WASHINGTON perspectives

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

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Proposed FY 2019 Medicare IPPS and LTCH Update Issued

The Centers for Medicare and Medicaid Services (CMS) have released a 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) 2019.

The document is on public display at the ***Federal Register*** office and is scheduled for publication May 7th. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-08705.pdf. This link will change upon publication. A comment period ending June 25th is provided

The IPPS tables are at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2019 IPPS 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-1694-P.

Comment

Since the IPPS' inception in 1983 for FY 1984, the time between its release by CMS to the Office of Management and Budget (OMB) for clearance by OMB is baffling to say the least. OMB always seems to sit on clearance. This rule was sent to OMB on January 18th. OMB finally signed off on April 20th. Why has it taken 3 months to review and release? The longer OMB takes to clear, the shorter time it gives CMS to review and adequately respond to provider comments.

This is another long rule – some 1,883 pages. It appears that CMS has reduced much history, which is good. Overall, this is a well written rule.

CMS still fails, to provide any help with page numbering. If the agency wants to assist the reader locate pertinent information and reduce burden, page numbers would be very helpful. It is not hard to do.

CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $4 billion in FY 2019. This compares to CMS' projection for FY 2018 of an increase of $2.4 billion.

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

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For many payment issues, the rule's Addendum **(beginning on page 1,585)** contains much concise and extremely helpful information.

As of March 2018, CMS says there were 3,257 IPPS acute care hospitals included in CMS' analysis. This represents approximately 54 percent of all Medicare-participating hospitals, and there are approximately 1,395 Critical Access Hospitals (CAHs).

The rule contains an extremely long Regulatory Impact analysis. However, the analysis is helpful in understanding the changes being made.

The material that follows is a section-by-section analysis of major components based on the rule. The material does not follow the order in the regulation.

I. PROPOSED CHANGES TO PAYMENT RATES UNDER IPPS (page 1,713 & addendum)

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 approximately 1.75 percent. This reflects a projected hospital market basket update of 2.8 percent reduced by a 0.8 percentage point multi-productivity adjustment. This also reflects a proposed +0.5 percentage point adjustment required by Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MARCA) for documentation and coding, and a -0.75 percentage point adjustment required by the ***Affordable Care Act*** (ACA).

CMS projects that the rate increase, together with other proposed changes will increase IPPS operating payments by approximately 2.1 percent, and that proposed changes in uncompensated care payments, capital payments, and the changes to the low-volume hospital payments will increase IPPS payments by an additional 1.3 percent for a total increase in IPPS payments of 3.4 percent.

Other additional payment adjustments will include continued 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 continued 1.0 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued upward and downward adjustments under the Hospital Value-Based Purchasing Program.

In sum, CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $4 billion in FY 2019.

Standardized Payment Rates

CMS is proposing the following FY 2019 standardized payment amounts. **(pages 1,708-1,709)**

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.25 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**
$3,863.17	**$1,793.01**	**$3,783.04**	**$1,755.82**	**$3,836.46**	**$1,780.61**	**$3,756.34**	**$1,743.43**
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,506.83	**$2,149.35**	**$3,434.09**	**$2,104.77**	**$3,482.58**	**$2,134.49**	**$3,409.86**	**$2,089.91**

The total labor/nonlabor amount for the full update (2 left columns) (hospitals that submit quality data and are meaningful EHR users is **$5,656.18**.

Note, CMS issued a correction notice (CN) on October 4, 2017 to the final FY 2018 IPPS rule that appeared in the August 14, 2017 ***Federal Register*****.** For informational purposes, the corrected FY 2018 rates appear below.

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	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,806.04	**$1,766.49**	**$3,729.99**	**$1,731.20**	**$3,780.69**	**$1,754.73**	**$3,704.65**	**$1,719.43**
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,454.97	**$2,117.56**	**$3,385.94**	**$2,075.25**	**$3,431.96**	**$2,103.46**	**$3,362.93**	**$2,061.15**

There are four possible applicable percentage increases that can be applied to the FY 2019 national standardized amount. The table below reflects these four options. **(page 799 & 1,589)**

FY 2019	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	2.8	2.8	2.8	2.8
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.7	-0.7
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.1	0	-2.1
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.8	-0.8	-0.8	-0.8
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Proposed Applicable Percentage Increase Applied to Standardized Amount	**1.25**	**-0.85**	**0.55**	**-1.55**

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** percent, as mandated by statute.

The following table **(pages 1,633-1,634)** illustrates the changes from the (corrected) FY 2018 national standardized amount to the proposed FY 2019 national standardized amount.

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2018 Base Rate after removing:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:
1. FY 2018 Geographic Reclassification Budget Neutrality **(0.987985)**	Labor (68.3%): $4,059.36	Labor (68.3%): $4,059.36	Labor (68.3%): $4,059.36	Labor (68.3%): $4,059.36
2. FY 2017 Operating Outlier Offset **(0.948998)**	Nonlabor (31.7%) $1,884.07	Nonlabor (31.7%) $1,884.07	Nonlabor (31.7%) $1,884.07	Nonlabor (31.7% $1,884.07
	(Combined labor and nonlabor = $5,943.43)	*(Combined labor and nonlabor = $5,943.43)*	*(Combined labor and nonlabor = $5,943.43)*	*(Combined labor and nonlabor = $5,943.43)*

	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
	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor = $5,943.42)*
Proposed FY 2018 Update Factor	1.0125	0.9915	1.0055	0.9845
Proposed FY 2019 MS-DRG Recalibration Budget Neutrality Factor	0.997896	0.997896	0.997896	0.997896
Proposed FY 2019 Wage Index Budget Neutrality Factor	1.001182	1.001182	1.001182	1.001182
Proposed FY 2019 Reclassification Budget Neutrality Factor	0.987084	0.987084	0.987084	0.987084
Proposed FY 2019 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
Proposed FY 2019 Rural Demonstration Budget Neutrality Factor	0.999325	0.999325	0.999325	0.999325
Adjustment for FY 2019 Required under Section 414 of Pub. L. 114-10 (MACRA	1.005	1.005	1.005	1.005
Proposed National Standardized Amount for FY 2019 if Wage Index is Greater Than 1.0000; **Labor/Non-Labor Share Percentage (68.3/31.7)**	**Labor: $3,863.17** **Nonlabor: $1,793.01**	**Labor: $3,783.04** **Nonlabor: $1,755.82**	**Labor: $3,836.46** **Nonlabor: $1,780.61**	**Labor: $3,756.34** **Nonlabor: $1,743.43**
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to1.0000; **Labor/Non-Labor Share Percentage (62.0/38.0)**	**Labor: $3,506.83** **Nonlabor: $2,149.35**	**Labor: $3,434.09** **Nonlabor: $2,104.77**	**Labor: $3,482.58** **Nonlabor: $2,134.49**	**Labor: $3,409.86** **Nonlabor: $2,089.91**

