor	0.997192	0.997192	0.997192	0.997192

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a 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
FY 2019 Wage Index Budget Neutrality Factor	1.000748	1.000748	1.000748	1.000748
FY 2019 Reclassification Budget Neutrality Factor	0.985932	0.985932	0.985932	0.985932
FY 2019 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
FY 2019 Rural Demonstration Budget Neutrality Factor	0.999467	0.999467	0.999467	0.999467
Adjustment for FY 2019 Required under Section 414 of Pub. L. 114-10 (MACRA	1.005	1.005	1.005	1.005
National Standardized Amount for FY 2019 if Wage Index is Greater Than 1.0000; **Labor/Non-Labor Share Percentage (68.3/31.7)**	**Labor: $3,858.62** **Nonlabor: $1,790.90**	**Labor: $3,775.81** **Nonlabor: $1,752.47**	**Labor: $3,831.02** **Nonlabor: $1,778.09**	**Labor: $3,748.21** **Nonlabor: $1,739.66**
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to1.0000; **Labor/Non-Labor Share Percentage (62.0/38.0)**	**Labor: $3,502.70** **Nonlabor: $2,146.82**	**Labor: $3,427.53** **Nonlabor: $2,100.75**	**Labor: $3,477.65** **Nonlabor: $2,131.46**	**Labor: $3,402.48** **Nonlabor: $2,085.39**

The combined FY 2019 labor and nonlabor amounts for a full update is **$5,649.52**. The FY 2018 total labor/nonlabor amount for the full update is $5,572.53. The change between the FY 2019 amount and the current amount is $76.99, or a net increase of 1.36 percent.

These amounts are before other adjustments such as the hospital value-based purchasing program, readmission program, and hospital acquired conditions program.

Comment (Pages 2,414 and 2,415)

CMS says 137 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they are identified as not meaningful EHR users but do submit quality information under section 1886(b)(3)(B)(viii) of the Act.

CMS says 49 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users.

CMS says 40 hospitals are estimated to not receive the market basket rate-of-increase for FY 2019 because they are identified as not meaningful EHR users and do not submit quality data under section 1886(b)(3)(B)(viii) of the Act.

Bottom line is few hospitals are not reporting quality and/or are not meaningful EHR users.

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2019 (Page 2,339)

The FY 2019 capital rate will be **$459.72.** The current amount is $453.95.

Outlier Payments (Page 2,303)

CMS is adopting an outlier fixed-loss cost threshold for FY 2019 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$25,769.** The current threshold amount is $26,601.

Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals (page 2,320)

CMS is adopting COLA factors for Alaska and Hawaii for FY 2019 as follows:

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) Updates and Issues (page 1,085)

The FY 2019 applicable percentage increase in the hospital-specific rate for SCHs and MDHs equals the applicable percentage increase set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS).

Depending on whether a hospital submits quality data and is a meaningful EHR user, CMS is adopting the same four possible applicable percentage increases in the table above for the hospital-specific rate applicable to SCHs and MDHs.

Medicare Dependent Hospitals

Section 50205 of the ***Bipartisan Budget Act of 2018*** extends the MDH program for discharges on or after October 1, 2017 through September 30, 2022.

Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area (or, as amended by the ***Bipartisan Budget Act of 2018***, as a hospital located in a State with no rural area that meets certain statutory criteria), has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years).

MDHs are paid based on the IPPS Federal rate or, if higher, the IPPS Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate.

CMS notes that, consistent with previous extensions of the MDH program, generally, a provider that was classified as an MDH as of September 30, 2017, was reinstated as an MDH effective October 1, 2017, with no need to reapply for MDH classification.

However, if the MDH had classified as an SCH or cancelled its rural classification under § 412.103(g) effective on or after October 1, 2017, the effective date of MDH status may not be retroactive to October 1, 2017. These hospitals need to reapply for MDH status.

Prior to the enactment of the ***Bipartisan Budget Act of 2018***, a hospital in an all-urban State was ineligible for MDH classification because it could not reclassify as rural. With the new provision added by section 50205 of the ***Bipartisan Budget Act of 2018***, a hospital in an all-urban State can apply and be approved for MDH classification if it can demonstrate that: (1) it meets the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, for the sole purposes of qualifying for MDH classification; and (2) it meets the MDH classification criteria at § 412.108(a)(1)(i) through (iii), which, as amended, would be redesignated as § 412.108(a)(1)(i) through (iv).

Because MDHs are paid based on the IPPS Federal rate, they continue to be eligible to receive empirically justified Medicare Disproportionate Share (DSH) payments and uncompensated care payments if their disproportionate patient percentage (DPP) is at least 15 percent.

Sole Community Hospitals

The Act defines a SCH as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. In addition, certain rural hospitals previously designated by the Secretary as essential access community hospitals are considered SCHs.

The IPPS Federal rate that is used in the MDH payment methodology is the same IPPS Federal rate that is used in the SCH payment methodology.

The prospective payment rate for SCHs for FY 2019 equals the higher of the applicable Federal rate, or the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge.

Comment

The material regarding applications to become a SCH or MDH is extensive. Most of the material pertains to regulation and legislative cites.

CMS reports that there are 312 SCHs and 140 MDHs.

Low Volume Hospitals (Pages 956)

Section 50204 of the ***Bipartisan Budget Act of 2018*** amended section 1886(d)(12) of the Act to provide for certain temporary changes to the low-volume hospital payment adjustment policy for FYs 2018 through 2022. For FY 2018, this provision extends the qualifying criteria and payment adjustment formula that applied for FYs 2011 through 2017.

For FYs 2019 through 2022, this provision modifies the discharge criterion and payment adjustment formula. In FY 2023 and subsequent fiscal years, the qualifying criteria and payment adjustment revert to the requirements that were in effect for FYs 2005 through 2010.

For FYs 2019 through 2022, a subsection (d) hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 3,800 total discharges during the fiscal year.

Hospitals with 500 or fewer total discharges during the fiscal year, the low-volume hospital payment adjustment is an additional 25 percent for each Medicare discharge.

For hospitals with fewer than 3,800 total discharges but more than 500 total discharges, the low-volume hospital payment adjustment will be calculated using the following formula:

[(95/330) minus (the number of total discharges/13,200)].

For FY 2019 and subsequent fiscal years, the discharge determination is made based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges.

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 written request must be received by its MAC no later than September 1, 2018 in order for the low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2018. If the request is later than September 1, the adjustment will become effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

CMS estimates the changes to the low-volume hospital payment adjustment policy will increase Medicare payments by $75 million in FY 2019 as compared to FY 2018. More specifically, in FY 2019, CMS estimates that 628 providers will receive approximately $426 million compared to CMS' estimate of 612 providers receiving approximately $345 million in FY 2018.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2019 (Page 1,412 and Page 2,408)

The FY 2019 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, 98 children's hospitals, the 5 short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, 18 religious nonmedical health care institutions, and 1 extended neoplastic disease care hospitals is the estimated percentage increase in the IPPS operating market basket for FY 2019 – that is, 2.9 percent.

Changes to Regulations Governing Excluded Units of Hospitals (Page 1,421)

CMS proposed to revise § 412.25(a)(1)(ii) to specify that the requirement that an excluded psychiatric or rehabilitation unit cannot be part of an IPPS-excluded hospital is only effective through cost reporting periods beginning on or before September 30, 2019, FY 2020.

CMS is finalizing its changes to § 412.25(a)(1)(ii) as proposed without modification, making a conforming change to § 412.25(a)(1)(iii) by replacing the phrase "beds that are not excluded from the inpatient prospective payment system" with the phrase "beds that are paid under the applicable payment system under which the hospital is paid." CMS is revising § 412.25(d) to specify that an IPPS-excluded hospital may not have an IPPS-excluded unit of the same type (psychiatric or rehabilitation) as the hospital.

Changes to Regulations Governing Satellite Facilities (Page 1,416)

CMS is adding a new paragraph (4) to § 412.22(h)(2)(iii)(A) to specify 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.

II. CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 807)

County Codes

For FY 2019, CMS will continue to use only the Federal Information Processing Standard (FIPS) county codes for purposes of cross-walking counties to CBSAs.

Core-Based Statistical Areas (CBSAs) Changes (Page 808)

The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013.

In a revised OMB Bulletin, No. 17-01, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. The new urban CBSA is as follows:

- Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

Worksheet S-3 Wage Data for the FY 2019 Wage Index (Page 823)

The FY 2019 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2015 (the FY 2018 wage indexes were based on data from cost reporting periods beginning during FY 2014).

