CALIFORNIA HOSPITAL ASSOCIATION

Federal Regulatory Summary

from the California Hospital Association

SUMMARY OF PROPOSED RULE — MAY 2019

FFY 2020 Medicare Inpatient Prospective Payment System

Overview

In the May 3 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule addressing rate updates and policy changes to the Medicare inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) prospective payment system (PPS) for federal fiscal year (FFY) 2020. The policy and payment provisions, if finalized, would be effective for FFY 2020 discharges, beginning October 1.

The following is a comprehensive summary of the proposed rule's provisions. Payment and policy changes related to the FFY 2020 LTCH PPS are addressed in a separate summary.

The proposed rule reflects annual updates to Medicare fee-for-service (FFS) inpatient payment rates and policies, as well as:

- Significant changes to the methodology for computing the area wage index intended to reduce the growing disparity between high- and-low-wage index hospitals. This proposal will adversely impact California hospitals and post-acute care providers, which stand to lose more than $100 million in hospital inpatient payments alone.
- Updates to Medicare disproportionate share hospital (DSH) payment policies
- Updates to program rules for the Value-Based Purchasing Program (VBP), Readmissions Reduction Program (RRP) and Hospital-Acquired Condition (HAC) Reduction Program
- Updates to payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive programs

To Comment

Comments are due to CMS June 24 by 2 p.m. (PT) and can be submitted electronically at www.regulations.gov; search the site for "CMS-1716-P."

Member Forum

Register for CHA's FFY 2020 IPPS member forum at 10 a.m. (PT) on June 11 to learn more about these policies and provide input for CHA's comments. Register by noon (PT) on June 10 at www.surveymonkey.com/r/TBR3NC3.

For Additional Information

Questions about this summary should be directed to Alyssa Keefe, vice president, federal regulatory affairs, at (202) 488-4688 or akeefe@calhospital.org. A CHA DataSuite analysis will be sent under separate cover. Questions about CHA DataSuite should be directed to Ronald Yaw, vice president, finance and economic analysis, at ryaw@calhospital.org or (916) 552-7695.

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FFY 2020 Payment Changes

The table below lists the federal operating and capital rates finalized for FFY 2020 compared to the rates currently in effect for FFY 2019. These rates include all market basket increases and reductions, as well as the application of an annual budget neutrality factor. These rates do not reflect hospital-specific adjustments, such as penalty for non-compliance under the IQR Program or EHR Meaningful Use Program, quality penalties/payments, disproportionate share hospital (DSH), etc.

	Final FFY 2019	Proposed FFY 2020	Percent Change
Federal Operating Rate	$5,646.08	$5,823.30	+3.14%
Federal Capital Rate	$459.41	$463.81	+0.96%

The table below provides details for proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2020.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Market Basket Update/Capital Input Price Index	+3.2%		1.5%
ACA-Mandated Reductions 0.5 percentage point (PPT) productivity reduction	-0.5 PPT		—
MACRA-Mandated **Retrospective** Documentation and Coding Adjustment	+0.5%	—	—
Annual Budget Neutrality Adjustment	-0.07%		-0.53%
Net Rate Update	*+3.14%*	*+2.63%*	*+0.96%*

Retrospective Coding Adjustment

CMS proposes to apply a retrospective coding adjustment of 0.5% to the federal operating rate in FFY 2020 as part of the third year (of six) of rate increases tied to the American Taxpayer Relief Act (ATRA). The coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by $11 billion over a four-year period, resulting in a cumulative rate offset of approximately negative 3.2%.

Effects of the IQR and EHR Incentive Programs

Beginning in FFY 2015, the IQR market basket penalty changed from negative two percentage points to a 25% reduction to the full market basket. The same year, the EHR meaningful use penalty began its three-year phase-in, starting at 25% of the full market basket; beginning with FFY 2017, the EHR meaningful use penalty is capped at 75%. As a result of the two penalty programs, the full market basket update is at risk. The following table displays the various update scenarios for FFY 2020.

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3.2% Market Basket minus 0.5 PPT productivity)	+2.7%			
Penalty for Failure to Submit IQR Quality Data (25% of the base Market Basket Update of 3.2%)	—	-0.8 PPT	—	-0.8 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base Market Basket Update of 3.2%)	—	—	-2.4 PPT	-2.4 PPT
Adjusted Net Market Basket Update (prior to other adjustments)	*+2.7%*	*+1.9%*	*-0.3%*	*-0.5%*

CMS estimates certain hospitals will not receive the full market basket rate-of-increase, including 39 that failed the quality data submission process or chose not to participate in the IQR program, and 211 that are not meaningful EHR users. CMS also estimates 32 hospitals will be subject to both reductions.

