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An Analysis and Commentary on Federal Health Care Issues
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August 5, 2019

Massive Final FY 2020 Medicare IPPS and LTCH Update Released

The Centers for Medicare and Medicaid Services (CMS) have released an extensively long final rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2020.

Some of the many items discussed include the following; (1) the hospital market basket increase; (2) MS-DRG documentation and coding; (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; and (11) changes to the LTCH system.

The 2,273-page document is currently on public display at the ***Federal Register*** office and is scheduled for publication August 16. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16762.pdf.

The IPPS tables are available on the CMS website at: https://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 Final Rule Home Page" or "Acute Inpatient—Files for Download."

The LTCH PPS tables are at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1716-F.

Comment

CMS projects this proposal would apply to approximately 3,300 acute care hospitals and to approximately 390 LTCH facilities for discharges occurring on and after October 1, 2019.

CMS says that acute care hospitals are estimated to experience an increase of approximately **$3.8 billion** in FY 2020, taking into account operating, capital, new technology, and low volume hospital payments. Approximately $3.5 billion of this estimated increase is due to the changes in operating payments, including $0.1 billion in uncompensated care payments, approximately $0.1 billion is due to the change in capital payments, approximately $0.2 billion is due to the change in new technology add-on payments, and approximately $-7 million is due to the change in low-volume hospital payments.

The proposed increase was stated as $4.7 billion. In several places in the final rule, CMS says the FY 2020 increase will be $3.9 billion.

The rule does contain a table of contents, but it only refers to major headings. No subheads/ sections are identified. Nonetheless, the table of contents is somewhat helpful. However, when CMS refers the reader to a particular section, it is still extremely difficult to locate

Note: For many payment issues, the rule's Addendum (beginning on page 1,972) contains much concise and extremely helpful payment information.

We noted in our analysis of the proposed rule that there were 3 major items. They were:

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

CMS actions on these are reflected in the material below.

Inpatient Prospective Payment System

Introductory Material

Some of the material cited below is excerpted from the rule's fact sheet. Additional details from the rule itself follow in subsequent sections.

Changes to Payment Rates under IPPS

The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 3.1 percent. This reflects a projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage point productivity adjustment (2.6 percent net). The increase also reflects a +0.5 percentage point adjustment required by legislation.

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

- Penalties for excess readmissions, which reflect an adjustment to a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid;
- A penalty (1.0 percent) for the worst-performing quartile under the Hospital Acquired Condition Reduction Program;
- Upward and downward adjustments under the Hospital Value-Based Purchasing Program; and,
- Downward adjustments for excessive hospital readmissions.

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

To address the impact of disparities on low wage index hospitals, CMS is finalizing its proposal to increase the wage index for hospitals with a wage index value below the 25th percentile. These hospitals' wage indexes will 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 policy will 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 response to public comments, CMS is modifying the budget neutrality adjustment for the policy. Overall Medicare spending will still not increase as a result of this policy, but CMS is accomplishing this through a budget neutrality adjustment to the standardized amount that is applied across all IPPS hospitals, rather than by a decrease to the wage index for hospitals above the 75th percentile as proposed.

CMS is also finalizing changes to the wage index "rural floor" calculation. Under the 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. CMS will remove urban to rural hospital reclassifications from the calculation of the rural floor wage index value.

In conjunction with these policies, CMS is finalizing a transition of a 5.0 percent cap for FY 2020 on any decrease in a hospital's wage index from its final wage index for FY 2019 to help mitigate any significant decreases in the wage index values for hospitals in FY 2020. That is, a hospital's final wage index for FY 2020 will not be less than 95 percent of its final wage index for FY 2019.

Medicare Uncompensated Care Payments (Disproportionate Share Hospitals/DSH)

CMS distributes a prospectively determined amount of uncompensated care payments to "Medicare disproportionate share hospitals" based on their relative share of uncompensated care. As required under law, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured people. In this rule, CMS will distribute roughly $8.4 billion in uncompensated care payments in FY 2020, an increase of approximately $78 million from FY 2019.

After consideration of public comments on the alternatives discussed in the proposed rule, CMS says it determined that the best available data on uncompensated care costs are from Worksheet S-10 of the **FY 2015 cost report**, in part because of conducted audits of this data. Accordingly, for FY 2020, CMS will use 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.

Hospital-Acquired Conditions (HAC) Reduction Program

CMS is finalizing as proposed to:

- Specify the dates to collect data used to calculate hospital performance for the FY 2022 HAC Reduction Program;
- Adopt eight removal factors CMS would use when deciding whether a measure should be removed from the HAC Reduction Program; all of these factors were previously adopted by the Hospital IQR and Hospital VBP Programs; and
- 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 finalizing its proposals to:

- Establish the performance period for the FY 2022 program year;
- Adopt eight removal factors CMS would use when deciding whether a measure should be removed from the Hospital Readmissions Reduction Program; all of these factors were previously adopted by the Hospital IQR and Hospital VBP Programs;
- Update the definition of "dual eligible," and the definitions of aggregate payments for excess readmissions, applicable condition, base operating DRG payment amount, and limitations on administrative and judicial review to align with previously finalized policies; and
- Adopt a sub-regulatory process to address potential non-substantive changes to the payment adjustment factor components.