CMS is finalizing its proposal, without modification, to eliminate other wage-related costs from the calculation of the wage index for the FY 2020 wage index and subsequent years. CMS is clarifying that all other wage-related costs, even those not reported on Worksheet S-3, Part II, Line 18 and Worksheet S-3, Part IV, Line 25 and subscripts, such as contract labor, are being removed from the calculation of the wage index, and CMS will update the cost report instructions accordingly.

Update of Policies Related to Other Wage-Related Costs, Clarification of the Calculation of Other Wage-Related Costs, and Proposals for FY 2020 and Subsequent Years (Page 823)

For FY 2018, CMS clarified that a cost must be a fringe benefit as described by the IRS and must be reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income in order to be considered an other wage-related cost on Line 18 of Worksheet S-3 and for the wage index.

In the FY 2018 IPPS/LTCH PPS final rule CMS clarified that a hospital may be able to report a wage-related cost (defined as the value of the benefit) that does not appear on the core list if the individual wage-related cost is greater than 1.0 percent of total salaries after the direct excluded salaries are removed (the sum of Worksheet S–3, Part II, Lines 11, 12, 13, 14, Column 4, and Worksheet S–3, Part III, Line 3, Column 4).

CMS says it inadvertently omitted Line 15 for Home Office Part A Administrator on Worksheet S-3, Part II from the denominator. Line 15 should be included in the denominator because Home Office Part A Administrator is added to Line 1 in the wage index calculation. Therefore, CMS is correcting the inadvertent omission of Line 15 from the denominator, and is clarifying that, for calculating the 1.0 percent test, each individual category of the other wage-related cost (that is, the numerator) should be divided by the sum of Worksheet S-3, Part III, Lines 3 and 4, Column 4 (that is, the denominator).

For the FY 2020 wage index and subsequent years, CMS will only include the wage-related costs on the core list in the calculation of the wage index and not to include any other wage-related costs in the calculation of the wage index.

Codify Policies Regarding Multicampus Hospitals (Page 837)

CMS proposed 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. To qualify for rural reclassification or SCH, RRC, or MDH status, CMS proposed that a hospital with remote locations must demonstrate that both the main campus and its remote location(s) satisfy the relevant qualifying criteria.

The proposals apply to hospitals with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the IPPS and that meet the provider-based criteria at § 413.65 as a main campus and a remote location of a hospital, also referred to as multicampus hospitals or hospitals with remote locations.

CMS is finalizing as proposed, without modification, its codification of policies regarding multicampus hospitals in the regulations at § 412.92, § 412.96, and § 412.108.

Occupational Mix Adjustment to the FY 2019 Wage Index (Page 859)

The FY 2019 occupational mix adjustment is based on the calendar year (CY) 2016 survey.

The FY 2019 unadjusted national average hourly wage and FY 2019 occupational mix adjusted national average hourly wage is:

Final Unadjusted National Average Hourly Wage	Final Occupational Mix Adjusted National Average Hourly Wage
$42.997789358	$42.955567020

The FY 2019 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$41.66099188
National LPN and Surgical Technician	$24.74107416
National Nurse Aide, Orderly, and Attendant	$16.96864849
National Medical Assistant	$18.13188525
National Nurse Category	$35.04005228

Application of the Rural, Imputed, and Frontier Floors

Rural Floor (Page 867)

The area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is referred to as the "rural floor." Section 3141 of the ACA also requires that a national budget neutrality adjustment be applied in implementing the rural floor. CMS estimates that 263 hospitals will receive an increase in their FY 2019 wage index due to the application of the rural floor.

Expiration of Imputed Floor Policy (Page 868)

Currently, there are three all-urban States: Delaware, New Jersey, and Rhode Island.

The imputed floor is set to expire effective October 1, 2018, and CMS says it is not extending the policy. There are 10 hospitals in New Jersey, 9 hospitals in Rhode Island, and 3 hospitals in Delaware that will no longer receive an increase in their FY 2019 wage index due to the expiration of the imputed floor policy.

State Frontier Floor for FY 2019 (Page 882)

Fifty (50) hospitals will receive the frontier floor value of 1.0000 for their FY 2019 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

FY 2019 Reclassification Requirements and Approvals (Page 884)

At the time this rule was constructed, the Medicare Geographic Classification Review Board (MGCRB) had completed its review of FY 2019 reclassification requests. Based on such reviews, there are 303 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2019.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2019, hospitals reclassified beginning in FY 2017 or FY 2018 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There are 230 hospitals approved for wage index reclassifications in FY 2017 that will continue for FY 2019, and 348 hospitals approved for wage index reclassifications in FY 2018 that will continue for FY 2019. All hospitals approved for reclassification for FY 2017, FY 2018, and FY 2019 total 881.

Applications for FY 2020 reclassifications are due to the MGCRB by September 4, 2018 (the first working day of September 2018). Applications and other information about MGCRB reclassifications may be obtained via the Internet on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html, or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 1508 Woodlawn Drive, Suite 100, Baltimore, MD 21207.

Revision of Reclassification Requirements for a Provider that is the Sole Hospital in the MSA (Page 890)

Section 412.230 of the regulations sets forth criteria for an individual hospital to apply for geographic reclassification to a higher rural or urban wage index area. One of these required criteria, under § 412.230(d)(1)(iii)(C), is that the hospital must demonstrate that its own average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located.

CMS is adopting for reclassification applications for FY 2021 and subsequent fiscal years, that a hospital provide its 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 3-year period considered by the MGCRB.

Clarification of Group Reclassification Policies for Multicampus Hospitals (Page 894)

Remote locations of hospitals in a distinct geographic area from the main hospital campus are eligible to seek wage index reclassification.

In Table 2 associated with this rule such locations are indicated with a "B" in the third digit of the CSA certification number (CCN).

Hospitals are eligible to seek both individual and county group reclassifications for these "B" locations through the MGCRB, using the wage data published for the most recent IPPS final rule for the "B" location.

"When a county group MGCRB reclassification includes a remote location of a hospital located in a different labor market area that has not yet been assigned a "B" number in Table 2 of the applicable IPPS final rule used to evaluate reclassification criteria, to help facilitate the MGCRB's review, the county group should submit the application to the MGCRB listing the remote location with a "B" in the third digit of its CCN. If the application is approved by the MGCRB, CMS will include the "B" location number, with applicable reclassification status and wage index values, in Table 2 of the subsequent IPPS final rule."

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 900)

Beginning with FY 2005, CMS established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the "out-migration" adjustment).

CMS is adding a new Table 4, "List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2019.". This table consists of the following: a list of counties that would be eligible for the out-migration adjustment for FY 2019 identified by FIPS county code, the FY 2019 out-migration adjustment, and the number of years the adjustment would be in effect. CMS says it believes this new table will make this information more transparent and provide the public with easier access to this information.

Reclassification from Urban to Rural under Section 1886(d)(8)(E) of the Act, Implemented at 42 CFR 412.103 and Change to Lock-In Date (Page 903)

A qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Hospitals must meet the criteria to be reclassified from urban to rural status under § 412.103, as well as fulfill the requirements for the application process.

CMS is changing one of the criteria – the lock-in date – to provide for additional time in the rate-setting process and to match the lock-in date with another existing deadline. Under this revision, there would no longer be a requirement that the hospital file its rural reclassification application by a specified date (which under the current policy is 70 days prior to the second Monday in June).

Any hospital with an approved rural reclassification by the lock-in date (that is now, 60 days after the *public display date* of the IPPS notice of *proposed* rulemaking at the Office of the ***Federal Register***) would be included in the wage index and budget neutrality calculations for setting payment rates for the next Federal fiscal year, regardless of the date of filing.

III. OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING SYSTEM (Page 927)

Changes to MS-DRGs Subject to Postacute Care Transfer Policy and MS-DRG Special Payments Policies (§ 412.4) (Page 927)

CMS proposed to make changes to a number of MS-DRGs, effective for FY 2019. Specifically, CMS proposed to:

- Assign CAR-T therapy procedure codes to MS-DRG 016 (revise the title: Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy);
- Delete MS-DRG 685 (Admit for Renal Dialysis) and reassign diagnosis codes from MS-DRG 685 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, 766, 767, 774, 775, 777, 778, 780, 781, and 782) and create 18 new MS-DRGs relating to Pregnancy, Childbirth and the Puerperium (MS-DRGs 783 through 788, 794, 796, 798, 805, 806, 807, 817, 818, 819, and 831 through 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);
- Reassign 12 ICD-10-PCS procedure codes from MS-DRGs 329, 330 and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 344, 345, and 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, 871, and 872 (Septicemia or Severe Sepsis with and without Mechanical Ventilation >96 Hours with and without MCC, respectively) to MS-DRG 864 (proposed revised title: Fever and Inflammatory Conditions).

