Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information[1]

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Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information CMS-1694-P

On April 24, 2018, the Centers for Medicare & Medicaid Services (CMS) proposed changes to empower patients through better access to hospital price information, improve the use of electronic health records, and make it easier for providers to spend time with their patients. The proposed rule issued today proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

The proposed policies in the IPPS and LTCH PPS proposed rule would further advance the agency's priority of creating a patient-centered healthcare system by achieving greater price transparency, interoperability, and significant burden reduction so that hospitals can operate with better flexibility and patients have what they need to become active healthcare consumers.

This fact sheet discusses major provisions of the proposed rule. The deadline for submitting comments on the proposed rule and the RFI is June 25, 2018. The proposed rule and the RFI (CMS-1694-P) can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-08705.pdf

Background on the IPPS and LTCH PPS

CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS sets base payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification – Medicare Severity Diagnosis-Related Groups (MS-DRGs) under the IPPS and Medicare Severity Long-Term Care Diagnosis-Related Groups (MS-LTC-DRGs) under the LTCH PPS – which are assigned at discharge.

By law, CMS is required to update payment rates for IPPS hospitals annually, and to account for changes in the prices of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital "market basket." The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area. Payment rates to LTCHs are typically updated annually according to a separate market basket based on LTCH-specific goods and services.

[1]Fact Sheet URL: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html; last accessed: May 11, 2018.

The proposed changes, which would apply to approximately 3,330 acute care hospitals and approximately 420 LTCHs, would affect discharges occurring on or after October 1, 2018.

Request for Information on Interoperability

In addition to payment and policy proposals, CMS is releasing a Request for Information to obtain feedback on positive solutions to better achieve interoperability or the sharing of healthcare data between providers. Specifically, CMS is requesting stakeholder feedback through a Request for Information on the possibility of revising Conditions of Participation related to interoperability as a way to increase electronic sharing of data by hospitals. This will inform next steps to advance this critical initiative. In the proposed rule, CMS is proposing to make changes to the EHR Incentive program to greater promote interoperability and to make the EHR Incentive program more flexible and less burdensome by placing a strong emphasis on measures that require the exchange of health information between providers and patients. This will inform the discussion on future regulatory action related to inpatient and long-term hospitals.

In responding to the RFI, commenters should provide clear and concise proposals that include data and specific examples. If the proposals involve novel legal questions, analysis regarding CMS' authority is welcome. CMS will not respond to RFI comment submissions in the final rule, but rather will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

Interoperability

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Eligible Hospitals, Critical Access Hospitals (CAHs), and Eligible Professionals (EPs)
In 2011, the Medicare and Medicaid EHR Incentive Programs were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology (CEHRT). In this rule, CMS is proposing to overhaul the Medicare and Medicaid Electronic Health Record Incentive Programs (also known as the "Meaningful Use" program) in order to better achieve program goals.

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 the set of 16. We propose 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, we propose 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.

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

We are 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.

We are 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, we are re-naming the Meaningful Use program "Promoting Interoperability." In addition, we seek 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. We also propose to remove certain measures which do not emphasize interoperability and the electronic exchange of health information.

Puerto Rico Hospitals in the Medicare EHR Incentive Program
We are proposing to codify the program instructions we have issued to subsection (d) Puerto Rico hospitals and to amend our regulations under Parts 412 and 495 such that the provisions that apply to eligible hospitals would include subsection (d) Puerto Rico hospitals unless otherwise indicated. These proposals include a shorter EHR reporting period in CY 2017 as a result of last year's Hurricane Maria.

Transparency

Online posting of standard charges. Under current law, hospitals are required to establish and make public a list of their standard charges. In an effort to encourage price transparency by improving public accessibility of charge information, CMS is updating its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet.

Request for Information. Additionally, CMS is concerned that challenges continue to exist for patients due to insufficient price transparency, including patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits. We are seeking information from the public regarding 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; and 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.

Meaningful Measures

This proposed rule would reduce the number of measures acute care hospitals are required to report across the 5 quality and value-based purchasing programs. This proposal was arrived at after a careful and holistic review of all quality measures. Measures were proposed for removal if they were duplicative, "topped out" (meaning that the overwhelming majority of providers are performing highly on them), or excessively burdensome to report. The proposal was aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. Overall, the proposed rule would eliminate a significant number of measures hospitals are currently required to report and "de-duplicate" measures across hospital quality programs. These proposals will remove a total of 19 measures from the quality programs and will de-duplicate another 21 measures, while adopting 1 claims-based readmissions measure.