The combined proposed FY 2019 labor and nonlabor amounts for a full update is **$5,656.18**. The FY 2018 total labor/nonlabor amount for the full update is $5,572.53. The change between the proposed FY 2019 amount and the current amount is $83.65.

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

Comment

CMS says 148 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they are identified as not meaningful EHR users but do submit quality information under section 1886(b)(3)(B)(viii) of the Act.

CMS says 54 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users.

CMS says 43 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they are identified as not meaningful EHR users and do not submit quality data under section 1886(b)(3)(B)(viii) of the Act.

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

Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2019 (page 1,655)

The proposed FY 2019 capital rate would be **$459.78.** The current amount is $453.95.

Proposed Outlier Payments (page 1,624)

CMS is proposing an outlier fixed-loss cost threshold for FY 2019 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$27,545.** The current amount is $26,601.

CMS says its current estimate, using available FY 2017 claims data, is that actual outlier payments for FY 2017 were approximately 5.53 percent of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2017, the percentage of actual outlier payments relative to actual total payments is higher than projected for FY 2017.

Proposed Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals (page 1,635)

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

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

Proposed Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) Updates and Issues (page 1,877, 825 & 879)

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

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

Medicare Dependent Hospitals

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

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

If the main campus of a hospital has 75 beds and its remote location has 30 beds, the bed count exceeds 100 beds and the hospital would not satisfy the criteria at § 412.108(a)(1)(i) (which is proposed to be redesignated as 412.108(a)(1)(ii)).

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

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

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

Because MDHs are paid based on the IPPS Federal rate, they continue to be eligible to receive empirically justified Medicare Disproportionate Share (DSH) payments and uncompensated care payments if their disproportionate patient percentage (DPP) is at least 15 percent, and CMS applies the same process to determine MDHs' eligibility for empirically justified Medicare DSH and uncompensated care payments as is done for all other IPPS hospitals.

Sole Community Hospitals

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

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

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

To minimize the lag between the effective date of rural reclassification under § 412.103 and the effective date for SCH status, CMS is proposing to revise § 412.92(b)(2)(i) and (b)(2)(iv) so that the effective date for SCH classification and for the payment adjustment would be the date that CMS receives the complete SCH application, effective for SCH applications received on or after October 1, 2018.

In addition, CMS is proposing to make parallel changes to the effective date for an MDH status determination under § 412.108(b)(4).

Low Volume Hospitals (page 808 & 1,759)

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

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

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

For qualifying hospitals with fewer than 3,800 total discharges but more than 500 total discharges, CMS is proposing the low-volume hospital payment adjustment for FYs 2019 through 2022 would be calculated using the following formula:

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

Based upon the best available data at this time, CMS estimates the changes to the low-volume hospital payment adjustment policy would increase Medicare payments by $72 million in FY 2019 as compared to FY 2018. More specifically, in FY 2019, CMS estimates that 622 providers would receive approximately $417 million compared to CMS' estimate of 606 providers receiving approximately $345 million in FY 2018.

Proposed Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2018 (page 1,661)

The proposed FY 2019 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, children's hospitals, the short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, RNHCIs, and extended neoplastic disease care hospitals is the estimated percentage increase in the IPPS operating market basket for FY 2019, would be 2.8 percent.

Proposed Changes to Regulations Governing Excluded Units of Hospitals (page 1,070)

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

Effective with cost reporting periods beginning on or after October 1, 2019, an IPPS-excluded hospital would be permitted to have an excluded psychiatric and/or rehabilitation unit. In addition, CMS is proposing to revise § 412.25(d) to specify that an IPPS-excluded hospital may not have an IPPS excluded unit of the same type (psychiatric or rehabilitation) as the hospital (for example, an IRF may not have an IRF unit).

II. PROPOSED CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (page 678)

For FY 2019, CMS is continuing to use only the FIPS county codes for purposes of cross-walking counties to CBSAs.

Proposed Core-Based Statistical Areas (CBSAs) Changes (page 679)

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

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

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

Currently, provider 130002 is the only hospital located in Twin Falls County, Idaho, and there are no hospitals located in Jerome County, Idaho. Thus, the proposed wage index for CBSA 46300 is calculated using the average hourly wage data for one provider (provider 130002).

Worksheet S-3 Wage Data for the Proposed FY 2019 Wage Index (page 684)

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

After excluding CAHs and hospitals with aberrant data, CMS calculated the proposed wage index using the Worksheet S-3, Parts II and III wage data of 3,260 hospitals.

Proposed Update of Policies Related to Other Wage-Related Costs, Clarification of the Calculation of Other Wage-Related Costs, and Proposals for FY 2020 and Subsequent Years (page 692)

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

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

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

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

Proposals to Codify Policies Regarding Multicampus Hospitals (page 698)

CMS is proposing to codify the policies for multicampus hospitals that CMS has developed in response to recent questions regarding CMS' treatment of multicampus hospitals for purposes other than geographic reclassification under the MGCRB.

The proposals apply to hospitals with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the IPPS and that meet the provider-based criteria at § 413.65 as a main campus and a remote location of a hospital, also referred to as multicampus hospitals or hospitals with remote locations. CMS is proposing that a main campus of a hospital cannot obtain an SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s), and vice versa.