MS-DRGs 023, 329, 330, 331, 698, 699, 700, 870, 871, and 872 are currently subject to the postacute care transfer policy. These MS-DRGs, as revised, would continue to qualify to be included on the list of MS-DRGs that are subject to the postacute care transfer policy.

CMS has developed a chart which sets forth the most recent analysis of the postacute care transfer policy criteria completed with respect to each of these proposed new or revised MS-DRGs.

CMS is finalizing these proposed changes to the MS-DRGs with the exception of the proposed revisions to MS-DRGs 329, 330, 331, 344, 345, and 336. Therefore, MS DRGs 329, 330, 331, 344, 345, and 336 are not included in the updated analysis of the postacute care transfer policy and special payment policy.

LIST OF REVISED MS-DRGs SUBJECT TO REVIEW OF SPECIAL PAYMENT POLICY STATUS FOR FY 2019					
Revised MS-DRG	MS-DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS-DRG	Special Payment Policy Status
023	Craniotomy with Major Device Implant or Acute CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator	7.3	$97,557	$96,623	Yes
698	Other Kidney and Urinary Tract Diagnoses with MCC	4.9	$18,290	$25,199	No
699	Other Kidney and Urinary Tract Diagnoses with CC	3.4	$16,872	$16,984	No
700	Other Kidney and Urinary Tract Diagnoses without CC/MCC	2.5	$14,283	$12,943	No
870	Septicemia or Severe Sepsis with Mechanical Ventilation >96 Hours	12.4	$0	$102,505	No
871	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with MCC	4.8	$19,860	$29,939	No
872	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours without MCC	3.7	$18,096	$17,399	No

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index and Discharge Criteria (§ 412.96) (Page 950)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Rural hospitals with fewer than 275 beds can qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2018, must have a CMI value for FY 2017 that is at least—

- 1.6612; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.4071
2	Middle Atlantic (PA, NJ, NY)	1.4701
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5492
4	East North Central (IL, IN, MI, OH, WI)	1.5743
5	East South Central (AL, KY, MS, TN)	1.5293
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.63935
7	West South Central (AR, LA, OK, TX)	1.6859
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7366
9	Pacific (AK, CA, HI, OR, WA)	1.6613

A hospital must also have the number of discharges for its cost reporting period that began during FY 2016 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

IME Adjustment Factor for FY 2019 (Page 967)

For discharges occurring during FY 2019, the formula multiplier is 1.35.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2019 (§ 412.106) (Page 969)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, is reduced to reflect changes in the percentage of individuals who are uninsured.

For FY 2014 and each subsequent fiscal year, a subsection (d) hospital (a PPS hospital) that would otherwise receive DSH payments made under section 1886(d)(5)(F) of the Act receives two separately calculated payments.

- Sole community hospitals (SCHs) that are paid under their hospital-specific rate are not eligible for Medicare DSH payments.
- Maryland hospitals are not eligible for Medicare DSH payments and uncompensated care payments because they are not paid under the IPPS.
- Medicare-dependent, small rural hospitals (MDHs) are paid based on the IPPS, subject to adjustments, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- IPPS hospitals that elect to participate in the Bundled Payments for Care Improvement Advanced Initiative (BPCI Advanced) model starting October 1, 2018, will continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

- IPPS hospitals that are participating in the Comprehensive Care for Joint Replacement Model continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

- Hospitals participating in the Rural Community Hospital Demonstration Program are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

There are 3 factors in determining the amount of such payments.

Calculation of Factor 1 for FY 2019 (Page 981)

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid for Medicare DSH payments for the fiscal year, and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the Act. In other words, this factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

In the proposed rule the Office of the Actuary estimated total DSH payments for FY 2019 would be $16.295 billion. The June 2018 Office of the Actuary's estimate for FY 2019, was approximately $16.339 billion.

Therefore, 25 percent of total estimated FY 2019 DSH payments equals approximately $4.085 billion.

CMS says **Factor 1 for FY 2019 is $12,254,291,878.57**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2019 ($16,339,055,838.09 minus $4,084,763,959.52).

Calculation of Factor 2 for FY 2019 (Page 994)

The statute states that, for FY 2018 and subsequent fiscal years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified), minus 0.2 percentage point for FYs 2018 and 2019.

The Actuary's projections for CY 2018 and CY 2019 is as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2018: 9.1 percent.
- Percent of individuals without insurance for CY 2019: 9.6 percent.
- Percent of individuals without insurance for FY 2019 (0.25 times 0.091) +(0.75 times 0.096): 9.48 percent

The statutory formula for factor 2 is equal to 1-|((0.0948-0.14)/0.14)| = 1- 0.3229= 0.6771 (67.71 percent) 0.6771 (67.71 percent) - .002 (0.2 percentage points for FY 2019 under section 1886(r)(2)(B)(ii) of the Act) = 0.6751 or 67.51 percent
0.6751= Factor 2

Therefore, the final Factor 2 for FY 2019 is **67.51 percent.**

The final FY 2019 uncompensated care amount is: $12,254,291,878.57 x 0.6751 = **$8,272,872,447.22**. The following shows the 75 percent amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" is $6.767 billion
- The FY 2019 "pool" will be $8.273 billion

Calculation of Factor 3 for FY 2018 (Page 1,006)

Factor 3 is equal to the percent, for each subsection (d) hospital, that represents the quotient of (1) the amount of uncompensated care for such hospital; and (2) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under section 1886(r) of the Act for such period (as so estimated, based on such data).

CMS is not making any proposals with respect to the development of Factor 3 for FY 2020 and subsequent fiscal years, fully transitioning the incorporation of data from Worksheet S–10 into the calculation of Factor 3 if used in FY 2020.

CMS is finalizing its proposal to use 2 years of Worksheet S-10 data from FY 2014 and FY 2015 cost reports in conjunction with data on low-income insured days that reflects Medicaid days from FY 2013 and SSI days from FY 2016, to calculate Factor 3 for FY 2019.

Therefore, for FY 2019, CMS will compute Factor 3 for each hospital by—

- Step 1: Calculating Factor 3 using the low-income insured days proxy based on FY 2013 cost report data and the FY 2016 SSI ratio,

- Step 2: Calculating Factor 3 based on the FY 2014 Worksheet S–10 data;

- Step 3: Calculating Factor 3 based on the FY 2015 Worksheet S–10 data; and

- Step 4: Averaging the Factor 3 values from Steps 1, 2, and 3; that is, adding the Factor 3 values from FY 2013, FY 2014, and FY 2015 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor 3.

Hospital Readmissions Reduction Program (HRRP): (Page 1098)

CMS says that the HRRP provides an incentive for hospitals to provide high quality patient care by reducing applicable IPPS hospital payments by up to 3.0 percent for excess hospital readmissions in six clinical areas.

The six applicable conditions/procedures are: acute myocardial infarction (AMI); heart failure (HF); pneumonia; total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG).

The ***21st Century Cures Act*** requires that CMS begin assessing eligible hospital readmission performance relative to hospitals with a similar proportion of dual-eligible Medicare-Medicaid patients. CMS will assign eligible hospitals into five equal sized peer groups based on their proportion of dual eligible patients.

CMS proposed several updates to clarify definitions needed to implement statutory requirements of the ***21st Century Cures Act***. CMS proposed to: (1) establish the applicable period for FY 2019, FY 2020 and FY 2021; (2) codify the previously adopted definition of "dual-eligible"; (3) codify the previously adopted definition of "proportion of dual-eligibles"; and (4) codify the previously adopted definition of "applicable period for dual-eligibility."

Measures under the HRRP would remain the same.

Comment

CMS estimates that 2,599 or 84.88 percent of hospitals will have their base operating MS-DRG payments reduced.

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes (Page 1,134)

The Hospital VBP Program adjusts payments to IPPS hospitals for inpatient services based on their performance on an announced set of measures. Section 1886(o)(7)(B) of the Act instructs the Secretary to reduce the base operating DRG payment amount for a hospital for each discharge in a fiscal year by an applicable percent. The FY 2019 program year is 2.00 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2019 will be approximately $1.9 billion.

