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An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

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Proposed FY 2020 Medicare IPPS and LTCH Update Released

The Centers for Medicare and Medicaid Services (CMS) have released an extensive and very lengthy proposed 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) 2020.

Among many items, the proposal addresses the following issues; (1) the hospital market basket increase; (2) the MS-DRG documentation and coding increase; (3) revisions to the calculation of the area wage index; (4) new technology add-on payments; (5) Medicare uncompensated care payments; (6) hospital-acquired conditions; (7) the hospital readmission program; (8) the hospital inpatient quality reporting system (9) the hospital value-based purchasing program; (10) the Medicare and Medicaid promoting interoperability programs; (11) and changes to the LTCH system.

The document is currently on public display at the ***Federal Register*** office and is scheduled for publication May 3rd. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08330.pdf.

The IPPS tables are available through the 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 2020 IPPS Proposed 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-1716-P.

Comment

CMS projects this proposal would apply to approximately 3,300 acute care hospitals and to approximately 390 LTCH facilities.

CMS states that "the rate increase, together with other changes to IPPS payment policies, would increase Medicare spending on inpatient hospital services in FY 2020 by approximately $4.7 billion."

This is a huge rule. Its long, some 1,824 pages.

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.

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No subheads/ sections are identified. When CMS refers the reader to a particular section, it is extremely difficult to locate.

Note: For many payment issues, the rule's Addendum (beginning on page 1,531) contains much concise and extremely helpful information.

Comment

The rule has 3 major items:

- Rates and increases
- Changes to the area wage index calculations
- Proposed changes to the disproportionate share hospital (DSH) data collection

The introductory material below is excerpted from the rule's fact sheet. Additional details from the rule itself follow in subsequent sections.

Inpatient Prospective Payment System

"Proposed Changes to Payment Rates under IPPS"

The proposed increase in operating payment rates would be approximately 3.2 percent. This reflects a projected hospital market basket update of 3.2 percent reduced by a 0.5 percentage point productivity adjustment as mandated by the ***Affordable Care Act*** (ACA). This also reflects a proposed +0.5 percentage point adjustment required by legislation for prior MS-DRG documentation and coding reductions.

Hospitals may be subject to other payment adjustments under the IPPS, including:

- Penalties for excess readmissions.
- Penalty (1.0 percent) for worst-performing quartile under the Hospital Acquired Condition Reduction Program
- Upward and downward adjustments under the Hospital Value-Based Purchasing Program.

"Rethinking Rural Health" – Changes to the Area Wage Index Calculation

CMS is proposing significant changes to the area wage index calculation.

CMS would increase the wage index for hospitals with a wage index value below the 25th percentile. These hospitals' wage indexes would be increased by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals. This proposed policy would be effective for at least 4 years, beginning in FY 2020, in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.

CMS would decrease the wage index for hospitals above the 75th percentile so that Medicare spending does not increase as a result of this proposal.

CMS is also proposing changes to the wage index "rural floor" calculation. Under law, the IPPS wage index value for an urban hospital cannot be less than the wage index value applicable to hospitals located in rural areas in the state. This is known as the "rural floor" provision. "It appears that hospitals in a limited number of states have used urban to rural hospital reclassifications to inappropriately influence the rural floor wage index value." To address this, CMS proposes removing urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.

In addition, to mitigate payment decreases due to these proposals, CMS proposes a 5.0-percent cap on any decrease in a hospital's wage index from its final wage index for FY 2019. That is, under this proposal a hospital's final wage index for FY 2020 would not be less than 95 percent of its final wage index for FY 2019.

Medicare Uncompensated Care Payments (Disproportionate Share Hospitals/DSH)

In this rule, CMS proposes distributing roughly $8.5 billion in uncompensated care payments in FY 2020, an increase of approximately $216 million from FY 2019.

For FY 2020, CMS proposes using a single year of data on uncompensated care costs from Worksheet S-10 of the Medicare cost report for FY 2015 to distribute these funds. In addition, CMS is seeking public comments on whether it should, due to changes in the reporting instructions that became effective for FY 2017, use a single year of Worksheet S-10 data from the FY 2017 cost reports.

Hospital-Acquired Conditions (HAC) Reduction Program

CMS is proposing to:

- Specify the dates to collect data used to calculate hospital performance for the FY 2022 HAC Reduction Program;
- Clarify administrative processes for validating National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) data submitted by hospitals to the Centers for Disease Control and Prevention (CDC).

Hospital Readmissions Reduction Program (HRRP)

CMS is proposing to:

- Establish the performance period for the FY 2022 program year;
- Update the definition of "dual eligible";
- Adopt a subregulatory process to address potential nonsubstantive changes to the payment adjustment factor components.

Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes updating the Hospital IQR Program's measure set. Specifically, the rule proposes to:

- Remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace with the proposed Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data measure beginning with the FY 2026 payment determination after 2 years of voluntary reporting of the Hybrid HWR measure; and establish reporting and submission requirements for the hybrid measures.
- Adopt two new opioid-related electronic clinical quality measures (eCQMs) beginning with the CY 2021 reporting period/FY 2023 payment determination:

    1. Safe Use of Opioids – Concurrent Prescribing eCQM, and
    2. Hospital Harm – Opioid-Related Adverse Events eCQM.

Also, CMS is proposing three changes for reporting eCQMs. These proposals align with the Promoting Interoperability Program's Clinical Quality Measure proposals:

- For the CY 2020 reporting period/FY 2022 payment determination and CY 2021 reporting period/FY 2023 payment determination, CMS will extend the current eCQM reporting and submission requirements finalized for the CY 2019 reporting period, such that hospitals submit one, self-

selected calendar quarter of discharge data for four self-selected eCQMs in the Hospital IQR Program measure set;

- For the CY 2022 reporting period/FY 2024 payment determination, to require hospitals to report one, self-selected calendar quarter of data for: (1) three self-selected eCQMs, and (2) the proposed Safe Use of Opioids – Concurrent Prescribing eCQM, for a total of four eCQMs;
- Require EHR technology be certified to all eCQMs available to report for the CY 2020 reporting period/FY 2022 payment determination and subsequent years.

Hospital Value-Based Purchasing (VBP) Program

CMS is proposing that the Hospital VBP Program would use the same data as the HAC Reduction Program to calculate the National Health Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures beginning with CY 2020 data collection, which is when the Hospital IQR Program will cease collecting data on those measures.

CMS is also proposing that the Hospital VBP Program would rely on the process used by the HAC Reduction Program to validate the NHSN HAI measures to ensure that the measure rates are accurate for use in the Hospital VBP Program.

In addition, CMS is estimating the performance standards that would apply to a number of measures in future program years.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

CMS is proposing to:

- Adopt one new claims-based outcome measure, the Surgical Treatment Complications for Localized Prostate Cancer measure, beginning with the FY 2022 program year;
- Remove one measure because the burden outweighs the benefit of its use, the External Beam Radiotherapy for Bone Metastases measure, beginning with the FY 2022 program year;
- Remove the current pain management questions from the version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey used in the PCHQR Program, beginning with October 1, 2019 discharges;
- Begin publicly reporting the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure in Calendar Year 2020;
- Begin publicly reporting data for the Colon and Abdominal Hysterectomy Surgical Site Infection, Methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium Difficile **(**CDI) and Healthcare Personnel Vaccination measures beginning with the October 2019 *Hospital Compare* release;
- Conduct confidential national reporting for four end-of-life measures and one unplanned readmissions measure to prepare hospitals for the public reporting of these measures.

Medicare and Medicaid Promoting Interoperability Programs

CMS is proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program attesting to CMS.