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

Proposed Occupational Mix Adjustment to the FY 2019 Wage Index (page 708)

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

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

Proposed Unadjusted National Average Hourly Wage	Proposed Occupational Mix Adjusted National Average Hourly Wage
$42.990625267	$42.948428861

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

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$41.67064907
National LPN and Surgical Technician	$24.68950438
National Nurse Aide, Orderly, and Attendant	$16.96671421
National Medical Assistant	$18.1339666
National Nurse Category	$35.05256013

Proposed Application of the Rural, Imputed, and Frontier Floors

Proposed Rural Floor (page 715)

The area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is referred to as the "rural floor." Section 3141 of the ACA also requires that a national budget neutrality adjustment be applied in implementing the rural floor. CMS estimates that 255 hospitals would receive an increase in their FY 2019 proposed wage index due to the application of the rural floor.

Proposed Expiration of Imputed Floor Policy (page 715)

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

The imputed floor is set to expire effective October 1, 2018, and in this FY 2019 proposed rule, CMS is not proposing to extend the imputed floor policy.

Proposed State Frontier Floor for FY 2019 (page 720)

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

FY 2019 Reclassification Requirements and Approvals (page 724)

At the time this proposed rule was constructed, the Medicare Geographic Classification Review Board (MGCRB) had completed its review of FY 2019 reclassification requests. Based on such reviews, there are 337 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2019.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2019, hospitals reclassified beginning in FY 2017 or FY 2018 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 259 hospitals approved for wage index reclassifications in FY 2017 that will continue for FY 2019, and 345 hospitals approved for wage index reclassifications in FY 2018 that will continue for FY 2019. Of all the hospitals approved for reclassification for FY 2017, FY 2018, and FY 2019, based upon the review at the time of this proposed rule, 941 hospitals are in a MGCRB reclassification status for FY 2019 (with 22 of these hospitals reclassified back to their geographic location).

Applications for FY 2019 reclassifications are due to the MGCRB by September 4, 2018 (the first working day of September 2018). 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 2018, via the Internet on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html, or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 1508 Woodlawn Drive, Suite 100, Baltimore, MD 21207

Proposed Revision of Reclassification Requirements for a Provider That Is the Sole Hospital in the MSA (page 727)

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

CMS is proposing that, for reclassification applications for FY 2021 and subsequent fiscal years, a hospital would provide the wage index data from the current year's IPPS final rule to demonstrate that it is the only hospital in its labor market area with wage data listed within the 3-year period considered by the MGCRB.

Clarification of Group Reclassification Policies for Multicampus Hospitals (page 732)

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

In Table 2 associated with this proposed rule (which is available via the Internet on the CMS website), such locations are indicated with a "B" in the third digit of the CCN.

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

Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (page 735)

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

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

Reclassification from Urban to Rural under Section 1886(d)(8)(E) of the Act, Implemented at 42 CFR 412.103 and Proposed Change to Lock-In Date (page 738)

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

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

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

The lock-in date does not affect the timing of payment changes occurring at the hospital-specific level as a result of reclassification from urban to rural under § 412.103.

Request for Public Comments on Wage Index Disparities (page 758)

Comment

This is an interesting section of the proposed rule. CMS is soliciting comments regarding changes to improve the wage index. The section extends some 25 pages and rehashes previous research into alternative area wage index construction.

Could this be the prelude to a new area wage index system?

III. OTHER DECISIONS AND PROPOSED CHANGES TO THE IPPS OPERATING SYSTEM (page 784)

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

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

- Assign CAR-T therapy procedure codes to MS-DRG 016 (proposed revised title: Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy);
- Delete MS-DRG 685 (Admit for Renal Dialysis) and reassign diagnosis codes from MS-DRG 685 to MS-DRGs 698, 699, and 700 (Other Kidney and Urinary Tract Diagnoses with MCC, with CC, and without CC/MCC, respectively);
- Delete 10 MS-DRGs (MS-DRGs 765, 766, 767, 774, 775, 777, 778, 780, 781, and 782) and create 18 new MS-DRGs relating to Pregnancy, Childbirth and the Puerperium (MS-DRGs 783 through 788, 794, 796, 798, 805, 806, 807, 817, 818, 819, and 831 through 833);
- Assign two additional diagnosis codes to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator);
- Reassign 12 ICD-10-PCS procedure codes from MS-DRGs 329, 330 and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 344, 345, and 346 (Minor Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively); and
- Reassign ICD-10-CM diagnosis codes R65.10 and R65.11 from MS-DRGs 870, 871, and 872 (Septicemia or Severe Sepsis with and without Mechanical Ventilation >96 Hours with and without MCC, respectively) to MS-DRG 864 (proposed revised title: Fever and Inflammatory Conditions).

MS-DRGs 023, 329, 330, 331, 698, 699, 700, 870, 871, and 872 are currently subject to the postacute care transfer policy. These MS-DRGs, as 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 has developed a chart which sets forth the most recent analysis of the postacute care transfer policy criteria completed with respect to each of these proposed new or revised MS-DRGs.

Excerpted from the chart are those revised MS-DRGs that would be subject to the postacute transfer policy: The entire chart and those that will not be subject to postacute care transfers starts on page 789.

List of Proposed New or Revised MS-DRGs Subject to Review of Postacute Care Transfer Policy Status For FY 2019						
Proposed New or Revised MS-DRG	**MS-DRG Title**	**Total Cases**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**

List of Proposed New or Revised MS-DRGs Subject to Review of Postacute Care Transfer Policy Status For FY 2019						
Proposed New or Revised MS-DRG	**MS-DRG Title**	**Total Cases**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**	**Postacute Care Transfers (55th percentile: 1,372)**
023	Craniotomy with Major Device	9,436	4,990	1,264	13.40%	Yes
329	Procedures with MCC (Proposed Revised)	35,361	21,816	7,058	19.96%	Yes
330	Major Small and Large Bowel Procedures with CC (Proposed Revised)	52,702	23,575	6,178	11.72%	Yes
331	Major Small and Large Bowel Procedures without CC/MCC (Proposed Revised)	29,685	6,713	543	1.83%*	Yes**
698	Other Kidney and Urinary Tract Diagnoses with MCC (Proposed Revised)	56,925	34,672	8,351	14.47%	Yes
699	Other Kidney and Urinary Tract Diagnoses with CC (Proposed Revised)	33,945	15,263	3,132	9.23%	Yes
700	Other Kidney and Urinary Tract Diagnoses without CC/MCC (Proposed Revised)	4,431	1,589	181	4.08%*	Yes**
870	Septicemia or Severe Sepsis with Mechanical Ventilation >96 Hours (Proposed Revised)	34,335	15,099	4,988	14.53%	Yes
871	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with MCC (Proposed Revised)	592,110	281,401	43,504	7.35%	Yes**
872	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours without MCC (Proposed Revised)	154,469	64,490	6,848	4.43%	Yes**

* Indicates a current postacute care transfer policy criterion that the MS-DRG did not meet.
** As described in the policy at 42 CFR 412.4(d)(3)(ii)(D), MS-DRGs that share the same base MS-DRG will all qualify under the postacute care transfer policy if any one of the MS-DRGs that share that same base MS-DRG qualifies.

