

A photograph of a modern office interior with large windows. Several business professionals in business attire are engaged in a meeting. In the foreground, a man in a dark suit is gesturing with his hand while talking to another man. In the background, a group of people are gathered around a table, looking at documents. The office has a glass railing and a bright, airy atmosphere.

# FY2019 IPPS/LTCH Proposed Rule

## HFMA Executive Summary

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# IPPS Operating Payment Rates to Increase 1.75%

- For most hospitals that successfully report quality measures and are meaningful users of EHRs, the proposed increase to operating payment rates is 1.75%
- The increase is the net result of a market basket update of 2.8%, 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	2.8
Multi-factor productivity adjustment	-0.8
ACA adjustment	-0.75
Subtotal	1.25
MACRA documentation and coding adjustment	+0.5
Net increase before budget neutrality factors applied	1.75

# Program and Policy Impacts on Payments

- **Hospital Readmissions Reduction Program (HRRP):** The HRRP program would reduce FY2019 payments to an estimated 2,610 hospitals, compared to 2,591 hospitals penalized in FY2018. Estimated savings to CMS will be \$566 million in FY2019, comparable to the \$564 million estimated in FY2018
- **Low Volume Hospitals:** Medicare payments increase by an estimated \$72 million in FY2019 compared to FY2018. 622 providers would receive approximately \$417 million, compared to 606 providers receiving \$345 million in FY2018.
- **Medicare DSH:** Traditional DSH payments increase an estimated 4.8 percent (about \$140 million).
- **Uncompensated Care:** Uncompensated care cost payments are estimated to increase 21.9% (\$1.484 billion), due to changes in the number of uninsured individuals in FY2019.

# Hospital VBP Program – Removal of Measures

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

# 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.
- CMS believes the Hospital VBP Program should measure priorities not measured by HRRP or HAC Reduction Program.
- Accordingly, CMS proposes 10 measures for removal from the Hospital VBP Program.
- Under the proposed rule, the total number of VBP Program measures for FY2021 would go down from 15 to 7 measures.

# Changes to Hospital VBP Program Domains and Weighting

- CMS proposes removal of the safety domain beginning with FY2021 payment. Current measures are proposed for removal then, no new measures are proposed, and the HAC Reduction Program focuses on the safety aspect of care quality.
- CMS proposes to change the name of the Clinical Care Domain to Clinical Outcomes beginning with FY2020.
- New proposed weighting would be 50% for Clinical Outcomes, 25% for Person and Community Engagement (HCAHPS), and 25% for Efficiency/Cost Reduction (Medicare spending per beneficiary, or MSPB).
- The greater weight given to Clinical Outcomes should move large, urban, teaching and safety net hospitals closer to the average Total Performance Score (TPS).



# Changes to Hospital Inpatient Quality Reporting (IQR) Program

- CMS proposes removal of 39 measures from the Hospital IQR Program from FY2020 through FY2023 payment determinations. 19 of these measures would still be used in the HRRP, Hospital VBP Program, or HAC Reduction Program.
- The proposed removal aligns with CMS's Meaningful Measure Initiative to streamline data reporting and remove duplicative measures.
- CMS seeks public comment on the proposed addition of two new measures to the Hospital IQR Program:
  - Hospital-wide mortality
  - Opioid-related adverse events

# Revisions Regarding Admission Order Documentation Requirements

- CMS notes concern with denials of payment for medically necessary inpatient admissions due to technical discrepancies with the documentation of admission orders.
- Accordingly, 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.
- CMS proposes a revision to 42 CFR §412.3(a) to remove 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 receive Medicare Part A payments. Documentation of relevant orders in the medical record is already required to substantiate medical necessity requirements.
- CMS's proposal will not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission.



# Changes to EHR Incentive Programs

- The Medicare and Medicaid EHR Programs have been renamed the Medicare and Medicaid Promoting Interoperability Programs.
- CMS proposes no changes to its previously finalized policy requiring eligible hospitals and CAHs to use EHR technology certified to the 2015 Edition of Certified EHR Technology (CEHRT).
- CMS proposes a new scoring methodology and new measures for the program. The current scoring system requires reporting on 6 objectives and 16 measures. The new methodology would include 4 objectives and 6 measures.
- New objectives and measures would 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; 35 – 40 points)
  - Public Health Data Exchange (2 measures; 10 points)
- CMS also seeks public comment on the future direction of the Promoting Interoperability Programs.

# Price Transparency

- CMS expresses concern that insufficient price transparency continues to challenge patients, including in the areas of surprise out-of-network bills and unhelpful chargemaster data.
- CMS is updating guidelines to require hospitals to make a list of current standard charges available via internet in a machine-readable format, updated at least annually.
- CMS also seeks public comment on related issues, including:
  - The proper definition of “standard charges”
  - Information most beneficial to patients
  - A requirement that hospitals inform patients of out-of-pocket costs before a service is provided
  - The role of providers in informing patients of out-of-pocket obligations
  - A requirement that providers give patients information on what Medicare pays for a particular service
  - Appropriate mechanisms for CMS to enforce price transparency

# For More Information

- Read a [full summary](#) of the proposed rule:
- Read the full [text](#) of the proposed rule:

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