Hospital Inpatient Quality Reporting (IQR) Program
The Hospital IQR Program collects and publishes data on quality measures for the inpatient hospital setting. In the FY 2019 IPPS/LTCH PPS proposed rule, 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). 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.

Measure Name	Removal Rationale
Healthcare-Associated Infection Measures ***Collected via Federal Data Registry***	
Catheter-Associated Urinary Tract Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Central Line-Associated Bloodstream Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Harmonized Procedure Specific Surgical Site Infection SSI Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Patient Safety Measures ***Collected via Claims***	
Patient Safety and Adverse Events Composite (PSI 90)	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Structural Measures ***Collected via Web-Based Tool***	
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***	
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Hospital 30-Day, All-Cause, Risk-Standardization Mortality Rate Following Heart Failure Hospitalization	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	Measure is duplicative of measure in the Hospital Value-Based Purchasing Program.
Coordination of Care Measures ***Collected via Claims***	
Hospital 30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization	Measure is duplicative of measure in the Hospital Readmissions Reduction Program.
Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery	Measure is duplicative of measure in the Hospital Readmissions Reduction Program.
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Measure is duplicative of measure in the Hospital Readmissions Reduction Program.

Measure Name	Removal Rationale
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization	Measure is duplicative of measure in the Hospital Readmissions Reduction Program.
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	Measure is duplicative of 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)	Measure is duplicative of 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/Payment Measures ***Collected via Claims***	
Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Measure is duplicative of 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***	
Median Time from ED Arrival to ED Departure for patients 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***	
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/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.

Measure Name	Removal Rationale
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.

In addition, to align with the Medicare and Medicaid EHR Incentive Programs, CMS is proposing two changes in relation to the reporting of electronic clinical quality measures (eCQMs) in the Hospital IQR Program:

1. For the calendar year 2019 reporting period/FY 2021 payment determination, require that hospitals submit one, self-selected calendar quarter of discharge data for 4 eCQMs in the Hospital IQR Program measure set, which is a continuation of the same reporting requirements previously adopted for the calendar year 2018 reporting period/FY 2020 payment determination; and
2. Require use of the 2015 Edition of certified electronic health record technology (CEHRT) for eCQMs beginning with the calendar year 2019 reporting period/FY 2021 payment determination.

CMS is also inviting public comment on two potential new quality measures for future inclusion in the Hospital IQR Program and on the potential future development and adoption of eCQMs generally. In addition, CMS is providing an update on accounting for social risk factors in the Hospital IQR Program; it 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

The Hospital VBP Program adjusts payments to IPPS hospitals for inpatient services based on their performance on an announced set of measures. In the FY 2019 IPPS/LTCH PPS proposed rule, CMS is proposing to implement updates to the Hospital VBP Program, including the removal of ten measures, all of which are also included in the Hospital IQR and/or HAC Reduction Program measure sets, and revised weighting of the Hospital VBP Program domains. 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. In this proposed rule, CMS proposes the following:

1. De-duplicate 10 measures:
   a. Remove all seven healthcare associated infection and patient safety measures from the Safety domain, as they are already in the HAC Reduction Program; and
   b. Remove three condition-specific payment measures from the Efficiency and Cost Reduction domain, as they are already in the Hospital IQR Program, while retaining the Medicare Spending per Beneficiary-Hospital measure; and
2. In conjunction with the proposed removal of the measures from the program, revise the program's domain weighting beginning with the FY 2021 program year by increasing the weight of the Clinical Care domain in calculating hospitals' total performance scores.

Measure Name	Removal Rationale
Healthcare-Associated Infection Measures ***Collected via Federal Data Registry***	
Catheter-associated Urinary Tract Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Facility-wide Inpatient Hospital-onset *Clostridium Difficile* Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Central Line-Associated Bloodstream Infection Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Harmonized Procedure Specific Surgical Site Infection SSI Outcome Measure	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.