Rural Referral Centers (RRCs) Proposed Annual Updates to Case-Mix Index and Discharge Criteria (§ 412.96) (page 803)

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.)

In addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2018, they must have a CMI value for FY 2017 that is at least—

- 1.66185; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

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

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.4071
2	Middle Atlantic (PA, NJ, NY)	1.4694
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5486
4	East North Central (IL, IN, MI, OH, WI)	1.5765
5	East South Central (AL, KY, MS, TN)	1.5289
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6387
7	West South Central (AR, LA, OK, TX)	1.6872
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7366
9	Pacific (AK, CA, HI, OR, WA)	1.6619

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2018, must also have the number of discharges for its cost reporting period that began during FY 2016 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or

- The median number of discharges for urban hospitals in the census region in which the hospital is located.

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

IME Adjustment Factor for FY 2019 (page 817)

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

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2019 (§ 412.106) (page 818)

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, is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care.

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 to receive empirically justified Medicare DSH payments and uncompensated care payments because they are not paid under the IPPS.
- Medicare-dependent, small rural hospitals (MDHs) are paid based on the IPPS, subject to adjustments, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- IPPS hospitals that elect to participate in the Bundled Payments for Care Improvement Advanced Initiative (BPCI Advanced) model starting October 1, 2018, will continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- IPPS hospitals that are participating in the Comprehensive Care for Joint Replacement Model) continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- Hospitals participating in the Rural Community Hospital Demonstration Program are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

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

Calculation of Factor 1 for FY 2018 (page 829)

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

The December 2017 Office of the Actuary estimate for Medicare DSH payments for FY 2019, without regard to the application of section 1886(r)(1) of the Act, was approximately $16.295 billion.

The estimate of empirically justified Medicare DSH payments for FY 2019, with the application of section 1886(r)(1) of the Act, is approximately $4.074 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2019).

Therefore, CMS is proposing that Factor 1 for FY 2019 will be **$12,221,027,954.62**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2018 ($16,294,703,939.49 minus $4,073,675,984.87).

Calculation of Factor 2 for FY 2019 (page 835)

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

The calculation of the proposed Factor 2 for FY 2019 using a weighted average of OACT's projections for CY 2018 and CY 2019 is as follows:

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

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

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

The proposed FY 2019 factor 2 uncompensated care amount is: $12,221,027,954.62 x 0.6751 = **$8,250,415,972.16.**

Calculation of Factor 3 for FY 2018 (page 844)

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

CMS is using Worksheet S-10 for calculating Factor 3. For this FY 2019 proposed rule, hospitals had to submit their amended FY 2014 and FY 2015 cost reports containing the revised Worksheet S-10 (or a completed Worksheet S–10 if no data were included on the previously submitted cost report) to the MAC no later than December 1, 2017.

CMS is proposing to advance the time period of the data used in the calculation of Factor 3 forward by 1 year and to use data from FY 2013, FY 2014, and FY 2015 cost reports to determine Factor 3 for FY 2019.

For FY 2019, in addition to the Worksheet S–10 data for FY 2014 and FY 2015, CMS is proposing to use Medicaid days from FY 2013 cost reports and FY 2016 SSI ratios.

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

Hospital Readmissions Reduction Program (HRRP): (page 880)

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

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

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

Measures under the HRRP would remain the same.

Comment

CMS estimates that 2,610 hospitals will have their base operating MS-DRG payments reduced.

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes (page 905)

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

CMS is proposing to implement updates to the Hospital VBP Program, including the removal of 10 measures, all of which are also included in the Hospital Inpatient Quality Reporting (IQR) and/or Hospital Acquired Condition (HAC) Reduction Program measure sets, and revised weighting of the Hospital VBP Program domains. CMS says these proposals are consistent with CMS' commitment to using a smaller set of more meaningful measures, focusing on patient-centered outcome measures, and taking into account opportunities to reduce paperwork and reporting burden on providers. CMS proposes the following deletions:

- Elective Delivery (NQF #0469) (PC-01) beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138) (CAUTI) Program beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139) (CLABSI) Program beginning with the FY 2021 program year;
- American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) (Colon and Abdominal Hysterectomy SSI) Program beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) (MRSA Bacteremia) Program beginning with the FY 2021 program year;
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717) (CDI) Program beginning with the FY 2021 program year;
- Patient Safety and Adverse Events (Composite) (NQF #0531) (PSI 90) Program effective with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction (NQF #2431) (AMI Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure (NQF #2436) (HF Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule; and

- Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (NQF #2579) (PN Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule.

In the FY 2018 IPPS/LTCH PPS final rule CMS finalized the measure set for the Hospital VBP Program for the FY 2020 program year. CMS notes that it is not proposing any changes to this measure set in this proposed rule.

For the FY 2021 program year, CMS is proposing to remove six measures from the Safety domain (PC-01, CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI), as all of the HAI measures will be retained in the Hospital Acquired Condition (HAC) Reduction Program, and to remove the Safety domain itself, as there would be no measures remaining in the domain, along with proposing to remove two measures from the Efficiency and Cost Reduction domain (AMI Payment and HF Payment). If these measure removals are finalized as proposed, the Hospital VBP Program measure set for the FY 2021 program year would contain the following measures:

Summary of Measures for the FY 2021 Program Year If Proposed Measure Removals Are Finalized		
Measure Short Name	Domain/Measure Name	NQF #
Person and Community Engagement Domain		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (including Care Transition Measure)	0166 (0228)
Clinical Outcomes Domain		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute MyocardialInfarction (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
THA/TKA	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Efficiency and Cost Reduction Domain		
MSPB	Medicare Spending Per Beneficiary (MSPB) – Hospital	2158

For the FY 2022 and FY 2023 program years, in addition to the eight measures CMS is proposing to remove for the FY 2021 program year (PC-01, CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, CDI, AMI Payment, and HF Payment), CMS is also proposing to remove the PN Payment measure, which would be entering the program beginning with the FY 2022 program year, and the PSI 90 measure, which would be entering the program beginning with the FY 2023 program year.