Hospital Inpatient Quality Reporting (IQR) Program

CMS is finalizing its proposals to:

- Remove the Claims-Based Hospital-Wide All-Cause Readmission measure (NQF #1789) beginning with the July 1, 2023 through June 30, 2024 reporting period, for the FY 2026 payment determination, and replace it with the newly adopted Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data measure (NQF #2879); require reporting of the Hybrid HWR measure beginning with the FY 2026 payment determination, following 2 years of voluntary reporting beginning July 1, 2021; and establish reporting and submission requirements for hybrid measures;
- Adopt the Safe Use of Opioids – Concurrent Prescribing electronic clinical quality measure (eCQM), with a clarification and update, beginning with the CY 2021 reporting period/FY 2023 payment determination; and,
- CMS is not finalizing its proposal to adopt the Hospital Harm – Opioid-Related Adverse Events eCQM.

Also, CMS is finalizing its proposals related to eCQM reporting requirements. These finalized proposals align with the Promoting Interoperability Program's Clinical Quality Measure requirements:

- For the CY 2020 reporting period/FY 2022 payment determination and CY 2021 reporting period/FY 2023 payment determination, to 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 finalized Safe Use of Opioids – Concurrent Prescribing eCQM, for a total of four eCQMs; and,
- To continue requiring 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

The Hospital VBP Program adjusts payments to hospitals under the IPPS in a fiscal year for inpatient services based on their performance on specified quality measures. CMS is finalizing that the Hospital VBP Program will 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 finalizing that the Hospital VBP Program will rely on the process used by the HAC Reduction Program to validate the NHSN HAI measures. In addition, CMS is establishing the performance standards that would apply to a number of measures in future program years.

Medicare and Medicaid Promoting Interoperability Programs

CMS is finalizing 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 finalizing its proposal to continue for the CY 2020 EHR reporting period 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 that arose from the stakeholder community citing implementation difficulties and provider burden. To minimize burden, CMS is also finalizing converting this measure from a numerator/denominator to a yes/no attestation beginning with the EHR reporting period in CY 2019.

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

Additionally, CMS is finalizing its plan to continue to align the CQM reporting requirements for the Promoting Interoperability Programs with similar requirements under the Hospital IQR Program. This includes finalizing the adoption of the new opioid-related quality measure Safe Use of Opioids – Concurrent Prescribing CQM.

New Technology

CMS is finalizing an increase to the add-on payment, beginning in FY 2020, from 50 percent to 65 percent, and additionally is increasing the add-on payment to 75 percent for certain antimicrobials.

In FY 2020, CMS will be making new technology add-on payments for 18 technologies. After consideration of public comments on the proposed rule, CMS has approved 9 of the 13 applications for new technology add-on payment for FY 2020. This final rule also finalizes the continuation of the new technology add-on payments for the 9 technologies currently receiving the add-on payment that will continue to be within their newness period in FY 2020.

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.

LTCH Quality Reporting Program (QRP)

LTCHs that do not satisfy the requirements of the quality program for a fiscal year receive a two percentage point reduction to their annual update to the LTCH PPS standard Federal rate for discharges for that fiscal year.

In the FY 2020 final rule, CMS is finalizing the adoption of 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 (SPADE) that assess functional status, cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, and social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation).

CMS is finalizing its proposal to modify the previously adopted Discharge to Community measure to exclude nursing home residents, moving the implementation date of future versions of the LTCH CARE Data Set from April to October, adopting data collection and public display periods for various measures, and announcing that it will 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 final 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 page numbers in red. These numbers are from the PDF version of the display copy file as posted on August 2nd. Items may be addressed in several different locations throughout the rule. Not all page sections are identified.

I. CHANGES TO PAYMENT RATES UNDER IPPS (Addendum Page 1,972)

Rate Update

The 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 3.0 percent. This reflects a projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage point multi-factor productivity (MFP) adjustment for a net increase of **2.6 percent.**

Also included is a +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 2.6 and 0.05 amounts result in an increase of 3.1 percent.

CMS displays four applicable percentage increases to the standardized amount for FY 2020, as specified in the following table. The market basket rate of increase below does NOT include the 0.5 percent documentation and coding adjustment (Refer page 1,976).

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**
Market Basket Rate-of-Increase	3.0	3.0	3.0	3.0
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.75	-0.75
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.25	0	-2.25
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.5
Applicable Percentage Increase Applied to Standardized Amount	2.6	0.35	1.85	-0.4

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 in the table below, is $6,041.28 for both wage index areas – those greater than 1.0000 and those with values equal to or less than 1.0000.

The following table (Pages 2,041-2,043) illustrates the changes from the FY 2019 national standardized amount to the final FY 2020 national standardized amount. 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 final FY 2020 update factors.

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 **(0.985335)** 2. FY 2019 Operating Outlier Offset **(0.948999)** 3. FY 2019 Rural Demonstration Budget Neutrality Factor **(0.999467)**	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,126.19 Nonlabor (31.7%) $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,126.19 Nonlabor (31.7%) $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,126.19 Nonlabor (31.7%) $1,915.09 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,126.19 Nonlabor (31.7%) $1,915.09 *(Combined labor and nonlabor = $6,041.28)*
	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,745.59 Nonlabor (38%): $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,745.59 Nonlabor (38%): $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,745.59 Nonlabor (38%): $2,295.69 *(Combined labor and nonlabor = $6,041.28)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,745.59 Nonlabor (38%): $2,295.69 *(Combined labor and nonlabor = $6,041.28)*
FY 2020 Update Factor****	~~1.027~~ 1.026	~~1.0030~~ 1.0035	~~1.0190~~ 1.0185	~~0.995~~ 0.996
FY 2020 MS-DRG Recalibration Budget Neutrality Factor	0.997649	0.997649	0.997649	0.997649
FY 2020 Wage Index Budget Neutrality Factor	1.001573	1.001573	1.001573	1.001573