CMS is proposing to continue for CY 2020 the Query of PDMP measure as optional and available for bonus points instead of being required as was finalized last year because of unintended and unforeseen challenges which arose from the stakeholder community citing implementation difficulties and provider burden. To minimize burden, CMS also proposes converting this measure from a numerator/denominator response to a yes/no attestation beginning with the EHR reporting period in CY 2019.

CMS is proposing to remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 from the Promoting Interoperability Program because of received feedback from stakeholders that this measure presents significant implementation challenges, leads to an increase in burden, and does not further interoperability.

Proposed Changes to Payment Rates under LTCH PPS

The LTCH site neutral payment rate cases will begin to be paid fully on the site neutral payment rate, rather than the transitional blended rate, for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

Overall, for FY 2020, CMS expects LTCH-PPS payments to increase by approximately 0.9 percent or $37 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system. LTCH PPS payments for FY 2020 for discharges paid using the standard LTCH payment rate are expected to increase by 2.3 percent after accounting for the proposed annual standard Federal rate update for FY 2020 of 2.7 percent, and an estimated decrease in outlier payments and other factors.

LTCH PPS payments for cases continuing to transition to the site neutral payment rates are expected to decrease by approximately 4.9 percent. This accounts for the LTCH site neutral payment rate cases that will no longer be paid a blended payment rate as the rolling statutory transition period ends for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

LTCH Quality Reporting Program (QRP)

CMS is proposing to adopt two new quality measures in satisfaction of the quality measure domain in the ***IMPACT Act*** pertaining to transferring health information as well as a number of standardized patient assessment data elements that assess either functional status, cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, or social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, or social isolation).

In response to stakeholder input, CMS is proposing to modify the previously adopted Discharge to Community measure to exclude nursing home residents who already reside in the nursing home, to move the implementation date of future versions of the LTCH CARE Data Set from April to October, to adopt data collection and public display periods for various measures, and to no longer publish a list of compliant LTCHs on the LTCH QRP website.

The material that follows is a section-by-section analysis of major components from the proposed rule. It does not follow the organization contained in the rulemaking. Not all items are presented.

To assist readers because CMS does not provide page numbers, we have added select pages numbers in red. These numbers are from the PDF version of the display copy file as posted on April 23rd.Items may be addressed in several different locations throughout the rule. Not all page sections are identified.

I. CHANGES TO PAYMENT RATES UNDER IPPS (Page 1,531)

Rate Update

The proposed 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 would be 3.2 percent. This reflects a projected hospital market basket update of 3.2 percent reduced by a 0.5 percentage point multi-factor productivity (MFP) adjustment for a net increase of **2.7 percent.**

Also included is a proposed +0.5 percentage point adjustment required by Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MARCA) for prior documentation and coding payment reductions. The 2.7 and 0.05 amounts result in an increase of 3.2 percent.

CMS displays four applicable percentage increases to the standardized amount for FY 2020, as specified in the following table. The 3.2 percent market basket rate of increase below does NOT include the 0.5 percent documentation and coding adjustment (Refer page 1535).

Proposed FY 2020 Applicable Percentage Increases for the IPPS				
FY 2020	**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**
Proposed Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.8	-0.8
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.4	0	-2.4
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.7**	**0.3**	**1.9**	**-0.5**

Standardized Payment Rates

The current FY 2019 standardized payment amounts, as corrected in the October 3, 2018 ***Federal Register,*** are as follows:

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**
$3,856.27	**$1,789.81**	**$3,773.51**	**$1,751.40**	**$3,828.68**	**$1,777.01**	**$3,745.93**	**$1,738.60**
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,500.57	**$2,145.51**	**$3,425.44**	**$2,099.47**	**$3,475.53**	**$2,130.16**	**$3,400.41**	**$2,084.12**

The current (FY 2019) large urban labor rate is $3,856.27 and the non-labor rate is $1,789.81 for a total of $5,646.08. The other area labor rate is $3500.57 and the non-labor component is $2,145.51 for a total of $5,646.08.

The total labor/nonlabor amount for the full update (left column) in the table below, (hospitals that submit quality data and are meaningful EHR users) is shown as $6,037.63 for both wage index areas – those greater than 1.0000 and those with values equal to or less than 1.0000. *This number is wrong*. CMS is showing an incorrect FY 2019 Geographic Reclassification Factor of 0.985932. That amount was also corrected in the October 3, 2018 ***Federal Register*** to be 0.985335. Dividing the FY 2019 payment amounts by those reflected in the table below, changes the FY 2020 base rate to $6,041.28.

The table below reflects the original numbers with strikeouts and the corrected amounts. Interesting that the proposed FY 2020 standardized amounts are correct as shown.

The following table (Pages 1,592-1,594) illustrates the changes from the FY 2019 national standardized amount to the proposed FY 2020 national standardized amount. As noted above, the total FY 2019 rates for both the urban and other areas (large and other) is $5,646.08. These amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors as shown below. The result is a total labor/ non-labor amount of $6,041.28. The $6,041.28 amount is then adjusted for FY 2020 by the items beginning with the proposed FY 2020 proposed update factor.

Changes from FY 2019 Standardized Amounts to the FY 2020 Standardized Amounts

	Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent)	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.3 Percent)**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.9 Percent)**	**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5.Percent)**
FY 2020 Base Rate after removing: 1. FY 2019 Geographic Reclassification Budget Neutrality **~~(0.985932)~~** **correct amount should be (0.985335)** per Oct 3, 2018 ***Federal Register***	If Wage Index is Greater Than 1.0000: Labor (68.3%): ~~$4123.70~~ $4,126.19 Nonlabor (31.7%) ~~$1,913.93~~ $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): ~~$4123.70~~ $4,126.19 Nonlabor (31.7%) ~~$1,913.93~~ $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): ~~$4123.70~~ $4,126.19 Nonlabor (31.7%) ~~$1,913.93~~ $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): ~~$4123.70~~ $4,126.19 Nonlabor (31.7%) ~~$1,913.93~~ $1,915.09 *(Combined labor and nonlabor = $6,041.28)*
2. FY 2019 Operating Outlier Offset **(0.948999)** 3. FY 2019 Rural Demonstration Budget Neutrality Factor **(0.999467)**	If Wage Index is less Than or Equal to 1.0000: Labor (62%): ~~$3,743.33~~ $3,745.59 Nonlabor (38%): ~~$2,294.30~~ $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): ~~$3,743.33~~ $3,745.59 Nonlabor (38%): ~~$2,294.30~~ $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): ~~$3,743.33~~ $3,745.59 Nonlabor (38%): ~~$2,294.30~~ $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): ~~$3,743.33~~ $3,745.59 Nonlabor (38%): ~~$2,294.30~~ $2,295.69 *(Combined labor and nonlabor = $6,041.28)*

	Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent)	Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.3 Percent)	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.9 Percent)	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5.Percent)
Proposed FY 2020 Update Factor	1.027	1.003	1.019	0.995
Proposed FY 2020 MS-DRG Recalibration Budget Neutrality Factor	0.998768	0.998768	0.998768	0.998768
Proposed FY 2020 Wage Index Budget Neutrality Factor	1.000915	1.000915	1.000915	1.000915
Proposed FY 2020 Reclassification Budget Neutrality Factor	0.986451	0.986451	0.986451	0.986451
Proposed FY 2020 Transition Budget Neutrality Factor	0.998349	0.998349	0.998349	0.998349
Proposed FY 2020 Operating Outlier Factor	0.949	0.949	0.949	0.949
Proposed FY 2020 Rural Demonstration Budget	0.999580	0.999580	0.999580	0.999580
Adjustment for FY 2020 Required under Section 414 of Pub. L. 114-10 (MACRA	1.005	1.005	1.005	1.005
Proposed National Standardized Amount for FY 2020 if Wage Index is Greater Than 1.0000; **Labor/Non-Labor Share Percentage (68.3/31.7)**	**Labor: $3,977.31** **Nonlabor: $1,845.99**	**Labor: $3,884.36** **Nonlabor: $1,802.85**	**Labor: $3,946.33** **Nonlabor: $1,831.61**	**Labor: $3,853.38** **Nonlabor: $1,788.47**
Proposed National Standardized Amount for FY 2020 if Wage Index is less Than or Equal to1.0000; **Labor/Non-Labor Share Percentage (62.0/38.0)**	**Labor: $3,610.45** **Nonlabor: $2,212.85**	**Labor: $3,526.07** **Nonlabor: $2,161.14**	**Labor: $3,582.32** **Nonlabor: $2,195.62**	**Labor: $3,497.95** **Nonlabor: $2,143.90**

The **labor-related** portion for areas with wage indexes greater than 1.0000 would continue at **68.3** percent. Areas with wage index values equal to or less than 1.000 would remain at **62.0.** (Page 1,539)

The change between the proposed FY 2020 amount and the current amount is $177.22, or a net increase of approximately 3.14 percent.