Hospital-Acquired Condition (HAC) Reduction Program (page 972)

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 administrative updates to receive and assess accuracy for five Healthcare Associated Infection measures currently included in the program. CMS is also proposing to update measure weighting to simplify the methodology and address concerns raised by small hospitals.

Proposed Revisions Regarding Admission Order Documentation Requirements (page 1,055)

CMS is proposing to revise the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment. Specifically, CMS is proposing to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.

Critical Access Hospitals (CAHs) (page 1,073)

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs).

Section 3126 of the ACA, authorizes a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties in order to improve access to and better integrate the delivery of acute care, extended care and other health care services to Medicare beneficiaries. The demonstration is titled "Demonstration Project on Community Health Integration Models in Certain Rural Counties," and is commonly known as the Frontier Community Health Integration Project (FCHIP) demonstration

Ten CAHs were selected for participation in the demonstration, which started on August 1, 2016. These CAHs are located in Montana, Nevada, and North Dakota.

CMS says that in the event that this demonstration is found to result in aggregate payments in excess of the amount that would have been paid if this demonstration were not implemented, CMS will comply with the budget neutrality requirement by reducing payments to all CAHs, not just those participating in the demonstration.

IV. CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (pages beginning 58)

Proposed FY 2019 MS-DRG Documentation and Coding Adjustment (page 59)

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

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

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

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

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

Note: The adjustments mandated by statue will never completely replace the offsets made during FYs 2014-2017.

Proposed Changes to Specific MS-DRG Classifications (page 64)

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

Laryngectomy (page 104)

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

***Chimeric Antigen Receptor (CAR) T-Cell Therapy* (page 105)**

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

Epilepsy with Neurostimulator (page 110)

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

Pacemaker Insertions (page 136)

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

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

Benign Lipomatous Neoplasm of Kidney (page 169)

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

Bowel Procedures (page 172)

CMS is proposing to reassign 12 ICD-10-PCS procedure codes from MS-DRGs 329, 330, and 331 to

Admit for Renal Dialysis (page 188)

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

Pregnancy, Childbirth and the Puerperium (page 191)

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

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

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

- Proposed new MS-DRG 783 (Cesarean Section with Sterilization with MCC);
- Proposed new MS-DRG 784 (Cesarean Section with Sterilization with CC);
- Proposed new MS-DRG 785 (Cesarean Section with Sterilization without CC/MCC);
- Proposed new MS-DRG 786 (Cesarean Section without Sterilization with MCC);
- Proposed new MS-DRG 787 (Cesarean Section without Sterilization with CC);
- Proposed new MS-DRG 788 Cesarean Section without Sterilization without CC/MCC);
- Proposed new MS-DRG 796 (Vaginal Delivery with Sterilization/D&C with MCC);

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

Systemic Inflammatory Response Syndrome (SIRS) of Non-Infectious Origin (page 226)

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

Proposed Changes to the Medicare Code Editor (MCE) (page 236)

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

Comment

CMS discusses a number of issues regarding the MCE and proposes several changes. Please refer to the rule for the technical specifics.

Changes to Surgical Hierarchies (page 256)

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

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

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

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

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

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

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

Other Items Being Addressed (beginning page 260)

CMS provides extensive discussions on the following:

- Proposed additions and deletions to the Diagnosis Code Severity Levels for FY 2019 (page 261)
- Principal Diagnosis Is Its Own CC or MCC (page 262)
- Proposed CC Exclusions List for FY 2019 (page 272)
- Comprehensive Review of CC List for FY 2019 (page 276)
- Review of Procedure Codes in MS DRGs 981 through 983 and 987 through 989 (page 282)
- Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (page 303)

Proposed Replaced Devices Offered without Cost or with a Credit (page 311)

For FY 2019, CMS is not proposing to add any MS-DRGs to the policy for replaced devices offered without cost or with a credit.

Other Policy Changes: Operating Room (O.R.) and Non-O.R. Issues (page 313)

CMS is addressing requests that it received regarding changing the designation of specific ICD–10–PCS procedure codes from non-O.R. to O.R. procedures, or changing the designation from O.R. procedure to non-O.R. procedure.

Comment

The MS-DRG material is extensive. It spans some 235 pages, but it is well written. Those involved in medical records and coding need to review this material indepth.

Add-On Payments for New Services and Technologies for FY 2018 (page 363)

Proposed FY 2019 Status of Technologies Approved for FY 2018 Add-On Payments (page 383)

Discontinued

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

Continued

- Defitelio® (Defibrotide). The maximum payment will remain at $75,900.
- Ustekinumab (Stelara®). The maximum payment for a case involving Stelara® would remain at $2,400 for FY 2019.
- Bezlotoxumab (ZINPLAVA™) The maximum new technology add-on payment amount for a case involving the use of ZINPLAVA™ is $1,900.

FY 2019 Applications for New Technology Add-On Payments (page 400)

CMS received 15 applications for new technology add-on payments for FY 2019. They are:

- KYMRIAH™ (Tisagenlecleucel) and YESCARTA™ (Axicabtagene Ciloleucel)
- VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection)
- VABOMERE™ (meropenem-vaborbactam)
- DURAGRAFT® Vascular Conduit Solution
- remedē® System
- Titan Spine nanoLOCK® (Titan Spine nanoLOCK® Interbody Device)
- Plazomicin
- GIAPREZA™
- GammaTile™
- Supersaturated Oxygen (SSO2) Therapy (DownStream® System)
- Cerebral Protection System (Sentinel® Cerebral Protection System)
- AZEDRA® (Ultratrace® iobenguane Iodine-131) Solution
- The A QUAB EAM System (Aquablation)
- AndexXa™ (Andexanet alfa)

Comment

In the past, we have observed the length and discussion of new technologies. This year's material is 278 pages. It would help if the discussion on these items were placed in a separate appendix. One must assume that most readers are only interested in actions being taken by the agency and not all the ongoing discussions and rational positions between CMS and the manufacturers.

V. PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2019 (page 1,078 & addendum)

***Proposed Updates to the Payment Rates for the LTCH PPS for FY 2019* (page 1,130)**

CMS is proposing an annual update to the LTCH PPS standard Federal payment rate of 1.15 percent. CMS is proposing to apply a factor of 1.0115 to the FY 2018 LTCH PPS standard Federal payment rate of $41,415.11 to determine the proposed FY 2019 LTCH PPS standard Federal payment rate.

CMS is proposing an annual update to the LTCH PPS standard Federal payment rate of -0.85 percent (that is, a proposed update factor of 0.9915) for FY 2019 for LTCHs that fail to submit the required quality reporting data for FY 2019 as required under the LTCH QRP.

CMS is also proposing to apply an area wage level budget neutrality factor to the proposed FY 2019 LTCH PPS standard Federal payment rate of 0.999713 based on the best available data at this time.

Finally, CMS is proposing to apply a one-time, permanent budget neutrality adjustment of 0.990535 for its proposed elimination of the 25-percent threshold policy

Accordingly, CMS is proposing an LTCH PPS standard Federal payment rate of **$41,482.98** (calculated as $41,415.11 x 1.0115 x 0.999713 x 0.990535) for FY 2019.

The labor-related share under the LTCH PPS for FY 2019 is 66.2 percent.

The FY 2019 LTCH PPS standard Federal payment rate wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS Web site.

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

High-Cost Outlier (HCO) Cases

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

CMS is establishing a fixed-loss amount of **$30,639** for LTCH PPS standard Federal payment rate cases for FY 2019. The current threshold is $27,382.

CMS is proposing a fixed-loss amount for site neutral payment rate cases of $27,545, basis, the outlier threshold will be the same as the IPPS rate or **$26,601.**

VI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (page 1,153)

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

- The Hospital IQR Program;
- The PCHQR Program; and
- The LTCH QRP Program.

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

Hospital IQR (page 1,153)

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

CMS is proposing to remove certain measures from the Hospital IQR Program, while retaining the same measures in one of the value-based purchasing programs (Hospital Value-Based Purchasing, Hospital Readmissions Reduction, and Hospital Acquired-Condition Reduction Programs). CMS says the proposals to remove these measures are consistent with CMS' commitment to using a smaller set of more meaningful measures. CMS is focusing on measures that provide opportunities to reduce both paperwork and reporting burden on providers and patient-centered outcome measures, rather than process measures. To accomplish these goals, CMS is proposing to adopt a new measure removal factor and to update the Hospital IQR Program's measure set as follows:

1. Adopt one additional factor to consider when evaluating measures for removal from the Hospital IQR Program measure set: "The cost associated with a measure outweighs the benefit of its continued use in the program".

2. Remove 18 previously adopted measures that are "topped out", no longer relevant, or where the burden of data collection outweighs the measure's ability to contribute to improved quality of care.

3. De-duplicate 21 measures to simplify and streamline measures across programs. These measures will remain in one of the other 4 hospital quality programs.

CMS is proposing to remove a total of 39 measures from the program, as summarized in the table below: (page 1,213)

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Structural Patient Safety Measures			
Safe Surgery Checklist	Safe Surgery Checklist Use	FY 2020	N/A
Patient Safety Culture	Hospital Survey on Patient Safety Culture	FY 2020	N/A
Patient Safety Measures			
PSI 90	Patient Safety and Adverse Events Composite	FY 2020	0531

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	FY 2021	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	FY 2021	1717
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	FY 2021	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	FY 2021	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	FY 2021	1716
Claims-Based Coordination of Care Measures			
READM-30- AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0505
READM-30- CABG	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2020	2515
READM-30- COPD	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2020	1891
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization	FY 2020	0330
READM-30- PNA	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	FY 2020	0506
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY 2020	1551
READM-30-STK	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	FY 2020	N/A
Claims-Based Mortality Measures			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	FY 2020	0229
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2021	1893
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	FY 2021	0468

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2022	2558
Claims-Based Patient Safety Measure			
Hip/Knee Complications	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY2023	1550
Claims-Based Payment Measures			
MSPB	Medicare Spending Per Beneficiary (MSPB) - Hospital Measure	FY 2020	2158
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment Measure	FY 2020	N/A
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	FY 2020	N/A
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	FY 2020	N/A
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	FY 2020	N/A
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	FY 2020	N/A
SFusion Payment	Spinal Fusion Clinical Episode-Based Payment Measure	FY 2020	N/A
Chart-Abstracted Clinical Process of Care Measures			
IMM-2	Influenza Immunization	FY 2021	1659
VTE-6	Incidence of Potentially Preventable VTE [Venous Thromboembolism]	FY 2021	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2021	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	FY 2022	0497
EHR-Based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))			
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	FY 2022	+
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	FY 2022	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2022	0495
EHDI-1a	Hearing Screening Prior to Hospital Discharge	FY 2022	1354
PC-01	Elective Delivery	FY 2022	0469

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
STK-08	Stroke Education	FY 2022	+
STK-10	Assessed for Rehabilitation	FY 2022	0441

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

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

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment* Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
Healthcare-Associated Infection Measures		
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
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 (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin -resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
Claims-based Patient Safety Measures		
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
PSI 04	Death Rate among Surgical Inpatients with Serious Treatable Complications	0351
	Claims-based Mortality Outcome Measures	
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	2558
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-STK	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke*	N/A
Claims-based Coordination of Care Measures		
READ-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

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

* CMS is proposing to remove 19 measures -- 17 claims-based measures and two structural measures -- beginning with the FY 2020 payment determination. These measures, which had previously been finalized for the FY 2020 payment determination are not included in this summary table.
** Measure listed twice, as both chart-abstracted and eCQM versions.
+ NQF endorsement has been removed.

