

A group of business professionals in a modern office setting with large windows. In the foreground, a man in a dark suit is looking towards the right. In the background, several other people are engaged in conversations, with one man holding a tablet. The office has a glass railing and a bright, airy atmosphere.

FY2019 IPPS/LTCH Final Rule

HFMA Executive Summary

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IPPS Operating Payment Rates to Increase 1.85%

- For most hospitals that successfully report quality measures and are meaningful users of EHRs, the proposed increase to operating payment rates is 1.85%
- The increase is the net result of a market basket update of 2.9%, less a negative 0.8% annual multi-factor productivity adjustment, an ACA required negative adjustment of 0.75%, and a positive adjustment of 0.5% required under MACRA

Factor	% Change
FY2019 Market Basket Update	2.9
Multi-factor productivity adjustment	-0.8
ACA adjustment	-0.75
Subtotal	1.35
MACRA documentation and coding adjustment	+0.5
Net increase before budget neutrality factors applied	1.85

Program and Policy Impacts on Payments

- **Hospital Readmissions Reduction Program (HRRP):** The HRRP program will reduce FY 2019 payments to an estimated for 2,559 hospitals, compared to 2,591 hospitals penalized in FY2018. Estimated savings from the program will be approximately \$566 million in FY 2019, or about the same as FY 2018.
- **Low Volume Hospitals:** Medicare payments will increase by \$75 million in FY 2019 compared to FY2018. 628 providers will receive approximately \$426 million in FY 2019, compared to 612 providers receiving approximately \$350 million in FY 2018.
- **Medicare DSH:** Traditional payments are expected to be \$16.339 billion. Medicare payments for uncompensated care costs are estimated to increase 22.3 percent (\$1.5 billion) due to changes in the number of uninsured individuals in FY 2019.
- **Uncompensated Care:** Uncompensated care payments will increase by approximately \$1.5 billion

Hospital VBP Program Measure Updates

CMS will adopt for the Hospital VBP Program the Hospital Inpatient Quality Reporting (IQR) Program's list of seven factors for removal of measures. It will also add an eighth factor, which will also be added to the Hospital IQR Program:

1. The measure is “topped out”
 2. It does not align with current clinical guidelines or practice
 3. Another more broadly applicable measure is available
 4. Performance or improvement on the measure does not result in better patient outcomes
 5. Another available measure is more strongly associated with patient outcomes
 6. Collection or public reporting of the measure leads to negative unintended consequences
 7. It is not feasible to implement the measure specifications
 8. Costs associated with a measure outweigh the benefit of its continued use (new)
- A measures will promptly be removed from the Hospital VBP Program without rulemaking if CMS believes the measure poses specific patient safety concerns.

Hospital VBP Program Measure Updates

- CMS will retain the patient safety domain and six of the measures from that domain in the VBP Program.
- CMS is not finalizing its proposals to remove the CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, CDI, or PSI 90 measures, beginning with the FY 2021 program year.
- The elective delivery measure (0469) is finalized for removal, beginning with the FY 2021 program year.
- The AMI Payment, HF Payment, and PN Payment measures will be removed from the VBP Program effective with the effective date of the final rule (10/1/18).
- The total number of VBP Program measures for FY 2021 is reduced from 15 to 12 measures.
- In FY 2022, there will be 13 measures, as the COPD mortality measure is will be added to the program.

Hospital VBP Program Domain Updates

- CMS will change the name of the Clinical Care domain to “Clinical Outcomes” beginning in FY 2020.
- CMS will not adopt its proposal to reweight the Clinical Outcomes domain at 50 percent.
- All four current domains will remain for the VBP Program, and will each continue to be weighted equally at 25 percent.

Impact of Meaningful Measures Initiative

- Launched in October 2017, Meaningful Measures is part of CMS's effort to reduce regulatory burdens.
- CMS is taking a holistic approach in evaluating the Hospital VBP Program, Hospital Readmissions Reduction Program, and Hospital Acquired Conditions Reduction Program together.
- While CMS proposed that the Hospital VBP Program should focus on measurement priorities not covered by the HRRP or the HAC Reduction Program, based on the comments on this proposal, it now believes that duplication of patient safety measures in the HAC Reduction Program and the VBP Program is appropriate.

Impact of Meaningful Measures Initiative

- Three measures finalized for removal from the Hospital VBP Program in FY 2019:
 - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction(NQF #2431)
 - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure (NQF #2436)
 - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (NQF #2579)
- One measure finalized for removal from the Hospital VBP Program in 2021:
 - Elective Delivery (NQF #0469) (PC-01) - beginning with FY 2021 program year
- The total number of VBP Program measures for FY 2021 is reduced from 15 to 12.
- Beginning in FY 2022, there will be 13 measures, with the addition of the COPD mortality measure that year.

Hospital VBP Program Domains and Weighting

- CMS will not remove the safety domain beginning with FY 2021 payment.
- CMS will change the name of the Clinical Care domain to “Clinical Outcomes” beginning in FY 2020.
- CMS will not adopt its proposal to reweight the Clinical Outcomes domain at 50 percent.
 - All four current domains will remain for the VBP Program, and each will continue to be weighted equally at 25 percent.