CMS proposed the removal of 10 measures, all of which are also included in the Hospital Inpatient Quality Reporting (IQR) and/or Hospital Acquired Condition (HAC) Reduction Program measure sets, and revised weighting of the Hospital VBP Program domains.

CMS proposed the following deletions:

- Elective Delivery (NQF #0469) (PC-01) beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138) (CAUTI) Program beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139) (CLABSI) Program beginning with the FY 2021 program year;
- American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) (Colon and Abdominal Hysterectomy SSI) Program beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) (MRSA Bacteremia) Program beginning with the FY 2021 program year;

- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717) (CDI) Program beginning with the FY 2021 program year;
- Patient Safety and Adverse Events (Composite) (NQF #0531) (PSI 90) Program effective with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction (NQF #2431) (AMI Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure (NQF #2436) (HF Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule; and
- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (NQF #2579) (PN Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule.

Comment

This material and discussion of measures extends 119 pages. CMS is not removing all the measures cited above. While the agency is trying to reduce reporting burden, it is not totally removing measures. Rather, it is only removing items that appear in more than one venue. Eliminating elements in the Value-Based purchasing arena means the item can still/ will be active in the quality reporting program, or other reporting vehicles. The tables below identify the measure sets for FYs 2020, 2021 and 2022 years.

Previously Adopted Measures for the FY 2020 Program Year

Measure Short Name	Domain/Measure Name	NQF #
Person and Community Engagement Domain		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)(including Care Transition Measure)	0166 (0228)
Clinical Outcomes Domain*		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
THA/TKA	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Safety Domain		
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753

Measure Short Name	Domain/Measure Name	NQF #
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
PC-01	Elective Delivery	0469
Efficiency and Cost Reduction Domain		
MSPB	Medicare Spending Per Beneficiary (MSPB) – Hospital	2158

Set out below are summaries of measures for the FY 2021, FY 2022, and FY 2023 program years based on CMS' finalized policies in this final rule.

Summary of Measures for the FY 2021 Program Year

Measure Short Name	Domain/Measure Name	NQF #
Person and Community Engagement Domain		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)(including Care Transition Measure)	0166 (0228)
Safety Domain		
Cauti	National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI	National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
Clinical Outcomes Domain*		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
Mort-30-PN (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	1893

Measure Short Name	Domain/Measure Name	NQF #
THA/TKA	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Efficiency and Cost Reduction Domain		
MSPB	Medicare Spending Per Beneficiary (MSPB) – Hospital	2158

* As discussed in section IV.I.2.c.(1) of the preamble of this final rule, CMS is finalizing its proposal to remove the PC-01 measure from the Hospital VBP Program beginning with the FY 2021 program year. However, as discussed in sections IV.I.2.c.(2) and IV.I.4.a.(2) of the preamble of this final rule, CMS is not finalizing its proposals to remove CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, CDI, and MRSA Bacteremia measures, or the Safety domain.
** In section IV.I.4.a.(1) of the preamble of this final rule, CMS discusses its decision to finalize changing the name of this domain from the Clinical Care domain to the Clinical Outcomes domain beginning with the FY 2020 program year.
*** As discussed in sections IV.I.2.c.(3) of the preamble of this final rule, CMS is finalizing its proposal to remove two measures from the Efficiency and Cost Reduction domain (AMI Payment and HF Payment), which would have entered the program beginning with the FY 2021 program year.

The rule contains tables for FYs 2022 and 2023 as well. **(Page 1,194)**

Also, the rule discusses weights and scoring items.

Hospital-Acquired Condition (HAC) Reduction Program (Page 1253)

The HAC Reduction Program establishes an incentive for hospitals to reduce hospital-acquired conditions by requiring the Secretary to reduce applicable IPPS payment by 1.0 percent to all subsection (d) hospitals that rank in the worst-performing 25 percent of all eligible hospitals. CMS proposed administrative updates to receive and assess accuracy for five Healthcare Associated Infection measures currently included in the program. CMS also proposed to update measure weighting to simplify the methodology and address concerns raised by small hospitals.

CMS finalized three changes to existing HAC Reduction Program policies as follows.

- Specify the dates of the time period used to calculate hospital performance for the FY 2021 HAC Reduction Program;
- Adopt administrative processes to receive and validate National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) data that is submitted by hospitals to the Centers for Disease Control and Prevention (CDC) beginning CY 2020; and
- Adopt a new scoring methodology, which will equally weight all measures used in a hospital's program score.

Measures under the HAC Reduction Program will stay the same.

CMS says that 804 hospitals will be in the Worst-Performing Quartile.

Payments for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 1,329)

CMS proposed to revise the regulation to specify that new urban teaching hospitals (that is, hospitals that qualify for an adjustment under § 412.105(f)(1)(vii) or § 413.79(e)(1), or both) may form a Medicare GME affiliated group and therefore be eligible to receive both decreases and increases to their FTE caps.

CMS is finalizing a policy that effective for Medicare GME affiliation agreements entered into on or after July 1, 2019, a new urban teaching hospital (that is, a hospital that established permanent FTE caps after 1996) may enter into a Medicare GME affiliated group and receive a decrease to its FTE caps if the decrease results from a Medicare GME affiliated group consisting solely of two or more new urban

teaching hospitals. In addition, CMS is finalizing a policy that, effective for Medicare GME affiliation agreements entered into on or after July 1, 2019, a new urban teaching hospital(s) may enter into a Medicare GME affiliated group with an existing teaching hospital(s) (that is, a hospital(s) with 1996 FTE caps) and receive a decrease to its FTE caps, as long as the new urban teaching's hospitals caps have been in effect for 5 or more years. That is, once a new urban teaching hospital's caps are effective, after a cap-building period, the new urban teaching hospital can participate in a Medicare GME affiliation agreement with an existing teaching hospital and receive a decrease to its FTE caps after an additional 5-year waiting period.

Revisions Regarding Admission Order Documentation Requirements (Page 1,390)

CMS is finalizing its proposal to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment. Specifically, CMS is finalizing its proposal to revise the regulation at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.

IV. CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Pages beginning 57)

FY 2019 MS-DRG Documentation and Coding Adjustment (Page 58)

The adoption of the MS-DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. Since then, there has been much concern by Congress and CMS about upcoding by hospitals to maximize payments.

Section 631 of the ***American Taxpayer Relief Act of 2012*** (ATRA) required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion over four years from FY 2014 through FY 2017.

With the end of payment reductions, beginning in FY 2018, CMS says it planned on making a full positive adjustment to return IPPS rates to their appropriate payment amounts; i.e., the amounts without any reductions used to recapture the $11 billion.

However, section 414 of MACRA replaced the single positive adjustment the agency intended to make with a 0.5 percent positive adjustment for each of FYs 2018 through 2023. Further, section 15005 of the **21st Century Cures Act** reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.

CMS will implement a positive 0.5 percentage point adjustment to the standardized amount for FY 2019. This would be a permanent adjustment to payment rates. CMS says it plans to propose future adjustments required under section 414 of MACRA for FYs 2020 through 2023 in future rulemaking.

Comment

The adjustments mandated by statue will never completely replace the offsets made during FYs 2014-2017. Those adjustments totaled 3.9 percent (0.8 percent for FYs 2014,2015, and 2016.The adjustment in 2017 totaled 1.5 percent (0.8+0.8+0.8+1.5=3.9). Current legislation would add back 0.4588 for 2018 and 0.5 for 2019, 2020, 2021, 2022 and 2023 for a total of 2.5 percent and with the 0.4588 for 2018, the add back will total 2.9588. A commenter correctly pointed this discrepancy. However, CMS has avoided an answer. **(Page 63)**

Changes to Specific MS-DRG Classifications (Page 66)

The following items are some of the major MS-DRG proposed changes for FY 2019. CMS discusses many comments at great length. However, for many CMS is not adopting any changes at this time. Those with no action are not addressed below.

***Laryngectomy* (Page 114)**

CMS proposed to revise the titles of Pre-MDC MS-DRGs 11, 12, and 13 from "Tracheostomy for Face, Mouth and Neck Diagnoses with MCC, with CC and without CC/MCC, respectively" to "Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC", "Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC", and "Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC", respectively, to reflect that laryngectomy procedures may also be assigned to these MS-DRGs. CMS is finalizing its proposal.

***Chimeric Antigen Receptor (CAR) T-Cell Therapy* (Page 116)**

CMS proposed to assign ICD-10-PCS procedure codes XW033C3 and XW043C3 to Pre-MDC MS-DRG 016 for FY 2019. In addition, CMS proposed to revise the title of MS-DRG 016 from "Autologous Bone Marrow Transplant with CC/MCC" to "Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy." CMS is finalizing its proposal.