	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 Lowest Quartile Budget Neutrality Factor	0.997987	0.997987	0.997987	0.997987
FY 2020 Reclassification Budget Neutrality Factor	0.985425	0.985425	0.985425	0.985425
FY 2020 Transition Budget Neutrality Factor	0.998838	0.998838	0.998838	0.998838
FY 2020 Operating Outlier Factor	0.949	0.949	0.949	0.949
FY 2020 Rural Demonstration Budget Neutrality Factor	0.999771	0.999771	0.999771	0.999771
Adjustment for FY 2020 Required under Section 414 of Pub. L. 114-10 (MACRA)	1.005	1.005	1.005	1.005
National Standardized Amount for FY 2020 if Wage Index is Greater Than 1.0000; **Labor/Non-Labor Share Percentage (68.3/31.7)**	**Labor: $3,962.17** **Nonlabor: $1,838.96**	**Labor: $3,875.28** **Nonlabor: $1,798.63**	**Labor: $3,933.21** **Nonlabor: $1,825.52**	**Labor: $3,846.32** **Nonlabor: $1,785.18**
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: $3,596.70** **Nonlabor: $2,204.43**	**Labor: $3,517.82** **Nonlabor: $2,156.09**	**Labor: $3,570.41** **Nonlabor: $2,188.32**	**Labor: $3,491.54** **Nonlabor: $2,139.97**

*** Note: The FY 2020 Update Factor in red and crossed out are the numbers in the final rule (page 2041) are the proposed update amounts. The correct amounts have been inserted. Using the correct update factors does NOT change the final FY 2020 rates.*

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 1,979)

The change between the final FY 2020 amount and the current amount is $155.05, or a net increase of approximately 2.75 percent.

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

Comment (Pages 2,136)

CMS says that 167 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 but do submit quality information.

CMS says that 41 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 30 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.

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

CMS is finalizing a FY 2020 capital rate of **$462.61.** The current amount is $459.41 (as corrected October 3, 2018)

Outlier Payments (Refer pages 2,027, 2034)

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 **$26,473.** The current threshold is $25,769

Comment (Refer page 2,037)

CMS says "our current estimate, using available FY 2018 claims data, is that actual outlier payments for FY 2018 were approximately 4.98 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 we projected for FY 2018. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do 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."

In most years, CMS has underpaid the 5.1 percent outlier pool. One must ask if the CMS policy about not making hospitals whole with regard to outliers is flawed and needs to be changed.

CMS says that making adjustments "would be neither necessary nor appropriate to make such an aggregate retroactive adjustment." This is an awful and wrong attitude response. The adjustments can be made prospectively.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2020 (Refer page 2,130)

The final 2020 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, 97 children's hospitals, the 6 short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, 16 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 – is 3.0 percent.

II. Changes to the Hospital Area Wage Index (Refer page 770)

Final Policies to Address Wage Index Disparities between High and Low Wage Index Hospitals (Refer page 864)

CMS proposed 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 finalizing its proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by 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, as proposed without modification. Based on the data for this final rule, for FY 2020, the 25th percentile wage index value across all hospitals is 0.8457. As proposed, this policy will be in effect for at least 4 fiscal years beginning October 1, 2019 in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.

CMS is ***not*** finalizing its proposal to base the budget neutrality adjustment on high wage hospitals. Instead, "consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act, and consistent with the alternative we considered in the proposed rule, we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner."

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 finalizing without modification its proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural.

Transition for Hospitals Negatively Impacted (Refer page 906)

Specifically, for FY 2020, CMS proposed to place a 5.0 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 proposed 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.

CMS is finalizing without modification its proposal.

Worksheet S-3

For the final rule FY 2020 wage index, CMS used the Worksheet S-3, Parts II and III wage data of 3,239 hospitals, and CMS used the occupational mix surveys of 3,136 hospitals which represented a "response" rate of 97 percent. (Refer Page 806)

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 FY 2020 Occupational Mix Adjusted National Average Hourly Wage is $44.15. (Refer Page 807)

The 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	$41.64
National LPN and Surgical Technician	$24.69
National Nurse Aide, Orderly, and Attendant	$16.97
National Medical Assistant	$18.13
National Nurse Category	$34.99

State Frontier Floor for FY 2020 (Refer page 815)

Forty-five (45) hospitals will 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 the Medicare Geographic Classification Review Board (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.

For FY 2020, 294 hospitals have been approved for reclassification. There are 290 hospitals approved for wage index reclassifications in FY 2018 that will continue for FY 2020, and 275 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 rule, 859 hospitals are in MGCRB reclassification status for FY 2020.

Applications for FY 2021 reclassifications are due to the MGCRB by September 3, 2019 (the first working day of September 2019). CMS notes that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d).

Applications and other information about MGCRB reclassifications may be obtained beginning in mid-July 2019, via the Internet on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html. , or by calling the MGCRB at (410) 786-1174.

Clarification Regarding Accepting the Out-Migration Adjustment When the Out-Migration Adjustment Changes After Reclassification (Refer page 824)

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.

A Lugar hospital is granted its status for 3 years.

Table 2 associated with this final rule (which is available on the CMS website) includes the final out-migration adjustments for the FY 2020 wage index.

For this final rule, Table 4 consists of the following: a list of counties that are eligible for the out-migration adjustment for FY 2020 identified by FIPS county code, the final FY 2020 out-migration adjustment, and the number of years the adjustment will be in effect.

CMS estimates 176 providers will receive the out-migration wage adjustment in FY 2020.