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

Comment (Pages 1,679-1,680)

CMS says that 211 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they are identified as not meaningful EHR users that do submit quality information.

CMS says that 39 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users.

CMS says 32 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they are identified as not meaningful EHR users that do not submit quality data under section.

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

Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2020 (Page 1,617)

CMS is proposing a FY 2020 capital rate of **$463.81.** The current amount is $459.41 (as corrected October 3, 2018)

Proposed Outlier Payments (Refer page 1,586)

CMS is adopting an outlier fixed-loss cost threshold for FY 2020 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 **$26,994.**

Comment (Refer page 1,590)

CMS notes that actual outlier payments for FY 2018 were approximately 4.94 percent of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2018, the percentage of actual outlier payments relative to actual total payments is lower than the agency projected for FY 2018.

Consistent with the policy and statutory interpretation that CMS has maintained since the inception of the IPPS, CMS does not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2018 are equal to 5.1 percent of total MS-DRG payments. The current threshold amount is $25,769.

In most years, CMS has underpaid their 5.1 percent outlier pool. One must ask if the CMS policy is long flawed and needs to be changed.

CMS also says that outlier payments for FY 2019 may only be 4.6 percent. If CMS needs to pay more outlier amounts in FY 2020 because it set its threshold too high for FY 2019, why is the threshold increasing for FY 2020?

Proposed Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2020 (Refer page 1,032)

The proposed FY 2020 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 2020 – that is 3.2 percent.

II. Proposed Changes to the Hospital Area Wage Index (Refer page 741)

Proposals to Address Wage Index Disparities between High and Low Wage Index Hospitals (Refer page 815)

CMS is proposing to reduce the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality. CMS is also changing the calculation of the rural floor.

Based on the data for this proposed rule, the 25th percentile wage index value across all hospitals is 0.8482. If this policy is adopted in the final rule, this number would be updated based on final wage index values.

CMS is proposing to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The proposed increase in the wage index for these hospitals would be equal to half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals.

For example, assume the otherwise applicable final FY 2020 wage index value for a geographically rural hospital is 0.6663, and the 25th percentile wage index value for FY 2020 is 0.8482. Half the difference between the otherwise applicable wage index value and the 25th percentile wage index value is 0.0910 (that is, (0.8482 - 0.6663)/2). Under CMS' proposal, the FY 2020 wage index value for such a hospital would be 0.7573 (that is, 0.6663 + 0.0910).

CMS is proposing that this policy would be effective for at least 4 years, beginning in FY 2020, in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.

In order to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile, CMS is proposing to decrease the wage index values for hospitals with high wage index values. CMS defines hospitals with wage index values above the 75th percentile wage index value across all hospitals for a fiscal year as "high wage index hospitals."

CMS is proposing to decrease the wage index values for high wage index hospitals by a uniform factor of the distance between the hospital's otherwise applicable wage index and the 75th percentile wage index value for a fiscal year across all hospitals. Based on the data for this proposed rule, the 75th percentile wage index value is 1.0351. Therefore, for example, if high wage index Hospital A had an otherwise applicable wage index value of 1.7351, the distance between that hospital's wage index value and the 75th percentile is 0.7000 (that is, 1.7351 - 1.0351).

CMS would next estimate the uniform multiplicative budget neutrality factor needed to reduce those distances for all high wage index hospitals so that the estimated decreased aggregate payments to high wage index hospitals offset the estimated increased aggregate payments to low wage index hospitals. CMS estimates this factor is 3.4 percent for FY 2020.

In the example provided above, the distance between Hospital A's wage index value and the 75th percentile would be reduced by 0.0238 (that is, the prior distance of 0.7000 * 0.034), and therefore the wage index for Hospital A after application of the proposed budget neutrality adjustment would be 1.7113 (that is, 1.7351 - 0.0238).

Preventing Inappropriate Payment Increases Due to Rural Reclassifications under the Provisions of 42 CFR 412.103 (Refer page 828)

The statute provides that, for discharges on or after October 1, 1997, 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. The statute also requires that a national budget neutrality adjustment be applied in implementing the rural floor.

CMS is proposing to remove urban to rural reclassifications from the calculation of "the wage index for rural areas in the State in which the county is located".

Proposed Transition for Hospitals Negatively Impacted (Refer page 834)

CMS notes that absent further adjustments, the combined effect of the proposed changes to the FY 2020 wage index could lead to significant decreases in the wage index values for some hospitals depending on the data for the final rule.

CMS is proposing to place a 5-percent cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2019. In other words, CMS is proposing that a hospital's final wage index for FY 2020 would not be less than 95 percent of its final wage index for FY 2019. This proposed transition would allow the effects of the proposed policies to be phased in over 2 years with no estimated reduction in the wage index of more than 5 percent in FY 2020.

Other Items

For FY 2020, CMS is continuing to use the Office of Management and Budget (OMB) delineations of wage areas that were adopted beginning with FY 2015 (based on the revised delineations issued in OMB Bulletin No. 13-01) to identify areas with updates as reflected in OMB Bulletin Nos. 15–01 and 17–01.

Calculation of the Occupational Mix Adjustment for FY 2020 (Refer page 770)

The proposed FY 2020 Occupational Mix Adjusted National Average Hourly Wage is $43.99

The proposed FY 2020 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows;

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$41.54
National LPN and Surgical Technician	$24.67
National Nurse Aide, Orderly, and Attendant	$16.95
National Medical Assistant	$18.14
National Nurse Category	$34.91

Proposed State Frontier Floor for FY 2020 (Refer page 774)

In this proposed rule, 45 hospitals would receive the frontier floor value of 1.0000 for their FY 2020 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

MGCRB Reclassification and Redesignation Issues for FY 2020 (Refer page 777)

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2020, hospitals reclassified beginning in FY 2018 or FY 2019 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 were 332 hospitals approved for wage index reclassifications in FY 2018 that will continue for FY 2020, and 274 hospitals approved for wage index reclassifications in FY 2019 that will continue for FY 2020. Of all the hospitals approved for reclassification for FY 2018, FY 2019, and FY 2020, based upon the review at the time of this proposed rule, 963 hospitals are in MGCRB reclassification status for FY 2020.

Clarification Regarding Accepting the Out-Migration Adjustment When the Out-Migration Adjustment Changes After Reclassification (Refer page 782)

CMS shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute if certain criteria are met. Rural hospitals in these counties are commonly known as "Lugar" hospitals. However, Lugar hospitals located in counties that qualify for the out-migration adjustment are required to waive their Lugar urban status in its entirety in order to receive the out-migration adjustment.

CMS says there are an estimated 171 providers that would receive the out-migration wage adjustment in FY 2020.

III. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2020 (§ 412.106) (Refer page 869)

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) that are paid based on the IPPS 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.