Epilepsy with Neurostimulator **(Page 126)**

CMS proposed to add ICD-10-CM diagnosis codes G40.109 and G40.111 to the listing of epilepsy diagnosis codes for cases assigned to MS-DRG 023, effective October 1, 2018. CMS is finalizing its proposal.

Pacemaker Insertions **(Page 154)**

CMS proposed to recreate pairs of procedure code combinations involving both the insertion of a pacemaker device with the insertion of a pacemaker lead to act as procedure code combination pairs or "clusters" in the GROUPER logic that are designated as O.R. procedures outside of MDC 5 when reported together. CMS also proposed to designate all the procedure codes describing the insertion of a pacemaker device or the insertion of a pacemaker lead as non-O.R. procedures when reported as a single, individual stand-alone code based.

CMS proposed to maintain the current GROUPER logic for MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with MCC and without MCC, respectively) where the listed procedure codes as shown in the ICD-10 MS-DRG Definitions Manual Version 35. CMS is finalizing its proposals.

Benign Lipomatous Neoplasm of Kidney **(Page 196)**

CMS proposed to reassign ICD-10-CM diagnosis code D17.71 from MS-DRGs 393, 394, and 395 (Other Digestive System Diagnoses with MCC, with CC, and without CC/MCC, respectively) under MDC 06 to MS-DRGs 686, 687, and 688 (Kidney and Urinary Tract Neoplasms with MCC, with CC, and without CC/MCC, respectively) under MDC 11 because this diagnosis code is used to describe a kidney neoplasm. CMS also proposed to reassign ICD-10-CM diagnosis code D17.72 from MS-DRGs 606 and 607 under MDC 09 to MS-DRGs 686, 687, and 688 under MDC 11. CMS is adopting its changes.

Admit for Renal Dialysis **(Page 188)**

CMS proposed to delete MS-DRG 685 and reassign ICD-10-CM diagnosis codes Z49.01, Z49.02, Z49.31, and Z49.32 from MS-DRG 685 to MS-DRGs 698, 699, and 700. CMS is adopting the proposal.

Pregnancy, Childbirth and the Puerperium **(Page 225)**

CMS proposed to delete the following 10 MS-DRGs under MDC 14:

- MS-DRG 765 (Cesarean Section with CC/MCC);
- MS-DRG 766 (Cesarean Section without CC/MCC);
- MS-DRG 767 (Vaginal Delivery with Sterilization and/or D&C);
- MS-DRG 774 (Vaginal Delivery with Complicating Diagnosis);
- MS-DRG 775 (Vaginal Delivery without Complicating Diagnosis);
- MS-DRG 777 (Ectopic Pregnancy);
- MS-DRG 778 (Threatened Abortion);
- MS-DRG 780 (False Labor);
- MS-DRG 781 (Other Antepartum Diagnoses with Medical Complications); and
- MS-DRG 782 (Other Antepartum Diagnoses without Medical Complications).

CMS proposed to create the following new 18 MS-DRGs under MDC 14:

- Proposed new MS-DRG 783 (Cesarean Section with Sterilization with MCC);
- Proposed new MS-DRG 784 (Cesarean Section with Sterilization with CC);
- Proposed new MS-DRG 785 (Cesarean Section with Sterilization without CC/MCC);
- Proposed new MS-DRG 786 (Cesarean Section without Sterilization with MCC);
- Proposed new MS-DRG 787 (Cesarean Section without Sterilization with CC);
- Proposed new MS-DRG 788 Cesarean Section without Sterilization without CC/MCC);

- Proposed new MS-DRG 796 (Vaginal Delivery with Sterilization/D&C with MCC);
- Proposed new MS-DRG 797 (Vaginal Delivery with Sterilization/D&C with CC);
- Proposed new MS-DRG 798 (Vaginal Delivery with Sterilization/D&C without CC/MCC);
- Proposed new MS-DRG 805 (Vaginal Delivery without Sterilization/D&C with MCC);
- Proposed new MS-DRG 806 (Vaginal Delivery without Sterilization/D&C with CC);
- Proposed new MS-DRG 807 (Vaginal Delivery without Sterilization/D&C without CC/MCC);
- Proposed new MS-DRG 817 (Other Antepartum Diagnoses with O.R. Procedure with MCC);
- Proposed new MS-DRG 818 (Other Antepartum Diagnoses with O.R. Procedure with CC);
- Proposed new MS-DRG 819 (Other Antepartum Diagnoses with O.R. Procedure without CC/MCC);
- Proposed new MS-DRG 831 (Other Antepartum Diagnoses without O.R. Procedure with MCC);
- Proposed new MS-DRG 832 (Other Antepartum Diagnoses without O.R. Procedure with CC); and
- Proposed new MS-DRG 833 (Other Antepartum Diagnoses without O.R. Procedure without CC/MCC).

CMS is adopting these changes.

***Systemic Inflammatory Response Syndrome (SIRS) of Non-Infectious Origin* (Page 268)**

CMS proposed to reassign ICD-10-CM diagnosis codes R65.10 and R65.11 to MS-DRG 864 and to revise the title of MS-DRG 864 to "Fever and Inflammatory Conditions." CMS is adopting its proposal.

Changes to the Medicare Code Editor (MCE) (Page 281)

The Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

Comment

CMS discusses a number of issues regarding the MCE and proposes several changes. Please refer to the rule for the technical specifics. This section is some 50 pages.

Changes to Surgical Hierarchies (Page 331)

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different MS-DRG within the MDC to which the principal diagnosis is assigned. CMS notes that it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single MS-DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function.

CMS proposed to revise the surgical hierarchy for MDC 14 (Pregnancy, Childbirth &the Puerperium) as follows:

- In MDC 14, CMS would delete MS-DRGs 765 and 766 (Cesarean Section with and without CC/MCC, respectively) and MS-DRG 767 (Vaginal Delivery with Sterilization and/or D&C) from the surgical hierarchy.

- CMS would sequence new MS-DRGs 783, 784, and 785 (Cesarean Section with Sterilization with MCC, with CC and without CC/MCC, respectively) above new MS-DRGs 786, 787, and 788 (Cesarean Section without Sterilization with MCC, with CC and without CC/MCC, respectively).

- CMS would sequence new MS-DRGs 786, 787, and 788 (Cesarean Section without Sterilization with MCC, with CC and without CC/MCC, respectively) above MS-DRG 768 (Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C).

- CMS would sequence new MS-DRGs 796, 797, and 798 (Vaginal Delivery with Sterilization/D&C with MCC, with CC and without CC/MCC, respectively) below MS-DRG 768 and above MS-DRG 770 (Abortion with D&C, Aspiration Curettage or Hysterotomy).

- Finally, CMS would sequence new MS-DRGs 817, 818, and 819 (Other Antepartum Diagnoses with O.R. procedure with MCC, with CC and without CC/MCC, respectively) below MS-DRG 770 and above MS-DRG 769 (Postpartum and Post Abortion Diagnoses with O.R. Procedure).

CMS is adopting it proposed changes.

Other Items Being Addressed (beginning Page 316)

CMS provides extensive discussions on the following:

- Additions and deletions to the Diagnosis Code Severity Levels for FY 2019 (page 317)
- Principal Diagnosis Is Its Own CC or MCC (page 322)
- CC Exclusions List for FY 2019 (page 335)
- Comprehensive Review of CC List for FY 2019 (page 345)
- Review of Procedure Codes in MS DRGs 981 through 983 and 987 through 989 (page 354)
- Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (page 377)
- Replaced Devices Offered without Cost or with a Credit (page 385)
- Other Policy Changes: Operating Room (O.R.) and Non-O.R. Issues (page 388)

Comment

The MS-DRG material is extensive. It spans more than 300 pages. It is well written and appears to provide a detailed analytic basis to the changes being made. Besides the items above there are others involving OR and Non OR issues.

Add-On Payments for New Services and Technologies for FY 2018 (Page 448)

FY 2019 Status of Technologies Approved for FY 2018 Add-On Payments

Discontinued

- EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
- GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE)
- Praxbind® Idarucizumab
- Vistogard™ (Uridine Triacetate)

Continued

- Defitelio® (Defibrotide). The maximum payment will increase to $80,500.
- Ustekinumab (Stelara®). The maximum payment will remain at $2,400 for FY 2019.
- Bezlotoxumab (ZINPLAVA™) The maximum payment will remain at $1,900.

