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# Regulatory Advisor Volume Nine

## CMS Releases 2019 Proposed Payment Rule for Inpatient and Long-Term Care Hospitals

*by Jenny Boese*

On April 25, 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2019 proposed Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Rule. The following includes a high level overview of key provisions in the proposed rule. The comment deadline for the more than 1,800-page proposed rule (CMS1694-9) is June 25, 2018. For information or assistance on commenting, contact Jenny Boese.

## INPATIENT PROSPECTIVE PAYMENT SYSTEM

According to CMS, roughly 3,330 acute care hospitals will be impacted by the changes in this rule, if finalized, beginning October 1, 2018. Those changes cover payment, policies, and quality programs.

### Payment and policy updates

#### Market-basket update

The rule provides a 2.8 percent market-basket update. After various mandated reductions are included, the net increase on average will be 1.75 percent. CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $4 billion in FY 2019.

#### Disproportionate Share Hospital (DSH)

Due to an increased percentage in the number of uninsured, CMS proposes to add another $1.5 billion to the pool of dollars which are distributed among DSH hospitals based on levels of uncompensated care. The total of this pool would then be $8.25 billion for FY 2019. CMS will also continue incorporating the uncompensated care cost data from Worksheet S-10 of the Medicare cost report into the methodology for distributing these funds. For FY 2019, CMS proposes using Worksheet S-10 data from FY 2014 and FY 2015 cost reports in combination with insured low-income days data from FY 2013 cost reports to determine the distribution of uncompensated care payments.

#### Price transparency

CMS follows through on its public statements to work towards more price transparency for consumers by updating its guidelines to specifically require hospitals to make public their standard charges via the Internet in a readable format and update them annually if there are changes.

#### Part A certification statements

CMS proposes removing the requirement for stating where in a medical record required information can be found.

#### Physician orders

CMS removes the requirement that a written inpatient order be present in the medical record as a condition of Part A payment. The agency found that this was an unnecessary regulatory burden.

#### Graduate Medical Education (GME)

CMS proposes to provide additional flexibility for new urban teaching hospitals to enter into Medicare GME affiliation agreements, which allow hospitals to share full time equivalent cap slots to accommodate the cross training of residents.

#### Cost report forms

CMS is proposing to require additional documentation in certain instances, including for teaching hospitals, bad debt, DSH, charity care, and uninsured discounts.

#### Wage index

CMS proposes allowing hospitals to use average hourly wage data from the current year's IPPS final rule that is available on the CMS website to demonstrate they are the only hospital in their Metropolitan Statistical Area for the purpose of meeting an exemption from certain wage index geographic reclassification. This change would begin in FY 2021.

#### IPPS-excluded units

CMS proposes to allow certain hospitals which are excluded from the IPPS (for example, LTCHs) to operate IPPS-excluded units as long as that arrangement would be allowed under the applicable hospital conditions of participation. In addition, CMS would not require an IPPS-excluded satellite of an IPPS-excluded unit of an IPPS-excluded hospital to comply with the separateness and control requirements so long as the satellite of the unit is not co-located with an IPPS hospital.

#### Low-volume adjustment (LVA) and Medicare Dependent Hospitals (MDH)

Under the *Bipartisan Budget Act of 2018*, Congress extended both the MDH and the LVA payment adjustments for another five years (through September 30, 2022). However, Congress altered the LVA criteria beginning in FY 2019. CMS tells LVA hospitals that they must also alert their Medicare Administrative Contractors (MACs) by May 24, 2018, that they qualify as an LVA under current criteria for the FY 2018, and must alert their MACs by Sept. 1, 2018, that they qualify under the new criteria beginning FY 2019. For an MDH, the MDH status is automatically reinstated.

### CAR-T-cell therapy

CMS is proposing to give these therapies a Medicare Severity-Diagnosis Related Group (MS-DRG) for 2019, but is also seeking comments on alternate payment models for these drugs.

### Rural Community Hospital and Frontier Demonstrations

CMS provides details on extending the Rural Community Hospital Demonstrations another five years, as required under the *21st Century Cures Act*. CMS also discusses the Frontier Community Health Integration Project (FCHIP) Demonstration, which tests new models for providing coordinated health care in the most sparsely-populated rural counties.

## Meaningful Use and other electronic health record (EHR) changes

CMS proposes to change the "Meaningful Use" program name to "Promoting Interoperability". This change is in line with the agency's desire to move forward with interoperability, and using the EHR program is one method it believes will help do so. Other proposed changes include:

### 90-day reporting period

For 2019 and 2020, the EHR reporting would be a minimum of a continuous 90-day period for each calendar year.