Impact Analysis

Detailed impact estimates are displayed in Table I (pages 19,624-19,630) of the proposed rule, which is partially reproduced below.

Hospital Type	All Proposed Rule Changes
All Hospitals	3.5%
Urban	3.5%
Urban – Pacific Region	4.1%
Rural	3.6%
Rural – Pacific Region	3.6%
Major Teaching	3.5%

CHA DataSuite analysis estimates that California hospitals will experience a slight increase of 1.7% in overall Medicare hospital inpatient payments in FFY 2020, as compared to FFY 2019. However, the impact varies significantly across hospitals and will vary dramatically by core-based statistical area (CBSA) as a result of the proposed changes to the area wage index noted below.

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2019 IPPS Payments	**$11,348,242,100**		**$856,228,000**		**$12,204,470,200**	
Provider Type Changes	$0	0.0%	($3,345,200)	-0.4%	($3,345,200)	0.0%
Marketbasket Update (Includes Budget Neutrality)	$353,325,700	3.1%	$10,185,300	1.2%	$363,511,600	3.0%
ACA-Mandated Marketbasket Reductions	($53,571,400)	-0.5%	*Not Applicable*		($53,571,400)	-0.4%
MACRA-Mandated Coding Adjustment	$54,017,000	0.5%	*Not Applicable*		$54,017,000	0.4%
Wage Index/GAF	$135,946,800	1.2%	$9,661,400	1.1%	$145,610,200	1.2%
Reducing Wage Index Disparities	($119,275,100)	-1.1%	($9,099,000)	-1.1%	($128,373,400)	-1.1%
> Increasing Bottom Quartile Wage Index Values	$0	0.0%	$0	0.0%	$0	0.0%
> Reducing Top Quartile Wage Index Values	($102,560,800)	-0.9%	($7,256,200)	-0.8%	($109,816,000)	-0.9%
> Application of 5% Stop Loss Adjustment	$2,143,700	0.0%	$153,200	0.0%	$2,296,800	0.0%
> Budget Neutrality Due to 5% Stop-Loss	($18,858,600)	-0.2%	($1,997,100)	0.0%	($20,855,800)	-0.2%
DSH: UCC Payment Changes [1]	($192,245,900)	-1.7%			($192,245,900)	-1.6%
> DSH UCC Distribution Factor Change	($210,935,000)	-1.9%	*Not Applicable*		($210,935,000)	-1.7%
Change in Hospital Specific Rate	$0	0.0%			$0	0.0%
MS-DRG Updates	$14,227,100	0.1%	$1,044,100	0.1%	$15,270,000	0.1%
Quality Based Payment Adjustments [2]	$802,900	0.0%	($100,200)	0.0%	$701,600	0.0%
Net Change due to Low Volume Adjustment	$2,400,700	0.0%	$154,600	0.0%	$2,555,100	0.0%
Estimated FFY 2020 IPPS Payments	**$11,543,873,400**		**$864,729,000**		**$12,408,601,400**	
Total Estimated Change FFY 2019 to FFY 2020¥	***$195,631,300***	***1.7%*** ▲	***$8,501,000***	***1.0%*** ▲	***$204,131,600***	***1.7%*** ▲

¥ The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2027. It is estimated that sequestration will reduce FFY 2020 IPPS-specific payments by: $248,173,000.