Measure Name	Removal Rationale
Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measures	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Patient Safety Measure ***Collected via Claims***	
Patient Safety and Adverse Events Composite	Measure is duplicative of measure in Hospital-Acquired Condition Reduction Program.
Patient Safety Measure ***Collected via Chart Abstraction***	
Elective Delivery	Cost of the measure outweighs the benefit of its continued use and duplicative of measure in the Hospital Inpatient Quality Reporting Program.
Resource Use/Payment Measures ***Collected via Claims***	
Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction	Measure is duplicative of 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	Measure is duplicative of 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	Measure is duplicative of 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-Acquired Conditions (HAC) Reduction Program

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 percent to all subsection (d) hospitals that rank in the worst-performing 25 percent of all eligible hospitals. In the FY 2019 IPPS/LTCH PPS proposed rule, 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 our methodology and address concerns raised by small hospitals.

Measures under the HAC Reduction Program would remain the same.

Hospital Readmissions Reduction Program (HRRP)

The HRRP provides an incentive for hospitals to provide high quality patient care by reducing applicable IPPS hospital payments by up to 3 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.

Measures under the HRRP would remain the same.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

In the FY 2019 IPPS/LTCH PPS proposed rule, CMS is proposing to collect a new measure, and remove six

previously-adopted measures. 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. Specifically, the proposed rule proposes to:

1. Adopt one new claims-based hospital 30-day unplanned readmission outcome measure beginning with the FY 2021 program year, and;
2. 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.

Measure Name	**Removal Rationale**
Structural Measures ***Collected via Web-Based Tool***	
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***	
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.

Long Term Care Hospital Quality Reporting Program (LTCH QRP)

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

- For the FY 2019 IPPS/LTCH PPS proposed rule, the LTCH QRP has prepared the following proposals to address the Meaningful Measures initiative goal of a parsimonious measure set that focuses on the most critical quality issues with the least burden for clinicians and providers. 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. CMS will continue to work with stakeholders on these operational challenges and may consider these measures for future use if they can be reported with lower burden.
- 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)

Federal Registry (NHSN)	
Measure Name	**Rationale**

CDC – Methicillin Resistant Staph Aureus Infection	The cost associated with the measure outweighs the benefit of its continued use and a measure that is more strongly associated with desired patient outcomes for the particular topic is available
CDC – Ventilator-Associated Events	An applicable measure for the particular topic is now available and was finalized for adoption in the FY 2018 IPPS/LTCH PPS
CMS Assessment Instrument	
Patient Influenza Vaccination Measure	The cost associated with the measure outweighs the benefit of its continued use.

Further, CMS is proposing to:

- Update to the methods by which LTCHs are notified of non-compliance with the requirements of the LTCH QRP.

In addition, CMS is seeking comment on:

- Moving the implementation of modifications to the LTCH CARE Data Set from April to October.

Burden Reduction

This rule proposes a variety of changes in response to suggestions from stakeholders on ways to reduce burden for hospitals. Overall, the rule would reduce the number of hours hospitals spend on paperwork by well over 2 million hours. In addition to proposals that would reduce the number of measures acute care hospitals are required to report across the 5 quality and value-based purchasing programs CMS is proposing to reduce burden by easing documentation requirements and providing flexibility in several areas, while still maintain patient and program integrity protections where they are needed. Specifically, CMS is proposing to:

- Remove the requirement that Part A certification statements detail *where* in the medical record the required information can be found.
- Reduce the number of denied claims for clerical errors in documenting physician admission orders by removing the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment.
- Provide more flexibility for new urban teaching hospitals to enter into Medicare Graduate Medical Education (GME) affiliation agreements, which allow hospitals to share full-time equivalent cap slots to accommodate the cross training of residents.
- Reduce documentation requirements by 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 requirements beginning in FY 2021.
- Revise our regulations to allow certain hospitals which are excluded from the IPPS (for example, LTCHs) to operate IPPS-excluded units (so long as such an arrangement would be allowed under the applicable hospital conditions of participation).
- Revise our regulations to allow that an IPPS-excluded satellite of an IPPS-excluded unit of an IPPS-excluded hospital would not have to comply with the separateness and control requirements so long as the satellite of the unit is not co-located with an IPPS hospital.