### 2015 CEHRT requirement

CMS proposes mandating that providers use the 2015 edition certified EHR technology (CEHRT) beginning in 2019 reporting period/2021 payment period. Failure to do so could result in Medicare reimbursement reductions.

### New scoring methodology

CMS is moving away from the pass/fail approach to a performance approach based on a 100-point scoring methodology. The new system will include four broad objectives (e-prescribing, health information exchange, provider to patient exchange, and public health and clinical data exchange). The required number of measures to report will be cut from 16 to 6. CMS is proposing three additional measures in 2019, two voluntary and one mandatory. The mandatory measure is "support electronic referral loops by receiving and incorporating health information," and the two voluntary measures are: query of prescription drug monitoring program and verify opioid treatment agreement.

These voluntary measures for 2019 move to mandatory in 2020. A minimum of 50 points is required to satisfactorily be a meaningful user. Five bonus points are given for reporting the two voluntary measures. The new scoring methodology would not apply to Medicaid-only eligible hospitals under the meaningful use incentive program. CMS proposes some exceptions in limited instances. CMS is also requesting feedback on a number of questions related to interoperability, measures, and these revisions.

### Clinical quality measures (CQMs) and electronic clinical quality measures (eCQMs)

For hospitals and Critical Access Hospitals that report clinical quality measures electronically, CMS is proposing the reporting period for the Medicare and Medicaid EHR Incentive Programs would be one, self-selected calendar quarter of data for four self-selected eCQMs for the CY 2019 reporting period/FY 2021 payment determination. CMS is also proposing to remove eight CQMs in 2020.

## Quality programs and measures

Overall, CMS proposes to remove 19 measures from its five quality programs and will "de-duplicate" another 21 measures, while adopting one claims-based readmissions measure. A quick summary of each of the five program changes follows. In addition, please review the CMS-created tables highlighting its measure changes for each of these five programs in the appendix.

### Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes to remove 18 measures that it believes are "topped out" or where the data collection burden outweighs the benefit. It also proposes to "de-duplicate" 21 measures which appear across multiple programs. These measures will remain in only one of the five quality programs. CMS will review the cost/benefit of a measure when evaluating removal. CMS is seeking feedback on two potential new quality measures. Also, the agency is providing an update on accounting for social risk factors in the Hospital IQR Program. CMS intends to include measure rates for certain measures stratified by patients' dual eligibility status beginning in the fall of 2018 in hospitals' confidential feedback reports.

### Hospital Value-Based Purchasing (VBP) Program

CMS is proposing to implement updates to the Hospital VBP Program, including the removal of 10 measures. These measures will continue to be included either under the IQR or Hospital-Acquired Conditions (HAC) programs. Seven of the measures removed are all of the health care associated infection and patient safety measures contained in the Safety domain. These will remain in the HAC program. In addition, CMS will remove three condition-specific payment measures from the Efficiency and Cost Reduction domain (these are in the IQR program) but will retain the Medicare Spending per Beneficiary-Hospital measure. CMS will increase the Clinical Care domain weighting beginning in FY 2021.

### HAC Reduction Program

CMS is proposing no changes in the measures used in 2019, but proposes measure weighting changes beginning in 2020.

### Hospital Readmissions Reduction Program (HRRP)

CMS proposes no measure changes to the HRRP program, but is required by the *21st Century Cures Act* to begin assessing eligible hospital readmission performance relative to hospitals with a similar proportion of dual-eligible Medicare-Medicaid patients. To do so, CMS will assign eligible hospitals into five equal sized peer groups based on their proportion of dual eligible patients and clarify definitions needed to implement this requirement.

### PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

For hospitals under the PCHQR program, CMS is proposing a new measure and the removal of six other measures. The new measure will be a claims-based hospital 30-day unplanned readmission outcome measure, which would begin with the FY 2021 program year. The six measures proposed for removal relate to health care associated infections, oncology, or prostate cancer. Both changes would being in the FY 2021 program year.

## CMS requests your feedback

CMS frequently seeks input from the public and stakeholders on a number of topics. The proposed rule highlights several key opportunities to provide feedback.

### Price transparency

CMS is concerned about insufficient price transparency. Patients are surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, as well as by facility fees and physician fees for emergency room visits. CMS is seeking feedback about the barriers preventing providers from informing patients of their out of pocket costs. What changes are needed to support greater transparency around patient obligations for their out of pocket costs? What can be done to better inform patients of these obligations; what role providers should play in this initiative? CMS is also considering making information regarding hospital non-compliance with the requirements public and also intends to consider additional enforcement mechanisms in future rulemaking.