Reclassification from Urban to Rural under Section 1886(d)(8)(E) of the Act, Implemented at 42 CFR 412.103 (Refer page 836)

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Specifically, section 1886(d)(8)(E) of the Act provides that, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital that satisfies certain criteria, the Secretary shall treat the hospital as being located in the rural part of the State in which the hospital is located.

Under current regulations at § 412.103(g)(1), hospitals may cancel a rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days before the end of its current cost reporting period, effective beginning with the next full cost reporting period.

III. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2020 (§ 412.106) (Refer page 950)

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.
Calculation of Factor 1 for FY 2020 (Refer page 961

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.

The June 2019 Office of Actuary (OACT) estimate for Medicare DSH payments for FY 2020, without regard to the application of section 1886(r)(1) of the Act, was approximately $16.583 billion. The proposed amount based on the OACT's in December 2019 was $16,857 billion.

Factor 1 for FY 2020 is $12,437,591,742.69, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2020 ($16,583,455,656.92).

Calculation of Factor 2 for FY 2020 (Refer Page 981)

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 final Factor 2 for FY 2020 is **67.14 percent.** It is currently 67.51 percent.

The final FY 2020 uncompensated care amount is $12,437,591,742.69 x 0.6714 = $8,350,599,096.04.

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" will be $8.351 billion

Calculation of Factor 3 for FY 2020 (Refer page 984)

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).

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

CMS now 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 considered the use of FY 2017 data.

CMS is, for purposes of determining uncompensated care costs and calculating Factor 3 for FY 2020, "uncompensated care" continuing to define 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).

Comment

The DSH material extends more than 100 pages.

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

Changes to MS-DRGs Subject to Postacute Care Transfer Policy and MS-DRG Special Payments Policies (§ 412.4) (Refer Page 918)

If the MS-DRG's total number of discharges to postacute care equals or exceeds the 55th percentile for all MS-DRGs and the proportion of short-stay discharges to postacute care to total discharges in the MS-DRG exceeds the 55th percentile for all MS-DRGs, CMS will apply the postacute care transfer policy to that MS-DRG and to any other MS-DRG that shares the same base MS-DRG.

For these MS-DRGs, hospitals receive 50 percent of the full MS-DRG payment, plus the single per diem payment, for the first day of the stay, as well as a per diem payment for subsequent days (up to the full MS-DRG payment (§ 412.4(f)(6)).

The following MS-DRGS will, beginning October 1, 2019, be subject to Medicare's postacute care transfer policy.

New or Revised MS -DRGs	MS -DRG Title
216	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
217	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
218	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
219	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
220	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
221	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC

Additionally, CMS is finalizing the proposal to remove MS-DRGs 273 and 274 from the list of MS-DRGs that are subject to the postacute care transfer policy and the special payment policy.

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index and Discharge Criteria (§ 412.96) (Refer Page 934)

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—

- 1.68645; 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)	1.4158
2	Middle Atlantic (PA, NJ, NY)	1.4932
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.57505
4	East North Central (IL, IN, MI, OH, WI)	1.5944
5	East South Central (AL, KY, MS, TN)	1.556
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.66795
7	West South Central (AR, LA, OK, TX)	1.71575
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.77435
9	Pacific (AK, CA, HI, OR, WA)	1.669

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.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Refer page 939)

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.

In accordance with CMS' previously established process, a hospital must make a written request for low-volume hospital status that is received by its MAC by September 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for low-volume hospital status in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges for the fiscal year beginning on or after October 1 immediately following the request.

A hospital receiving the low-volume hospital payment adjustment for FY 2019 may continue to receive a low-volume hospital payment adjustment for FY 2020 without reapplying if it continues to meet the applicable mileage and discharge criteria.

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.

Comment

In FY 2020, CMS estimates that 594 providers will receive approximately $442 million compared to the estimate of 600 providers receiving approximately $449 million in FY 2019.

Indirect Medical Education (IME) Payment Adjustment Factor (Refer Page 949)

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

V. Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (Page 54)

Comment

CMS is making many changes to a number of MS-DRGs, effective for FY 2020. It also discusses DRG weighting and other factors. There are additions and deletions to the MS-DRGs.

This is a relatively long and detailed section. It begins on page 54 and extends to page 346. The material below identifies some items being addressed only by name and corresponding page numbers.