CMS notes that it received 15 applications for New Technology Add-On Payments (page 486). None were approved during the proposed rulemaking. Those that are now approved are as follows:

- KYMRIAH™ (Tisagenlecleucel) and YESCARTA™ (Axicabtagene Ciloleucel). The maximum payment will be $186,500.
- VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection). The maximum average cost used in the inpatient hospital setting is $72,850 ($7,750 cost per vial * 9.4 vials).
- VABOMERE™ (meropenem-vaborbactam). The maximum new technology add-on payment is $5,544.
- remedē® System. The maximum new technology add-on payment for is $17,250.

- Plazomicin. The maximum new technology add-on payment is $2,722.50.
- GIAPREZA™. The maximum new technology add-on payment is $1,500.
- Cerebral Protection System (Sentinel® Cerebral Protection System). The maximum new technology add-on payment is $1,400.
- The A QUAB EAM System (Aquablation). The maximum new technology add-on payment is $1,250.
- AndexXa™ (Andexanet alfa). The maximum new technology add-on payment is $14,062.50.

Comment

In the past, we have observed the length and discussion of new technologies. This year's material is 358 pages. It would help if the full discussion on these items were placed in a separate appendix. One must assume that most readers are only interested in actions being taken by the agency regarding the item as a new or discontinued technology and its payment amount, and not all the ongoing discussions and rational positions between CMS and the manufacturers.

V. CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2019 (Page 1,437 & Addendum 2,363)

Updates to the Payment Rates for the LTCH PPS for FY 2019

CMS is adopting an annual update to the LTCH PPS standard Federal payment rate of 1.35 percent based on a market basket increase of 2.9 percent reduced by the multi-productivity factor of 0.8 percent and an ACA mandate reduction of 0.75 percent (2.9-0.8-0.75).

CMS will apply budget neutrality adjustment factors for the changes related to the area wage adjustment (that is, changes to the wage data and labor-related share) of 0.999713, and the elimination of the 25-percent threshold policy for FY 2019 of 0.990884.

Accordingly, CMS the LTCH PPS standard Federal payment rate will be **$41,579.65** (calculated as the FY 2018 rate of $41,415.11 x 1.035 x 0.999713 x 0.990884.

For LTCHs that fail to submit quality reporting data for FY 2019, CMS is establishing an LTCH PPS standard Federal payment rate of $40,759.12 (calculated as $41,415.11 x 0.9935 x 0.999713 x 0.990884).

The labor-related share under the LTCH PPS for FY 2019 will be 66.0 percent. The current amount is 66.2 percent.

The FY 2019 LTCH PPS standard Federal payment rate wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas).

There is a COLA for Alaska and Hawaii. Those values are the same as for the IPPS (see above).

High-Cost Outlier (HCO) Cases

In addition, section 1886(m)(7)(B) of the Act requires, beginning in FY 2018, that the fixed-loss amount for HCO payments be determined so that the estimated aggregate amount of HCO payments for such cases in a given year are equal to 99.6875 percent of the 8.0 percent estimated aggregate payments for standard Federal payment rate cases (that is, 7.975 percent). In other words, sections 1886(m)(7)(A) and (7)(B) requires that CMS adjust the standard Federal payment rate each year to ensure budget neutrality for HCO payments as if estimated aggregate HCO payments made for standard Federal payment rate discharges remain at 8.0 percent, while the fixed-loss amount for the HCO payments is set each year so that the estimated aggregate HCO payments for standard Federal payment rate cases are 7.975 percent of estimated aggregate payments for standard Federal payment rate cases.

CMS is establishing a fixed-loss amount of **$27,124.** It was proposed at $30,639. The current threshold is $27,382.

CMS is establishing a fixed-loss amount for site neutral payment rate cases of $25,769, which is the same FY 2019 IPPS fixed-loss amount

Comment

On many occasions we have stated that PPS updates contain too much, excessive and redundant materials. The section is a perfect example. This section is 89 pages long with an extensive history of the LTCH rate setting system. Does it truly need to be so long?

Again, the important items are the FY 2019 rate increase and related factors to update the numbers to FY 2019, outlier thresholds and budget neutrality rationales.

VI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (Page 1,526)

CMS is making changes to the following Medicare quality reporting systems:

- The Hospital IQR Program;
- The PPS Cancer Hospital Quality Reporting Program; and
- The LTCH QRP Program.

In addition, CMS is adopting changes to the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid EHR Incentive Programs) for eligible hospitals and critical access hospitals (CAHs).

Hospital IQR (page 1,526)

The Hospital IQR Program had previously finalized 62 measures for the FY 2019 payment determination and subsequent years.

CMS proposed to remove a total of 39 measures from the program. CMS is finalizing the removal of all 39 measures with some modifications. They are as follows **(Page 1,686):**

Summary of Hospital IQR Program Measures Newly Finalized for Removal			
Short Name	**Measure Name**	**First Payment Determination Year for Removal**	**NQF #**
Structural Patient Safety Measures			
Safe Surgery Checklist	Safe Surgery Checklist Use	FY 2020	N/A
Patient Safety Culture	Hospital Survey on Patient Safety Culture	FY 2020	N/A
Patient Safety Measures			
PSI 90	Patient Safety and Adverse Events Composite	FY 2020	0531
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	FY 2022	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	FY 2022	1717
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	FY 2022	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	FY 2022	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	FY 2022	1716

Summary of Hospital IQR Program Measures Newly Finalized for Removal			
Short Name	**Measure Name**	**First Payment Determination Year for Removal**	**NQF #**
Claims-Based Coordination of Care Measures			
READM-30-AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0505
READM-30-CABG	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2020	2515
READM-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2020	1891
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure (HF) Hospitalization	FY 2020	0330
READM-30-PNA	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	FY 2020	0506
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY 2020	1551
READM-30-STK	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	FY 2020	N/A
Claims-Based Mortality Measures			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	FY 2020	0229
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2021	1893
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	FY 2021	0468
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2022	2558
Claims-Based Patient Safety Measure			
Hip/Knee Complications	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY 2023	1550
Claims-Based Payment Measures			
MSPB	Medicare Spending Per Beneficiary (MSPB) - Hospital Measure	FY 2020	2158

Summary of Hospital IQR Program Measures Newly Finalized for Removal			
Short Name	**Measure Name**	**First Payment Determination Year for Removal**	**NQF #**
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment Measure	FY 2020	N/A
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	FY 2020	N/A
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	FY 2020	N/A
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	FY 2020	N/A
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	FY 2020	N/A
SFusion Payment	Spinal Fusion Clinical Episode-Based Payment Measure	FY 2020	N/A
Chart-Abstracted Clinical Process of Care Measures			
IMM-2	Influenza Immunization	FY 2021	1659
VTE-6	Incidence of Potentially Preventable VTE [Venous Thromboembolism]	FY 2021	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2021	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	FY 2022	0497
EHR-Based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))			
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	FY 2022	+
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	FY 2022	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2022	0495
EHDI-1a	Hearing Screening Prior to Hospital Discharge	FY 2022	1354
PC-01	Elective Delivery	FY 2022	0469
STK-08	Stroke Education	FY 2022	+
STK-10	Assessed for Rehabilitation	FY 2022	0441

* Measure is finalized for removal in chart-abstracted form, but will be retained in eCQM form.
+ NQF endorsement removed.