Proposed Calculation of Factor 1 for FY 2020 (Refer page 880)

Factor 1 is the difference between CMS' estimate of: (1) the amount that would have been paid as Medicare DSH payments for the fiscal year, in the absence of the new payment provision; 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 the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

For purposes of calculating Factor 1 and modeling the impact of this FY 2020 IPPS/LTCH PPS proposed rule, CMS used the Office of the Actuary's December 2018 Medicare DSH estimates, which were based on data from the September 2018 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2019 IPPS/LTCH PPS final rule IPPS Impact File.

The estimate of empirically justified Medicare DSH payments for FY 2020 is approximately $4.214 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2020).
CMS is proposing that **Factor 1 for FY 2020 would be $12,643,011,209.74**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2020 ($16,857,348,279.65 minus $4,214,337,069.91).

Proposed Calculation of Factor 2 for FY 2020 (Refer Page 888)

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).

The Actuary's projections for CY 2019 and CY 2020 are as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2018: 9.4 percent.
- Percent of individuals without insurance for CY 2020: 9.4 percent.
- Percent of individuals without insurance for FY 2019 (0.25 times 0.094) +(0.75 times 0.094): 9.4 percent
- Percent of individuals without insurance for FY 2020 (0.25 times 0.094) + (0.75 times 0.094): 9.4 percent 1-|((0.094 - 0.14)/0.14)| = 1 - 0.3286 = 0.6714 (67.14 percent).

Therefore, the proposed Factor 2 for FY 2020 is **67.14 percent.** It is currently 67.51 percent.

The proposed FY 2020 uncompensated care amount is: $12,643,011,209.74 x 0.6714 = $8,488,517,726.22. 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" was $6.767 billion
- The FY 2019 "pool" is $8.273 billion
- The FY 2020 "pool" would be $8.489 billion

Proposed Calculation of Factor 3 for FY 2020 (Refer page 905)

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).

Proposed Methodology for Calculating Factor 3 for FY 2020 (Refer page 917)

CMS believes that, on balance, the FY 2015 Worksheet S-10 data are the best available data to use for calculating Factor 3 for FY 2020. However, as an alternative CMS also has considered the use of FY 2017 data. CMS is seeking public comments on this alternative and, based on the public comments received, CMS could adopt it in the FY 2020 final rule.

CMS is proposing that, for purposes of determining uncompensated care costs and calculating Factor 3 for FY 2020, "uncompensated care" would continue to be defined as the amount on Line 30 of Worksheet S–10, which is the cost of charity care (Line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (Line 29).

For FY 2020, CMS is proposing to compute Factor 3 for each hospital.

Hospitals have 60 days from the date of public display of this FY 2020 IPPS/LTCH PPS proposed rule to review the table and supplemental data file published on the CMS website in conjunction with the proposed rule and to notify CMS in writing of any inaccuracies. Comments that are specific to the information included in the table and supplemental data file can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov.

CMS says that 2,430 hospitals are projected to be eligible for DSH in FY 2020.

IV. Other Decisions and Proposed Changes to the IPPS for Operating System

Proposed Changes to MS-DRGs Subject to Postacute Care Transfer Policy and MS-DRG Special Payments Policies (§ 412.4 (Refer page 838)

For FY 2020, CMS is proposing to make changes to a number of MS-DRGs. Specifically, CMS is proposing to:

- Reassign procedure codes from MS-DRGs 216 through 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, CC and without CC/MCC, respectively); MS-DRGs 219 through 221 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC, CC and without CC/MCC, respectively); and MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively); and create new MS-DRGs 319 and 320 (Other Endovascular Cardiac Valve Procedures with and without MCC, respectively); and

- Delete MS-DRGs 691 and 692 (Urinary Stones with ESW Lithotripsy with CC/MCC and without CC/MCC, respectively) and revise the titles for MS-DRGs 693 and 694 to "Urinary Stones with MCC" and "Urinary Stones without MCC", respectively.

MS-DRGs 216, 217, 218, 219, 220, and 221 are currently subject to the postacute care transfer policy. As a result, these MS-DRGs, as proposed to be revised, would continue to qualify to be included on the list of MS-DRGs that are subject to the postacute care transfer policy.

CMS is proposing to remove MS-DRGs 273 and 274 from the list of MS-DRGs that are subject to the postacute care transfer policy.

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index and Discharge Criteria (§ 412.96) (Refer Page 855)

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, 2019, must have a CMI value for FY 2018 that is at least—

- 1.68555; 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)	1.4231
2	Middle Atlantic (PA, NJ, NY)	1.4920
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5760
4	East North Central (IL, IN, MI, OH, WI)	1.5921

Region		Case Mix Index Value
5	East South Central (AL, KY, MS, TN)	1.5579
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.67025
7	West South Central (AR, LA, OK, TX)	1.7172
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7769
9	Pacific (AK, CA, HI, OR, WA)	1.6679

A hospital must also have the number of discharges for its cost reporting period that began during FY 2017 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.

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Refer page 859)

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.

Consistent with previously established process, for FY 2020, CMS is proposing that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria

For FY 2020, CMS is proposing that a hospital's written request must be received by its MAC no later than September 1, 2019

Qualifying hospitals with 500 or fewer total discharges will receive a low-volume hospital payment adjustment of 25 percent. For qualifying hospitals with fewer than 3,800 discharges but more than 500 discharges, the low-volume payment adjustment is calculated by subtracting from 25 percent the proportion of payments associated with the discharges in excess of 500. As such, for qualifying hospitals with fewer than 3,800 total discharges but more than 500 total discharges, the low-volume hospital payment adjustment for FYs 2019 through 2022 is calculated using the following formula:

Low-Volume Hospital Payment Adjustment = 0.25 – [0.25/3300] x (number of total discharges - 500) = (95/330) - (number of total discharges/13,200).

For this purpose, CMS specified that the "number of total discharges" is determined as total discharges, which includes Medicare and non-Medicare discharges during the fiscal year, based on the hospital's most recently submitted cost report.

Indirect Medical Education (IME) Payment Adjustment Factor (Refer Page 868)

No change here; the IME formula multiplier remains at 1.35.

V. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (Page 55)

Comment

CMS is proposing to make many changes to a number of MS-DRGs, effective for FY 2020. It also discusses DRG weighting and other factors.

This is a relatively long and detailed section. It begins on page 55 and extends to page 370. The material below identifies some items being proposed only by name and corresponding page numbers.

Proposed changes to Specific MS-DRG Classifications

- Peripheral ECMO – (Refer pages 64-76)
- Allogeneic Bone Marrow Transplant – (Refer pages 78-92)
- Carotid Artery Stent Procedures – (Refer pages 100-107)
- Pulmonary Embolism – (Refer pages 107-110)
- Transcatheter Mitral Valve Repair with Implant – (Refer pages 110-134)
- Revision of Pacemaker Lead – (Refer pages 135-136)
- Knee Procedures with Principal Diagnosis of Infection – (Refer pages 136-153)
- Neuromuscular Scoliosis – (Refer pages 153-157)
- Secondary Scoliosis and Secondary Kyphosis – (Refer pages 153-164)
- Extracorporeal Shock Wave Lithotripsy (ESWL) – (Refer pages 164-186)
- Diagnostic Imaging of Male Anatomy – (Refer pages 186-188)
- Proposed Reassignment of Diagnosis Code O99.89 – (Refer pages 188-198)
- Proposed Assignment of Diagnosis Code R93.89 – (Refer pages 202-204)
- Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 through 983 or MS-DRGs 987 through 989 into MDCs – (Refer pages 204-205)
- Gastrointestinal Stromal Tumors with Excision of Stomach and Small Intestine – (Refer pages 205-208)
- Peritoneal Dialysis Catheter Complications – (Refer pages 208-211)
- Bone Excision with Pressure Ulcers – (Refer pages 211-214)
- Lower Extremity Muscle and Tendon Excision – (Refer pages 214-219)
- *Kidney Transplantation Procedures* – (Refer pages 219-221)
- *Insertion of Feeding Device* – (Refer pages 221-225)
- *Basilic Vein Reposition in Chronic Kidney Disease* – (Refer pages 225-227)
- *Colon Resection with Fistula* – (Refer pages 227-229)
- *Stage 3 Pressure Ulcers of the Hip* – (Refer pages 230-233)
- *Finger Cellulitis* – (Refer pages 235-238)
- *Gastric Band Procedure Complications or Infections* – (Refer pages 241-244)
- *Peritoneal Dialysis Catheters* – (Refer page 244-244)
- *Occlusion of Left Renal Vein* – (Refer pages 244-246)
- *Bronchoalveolar Lavage* – (Refer pages 251-252)
- *Percutaneous Drainage of Pelvic Cavity* – (Refer page 253)
- *Percutaneous Removal of Drainage Device* – (Refer pages 253-254)
- *Percutaneous Occlusion of Gastric Artery* – (Refer pages 254-255)

Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020 (Refer page 264)

The diagnosis codes for which CMS is proposing a change in severity level are shown in Table 6P.1c. which is available at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Of the 71,932 diagnosis codes included in CMS' analysis, the net result would be a decrease of 145 (3,244 – 3,099) codes designated as an MCC, a decrease of 837 (14,528 – 13,691) codes designated as a CC, and an increase of 982 (55,142 – 54,160) codes designated as a non-CC.

Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2020(Refer page 320)

The following tables identify the proposed additions and deletions to the diagnosis code MCC severity levels list and the proposed additions and deletions to the diagnosis code CC severity levels list for FY 2020 and are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

- Table 6I.1--Proposed Additions to the MCC List--FY 2020;
- Table 6I.2--Proposed Deletions to the MCC List--FY 2020;
- Table 6J.1--Proposed Additions to the CC List--FY 2020; and,
- Table 6J.2--Proposed Deletions to the CC List--FY 2020.

Proposed Changes to the ICD-10-CM and ICD-10-PCS Coding Systems

To identify new, revised and deleted diagnosis and procedure codes, for FY 2020, CMS has developed the following tables; (Refer page 323)

- Table 6A.--New Diagnosis Codes,
- Table 6B.--New Procedure Codes,
- Table 6C.--Invalid Diagnosis Codes,
- Table 6D.--Invalid Procedure Codes,
- Table 6E.--Revised Diagnosis Code Titles, and
- Table 6F.--Revised Procedure Code Titles for this proposed rule.

Proposed Changes to the Medicare Code Editor (MCE) (Refer page 324)

Proposed Changes Surgical Hierarchies (Refer page 332)

Replaced Devices Offered without Cost or with a Credit (Refer page 342)

VI. Proposed Add-On Payments for New Services and Technologies for FY 2020 (Refer page 370)

Comment

The subject of new technology is long. This year's proposed discussion runs some 371 pages (from 370 to 741).

Proposed FY 2020 Status of Technologies Approved for FY 2019 New Technology Add-On Payments

Discontinued

- Defitelio® (Defibrotide).
- Ustekinumab (Stelara®).
- Bezlotoxumab (ZINPLAVA™)

Continuing

- KYMRIAH™ (Tisagenlecleucel) and YESCARTA™ (Axicabtagene Ciloleucel). The maximum payment would be increased to $242,450 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize its proposed change to the calculation of the new technology add-on payment amount, the maximum new technology add-on payment for a case involving KYMRIAH® or YESCARTA® would remain at $186,500 for FY 2020.

- VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection). CMS is proposing that the maximum new technology add-on payment amount for a case involving the use of VYXEOS™ would be $47,353.50 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving VYXEOS™ would remain at $36,425 for FY 2020.

- f. VABOMERE. The maximum new technology add-on payment amount for a case involving the use of VABOMERE™ would be $7,207.20 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving VABOMERE™ would remain at $5,544 for FY 2020

- remedē® System. The maximum new technology add-on payment amount for a case involving the use of the remedē® System would be $22,425 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving the remedē® System would remain at $17,250 for FY 2020

- ZEMDRI™ (Plazomicin). The he maximum new technology add-on payment amount for a case involving the use of ZEMDRI™ would be $3,539.25 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving ZEMDRI™ would remain at $2,722.50 for FY 2020.

- GIAPREZA™. The maximum new technology add-on payment amount for a case involving the use of GIAPREZA™ would be $1,950 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new

technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving GIAPREZA™ would remain at $1,500 for FY 2020.

- Cerebral Protection System (Sentinel® Cerebral Protection System). The maximum new technology add-on payment amount for a case involving the use of the Sentinel® Cerebral Protection System would be $1,820 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving the Sentinel® Cerebral Protection System would remain at $1,400 for FY 2020.

- The A QUAB EAM System (Aquablation). The maximum new technology add-on payment amount for a case involving the use of the AQUABEAM System would be $1,625 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving the AQUABEAM System would remain at $1,250 for FY 2020.

- AndexXa™ (Andexanet alfa). The maximum new technology add-on payment amount for a case involving the use of AndexXa™ would be $18,281.25 for FY 2020; that is, 65 percent of the average cost of the technology. However, if CMS does not finalize the proposed change to the calculation of the new technology add-on payment amount, CMS is proposing that the maximum new technology add-on payment for a case involving AndexXa™ would remain at $14,062.50 for FY 2020.

Proposed FY 2020 Applications for New Technology Add-On Payments

CMS received 18 applications for new technology add-on payments for FY 2020. One has been withdrawn.

The 17 others are as follows; All are pending approval.

- AZEDRA® (Ultratrace® iobenguane Iodine-131) Solution
- CABLIVI® (caplacizumab-yhdp)
- CivaSheet®
- CONTEPO™ (Fosfomycin for Injection)
- DuraGraft® Vascular Conduit Solution
- Eluvia™ Drug-Eluting Vascular Stent System
- ELZONRIS™ (tagraxofusp, SL-401)
- Erdafitinib
- ERLEADA™ (Apalutamide)
- SPRAVATO (Esketamine)
- XOSPATA
- GammaTile™
- Imipenem, Cilastatin, and Relebactam (IMI/REL) Injection
- JAKAFI™ (Ruxolitinib)
- Supersaturated Oxygen (SSO2) Therapy (DownStream® System)
- T2Bacteria® Panel (T2 Bacteria Test Panel)
- VENCLEXTA®

Request for Information on the New Technology Add-On Payment Substantial Clinical Improvement Criterion (Refer 714)

CMS is requesting feedback on whether new or changed regulatory provisions or new or changed guidance regarding additional aspects of the substantial clinical improvement evaluation process in the following areas would be helpful.

- "What role should substantial clinical improvement play in our payment policies to ensure these policies do not discourage appropriate utilization of new medical services and technologies?
- "How should CMS determine what existing technologies are appropriate comparators to new technologies? How should CMS evaluate a technology when its comparators have different measured clinical outcomes?
- "Should CMS provide more specificity or greater clarity on the types of evidence or study designs that may be considered by the agency in evaluating substantial clinical improvement?
- "Should CMS consider evidence regarding the off-label use of a new technology? If so, what is the appropriate use of that evidence when evaluating a new technology for an FDA approved or cleared indication? Are there other new technology add-on payment or device pass-through payment changes that CMS should consider regarding off-label use?
- "We note that, while additional specificity and guidance on substantial clinical improvement may be helpful, this may also have the unintended consequence of limiting future flexibility in the evaluation of future applications, especially as new technologies are continually emerging. How should CMS balance these considerations in the evaluation of new technologies as it considers potential future steps? Towards this end, would it be helpful to the goal of both predictability and flexibility if the agency explained the types of information or evidence that are not required for a finding of substantial clinical improvement?
- "Currently, our regulations at § 412.87 require that we announce the results of the new technology add-on payment determinations in the Federal Register as part of our annual updates and changes to the IPPS. We also are seeking public comments on revising this requirement to allow the new technology add-on payment determinations, including but not limited to determinations of substantial clinical improvement, to be announced annually in the Federal Register separate from the annual updates and changes to the IPPS."