Changes to Hospital Inpatient Quality Reporting (IQR) Program

- CMS finalizes its proposal to remove 39 measures from the Hospital IQR Program for FYs 2020 through 2023 payment determinations.
- 19 of these measures will continue to be used in either the HRRP, the Hospital VBP Program, or the HAC Reduction Program.
 - Hospital-specific performance on these 19 measures will still be reported on *Hospital Compare*.
- The removal aligns with CMS's Meaningful Measure Initiative to streamline data reporting and remove duplicative measures.
- CMS responded to comments and noted it will consider them as it develops future policy regarding the potential inclusion of two new measures to the Hospital IQR Program:
 - Hospital-wide mortality
 - Opioid-related adverse events

Revisions Regarding Admission Order Documentation Requirements

- CMS finalizes its proposal to revise the regulation at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.
- CMS expressed concern with denials of payment for medically necessary inpatient admissions due to technical discrepancies with the documentation of admission orders.
- If the hospital is operating in accordance with the hospital conditions of participation (CoPs), medical reviews should focus on whether the admission was medically reasonable and necessary, not on occasional, inadvertent signature documentation issues.
- The requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission will not change.

Changes to EHR Incentive Programs

- The Medicare and Medicaid EHR Incentive Programs has been renamed the Medicare and Medicaid Promoting Interoperability Programs.
- Hospitals that are not meaningful EHR users under the Medicare Promoting Interoperability Program are subject to a reduction of 2.175 percent in the update factor for FY 2019.
- Eligible hospitals and CAHs are still required to use EHR technology certified to the 2015 Edition of Certified EHR Technology (CEHRT).
- For 2019 and 2020, program participants must attest to meaningful use to CMS or to the state for a minimum reporting period of any continuous 90-day period during the calendar year (2019 or 2020, respectively).

Changes to EHR Incentive Programs

- CMS adopts major changes to the scoring system used to determine whether an eligible hospital or CAH has met the meaningful use requirements beginning with the 2019 reporting period.
- The new methodology requires eligible hospitals and CAHs to report on four objectives and six measures. A score of 50 points or more will satisfy the meaningful use requirement.
 - Eligible hospitals and CAHs earning a score of less than 50 points will not be considered meaningful users.
- New objectives and measures include:
 - e-Prescribing (1 to 3 measures; 5 to 15 points; includes 2 optional new measures)
 - Health Information Exchange (2 measures; 40 points)
 - Provider to Patient Exchange (1 measure; 40 points)
 - Public Health Data Exchange (2 measures; 10 points)

Price Transparency

- CMS expresses concern that insufficient price transparency continues to challenge patients, particularly in areas of surprise out-of-network bills and unhelpful chargemaster data.
- Upon request in the proposed rule, CMS received comments on how hospitals and other providers can provide useful information to help consumers understand the costs of health care services.
- In order to promote greater price transparency, CMS will update guidelines to require hospitals to make a list of current standard charges available via internet in a machine-readable format, updated at least annually. This is the only change that it is making at this time.

Electronic Interoperability

- For 2019 and 2020, Medicare and Medicaid Promoting Interoperability Program participants must attest to meaningful use to CMS or to the state for a minimum reporting period of any continuous 90-day period during CY 2019 or CY 2020, respectively.
- CMS requested public comment on the future direction of the Promoting Interoperability Programs.
- Although it received approximately 313 timely comments, it did not summarize nor responded to them.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

- Four cancer-related measures will be removed from the PCHQR Program beginning with FY 2021 because CMS considers them to be “topped out”:
 - Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382)
 - Oncology: Pain Intensity Quantified (NQF #0384)
 - Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389)
 - Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)
- A final decision on removal of two infection measures under the new cost removal factor 8 is deferred most likely until the 2019 Hospital OPPS final rule:
 - NHSN CLABSI (NQF #0139)
 - NHSN CAUTI (NQF #0138)

The following new claims-based measure will be added to the program:

- 30-Day Unplanned Readmissions for Cancer Patients (NQF #3188).

Long Term Care Hospital Updates

- **Annual Payment Increase:** FY 2019 update for hospitals submitting quality data is 1.35%, reflecting a market basket increase of 2.9%, minus 0.8% MFP, and 0.75% ACA reduction.
 - LTCHs failing to submit data to the LTCH QRP, will see a 2.0% (-0.65%) reduction in the annual update
- **Payment Rate Impact:** Overall impact of the payment rate and policy changes, for all LTCHs from FY 2018 to FY 2019, will be an increase 0.9 percent or \$39 million in aggregate payments (from \$4.502 billion to \$4.540 billion).
- **High-Cost Outlier (HCO) Case Payments:** Established threshold is \$27,124
- **Fixed-Loss Amount:** The FY 2019 fixed-loss amount of \$27,124; for site neutral cases; \$25,769

Long Term Care Hospital Updates

Elimination of the “25-Percent Threshold Policy” Adjustment: CMS is eliminating the 25% threshold policy because aggregate LTCH PPS payments are sufficient.

- The agency is working to make elimination of this policy budget neutral in order to ensure that elimination of the policy does not increase aggregate LTCH PPS payments in FY 2019 and future years.
- **Long-Term Care Hospital Quality Reporting Program:** Three measures are finalized for removal from the LTCH QRP measure set. Removal of these measures are estimated to reduce costs by \$1,149 per LTCH annually, or \$482,469 for all LTCHs.

For More Information

- Read a full summary of the final rule.
- Read the full text of the final rule.

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