The table below summarizes the Hospital IQR Program measure set for the FY 2020 payment determination (including previously adopted measures, but not including measures finalized for removal beginning with the FY 2020 payment determination in this final rule) **(Page 1,690)**:

Measures for the FY 2020 Payment Determination*		
Short Name	**Measure Name**	**NQF #**
Healthcare-Associated Infection Measures		
CAUTI	National Healthcare Safety Network Catheter- associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	National Healthcare Safety Network Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CLABSI	National Healthcare Safety Network Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
MRSA Bacteremia	National Healthcare Safety Network Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
Claims-Based Patient Safety Measures		
Hip/Knee Complications	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
PSI 04	Death Rate among Surgical Inpatients with Serious Treatable Complications	0351
Claims-Based Mortality Measures		
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-PN	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-STK	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Acute Ischemic Stroke	N/A
Claims-Based Coordination of Care Measures		
READM-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	2882
Claims-Based Payment Measures		
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia	2579
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty Associated with an Episode-of-Care for Primary Elective Total Hip	N/A

Measures for the FY 2020 Payment Determination*		
Short Name	**Measure Name**	**NQF #**
	Arthroplasty and/or Total Knee Arthroplasty	
Chart-Abstracted Clinical Process of Care Measures		
ED-1**	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2**	Admit Decision Time to ED Departure Time for Admitted Patients	0497
IMM-2	Influenza Immunization	1659
PC-01**	Elective Delivery	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	+
EHR-Based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))		
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	+
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	+
ED-1**	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2**	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI-1a	Hearing Screening Prior to Hospital Discharge	1354
PC-01**	Elective Delivery	0469
PC-05	Exclusive Breast Milk Feeding	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
STK-08	Stroke Education	+
STK-10	Assessed for Rehabilitation	0441
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Patient Experience of Care Survey Measures		
HCAHPS***	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition Measure)	0166 (0228)

* As discussed in section VIII.A.5. of the preamble of this final rule, CMS is finalizing its proposals to remove 19 measures – 17 claims-based measures and two structural measures -- beginning with the FY 2020 payment determination. These measures, which had previously been finalized for the FY 2020 payment determination are not included in this summary table.
** Measure listed twice, as both chart-abstracted and eCQM versions.
*** CMS has proposed to update the HCAHPS Survey by removing the Communication About Pain questions effective with January 2022 discharges, for the FY 2024 payment determination and subsequent years. CMS refers readers to the CY 2019 OPPS/ASC proposed rule (available at: https://www.regulations.gov/document?D=CMS-2018-0078-0001).
+ NQF endorsement has been removed.

The rule also contains charts of measures for the FY 2021 year and FY 2022 year.

***PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program* (Page 1,814)**

The PCHQR Program collects and publishes data from 11 PPS-exempt cancer hospitals on an announced set of quality measures. CMS has finalized the adoption of a new measure, the removal of four previously adopted measures, and the adoption of a new measure removal factor. Specifically, in this final rule, CMS is finalizing the following proposals:

- Adoption of one new claims-based outcome measure beginning with the CY 2019 reporting period, Proportion of 30-Day Unplanned Readmissions for Cancer Patients measure (NQF #3188);

- 2. Removal of four measures based on measure performance, beginning with the CY 2019 reporting period:

    - Oncology: Radiation Dose Limits to Normal Tissues;
    - Oncology: Medical and Radiation – Pain Intensity Quantified;
    - Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients; and
    - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients; and

- 3. Adoption of one additional factor to consider when evaluating potential measures for removal from the PCHQR Program measure set, "The cost associated with the measure outweighs the benefit of its continued use in the program."

***Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes* (Page 1,873)**

Under the LTCH QRP, the applicable annual update to the LTCH PPS standard Federal rate for discharges for an LTCH is reduced by two percentage points if the LTCH does not submit to CMS data in accordance with the requirements of the LTCH QRP.

The final rule removes measures that either have significant operational challenges with reporting or are duplicative of other measures in the program.

- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716) (beginning with the FY 2020 LTCH QRP)
- National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure (beginning with the FY 2020 LTCH QRP
- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) (beginning with the FY 2021 LTCH QRP)

Further, CMS finalizes the following:

- An update to the methods by which LTCHs are notified of non-compliance with the requirements of the LTCH QRP.
- An additional measure removal factor—the costs associated with a measure outweigh the benefit of its continued use in the program.

Changes to the Medicare and Medicaid EHR Incentive Programs (now referred to as the Medicare and Medicaid Promoting Interoperability Programs) **(Page 1,916)**

In 2011, the Medicare and Medicaid Promoting Interoperability Programs (known then as the Medicare and Medicaid EHR Incentive Programs) were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology (CEHRT). In this final rule, CMS overhauls the Medicare and Medicaid Promoting Interoperability. Key provisions of this overhaul include the following:

- An EHR reporting period of a minimum of any continuous 90-day period in each of calendar years (CYs) 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency.

- A new performance-based scoring methodology consisting of a smaller set of objectives that will provide a more flexible, "less-burdensome structure, allowing eligible hospitals and CAHs to place their focus back on patients."

- CMS finalizes two new e-Prescribing measures related to e-prescribing of opioids (Schedule II controlled substances).

    - The Query of Prescription Drug Monitoring Program (PDMP) measure will be optional in CY 2019 and will be required beginning in CY 2020. This will allow additional time to develop, test, and refine certification criteria and standards and workflows, while taking an aggressive stance to combat the opioid epidemic.
    - The Verify Opioid Treatment Agreement will be optional for both CYs 2019 and 2020. CMS says it believes that extending the optional reporting status will allow health care providers additional time to research and implement methods for verifying the existence of an opioid treatment agreement, expansion of the use of such agreements in practice, and development of system changes and clinical workflows.
    -

CMS also reiterates that beginning with an EHR reporting period in CY 2019, all eligible hospitals and CAHs under the Medicare and Medicaid Promoting Interoperability Programs are required to use the 2015 Edition of CEHRT.

Electronic Clinical Quality Measures (eCQMs)

For eligible hospitals and CAHs that report CQMs electronically, the reporting period for the Medicare and Medicaid EHR Incentive Programs would be one, self-selected calendar quarter of CY 2019 data, reporting on at least 4 self-selected CQMs from a set of 16.

The submission period for the Medicare EHR Incentive Program will be the 2 months following the close of the calendar year, ending February 29, 2020. In addition, beginning with the 2020 reporting period, CMS will remove 8 of the 16 CQMs.

The table below lists the 16 CQMs available for eligible hospitals and CAHs to report under the Medicare and Medicaid PI Programs beginning in CY 2017

Short Name	Measure Name	NQF Number
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
ED–3	Median Time from ED Arrival to ED Departure for Discharged ED Patients	0496
CAC–3	Home Management Plan of Care Document Given to Patient/Caregiver	+
ED–1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495

Short Name	Measure Name	NQF Number
ED–2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI–1a	Hearing Screening Prior to Hospital Discharge	1354
PC–01	Elective Delivery (Collected in aggregate, submitted via web-based tool or electronic clinical quality measure)	0469
PC–05	Exclusive Breast Milk Feeding*	0480
STK–02	Discharged on Antithrombotic Therapy	0435
STK–03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK–05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK–06	Discharged on Statin Medication	0439
STK–08	Stroke Education	+
STK–10	Assessed for Rehabilitation	0441
VTE–1	Venous Thromboembolism Prophylaxis	0371
VTE–2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372

+ NQF endorsement has been removed.
* Measure name has been shortened. CMS refers readers to annually updated measure specifications on the CMS eCQI Resource Center webpage for further information at: https://www.healthit.gov/newsroom/ecqiresource-center.

The eight eCQMs CMS is proposing to be removed are:

- Primary PCI Received Within 90 Minutes of Hospital Arrival (NQF #0163) (AMI-8a);
- Home Management Plan of Care Document Given to Patient/Caregiver (CAC-3);
- Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495) (ED-1);
- Hearing Screening Prior to Hospital Discharge (NQF #1354) (EHDI-1a);
- Elective Delivery (NQF #0469) (PC-01);
- Stroke Education (STK-08) (adopted at 78 FR 50807;
- Assessed for Rehabilitation (NQF #0441) (STK-10); and
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF 0496) (ED-3).

Comment

This another long, complex and detailed section. CMS spends nearly 200 pages discussing the changes above and scoring issues.

VII REVISIONS OF THE SUPPORTING DOCUMENTATION REQUIRED FOR SUBMISSION OF AN ACCEPTABLE MEDICARE COST REPORT (Page 2,099)

Section 413.24(f)(5)(i) of the regulations provides that a provider's Medicare cost report is rejected for lack of supporting documentation if it does not include the Provider Cost Reimbursement Questionnaire (also known as Form CMS-339).CMS will, as proposed, incorporate the Provider Cost Reimbursement Questionnaire, Form CMS-339, into the OPO and Histocompatibility Laboratory cost report, Form CMS-216. CMS says the incorporation of the Form CMS-339 into the Form CMS-216 will complete its incorporation of the Form CMS-339 into all Medicare cost reports.

Section 413.24(f)(5)(i) provides that a Medicare cost report for a teaching hospital is rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System (IRIS) diskette. Effective for cost reports filed on or after October 1, 2018, CMS proposed to add the requirement that IRIS data contain the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts of direct GME and IME FTE residents reported in the cost report. However, CMS is not adopting this item because the IRIS software is available.

CMS will require that the Medicare bad debt listing correspond to the bad debt amount claimed in the provider's cost report, in order for the provider to have an acceptable cost report submission under § 413.24(f)(5).