Proposed Alternative Inpatient New Technology Add-On Payment Pathway for Transformative New Devices (Refer page 730)

CMS is proposing that, for applications received for new technology add-on payments for FY 2021 and subsequent fiscal years, if a medical device is part of the FDA's Breakthrough Devices Program and received FDA marketing authorization, it would be considered new and not substantially similar to an existing technology for purposes of the new technology add-on payment under the IPPS.

CMS also is proposing that the medical device would not need to meet the requirement under § 412.87(b)(1) that it represent an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

Proposed Change to the Calculation of the Inpatient New Technology Add-On Payment (Refer page 737)

CMS is proposing that, beginning with discharges on or after October 1, 2019, if the costs of a discharge involving a new technology (determined by applying CCRs as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 65 percent of the costs of the new medical service or technology; or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment. Unless the discharge qualifies for an outlier payment, the additional Medicare payment would be limited to the full MS-DRG payment plus 65 percent of the estimated costs of the new technology or medical service.

VII Hospital Readmissions Reduction Program (HRRP): (Refer page 935)

The Hospital Readmissions Reduction Program currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery.

CMS is proposing to update its previously finalized definition of "dual-eligible" to specify that, for the payment adjustment factors beginning with the FY 2021 program year, "dual-eligible" is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in data sourced from the State ***Medicare Modernization Act*** (MMA) files for the month the beneficiary was discharged from the hospital, except for those patient beneficiaries who die in the month of discharge, who will be identified using the previous month's data sourced from the State MMA files.

The updated definition is necessary to account for misidentification of the dual-eligible status of patient beneficiaries who die in the month of discharge, which can occur under the current definition.

CMS is proposing to adopt a policy under which the agency would use a subregulatory process to make nonsubstantive changes to the payment adjustment factor components used for the Hospital Readmissions Reduction Program.

CMS previously adopted the payment adjustment factor components policies through the notice-and-comment rulemaking process. "The Hospital Readmissions Reduction Program relies on these payment adjustment factor components, including, but not limited to, dual proportion, peer group assignment, peer group median ERR, neutrality modifier, and ratio of DRG payments to total payments, to determine hospital payments in each fiscal year. Each year, we provide details on most of that information in the Hospital Specific Report (HSR) User Guide located on QualityNet website at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772412669. However, there are times when data sourcing and other technical aspects of the payment adjustment factor components change and require updating, even when those changes do not alter the intent of our previously finalized policies. Because the updates to data sourcing and technical aspects of the components are not always linked to the timing of regulatory actions, we believe this proposed policy is prudent to allow for the use of the most up-to-date, accurate information. We reiterate that we would continue to consider all changes to the framework of the components themselves as substantive changes that we would propose through the notice-and-comment rulemaking process.

For FY 2020, a hospital subject to the Hospital Readmissions Reduction Program would have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

CMS estimates the following hospitals will be subject to a payment reduction of up to 3.0 percent.

Percentage of Hospitals Penalized and Penalty as Share of Payments for FY 2020 Hospital Readmissions Reduction Program				
	Number of Eligible Hospitals	**Number of Penalized Hospitals**	**Percentage of Hospitals Penalized (%)**	**Penalty as a share of payments (%)**
All Hospitals	3,062	2,599	84.88	0.67

Comment

The items, issues, and requirements in the hospital readmission program, hospital acquired conditions, and hospital value-based programs are all detailed and complex requiring indepth analysis.

VIII. Hospital Value-Based Purchasing (VBP) Program: Policy Changes (Refer page 955)

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 2020 program year would be 2.00 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2020 will be approximately $1.9 billion, or a total of approximately $1.9 billion.

CMS repeats many tables from last year's rule, but is not making any changes to those tables.

The newly established performance standards for the FY 2025 program year for the Clinical Outcomes domain and the Efficiency and Cost Reduction domain are set out in the table below.

Newly Established Performance Standards for the FY 2025 Program Year		
Measure Short Name	**Achievement Threshold**	**Benchmark**
Clinical Outcomes Domain		
MORT-30-AMI	0.872624	0.889994
MORT-30-HF	0.883990	0.910344
MORT-30-PN (updated cohort)	0.841475	0.874425
MORT-30-COPD	0.915127	0.932236
MORT-30-CABG	0.970100	0.979775
COMP-HIP-KNEE**	0.025332	0.017946
Efficiency and Cost Reduction Domain		
MSPB	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period.

Summary of Previously Adopted Measures for the FY 2022 and FY 2023 Program Years

Summary of Previously Adopted Measures for the FY 2022 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

Summary of Previously Adopted Measures for the FY 2022 Program Year		
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
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 (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
COMP-HIP-KNEE*	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

* CMS notes that it is updating the short name of the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550) from THA/TKA to COMP-HIPKNEE in order to maintain consistency with the updated Measure ID and short name used in tables on the Hospital Compare website and hospital reports for the Hospital VBP Program. This updated name is used throughout section IV.H. of the preamble of this proposed rule.

Summary of Previously Adopted Measures for the FY 2023 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	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure	0753

Summary of Previously Adopted Measures for the FY 2023 Program Year		
Measure Short Name	**Domain/Measure Name**	**NQF #**
Hysterectomy SSI	Specific Surgical Site Infection (SSI) Outcome Measure	
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
CMS PSI 90*	CMS Patient Safety and Adverse Events Composite*	0531
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 (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
COMP-HIP-KNEE	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

*CMS notes that it has updated the name of the Patient Safety and Adverse Events Composite (PSI 90) to the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) when it is used in CMS programs due to transition of the measure from AHRQ to CMS

IX. Hospital-Acquired Condition (HAC) Reduction Program (Refer page 983)

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 is proposing to clarify policies that were finalized for the HAC Reduction Program in the FY 2019 IPPS/LTCH PPS final rule, so that they are implemented as intended. CMS is specifically proposing to: (1) adopt a measure removal policy that aligns with the removal factor policies previously adopted in other quality reporting and quality payment programs; (2) clarify administrative policies for validation of the CDC NHSN HAI measures; (3) adopt the data collection periods for the FY 2022 program year; and (4) update regulations for the HAC Reduction Program at 42 CFR 412.172(f) to reflect policies finalized in the FY 2019 IPPS/LTCH PPS final rule.

Proposed Change to the Previously Finalized Validation Selection Methodology

In the FY 2019 IPPS/LTCH PPS final rule, CMS finalized a policy to select 200 additional hospitals for targeted validation and five targeting criteria. While CMS is retaining the same targeting criteria that was finalized last year, the agency is proposing to change the number of hospitals targeted from exactly 200 hospitals to "up to 200 hospitals."

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

X. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS
(Refer page 1,111)

Proposed New Measures for the Hospital IQR Program Measure Set

CMS is proposing to: (1) adopt two new quality measures beginning with the FY 2023 payment determination; and (2) expand the voluntary reporting status of the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (Hybrid HWR measure).

CMS would add the following two opioid-related electronic clinical quality measures (eCQMs) to the Hospital IQR Program eCQM measure set, beginning with the CY 2021 reporting period/FY 2023 payment determination: (1) Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e); and (2) Hospital Harm – Opioid-Related Adverse Events eCQM.