Changes to Specific MS-DRG Classifications

- Peripheral ECMO – (Refer page 67)
- Allogeneic Bone Marrow Transplant – (Refer page 86)
- Chimeric Antigen Receptor (CAR) T-Cell Therapies -- Refer Page 100)
- Carotid Artery Stent Procedures – (Refer page 114)
- Pulmonary Embolism – (Refer page 122)
- Transcatheter Mitral Valve Repair with Implant – (Refer page 125)
- Revision of Pacemaker Lead – (Refer page 149)
- Knee Procedures with Principal Diagnosis of Infection – (Refer pages 150)
- Neuromuscular Scoliosis – (Refer page 168)
- Secondary Scoliosis and Secondary Kyphosis – (Refer page 172)
- Extracorporeal Shock Wave Lithotripsy (ESWL) – (Refer page 178)
- Diagnostic Imaging of Male Anatomy – (Refer page 200)
- Reassignment of Diagnosis Code O99.89 – (Refer page 202)
- Skin Graft to Perineum for Burn — (Refer page 213)
- Assignment of Diagnosis Code R93.89 – (Refer page 218)
- Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 through 983 or MS-DRGs 987 through 989 into MDCs – (Refer page 220)
- Gastrointestinal Stromal Tumors with Excision of Stomach and Small Intestine – (Refer page 221)
- Peritoneal Dialysis Catheter Complications – (Refer page 226)
- Bone Excision with Pressure Ulcers – (Refer page 230)
- Lower Extremity Muscle and Tendon Excision – (Refer page 234)
- Kidney Transplantation Procedures – (Refer page 238)
- Insertion of Feeding Device – (Refer page 242)
- Basilic Vein Reposition in Chronic Kidney Disease – (Refer page 246)
- Colon Resection with *Fistula* – (Refer pages 248)
- Reassignment of Procedures among MS-DRGs 981 through 983 and 987 through 989 (Page 252)
- Stage 3 Pressure Ulcers of the Hip – (Refer page 253)
- Gastric Band Procedure Complications or Infect*ions* – (Refer page 258)
- Finger Cellulitis – (Refer page 259)
- Multiple Trauma with Internal Fixation of Joints – (Refer page 264)
- Totally Implantable Vascular Access Devices – (Refer page 265)
- Gastric Band Procedure Complications or Infections – (Refer page 267)
- Peritoneal Dialysis Catheters – (Refer page 269)
- Occlusion of Left Renal Vein – (Refer page 270)
- Bronchoalveolar Lavage – (Refer page 278)
- Percutaneous Drainage of Pelvic Cavity – (Refer page 280)
- Percutaneous Removal of Drainage Device – (Refer page 282)
- Percutaneous Occlusion of Gastric Artery – (Refer page 283)
- Endoscopic Insertion of Endobronchial Valves – (Refer page 289)

Additions and Deletions to the Diagnosis Code Severity Levels for FY 2020 (Refer page 311)

The following tables identify the additions and deletions to the diagnosis code MCC severity levels list and the 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.

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

CC Exclusions List for FY 2020 (Refer page 311)

The finalized CC Exclusions List are displayed in the following tables:

6G.1,
6G.2,
6H.1,
6H.2.
6K

Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Refer page 314)

To identify new, revised and deleted diagnosis and procedure codes, for FY 2020, CMS has developed the following tables:

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 final rule.

Changes to the Medicare Code Editor (MCE) (Refer page 321)

Changes Surgical Hierarchies (Refer page 330)

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

VI. Add-On Payments for New Services and Technologies for FY 2020 (Refer page 371)

Comment

The subject of new technology is long. This year's discussion runs nearly 400 pages (from 371 to 770).

CMS is adopting its proposed change in payment amounts from 50 percent to 65 percent and to 75 percent for certain antimicrobial products.

Previous Technologies Approved for New Technology Add-On Payments and FY 2020 Status

Discontinued (3)

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

Continuing (9)

- KYMRIAH™ (Tisagenlecleucel) and YESCARTA™ (Axicabtagene Ciloleucel). The maximum payment will be increased to $242,450 for FY 2020; that is, 65 percent of the average cost of the technology. (Refer page 390)

- VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection). The maximum add-on payment involving the use of VYXEOS™ will be $47,352.50 for FY 2020. (Refer page 396)

- VABOMERE™ (meropenem-vaborbactam) The maximum new technology add-on payment amount for a case involving the use of VABOMERE™ will be $8,316.00 for FY 2020. (Refer page 399)

- remedē® System. The maximum new technology add-on payment amount for a case involving the use of the remedē® System will be $22,425 for FY 2020. (Refer page 404)

- ZEMDRI™ (Plazomicin). The maximum new technology add-on payment amount for a case involving the use of ZEMDRI™ will be $4,083.75 for FY 2020; that is, 75 percent of the average cost of the technology. (CMS is increasing payment to 75 percent for certain antimicrobial products, of the average cost of the technology.) (Refer page 409)

- GIAPREZA™. The maximum new technology add-on payment amount for a case involving the use of GIAPREZA™ will be $4,083.75 for FY 2020. (Refer page 411)

- 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 will be $1,820 for FY 2020. (Refer page 413)

- The A QUAB EAM System (Aquablation). The maximum new technology add-on payment amount for a case involving the use of the AQUABEAM System will 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 $1,625 for FY 2020. (Refer page 416)

- AndexXa™ (Andexanet alfa). The maximum new technology add-on payment amount for a case involving the use of AndexXa™ will be $18,281.25 for FY 2020. (Refer page 420)

FY 2020 Applications for New Technology Add-On Payments

CMS received 18 applications for new technology add-on payments for FY 2020. One was withdrawn prior to the proposed rulemaking, and CMS now says 3 more proposals have been withdrawn and one failed to receive FDA approval prior to July 1.

Of the 13 remaining 9 have been approved as follows, and 4 have been declined.

- AZEDRA® (Ultratrace® iobenguane Iodine-131) Solution. The maximum new technology add-on payment for a case involving the use of AZEDRA® is $98,150 for FY 2020. (Refer page 423)
- CABLIVI® (caplacizumab-yhdp) The maximum new technology add-on payment for a case involving the use of CABLIVI® is $33,215 for FY 2020. (Refer page 448)
- ELZONRIS™ (tagraxofusp, SL-401) The maximum new technology add-on payment for a case involving the use of ELZONRIS™ is $125,448.05 for FY 2020. (Refer page 534)
- Balversa™ (Erdafitinib). As a result, the maximum new technology add-on payment for a case involving the use of Balversa™ is $3,563.23 for FY 2020. (Refer page 554)
- ERLEADA™ (Apalutamide) The maximum new technology add-on payment for a case involving the use of ERLEADA™ is $1,858.25 for FY 2020. (Refer page 567)
- SPRAVATO (Esketamine) The maximum new technology add-on payment for a case involving the use of Spravato is $1,014.79 for FY 2020. (Refer page 584)
- XOSPATA® (gilteritinib)GammaTile™ The maximum new technology add-on payment for a case involving the use of XOSPATA® is $7,312.50 for FY 2020. (Refer page 618)
- JAKAFI™ (Ruxolitinib) The maximum new technology add-on payment for a case involving the use of JAKAFI™ is $3,977.06 for FY 2020. (Refer page 651)
- T2Bacteria® Panel (T2 Bacteria Test Panel) The maximum new technology add-on payment for a case involving the use of the T2Bacteria test panel is $97.50 for FY 2020. (Refer page 618)