The proposal also contains charts of measures for the FY 2021 year (page 1,220) and FY 2022 year (page 1,222),

***PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program* (page 1,271)**

CMS is proposing to collect a new measure, and remove six previously-adopted measures. Specifically, the proposed rule would:

- Adopt one new claims-based hospital 30-day unplanned readmission outcome measure (NQF # 3188) beginning with the FY 2021 program year, and;

- Remove 6 measures, each of which addresses healthcare associated infections, oncology, or prostate cancer. Beginning with the FY 2021 program year. CMS assessed the PCHQR measure set and determined that with respect to the six measures being proposed for removal, most hospitals either performed at very high levels for several measures with little variation, or the burden associated with the measures outweighed the benefit of their continued use in the program.

CMS is proposing to remove four web-based, structural measures from the PCHQR Program beginning with the FY 2021 program year because they are topped-out:

- Oncology: Radiation Dose Limits to Normal Tissues (PCH-14/NQF #0382);
- Oncology: Medical and Radiation – Pain Intensity Quantified (PCH-16/NQF #0384);
- Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients (PCH-17/NQF #0390); and
- Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk
- Patients (PCH-18/NQF #0389).

CMS also is proposing to remove to two National Healthcare Safety Network (NHSN) chart-abstracted measures and, beginning with the FY 2021 program year.

- NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (PCH-5/NQF #0138);
- NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (PCH-4/NQF #0139).

The table below summarizes what the PCHQR Program measure set would look like for the FY 2021 program year if CMS finalizes its measure removal proposals and its proposal to adopt the 30-Day Unplanned Readmissions for Cancer Patients measure (NQF #3188):

Short Name	NQF #	Measure Name
Safety and Healthcare-Associated Infection (HAI)		
Colon and Abdominal Hysterectomy SSI	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure [currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery]
CDI	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure
MRSA	1716	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* Bacteremia Outcome Measure
HCP	0431	National Healthcare Safety Network (NHSN) Influenza Vaccination Coverage Among Healthcare Personnel
Clinical Process/Oncology Care Measures		
N/A	0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology
EOL-Chemo	0210	Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

Short Name	NQF #	Measure Name
EOL-Hospice	0215	Proportion of Patients Who Died from Cancer Not Admitted to Hospice
Intermediate Clinical Outcome Measures		
EOL-ICU	0213	Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life
EOL-3DH	0216	Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days
Patient Engagement/Experience of Care		
HCAHPS	0166	HCAHPS
Clinical Effectiveness Measure		
EBRT	1822	External Beam Radiotherapy for Bone Metastases
Claims Based Outcome Measures		
N/A	N/A	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
N/A*	3188	30-Day Unplanned Readmissions for Cancer Patients

* Measure proposed for adoption for the FY 2021 program year and subsequent years.

Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes
(page 1,310)

CMS is proposing to remove the following measures. These measures either have significant operational challenges with reporting or are duplicative of other measures in the program.

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

The LTCH QRP currently has 19 measures for the FY 2020 program year, which are outlined in the following table:

Short Name	Measure Name & Data Source
LTCH CARE Data Set	
Pressure Ulcer	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Patient Influenza Vaccine	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)(NQF #0680)
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)

Short Name	Measure Name & Data Source
Functional Assessment	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Application of Functional Assessment	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Change in Mobility	Functional Outcome Measure: Change in Mobility Among Long- Term Care Hospital (LTCH) Patients Requiring Ventilator Support (NQF #2632)
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
Compliance SBT	Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
Ventilator Liberation	Ventilator Liberation Rate
NHSN	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
CLABSI	National Healthcare Safety Network (NHSN) Central Line-associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716)
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)
VAE	National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure
Claims-Based	
MSPB LTCH	Medicare Spending Per Beneficiary (MSPB)-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
DTC	Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

* The measure will be replaced with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure, effective July 1, 2018.

Proposed Changes to the Medicare and Medicaid EHR Incentive Programs (now referred to as the Medicare and Medicaid Promoting Interoperability Programs) ***(page 1331)***

Beginning with an EHR reporting period in CY 2019, CMS is reiterating that all eligible hospitals and CAHs under the Medicare and Medicaid EHR Incentive Programs are required to use the 2015 Edition of CEHRT.

CMS is proposing that EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020.

CMS is proposing to overhaul the Medicare and Medicaid EHR Incentive Programs to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. To better reflect this new focus, CMS is re-naming the Meaningful Use program "Promoting Interoperability." In addition, CMS

seeks to accomplish this through proposals for a new scoring methodology as well as proposals for new measures including: Query of the PDMP, and Verify Opioid Treatment Agreement, related to e-prescribing of opioids (Schedule II controlled substances) that align with the overall agency initiative on the treatment of opioid and substance use disorders. CMS also proposes to remove certain measures which do not emphasize interoperability and the electronic exchange of health information.

The tables below illustrate CMS' proposal for the new scoring methodology.

Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in 2019

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	Bonus: Verify Opioid Treatment Agreement	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) Choose one or more additional: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points

Proposed Performance-Based Scoring Methodology Beginning with EHR Reporting Periods in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	5 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points
	Bonus: Verify Opioid Treatment Agreement	5 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	35 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) Choose one or more additional: Immunization Registry Reporting Electronic Case Reporting Public Health Registry	10 points

Objectives	Measures	Maximum Points
	Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	

Summary of Measures Proposals

Measure Status	Measure
Measures retained from Stage 3 with no modifications*	e-Prescribing Immunization Registry Reporting Syndromic Surveillance Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting
Measures retained from Stage 3 with modifications	Send a Summary of Care (Proposed Name: Supporting Electronic Referral Loops by Sending Health Information) Provide Patient Access (Proposed Name: Provide Patients Electronic Access to Their Health Information)
Removed measures	Request/Accept Summary of Care Clinical Information Reconciliation Patient-Specific Education Secure Messaging View, Download or Transmit Patient Generated Health Data
New measures	Query of Prescription Drug Monitoring Program (PDMP) Verify Opioid Treatment Agreement Support Electronic Referral Loops by Receiving and Incorporating Health Information

Electronic Clinical Quality Measures (eCQMs)

For eligible hospitals and CAHs that report CQMs electronically, the reporting period for the Medicare and Medicaid EHR Incentive Programs would be one, self-selected calendar quarter of CY 2019 data, reporting on at least 4 self-selected CQMs from a set of 16. CMS proposes the submission period for the Medicare EHR Incentive Program would be the 2 months following the close of the calendar year, ending February 29, 2020. In addition, beginning with the 2020 reporting period, CMS proposes to remove 8 of the 16 CQMs consistent with CMS' commitment to producing a smaller set of more meaningful measures and in alignment with the Hospital IQR Program.