Summary of Previously Finalized Hospital IQR Program Measures for the FY 2022 Payment Determination

Measures for the FY 2022 Payment Determination		
Short Name	**Measure Name**	**NQF #**
National Healthcare Safety Network Measures		
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
Claims-Based Patient Safety Measures		
COMP-HIP-KNEE *++	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
CMS PSI 04	CMS Death Rate among Surgical Inpatients with Serious Treatable Complications	+
Claims-Based Mortality Measures		
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	N/A
Chart-Abstracted Clinical Process of Care Measures		
PC-01	Elective Delivery	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500

Measures for the FY 2022 Payment Determination		
Short Name	**Measure Name**	**NQF #**
EHR-based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))		
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
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
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)

* Finalized for removal from the Hospital IQR Program beginning with the FY 2023 payment determination, as discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41558 through 41559).
** In the CY 2019 OPPS/ASC PPS final rule with comment period (83 FR 59140 through 59149), CMS finalized removal of the Communication About Pain questions from the HCAHPS Survey effective with October 2019 discharges, for the FY 2021 payment determination and subsequent years.
+ Measure is no longer endorsed by the NQF, but was endorsed at time of adoption.
Section 1886(b)(3)(B)(viii)(IX)(bb) of the Act authorizes the Secretary to specify a measure that is not endorsed by the NQF as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the inpatient setting.
++ CMS has updated the short name for the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550) measure from Hip/Knee Complications to COMP-HIP-KNEE in order to maintain consistency with the updated Measure ID and hospital reports for the Hospital Compare website.

Summary of Previously Finalized and Newly Proposed Hospital IQR Program Measures for the FY 2023 Payment Determination

Measures for the FY 2023 Payment Determination		
Short Name	**Measure Name**	**NQF #**
National Healthcare Safety Network Measures		
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
Claims-Based Patient Safety Measures		
CMS PSI 04	CMS Death Rate among Surgical Inpatients with Serious Treatable Complications	+
Claims-Based Mortality Measures		
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

Measures for the FY 2023 Payment Determination		
Short Name	**Measure Name**	**NQF #**
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	N/A
Chart-Abstracted Clinical Process of Care Measures		
PC-01	Elective Delivery	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
EHR-based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))		
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Harm-ORAE**	Hospital Harm –Opioid-Related Adverse Events	++
PC-05	Exclusive Breast Milk Feeding	0480
Safe Use of Opioids**	Safe Use of Opioids – Concurrent Prescribing	3316e
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
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)

* In section VIII.A.6. of the preamble of this proposed rule, CMS is proposing to remove the claims-only Hospital-Wide All-Cause Unplanned Readmission (HWR claims -only) measure (NQF #1789) and in VIII.A.5.b. of the preamble of this proposed rule CMS is proposing to replace it with the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (NQF #2879) (Hybrid HWR measure), beginning with the FY 2026 payment determination. The proposed removal of the HWR claims-only measure is contingent on CMS finalizing its proposal to adopt the Hybrid HWR measure. CMS is proposing to align the removal of the HWR claims only measure such that its removal aligns with the end of the proposed 2-year voluntary reporting period and the beginning of the proposed mandatory data submission and public reporting of the Hybrid HWR measure.

** Newly proposed in this proposed rule to add to the eCQM measure set, beginning with the CY 2021 reporting period/FY 2023 payment determination.

+ Measure is no longer endorsed by the NQF but was endorsed at time of adoption. Section 1886(b)(3)(B)(viii)(IX)(bb) of the Act authorizes the Secretary to specify a measure that is not endorsed by the NQF as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the inpatient setting.

++ This measure was submitted for endorsement by NQF's Patient Safety Standing Committee for the Spring 2019 cycle, with a complete review of measure validity and reliability current scheduled for June 2019.

Comment

The IQR section is 99 pages. There is much detail about reporting times, and other related items.

XI. Proposed Changes to the Payment Rates for the LTCH PPS for FY 2020
(Refer page 1,624)

Proposed Updates to the Payment Rates for the LTCH PPS for FY 2020

CMS is proposing to establish an annual update to the LTCH PPS standard Federal payment rate of 2.7 percent for FY 2020. CMS is proposing to apply a factor of 1.027 to the FY 2019 LTCH PPS standard Federal payment rate of $41,558.68 to determine the proposed FY 2020 LTCH PPS standard Federal payment rate.

Additionally, CMS is proposing to apply a temporary budget neutrality adjustment factor of 0.990741 to the LTCH PPS standard Federal payment rate for the cost of the elimination of the 25-percent threshold policy for FY 2020 after removing the temporary budget neutrality adjustment factor of 0.990884 that was applied to the LTCH PPS standard Federal payment rate for the cost of the elimination of the 25-percent threshold policy for FY 2019 (or a temporary, one-time factor of 0.999856).

Consistent with § 412.523(d)(4), CMS also is proposing to apply an area wage level budget neutrality factor to the proposed FY 2020 LTCH PPS standard Federal payment rate of 1.0064747.

These changes result in a LTCH PPS standard Federal payment rate of **$42,950.91** (calculated as $41,558.68 x 0.999856 x 1.027 x 1.0064747) for FY 2020.

The labor-related share under the LTCH PPS for FY 2020 will be 66.0 percent, the same as the current percentage.

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) on the CMS website.

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

High-Cost Outlier (HCO) Cases

Under the regulations at § 412.525(a)(2)(ii) and as required by section 1886(m)(7) of the Act, the fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875 percent of 8 percent (that is, 7.975 percent) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

The proposed fixed-loss amount for HCO cases for FY 2020 would be **$29,997**. This is significantly higher than the FY 2019 fixed-loss amount of $27,121 (as corrected).

CMS is establishing a fixed-loss amount for site neutral payment rate cases of $26,994, which is the same proposed FY 2020 IPPS fixed-loss amount.

Other

CMS estimates that overall LTCH PPS payments in FY 2020 will increase by approximately 0.9 percent (or approximately $37 million)

Proposed Changes to the Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
(Refer page 1,248)

CMS is proposing to adopt two measures beginning with FY 2022: (1) Transfer of Health Information to the Provider–Post-Acute Care (PAC); and (2) Transfer of Health Information to the Patient–Post-Acute Care (PAC).

In addition, CMS is proposing to update the specifications for the Discharge to Community–Post Acute Care (PAC) LTCH QRP measure to exclude baseline nursing facility (NF) residents from the measure.

Comment

The LTCH hospital reporting section consumes some 160 pages.

Final Comments and Regulatory Analysis

The sheer size of recent CMS PPS updates is difficult to summarize and analyze. There are many items that cannot be covered. To do so could make such analysis almost as long as the rules themselves. Compounding the situation is the lack of a complete table of contents to allow the reader the ability to easily purview the document. As mentioned earlier, page numbers would be very helpful.

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

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 ponder 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 CMS' analysis of reporting burden it appears many hours are being devoted to the system. But, what have been the outcomes?

It should not be a surprise that Medicare payments are increasing in the DSH area. It's simple to understand, more individuals are losing their health care coverage.

Finally, CMS is proposing changes to the area wage index. This issue is politically akin to Congress trying to tamper with Social Security and Medicare benefits. Time will both the impact and viability of the proposal.

Below is a table from the proposal's regulatory analysis section providing some insight to Medicare's attempt to "refine" the area wage index.