VII Hospital Readmissions Reduction Program (HRRP): (Refer page 1,074)

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 finalizing, without modification, that beginning in FY 2021, a "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 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.

CMS is adopting a policy under which the agency would use a sub-regulatory process to make non-substantive changes to the payment adjustment factor components used for the Hospital Readmissions Reduction Program.

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 2,583 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	3,027	2,583	85.33	0.69

VIII. Hospital Value-Based Purchasing (VBP) Program: Policy Changes (Refer page 1,115)

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 will 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.

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

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

Summary of Previously Adopted Measures for the FY 2022 Program Year		
Measure Short Name	**Domain/Measure Name**	**NQF #**
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin- resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
Clinical Outcomes Domain		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN (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

Summary of Previously Adopted Measures for the FY 2023 Program Year		
Measure Short Name	**Domain/Measure Name**	**NQF #**
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
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

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.

The previously established and newly established performance standards for the measures in the FY 2022 program year are set out in the tables.

Previously Established and Newly Established Performance Standards for the FY 2022 Program Year: Safety, Clinical Outcomes, and Efficiency and Cost Reduction Domains		
Measure Short Name	**Achievement Threshold**	**Benchmark**
Safety Domain♦		
CAUTI*	0.727	0.000
CLABSI*	0.633	0.000
CDI*	0.646	0.047
MRSA Bacteremia*	0.748	0.000
Colon and Abdominal Hysterectomy SSI*	0.749 0.727	0.000 0.000
Clinical Outcomes Domain		
MORT-30-AMI#	0.861793	0.881305
MORT-30-HF#	0.879869	0.903608
MORT-30-PN (updated cohort) #	0.836122	0.870506
MORT-30-COPD#	0.920058	0.936962
MORT-30-CABG#†	0.968210	0.979000
COMP-HIP-KNEE*#	0.029833	0.021493
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.

♦ The newly established performance standards displayed in this table for the Safety domain measures were calculated using 4 quarters of CY 2018 data.

* Lower values represent better performance.

Previously established performance standards.

† After publication of the FY 2017 IPPS/LTCH PPS final rule, CMS determined there was a display error in the performance standards for this measure. Specifically, the Achievement Threshold and Benchmark values, while accurate, were presented in the wrong categories. CMS corrected this issue in the FY 2018 IPPS/LTCH PPS final rule, and the correct performance standards are displayed in the table.

Newly Established Performance Standards for the FY 2022 Program Year: Person and Community Engagement Domain±			
HCAHPS Survey Dimension	Floor (minimum)	Achievement Threshold (50th percentile)	Benchmark (mean of top decile)
Communication with Nurses	15.73	79.18	87.53
Communication with Doctors	19.03	79.72	87.85
Responsiveness of Hospital Staff	25.71	65.95	81.29
Communication about Medicines	10.62	63.59	74.31
Hospital Cleanliness & Quietness	5.89	65.46	79.41
Discharge Information	66.78	87.12	91.95
Care Transition	6.84	51.69	63.11
Overall Rating of Hospital	19.09	71.37	85.18

± The newly established performance standards displayed in this table were calculated four quarters of CY 2018 data.

Comment

The rule contains similar tables for FY 2023, FY 2024, and FY 2025

IX. Hospital-Acquired Condition (HAC) Reduction Program (Refer page 1,146)

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.

HAC Reduction Program Measures for FY 2020		
Short Name	Measure Name	NQF #
CMS PSI 90	CMS Patient Safety and Adverse Events Composite (PSI)	0531
CAUTI	CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CLABSI	CDC 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 (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus*(MRSA) Bacteremia Outcome Measure	1716

CMS says that it expects 792 hospitals will be in the Worst-Performing Quartile.

X. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS
(Refer page 1,328)

New Measures for the Hospital IQR Program Measure Set

CMS is finalizing its proposal to adopt the Safe Use of Opioids – Concurrent Prescribing eCQM beginning with the CY 2021 reporting period/FY 2023 payment determination with a clarification and update to the technical specifications so that the measure is clearly applicable only to the inpatient setting. The updated measure specifications can be found at the eCQI Resource Center's Pre-rulemaking Eligible Hospital/Critical Access Hospital eCQMs website, available at: https://ecqi.healthit.gov/pre-rulemaking-eh-cah-ecqms.

CMS is not finalizing its proposal to adopt the Hospital Harm – Opioid-Related Adverse Events eCQM.

CMS is finalizing its proposal to adopt the Hybrid HWR measure into the Hospital IQR Program in a stepwise fashion. CMS will first accept data submissions for the Hybrid HWR measure during two voluntary reporting periods. The first voluntary reporting period will run from July 1, 2021 through June 30, 2022, and the second will run from July 1, 2022 through June 30, 2023. Hospitals will be required to report the Hybrid HWR measure, beginning with the reporting period which runs from July 1, 2023 through June 30, 2024, impacting the FY 2026 payment determination, and for subsequent years

CMS is finalizing its proposal to remove the Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure in conjunction with finalizing its proposal to replace the measure by making the Hybrid HWR measure mandatory beginning with the reporting period which runs from July 1, 2023 through June 30, 2024, impacting the FY 2026 payment determination.