Innovation

Each year in the proposed rule, CMS addresses the applications for new technology add-on payments under the IPPS by presenting its evaluation and analysis of the applications. CMS does not make proposals in the rule, but rather describes any concerns it may have with regard to whether a particular technology meets the

criteria for payment as a new technology and seeks additional information as needed for use in making a decision on the applications in the final rule. Included among the 15 applications for new technology add-on payment for FY 2019 presented in this year's proposed rule are applications for Chimeric Antigen Receptor (CAR) T-cell therapy. Separately, for FY 2019, CMS is proposing to reassign CAR T-cell therapy to a higher-weighted MS-DRG, and is seeking comment on alternative MS-DRG assignment.

Proposed Changes to Payment Rates under IPPS

The proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 1.75 percent. This reflects the projected hospital market basket update of 2.8 percent reduced by a 0.8 percentage point productivity adjustment. This also reflects a proposed +0.5 percentage point adjustment required by legislation, and the -0.75 percentage point adjustment to the update required by the Affordable Care Act.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, 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 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.

Medicare Uncompensated Care Payments

CMS distributes a prospectively determined amount to Medicare disproportionate share hospitals based on their relative share of uncompensated care nationally. As required under law, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured individuals and other factors. In this rule, CMS is proposing to distribute roughly $8.25 billion in uncompensated care payments in FY 2019, an increase of approximately $1.5 billion from the FY 2018 amount due to both an increase in the CMS Office of the Actuary's estimate of payments that would otherwise be made for Medicare DSH and an updated estimate of the change in the percentage of uninsured individuals since 2014 based on the latest available data.

For FY 2019, CMS proposes to continue incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report into the methodology for distributing these funds. Specifically, for FY 2019, CMS proposes to use 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.

Proposed LTCH PPS Changes

Nationwide, most inpatients are treated in acute care hospitals, but some are admitted to LTCHs. In this proposed rule, CMS is proposing to update the LTCH PPS standard Federal payment rate by 1.15 percent. This is the payment rate applicable to LTCH patients that meet certain clinical criteria under the dual rate LTCH PPS payment system required by the Pathway for SGR Reform Act of 2013. Overall, based on the changes included in this proposed rule, CMS projects that LTCH PPS payments would decrease by approximately 0.1 percent, or $5 million in FY 2019, which reflects the continued phase-in of the dual payment rate system, which was recently extended through FY 2019 by the Bipartisan Budget Act of 2018.

In addition, CMS is proposing to eliminate the 25-percent threshold policy in a budget neutral manner. Under this proposal, the LTCH PPS standard Federal payment rate is adjusted by a factor (-0.9 percent) to maintain aggregate LTCH PPS payments at the estimated levels they would be in absence of this proposed change.

Rural Community Hospital Demonstration

The Rural Community Hospital Demonstration was originally authorized for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and extended for another 5-year period by sections 3123 and 10313 of the Affordable Care Act. Section 15003 of the Cures Act extended the demonstration for another 5-year period.

The demonstration is required to be budget neutral. Each year since 2004, CMS has included a segment specific to the demonstration program in the IPPS/LTCH PPS proposed and final rules. On an annual basis, this segment has detailed the status of the demonstration, as well as the methodology for ensuring budget neutrality. Each of the past 13 years, CMS has adjusted the IPPS rates by an amount sufficient to account for the added costs of the demonstration program, thus applying budget neutrality across the payment system as a whole rather than merely across the participants in the demonstration program.

In the FY 2019 IPPS/LTCH PPS proposed rule, we provide a summary of the previous legislative provisions and their implementation, as well as our final policies for implementation of the extension period authorized by the Cures Act. We also describe the budget neutrality methodology finalized in accordance with these policies, and identify the amount of the proposed adjustment to the IPPS rates for FY 2019.

Frontier Community Health Integration Project (FCHIP) Demonstration

Section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275), as amended by section 3126 of the Affordable Care Act, 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 Critical Access Hospitals are participating in the FCHIP Demonstration, which aims to test new models of health care delivery in the most sparsely populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. This Demonstration is for three years and it began on August 1, 2016.

In the FY 2019 IPPS/LTCH PPS proposed rule, we reiterate our previously announced policy to address the budget neutrality requirement for the demonstration in the event the demonstration is found not to have been budget neutral.

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