Comparison of FY 2019 and Proposed FY 2020 IPPS Estimated Payments Due to Proposed Rural Floor with National Budget Neutrality

FY 2019 Final Rule Correction Notice					FY 2020 Proposed Rule			
State	Number of Hospitals (1a)	Number of Hospitals That Received the Rural Floor (2a)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3a)	Difference in (millions) (4a)	Number of Hospitals (1b)	Number of Hospitals That Would Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Proposed Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Alabama	84	2	-0.3	$ -5	84	1	-0.2	$ -3
Alaska	6	3	0.1	0	6	3	1.1	2
Arizona	56	33	1.3	26	54	2	-0.2	-3
Arkansas	45	0	-0.3	-3	46	0	-0.2	-2
California	297	59	0.4	42	297	52	0.8	102
Colorado	45	9	0.7	9	49	10	0.8	12
Connecticut	30	8	1.3	21	30	0	-0.2	-4
Delaware	6	0	-0.3	-2	6	0	-0.2	-1

FY 2019 Final Rule Correction Notice					FY 2020 Proposed Rule			
State	Number of Hospitals (1a)	Number of Hospitals That Received the Rural Floor (2a)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3a)	Difference in (millions) (4a)	Number of Hospitals (1b)	Number of Hospitals That Would Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Proposed Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Washington, DC	7	0	-0.3	-2	7	0	-0.2	-1
Florida	168	7	-0.3	-20	168	7	-0.2	-12
Georgia	101	0	-0.3	-8	100	1	-0.2	-5
Hawaii	12	6	-0.1	0	12	0	-0.1	0
Idaho	14	0	-0.3	-1	16	0	-0.2	-1
Illinois	125	2	-0.3	-14	126	2	-0.2	-10
Indiana	85	0	-0.3	-7	85	0	-0.2	-5
Iowa	34	0	-0.3	-3	34	3	-0.2	-2
Kansas	51	0	-0.2	-2	51	0	-0.2	-2
Kentucky	64	0	-0.3	-5	64	0	-0.2	-3
Louisiana	90	0	-0.3	-5	89	0	-0.2	-3
Maine	17	0	-0.3	-2	17	0	-0.2	-1
Massachusetts	56	29	3.3	123	55	10	0.5	21
Michigan	94	0	-0.3	-14	94	0	-0.2	-8
Minnesota	49	0	-0.2	-6	48	0	-0.1	-4
Mississippi	59	0	-0.3	-3	59	0	-0.2	-2
Missouri	72	0	-0.2	-6	72	0	-0.1	-2
Montana	13	1	-0.2	-1	13	1	-0.2	-1
Nebraska	23	0	-0.3	-2	23	0	-0.2	-1
Nevada	22	3	0.4	3	22	2	0.6	6
New Hampshire	13	8	2.4	14	13	8	1	6
New Jersey	64	0	-0.4	-16	64	0	-0.2	-9
New Mexico	24	2	-0.2	-1	24	0	-0.1	-1
New York	149	16	-0.3	-21	146	14	-0.2	-13
North Carolina	84	0	-0.3	-9	83	0	-0.2	-6
North Dakota	6	3	0.4	1	6	3	0.6	2
Ohio	130	7	-0.3	-11	129	6	-0.2	-7
Oklahoma	79	2	-0.3	-4	79	1	0	0
Oregon	34	1	-0.2	-2	34	1	-0.1	-1
Pennsylvania	150	3	-0.3	-17	150	1	-0.2	-10
Puerto Rico	51	11	0.1	0	50	8	0.2	0
Rhode Island	11	0	-0.4	-1	11	0	-0.2	-1
South Carolina	54	6	-0.1	-1	54	5	-0.1	-3
South Dakota	17	0	-0.2	-1	16	0	-0.1	0
Tennessee	90	6	-0.3	-7	90	6	-0.2	-4
Texas	310	13	-0.3	-18	303	9	-0.2	-12

FY 2019 Final Rule Correction Notice					FY 2020 Proposed Rule			
State	Number of Hospitals (1a)	Number of Hospitals That Received the Rural Floor (2a)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3a)	Difference in (millions) (4a)	Number of Hospitals (1b)	Number of Hospitals That Would Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Proposed Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Utah	31	0	-0.3	-2	31	0	-0.2	-1
Vermont	6	0	-0.2	0	6	0	-0.1	0
Virginia	74	1	-0.2	-6	72	5	-0.1	-2
Washington	48	3	-0.3	-7	49	3	-0.2	-4
West Virginia	29	2	-0.2	-1	29	2	-0.1	-1
Wisconsin	66	5	-0.3	-5	66	0	-0.2	-3
Wyoming	10	2	0	0	10	0	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				
MS-DRG	MS-DRG Title	Discharges	Proposed FY 2020 Weights	Final FY 2019 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	114,574	1.0608	1.0315	2.84%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	151,250	1.2130	1.2353	-1.81%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	141,874	1.1444	1.1907	-3.89%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	149,380	1.3440	1.3167	2.07%
194	SIMPLE PNEUMONIA & PLEURISY W CC	138,682	0.9301	0.9002	3.32%
291	HEART FAILURE & SHOCK W MCC	379,782	1.3499	1.3454	0.33%
378	G.I. HEMORRHAGE W CC	109,027	1.0840	0.9903	9.46%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	158,909	0.7824	0.7554	3.57%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	453,608	1.9893	1.9898	-0.03%
603	CELLULITIS W/O MCC	108,755	0.8568	0.8477	1.07%
641	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS, ELECTROLYTES, W/O MCC	117,252	0.8144	New	NA
683	RENAL FAILURE W CC	148,599	0.9320	0.9190	1.41%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	141,833	0.7967	0.7941	0.33%

	LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS				
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	591,892	1.8744	1.8564	0.97%
872	SEPICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/o MCC	187,793	1.0961	1.0529	4.10%
	Total Discharges	3,093,210			

This year, 2 DRGs that previously had more than 100,000 had fewer discharges and are removed from the table above – DRGs 292 (Heart Failure & Shock W CC) and DRG 682 (Renal Failure W MCC). A new DRG has been added – DRG 641 (Misc Disorders of Nutrition)

These 15 MS-DRGs contain 3.1 million discharges or approximately 33 percent of the 9.5 million MS-DRG discharges.

The following IPPS tables for this proposed rule 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 2020 IPPS Proposed Rule Home Page" or "Acute Inpatient--Files for Download."

Table 2—Proposed Case-Mix Index and Wage Index Table by CCN—FY 2020
Table 3—Proposed Wage Index Table by CBSA—FY 2020
Table 4—Proposed List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2020
Table 5—Proposed List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay—FY 2020
Table 6A—New Diagnosis Codes--FY 2020
Table 6B—New Procedure Codes--FY 2020
Table 6C—Invalid Diagnosis Codes--FY 2020
Table 6D—Invalid Procedure Codes--FY 2020
Table 6E—Revised Diagnosis Code Titles--FY 2020
Table 6F—Revised Procedure Code Titles--FY 2020
Table 6G.1—Proposed Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2020
Table 6G.2—Proposed Principal Diagnosis Order Additions to the CC Exclusions List--FY 2020
Table 6H.—Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2020
Table 6H.2.Proposed Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2020
Table 6I.1—Proposed Additions to the MCC List--FY 2020
Table 6I.2—Proposed Deletions to the MCC List--FY 2020
Table 6J.1—Proposed Additions to the CC List--FY 2020
Table 6J.2—Proposed Deletions to the CC List--FY 2020
Table 6P—ICD-10-CM and ICD-10-PCS Codes for Proposed MS-DRG Changes—FY 2020 (Table 6P contains multiple tables, 6P.1a. through 6P.1e., that include the ICD-10-CM and ICD-10-PCS code lists relating to proposed specific MS-DRG changes. These tables are referred to throughout section II.F. of the preamble of this proposed rule.)
Table 7A—Proposed Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2018 MedPAR Update—December 2018 GROUPER Version 36 MS-DRGs
Table 7B—Proposed Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2018 MedPAR Update—December 2018 GROUPER Version 37 MS-DRGs
Table 8A—Proposed FY 2020 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
Table 8B—Proposed FY 2020 Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals
Table 16—Proposed Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2020

Table 18—Proposed FY 2020 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this FY 2020 proposed rule are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1716-P:

Table 8C.—Proposed FY 2020 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)

Table 11—Proposed MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2019 through September 30, 2020

Table 12A.—Proposed LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2019 through September 30, 2020

Table 12B.—Proposed LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2019 through September 30, 2020