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

Short Name	Measure Name	NQF Number
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
ED–3	Median Time from ED Arrival to ED Departure for Discharged ED Patients	0496
CAC–3	Home Management Plan of Care Document Given to Patient/Caregiver	+
ED–1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED–2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI–1a	Hearing Screening Prior to Hospital Discharge	1354

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

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

The eight eCQMs CMS is proposing to remove from the table beginning with the reporting period in CY 2020. for are:

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

IV PROPOSED REVISIONS OF THE SUPPORTING DOCUMENTATION REQUIRED FOR SUBMISSION OF AN ACCEPTABLE MEDICARE COST REPORT (page 1,448)

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

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

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

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

CMS is proposing that, effective for cost reporting periods beginning on or after October 1, 2018, in order for a provider claiming costs on its cost report that are allocated from a home office or chain organization to have an acceptable cost report submission under § 413.24(f)(5), a Home Office Cost Statement completed by the home office or chain organization that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report must be submitted as a supporting document with the provider's cost report.

VII REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES VIA THE INTERNET (page 1,464)

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

Final Comments and Regulatory Analysis

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

As noted in previous analyses, the topic of quality and its requirements appears to have become the 800-pound gorilla of Medicare rules and regulations. The material is just overwhelming. For example, CMS spends more than 170 pages addressing just possible new reporting measures for the IQR system.

Those individuals responsible for quality reporting need to pay careful attention to the voluminous changes presented. Failure to do so could result in reduced payments for not providing required measures.

CMS provides an extensive regulatory analysis section identifying and quantifying many of the changes in this final rule.

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

The following is CMS' FY 2019 estimate of the national budget neutrality statewide calculations. While CMS said it wouldn't provide this information in the future, it has for FY 2019.

Proposed FY 2019 IPPS Estimated Payments Due to Proposed Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Would Receive the Rural Floor (2)	Proposed Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3)	Difference (in millions) (4)
Alabama	84	2	-0.3	$-4
Alaska	6	1	-0.2	$0
Arizona	56	4	-0.2	$-3
Arkansas	45	0	-0.3	$-3
California	297	63	0.4	$48
Colorado	46	9	0.6	$8
Connecticut	30	17	5.5	$90
Delaware	6	1	-0.3	$-1
Washington, D.C.	7	0	-0.3	$-2
Florida	168	8	-0.2	$-17
Georgia	101	0	-0.3	$-7
Hawaii	12	0	-0.2	$-1
Idaho	14	0	-0.2	$-1
Illinois	125	2	-0.3	$-12
Indiana	85	0	-0.3	$-7
Iowa	34	0	-0.3	$-3
Kansas	51	0	-0.2	$-2

Proposed FY 2019 IPPS Estimated Payments Due to Proposed Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Would Receive the Rural Floor (2)	Proposed Percent Change in Payments due to Application of Rural Floor with Budget Neutrality (3)	Difference (in millions) (4)
Kentucky	64	0	-0.2	$-4
Louisiana	90	0	-0.3	$-4
Maine	17	0	-0.3	$-1
Massachusetts	56	35	1.4	$49
Michigan	94	0	-0.3	$-12
Minnesota	49	0	-0.2	$-5
Mississippi	59	0	-0.3	$-3
Missouri	72	0	-0.2	$-6
Montana	13	2	-0.2	$-1
Nebraska	23	0	-0.2	$-2
Nevada	22	3	0.4	$4
New Hampshire	13	4	0.7	$4
New Jersey	64	10	-0.4	$-13
New Mexico	25	2	-0.2	$-1
New York	149	18	-0.2	$-16
North Carolina	84	0	-0.2	$-9
North Dakota	6	5	1.2	$4
Ohio	129	7	-0.2	$-9
Oklahoma	79	1	-0.3	$-4
Oregon	34	1	-0.2	$-2
Pennsylvania	150	3	-0.3	$-14
Puerto Rico	51	11	0.2	$0
Rhode Island	11	10	-0.3	$-1
South Carolina	54	6	0	$-1
South Dakota	17	0	-0.2	$-1
Tennessee	90	6	-0.3	$-6
Texas	311	14	-0.2	$-12
Utah	31	0	-0.2	$-1
Vermont	6	0	-0.2	$0
Virginia	74	1	-0.2	$-5
Washington	48	4	-0.3	$-6
West Virginia	29	2	-0.1	$-1
Wisconsin	66	1	-0.3	$-5
Wyoming	10	2	0.4	$1

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

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2019 Proposed Rule				
MS-DRG	**MS-DRG Title**	**Proposed FY 2019 Weights**	**Final FY 2018 Weights**	**Percentage Change**
65*	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0043	1.0313	-2.62%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2332	1.2198	1.10%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1900	1.1528	3.23%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3048	1.3733	-4.99%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.8949	0.9333	-4.11%
291	HEART FAILURE & SHOCK W MCC	1.3424	1.4761	-9.06%
292	HEART FAILURE & SHOCK W CC	0.9143	0.9589	-4.65%
378	G.I. HEMORRHAGE W CC	0.9849	0.9704	1.49%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7532	0.7594	-0.82%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9995	2.0522	-2.57%
603	CELLULITIS W/O MCC	0.8445	0.8503	-0.68%
682	RENAL FAILURE W MCC	1.5024	1.4845	1.21%
683	RENAL FAILURE W CC	0.9074	0.9293	-2.36%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7846	0.7946	-1.26%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8418	1.8231	1.03%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0390	1.0547	-1.49%

* For FY 2018 this MS-DRG was number 69. It is proposed to be renumbered to 65

These 16 MS-DRGs contain 3,209,319 million discharges or approximately 34 percent of the 9,591,000 million MS-DRG discharges.

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