### Interoperability

CMS has consistently stated it desires to press for interoperability and is seeking comments on how to improve the sharing of health care data between providers. CMS is considering revising the Medicare Conditions of Participation related to interoperability as a way to increase electronic sharing of data by hospitals. CMS specifically asks commenters to provide a clear and concise proposal that includes data and examples. If the proposals involve novel legal questions, analysis regarding CMS's authority is welcome.

# LONG-TERM CARE HOSPITALS (LTCH)

According to CMS, nearly 420 LTCHs will be impacted by the changes in this rule, if finalized, beginning October 1, 2018. Those changes cover payment, policies, and quality programs.

## Payment and policy changes

### Market-basket update

CMS is proposing a 1.15 percent update, assuming all clinical requirements are met. As FY 2019 continues the phase-in of the dual payment systems, the overall update to LTCH's will be a negative 0.01 percent decrease or $5 million.

### 25 Percent Rule

CMS is proposing to eliminate the 25 Percent Rule entirely.

## Quality program

### Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

CMS continues its commitment to remove burdensome measures and proposes removing:

- 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); and, 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)

CMS also proposes to update its methods to notify LTCHs of non-compliance. CMS is seeking comments on changing the implementation of changes to the LTCH CARE Data Set from April to October.

## Author

Jenny Boese is the Director of Health Care Policy and has over 23 years of government relations and policy experience, with over half of her career spent dedicated to health care policy and the health care industry. Contact Jenny through CLAconnect.com or 608-662-7636.

## About CliftonLarsonAllen

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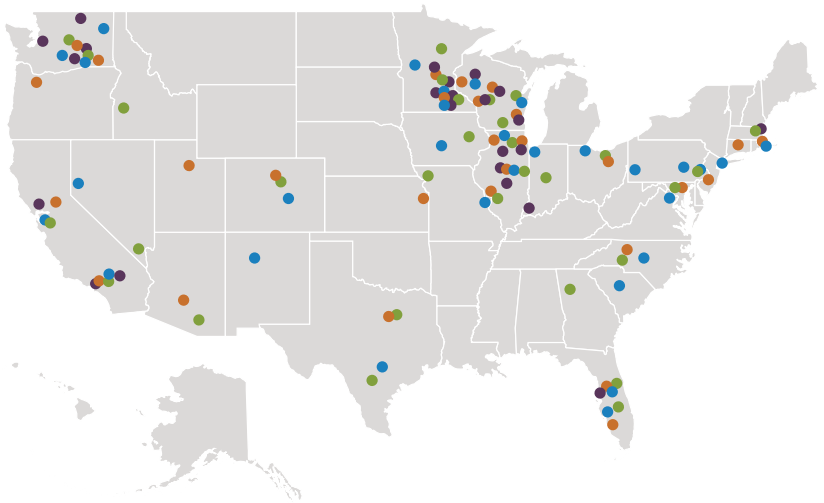

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## Hospital Inpatient Quality Reporting (IQR) Program removed measures

### Health Care-Associated Infection Measures

*Collected via Federal Data Registry*

| Measure Name | Removal Rationale |
|---|---|
| Catheter-Associated Urinary Tract Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Central Line-Associated Bloodstream Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Harmonized Procedure Specific Surgical Site Infection SSI Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |

### Patient Safety Measures

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Patient Safety and Adverse Events Composite | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty | Duplicates measure in the Hospital Value-Based Purchasing Program |

### Structural Measures

*Collected via web-based tool*

| Measure Name | Removal Rationale |
|---|---|
| Hospital Survey on Patient Safety Culture | Measure does not result in better patient outcomes. |
| Safe Surgery Checklist Use | Cost of the measure outweighs the benefit of its continued use. |

### Mortality Outcome Measures

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization | Duplicates measure in the Hospital Value-Based Purchasing Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery | Duplicates measure in the Hospital Value-Based Purchasing Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization | Duplicates measure in the Hospital Value-Based Purchasing Program |
| Hospital 30-Day, All-Cause, Risk-Standardization Mortality Rate Following Heart Failure Hospitalization | Duplicates measure in the Hospital Value-Based Purchasing Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization | Duplicates measure in the Hospital Value-Based Purchasing Program |

### Coordination of Care Measures

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Hospital 30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) | Duplicates measure in the Hospital Readmissions Reduction Program |
| Hospital 30-Day Risk-Standardized Readmission Rate Following Stroke Hospitalization | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Hospital-Wide Readmissions). |

### Resource Use and Payment Measures

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Payment-Standardized Medicare Spending Per Beneficiary (MSPB) | Duplicates measure in the Hospital Value-Based Purchasing Program |
| Cellulitis Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Kidney, Urinary Tract Infection Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Spinal Fusion Clinical Episode-Based Payment Measure | Cost of the measure outweighs the benefit of its continued use and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |

### Clinical Process of Care Measures

*Collected via chart abstraction*

| Measure Name | Removal Rationale |
|---|---|
| Median Time from ED Arrival to ED Departure for Admitted ED Patients | Cost of the measure outweighs the benefit of its continued use. |
| Admit Decision Time to ED Departure Time for Admitted Patients | Cost of the measure outweighs the benefit of its continued use and eCQM version of the measure will remain in the Hospital Inpatient Quality Reporting Program. |
| Influenza Immunization | Measure performance is "topped-out." |
| Incidence of Potentially Preventable Venous Thromboembolism Prophylaxis | Cost of the measure outweighs the benefit of its continued use. |

### Electronic Clinical Quality Measures

*Collected via electronic health record*

| Measure Name | Removal Rationale |
|---|---|
| Primary PCI Received Within 90 Minutes of Hospital Arrival | Cost of the measure outweighs the benefit of its continued use. |
| Home Management Plan of Care Document Given to Patient or Caregiver | Cost of the measure outweighs the benefit of its continued use. |
| Median Time from ED Arrival to ED Departure for Admitted ED Patients | Cost of the measure outweighs the benefit of its continued use. |
| Hearing Screening Prior to Hospital Discharge | Cost of the measure outweighs the benefit of its continued use. |
| Elective Delivery | Cost of the measure outweighs the benefit of its continued use. |
| Stroke Education | Cost of the measure outweighs the benefit of its continued use. |
| Assessed for Rehabilitation | Cost of the measure outweighs the benefit of its continued use. |

## Hospital Value-Based Purchasing Program Removed Measures

### Health Care-Associated Infection Measures

*Collected via Federal Data Registry*

| Measure Name | Removal Rationale |
|---|---|
| Catheter-Associated Urinary Tract Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Central Line-Associated Bloodstream Infection Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Harmonized Procedure Specific Surgical Site Infection SSI Outcome Measure | Duplicates measure in Hospital-Acquired Condition Reduction Program |
| Facility-wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measures | Duplicates measure in Hospital-Acquired Condition Reduction Program |

### Patient Safety Measure

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Patient Safety and Adverse Events Composite | Duplicates measure in Hospital-Acquired Condition Reduction Program |

### Patient Safety Measure

*Collected via chart abstraction*

| Measure Name | Removal Rationale |
|---|---|
| Elective Delivery | Cost of the measure outweighs the benefit of its continued use and duplicates measure in the Hospital Inpatient Quality Reporting Program. |

### Resource Use and Payment Measures

*Collected via claims*

| Measure Name | Removal Rationale |
|---|---|
| Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction | Duplicates measure in the Hospital Inpatient Quality Reporting Program and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure | Duplicates measure in the Hospital Inpatient Quality Reporting Program and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |
| Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia | Duplicates measure in the Hospital Inpatient Quality Reporting Program and measure data are also captured under a more broadly applicable measure (Medicare Spending Per Beneficiary). |

## Hospital Readmissions Reduction Program (HRRP) Removed Measures

### Structural Measures

*Collected via web-based tool*

| Measure Name | Removal Rationale |
|---|---|
| Oncology: Radiation Dose Limits to Normal Tissues | Measure performance is topped-out. |
| Oncology: Medical and Radiation – Pain Intensity Quantified | Measure performance is topped-out. |
| Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients | Measure performance is topped-out. |
| Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients | Measure performance is topped-out. |

### Health Care-Associated Infection Measures

*Collected via Federal Data Registry*

| Measure Name | Removal Rationale |
|---|---|
| Catheter-Associated Urinary Tract Infection Outcome Measure | Cost of the measure outweighs the benefit of its continued use. |
| Central Line-Associated Bloodstream Infection Outcome Measure | Cost of the measure outweighs the benefit of its continued use. |

## PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Removed Measures

### Structural Measures

*Collected via web-based tool*

| Measure Name | Removal Rationale |
|---|---|
| Oncology: Radiation Dose Limits to Normal Tissues | Measure performance is topped-out. |
| Oncology: Medical and Radiation – Pain Intensity Quantified | Measure performance is topped-out. |
| Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients | Measure performance is topped-out. |
| Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients | Measure performance is topped-out. |

### Healthcare-Associated Infection Measures

*Collected via Federal Data Registry*

| Measure Name | Removal Rationale |
|---|---|
| Catheter-Associated Urinary Tract Infection Outcome Measure | Cost of the measure outweighs the benefit of its continued use. |
| Central Line-Associated Bloodstream Infection Outcome Measure | Cost of the measure outweighs the benefit of its continued use. |

*Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html*