Currently, in order for a DSH eligible hospital to have an acceptable cost report submission, there is no requirement for the hospital to also submit a listing of its Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's cost report, as a supporting document. CMS will, effective for cost reporting periods beginning on or after October 1, 2018, require DSH eligible hospitals to submit this supporting data with their cost reports.

CMS is finalizing its proposed policy, without modification, that, effective for cost reporting periods beginning on or after October 1, 2018, for DSH eligible hospitals reporting charity care and/or uninsured discounts, a cost report will be rejected for lack of supporting documentation if it does not include a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the hospital's cost report.

CMS is finalizing its Home Office documentation proposal with modifications:

> First, instead of requiring providers to submit the Home Office Cost Statement individually with their cost report submission, CMS is requiring instead that the home office or chain organization submit the Home Office Cost Statement directly to the servicing contractors for its providers when the home office or chain organization has allocated costs to its providers. When the home office submits its Home Office Cost Statement to its servicing contractor, the home office must also submit a copy of the Home Office Cost Statement to each of the contractors of its chain providers. For example, if a chain organization has 25 providers serviced by 2 different contractors, the home office must submit its Home Office Cost Statement to each contractor
>
> Second, CMS is applying different rules for situations where the provider and the home office have the same fiscal year end and where the provider and the home office have a different fiscal year end. Thus, effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with the same fiscal year end, a cost report will be rejected for lack of supporting documentation if the home office or chain organization has not completed and submitted to the chain provider's contractor a Home Office Cost Statement that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report. Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization that has a different fiscal year end, a cost report will be rejected for lack of supporting documentation if the home

office or chain organization has not completed and submitted to the chain provider's contractor a Home Office Cost Statement that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report.

VIII REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES VIA THE INTERNET (2,135)

Under current law, hospitals are required to establish and make public a list of their standard charges. In an effort to encourage price transparency by improving public accessibility of charge information, effective CY 2019 CMS updated its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet in a machine readable format, and to update this information at least annually, or more often as appropriate.

Final Comments and Regulatory Analysis

Quality Reporting is an ever growing extensive, complex, costly and burdensome activity. The material in this rule reflects the huge requirements of compliance. This analysis has not discussed issues, in-depth, relating to eCQMs, timing and reporting, validations, PPS Cancer Hospitals, LTCH hospitals, and other related items.

As noted in previous analyses, the topic of quality and its requirements appears to have become the 800-pound gorilla of Medicare rules and regulations. The material is just overwhelming. For example, CMS spends nearly 600 pages addressing quality reporting issues and measures.

CMS says its quality initiative is improving quality. However, is CMS truly improving patient outcomes? Much is said about making the patient a better informed consumer. However, in many situations, patients are not the decision-makers in selecting providers and services. Rather, much depends on the situation. For example, someone having a heart attack is not going to his or her computer to review provider statistics. They simply want to be treated as soon as possible. It's truly time to refocus on the ever increasing pervasiveness of the reporting. Based on the number of comments in this rule, it appears many hours are being devoted to the system. But, what have been the outcomes?

Over the past few years, there has been both consternation and dismay by many states over an ACA amendment that reversed a CMS rule that would have set area wage index budget neutrality on a statewide basis when urban areas in a state have a lower wage index value than the statewide rural amount. The ACA requirement imposes such budget neutrality on a national basis.

The following is CMS' FY 2019 estimate of the national budget neutrality statewide calculations.

FY 2019 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Will Receive the Rural Floor (2)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3)	Difference (in millions) (4)
Alabama	84	3	-0.3	$-5
Alaska	6	3	0.1	$0
Arizona	56	45	3.0	$58
Arkansas	45	0	-0.3	$-4
California	297	60	0.3	$38
Colorado	46	9	0.6	$7
Connecticut	30	10	2.0	$32
Delaware	6	0	-0.4	$-2
Washington, D.C.	7	0	-0.4	$-2
Florida	168	7	-0.3	$-23
Georgia	101	0	-0.3	$-9
Hawaii	12	0	-0.3	$-1
Idaho	14	0	-0.3	$-1
Illinois	125	2	-0.4	$-16
Indiana	85	0	-0.3	$-8
Iowa	34	0	-0.3	$-3
Kansas	51	0	-0.3	$-3
Kentucky	64	0	-0.3	$-6

FY 2019 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Will Receive the Rural Floor (2)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3)	Difference (in millions) (4)
Louisiana	90	0	-0.3	$-5
Maine	17	0	-0.3	$-2
Massachusetts	56	29	3.3	$121
Michigan	94	0	-0.4	$-15
Minnesota	49	0	-0.3	$-6
Mississippi	59	0	-0.3	$-4
Missouri	72	0	-0.3	$-7
Montana	13	1	-0.2	$-1
Nebraska	23	0	-0.3	$-2
Nevada	22	3	0.3	$3
New Hampshire	13	8	2.3	$14
New Jersey	64	0	-0.5	$-18
New Mexico	24	2	-0.2	$-1
New York	149	16	-0.3	$-24
North Carolina	84	0	-0.3	$-10
North Dakota	6	3	0.4	$1
Ohio	130	7	-0.3	$-12
Oklahoma	79	2	-0.3	$-5
Oregon	34	1	-0.3	$-3
Pennsylvania	150	3	-0.4	$-19
Puerto Rico	51	11	0.1	$0
Rhode Island	11	0	-0.4	$-2
South Carolina	54	6	-0.1	$-2
South Dakota	17	0	-0.2	$-1
Tennessee	90	6	-0.3	$-8
Texas	310	13	-0.3	$-20
Utah	31	0	-0.3	$-2
Vermont	6	0	-0.2	$0
Virginia	74	1	-0.3	$-7
Washington	48	3	-0.4	$-8
West Virginia	29	2	-0.2	$-2
Wisconsin	66	5	-0.3	$-5
Wyoming	10	2	0	$0

The following table identifies those MS-DRGs with 100,000 or more discharges (from rule's tables 5 and 7B).

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2019					
MS-DRG	**MS-DRG Title**	**Discharges**	**Final FY 2019 Weights**	**Final FY 2018 Weights**	**Percentage Change**
65*	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	121,685	1.0315	1.0313	0.02%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	168,648	1.2353	1.2198	1.27%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	217,237	1.1907	1.1528	3.29%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	104,763	1.3167	1.3733	-4.12%
194	SIMPLE PNEUMONIA & PLEURISY W CC	107,100	0.9002	0.9333	-3.55%
291	HEART FAILURE & SHOCK W MCC	369,287	1.3454	1.4761	-8.85%
292	HEART FAILURE & SHOCK W CC	104,082	0.9198	0.9589	-4.08%
378	G.I. HEMORRHAGE W CC	136,042	0.9903	0.9704	2.05%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	159,979	0.7554	0.7594	-0.53%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	498,166	1.9898	2.0522	-3.04%
603	CELLULITIS W/O MCC	112,440	0.8477	0.8503	-0.31%
682	RENAL FAILURE W MCC	104,020	1.5320	1.4845	3.20%
683	RENAL FAILURE W CC	143,601	0.9190	0.9293	-1.11%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	153,347	0.7941	0.7946	-0.06%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	583,535	1.8564	1.8231	1.83%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	165,853	1.0529	1.0547	-0.17%
	Total Discharges	3,249,785			

These 16 MS-DRGs contain 3,249,785 million discharges or approximately 34 percent of the 9,628,547 million MS-DRG discharges.

The following IPPS tables are generally available through the Internet on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Click on the link on the left side of the screen titled, "FY 2019 IPPS Final Rule Home Page" or "Acute Inpatient--Files for Download."

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Table 6A New Diagnosis Codes--FY 2019
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Table 6C Invalid Diagnosis Codes--FY 2019
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Table 6G.1 Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2019
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Table 6I Complete MCC List--FY 2019
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Table 6K Complete List of CC Exclusions--FY 2019
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Table 7A Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2017 MedPAR Update—March 2018 GROUPER V35.0 MS-DRGs
Table 7B Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2017 MedPAR Update—March 2018 GROUPER V36.0 MS-DRGs
Table 8A FY 2019 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
Table 8B FY 2019 Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals
Table 15 FY 2019 Readmissions Adjustment Factors (Table 15 will be posted on the CMS website in the fall of 2018.)
Table 16A Updated Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2019
Table 18 FY 2019 Medicare DSH Uncompensated Care Payment Factor 3
Table 8C FY 2019 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
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Table 12A LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2018 through September 30, 2019
Table 12B LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2018 through September 30, 2019