Summary of Previously Finalized and Newly Finalized Hospital IQR Program Measures (Refer page 1,456)

The following table summarizes the previously finalized Hospital IQR Program measure set 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-HW R	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		

Measures for the FY 2022 Payment Determination		
Short Name	**Measure Name**	**NQF #**
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
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 Finalized Hospital IQR Program Measures for the FY 2023 Payment Determination (Page 1,458)

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

Measures for the FY 2023 Payment Determination		
Short Name	**Measure Name**	**NQF #**
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-HW R*	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
EHR-base d 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
Safe Use of Opioids**	Safe Use of Opioids – Concurrent Prescribing	
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	0166

Measures for the FY 2023 Payment Determination		
Short Name	**Measure Name**	**NQF #**
	and Systems Survey (including Care Transition Measure)	(0228)

* In section VIII.A.6. of the preamble of this final rule, CMS is finalizing its proposal to remove the claims-only Hospital-Wide All-Cause Unplanned Readmission (HWR claims-only) measure (NQF #1789). CMS is finalizing its proposal 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.
** Newly finalized in this final rule to add to the eCQM measure set, beginning with the CY 2021 reporting period/FY 2023 payment determination with a clarification and update.
+ 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.

Comment

The IQR section is nearly 200 pages. There is much detail about reporting times, and other related items.

XI. Changes to the Payment Rates for the LTCH PPS for FY 2020 (Refer page 2,071)

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

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of 2.5 percent for FY 2020. CMS is applying a factor of 1.025 to the FY 2019 LTCH PPS standard Federal payment rate of $41,558.68 to determine the FY 2020 LTCH PPS standard Federal payment rate.

Additionally, CMS is applying a temporary budget neutrality adjustment factor of 0.990737 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 0.990878 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 0.999858).

CMS is applying an area wage budget neutrality adjustment of 1.0020203.

Accordingly, CMS is establishing an LTCH PPS FY 2020 standard Federal payment rate of **$42,677.63** (calculated as $41,558.68 (current rate) x 0.999858 x 1.025 x 1.0020203) = $42,677.63.

The labor-related share under the LTCH PPS for FY 2020 will be 66.3 percent. The current labor share is 66.0 percent.

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 fixed-loss amount for HCO cases for FY 2020 will be **$26,778**. The current FY 2019 fixed-loss amount is $27,121 (as corrected).

CMS is establishing a fixed-loss amount for site neutral payment rate cases of $26,473, which is the same FY 2020 IPPS fixed-loss amount

The table below illustrates an example of the components of the calculations.

Unadjusted LTCH PPS Standard Federal Prospective Payment Rate	$42,677.64
Labor-Related Share	x 0.663
Labor-Related Portion of the LTCH PPS Standard Federal Payment Rate	= $28,295.28
Wage Index (CBSA 16974)	x 1.0405
Wage-Adjusted Labor Share of the LTCH PPS Standard Federal Payment Rate	= $29,441.24
Nonlabor-Related Portion of the LTCH PPS Standard Federal Payment Rate ($42,677.64x 0.337)	+ $14,382.36
Adjusted LTCH PPS Standard Federal Payment Amount	= $43,823.60
MS-LTC-DRG 189 Relative Weight	x 0.9616
Total Adjusted LTCH PPS Standard Federal Prospective Payment	= $42,140.77

Final Comments and Regulatory Analysis

The rule is fairly well written. Nonetheless, its sheer size and the continuing increase in the size of recent CMS PPS updates make it difficult to summarize and analyze. There are many items that cannot be covered in this analysis. To do so could make such analysis almost as long as the rules itself.

The rule does not contain clear final decision sections. Providing such would truly help understand CMS' final actions.

There is still too much "boiler plate," that is repeated history. What would be nice is a simple rule that says these are the changes from last year's rule. The is little or no reason to tell us what happened in 1997, 2000, etc.

The rule contains a very descriptive and helpful regulatory analysis.

Quality Reporting is an ever growing extensive, complex, costly and burdensome activity. This analysis has not discussed issues, in-depth, relating to eCQMs, timing reporting, validations, PPS Cancer Hospitals, LTCH hospitals, and other related quality items.

CMS says its quality initiative is improving quality Is it?

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 making changes to the area wage index. This issue is politically akin to Congress trying to tamper with Social Security and Medicare benefits.

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

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

	FY 2019 Final Rule Correction Notice				FY 2020 Final 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 Will Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Alabama	84	2	-0.3	$ -5	83	1	-0.1	$-2
Alaska	6	3	0.1	0	6	3	1.1	$2
Arizona	56	33	1.3	26	54	2	-0.1	$-2
Arkansas	45	0	-0.3	-3	46	0	-0.1	$-2
California	297	59	0.4	42	297	52	0.6	$78
Colorado	45	9	0.7	9	49	9	0.5	$7
Connecticut	30	8	1.3	21	30	0	-0.2	$-3
Delaware	6	0	-0.3	-2	6	0	-0.1	$-1
Washington, D.C.	7	0	-0.3	-2	7	0	-0.2	$-1

	FY 2019 Final Rule Correction Notice				FY 2020 Final 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 Will Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Florida	168	7	-0.3	-20	168	7	-0.1	$-10
Georgia	101	0	-0.3	-8	100	1	-0.1	$-4
Hawaii	12	6	-0.1	0	12	0	-0.1	$0
Idaho	14	0	-0.3	-1	16	0	-0.1	$-1
Illinois	125	2	-0.3	-14	126	2	-0.2	$-8
Indiana	85	0	-0.3	-7	85	0	-0.2	$-4
Iowa	34	0	-0.3	-3	34	3	-0.1	$-1
Kansas	51	0	-0.2	-2	51	0	-0.1	$-1
Kentucky	64	0	-0.3	-5	64	0	-0.1	$-2
Louisiana	90	0	-0.3	-5	89	0	-0.1	$-2
Maine	17	0	-0.3	-2	17	0	-0.1	$-1
Massachusetts	56	29	3.3	123	55	11	0.6	$25
Michigan	94	0	-0.3	-14	94	0	-0.2	$-6
Minnesota	49	0	-0.2	-6	48	0	-0.1	$-3
Mississippi	59	0	-0.3	-3	59	0	-0.1	$-2
Missouri	72	0	-0.2	-6	72	0	-0.1	$-3
Montana	13	1	-0.2	-1	13	1	-0.1	$0
Nebraska	23	0	-0.3	-2	23	0	-0.1	$-1
Nevada	22	3	0.4	3	22	3	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	$-7
New Mexico	24	2	-0.2	-1	24	0	-0.1	$-1
New York	149	16	-0.3	-21	146	12	-0.1	$-11
North Carolina	84	0	-0.3	-9	83	0	-0.1	$-5
North Dakota	6	3	0.4	1	6	3	0.3	$1
Ohio	130	7	-0.3	-11	129	7	-0.1	$-5
Oklahoma	79	2	-0.3	-4	78	1	-0.1	$-2
Oregon	34	1	-0.2	-2	34	1	-0.1	$-1
Pennsylvania	150	3	-0.3	-17	150	1	-0.2	$-8
Puerto Rico	51	11	0.1	0	50	8	0.3	$0
Rhode Island	11	0	-0.4	-1	11	0	-0.2	$-1
South Carolina	54	6	-0.1	-1	54	5	-0.1	$-2
South Dakota	17	0	-0.2	-1	16	0	-0.1	$0
Tennessee	90	6	-0.3	-7	90	7	-0.1	$-2
Texas	310	13	-0.3	-18	302	10	-0.1	$-9

FY 2019 Final Rule Correction Notice					FY 2020 Final 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 Will Receive the Rural Floor (2b)	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3b)	Difference in (millions) (4b)
Utah	31	0	-0.3	-2	31	0	-0.1	$-1
Vermont	6	0	-0.2	0	6	0	-0.1	$0
Virginia	74	1	-0.2	-6	72	1	0	$-1
Washington	48	3	-0.3	-7	49	3	-0.1	$-3
West Virginia	29	2	-0.2	-1	29	2	-0.1	$0
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**	**Final FY 2020 Weights**	**Final FY 2019 Weights**	**Percentage Change**
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	115,712	1.0277	1.0315	-0.37%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	151,699	1.2157	1.2353	-1.59%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	144,919	1.1440	1.1907	-3.92%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	164,243	1.3335	1.3167	1.28%
194	SIMPLE PNEUMONIA & PLEURISY W CC	133,762	0.8886	0.9002	-1.29%
291	HEART FAILURE & SHOCK W MCC	392,424	1.3458	1.3454	0.03%
378	G.I. HEMORRHAGE W CC	134,042	0.9881	0.9903	-0.22%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	146,347	0.7615	0.7554	0.81%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	451,333	1.9684	1.9898	-1.08%
603	CELLULITIS W/O MCC	103,969	0.8435	0.8477	-0.50%
682	Renal FAILURE W MCC	103,315	1.4780	1.532	-3.52%
683	RENAL FAILURE W CC	140,992	0.8973	0.919	-2.36%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	139,914	0.7908	0.7941	-0.42%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	615,545	1.8663	1.8564	0.53%

This year, 1 DRGs that previously had more than 100,000 had fewer discharges is removed from the table above – DRG 641 (Misc Disorders of Nutrition). A new DRG has been added – DRG 682

Most FY 2020 weights for these DRGs will be less than those in FY 2019.

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 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 Final Rule Home Page" or "Acute Inpatient--Files for Download."

Table 2	Case-Mix Index and Wage Index Table by CCN
Table 3	Wage Index Table by CBSA
Table 4	List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act
Table 5	List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay
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
Table 6F	Revised Procedure Code Titles
Table 6G.1	Secondary Diagnosis Order Additions to the CC Exclusions List
Table 6G.2	Principal Diagnosis Order Additions to the CC Exclusions List
Table 6H.	Secondary Diagnosis Order Deletions to the CC Exclusions List
Table 6H.2.	Principal Diagnosis Order Deletions to the CC Exclusions List
Table 6I	Complete MCC List
Table 6I.1	Additions to the MCC List
Table 6I.2	Deletions to the MCC List
Table 6J	Complete CC list
Table 6J.1	Additions to the CC List
Table 6J.2	Deletions to the CC List
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 final rule.)
Table 7A	Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2018 MedPAR Update—December 2018 GROUPER Version 36 MS-DRGs
Table 7B	Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2018 MedPAR Update—December 2018 GROUPER Version 37 MS-DRGs
Table 8A	Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
Table 8B	Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals
Table 16	Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors
Table 18	FY 2020 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this 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-F:

Table 8C.	FY 2020 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
Table 11	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	LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2019 through September 30, 2020
Table 12B	LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, through September 30, 2020