Outlier Payments

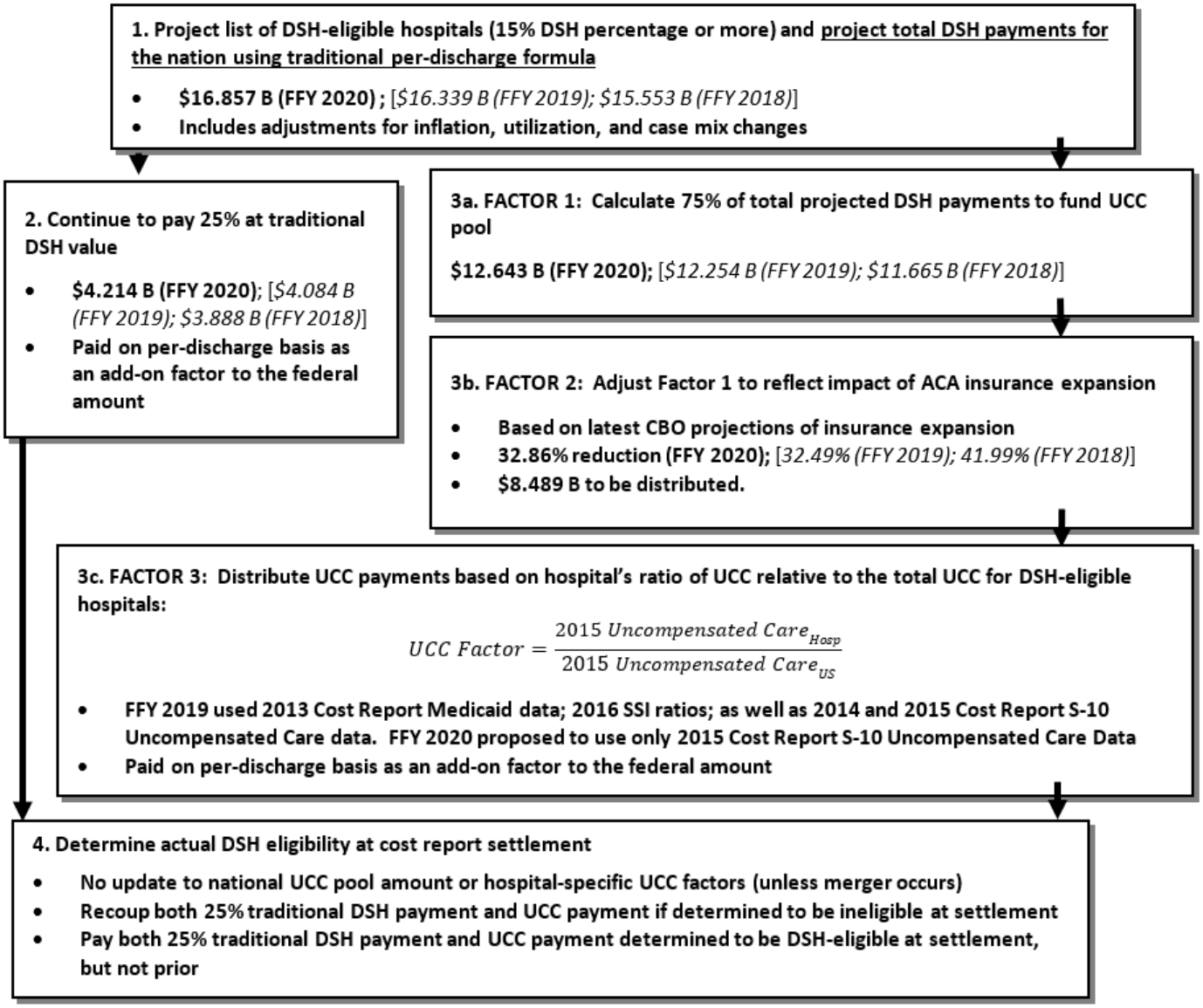
Due to prior concerns over CMS' decision to not consider outlier reconciliation in the outlier threshold development for a given fiscal year, CMS now believes incorporating historic cost report outlier reconciliations when developing the threshold is a reasonable approach and would provide a better predictor for upcoming fiscal year. Therefore, for FFY 2020, CMS proposes to incorporate total outlier reconciliation dollars from the FFY 2014 cost reports into the outlier model.

To maintain outlier payments at 5.1% of total IPPS payments, CMS proposes an outlier threshold of $26,994 for FFY 2020. The proposed threshold is 4.75% higher than the FFY 2019 outlier threshold of $25,769.

Medicare DSH

The Affordable Care Act (ACA) mandates the implementation of new Medicare DSH calculations and payments to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75%, referred to as the uncompensated care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This pool is to be distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2019 to FFY 2020. More detailed information and background follows.



Background

Medicare makes DSH and UCC payments to IPPS hospitals that serve a number of low-income patients above a certain threshold. Low-income is defined as Medicare eligible patients also receiving supplemental security income (SSI) and Medicaid patients not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC, the proportion of inpatient days for each of these subsets of patients is used.

Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the ACA required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would be made under Section 1886(d)(5)(F) without application of the ACA
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the Secretary's estimates of the factors used to determine and distribute UCC. UCC payments are only made to hospitals eligible to receive DSH payments that are paid using the national standardized amount; sole community hospitals (SCHs) paid on the basis of hospital-specific rates, hospitals not paid under the IPPS, and hospitals in Maryland paid under a waiver are ineligible to receive DSH and, therefore, UCC payments.

Proposed FFY 2020 Factor 1

CMS estimates this figure based on the most recent data available and does not adjust it at a later date based on actual data. For FFY 2020, CMS uses the Office of the Actuary's (OACT) December 2018 Medicare DSH estimates, which were based on the September 2018 update of the Healthcare Cost Report Information System (HCRIS) and the FFY 2019 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's December 2018 Medicare estimate of DSH is $16.857 billion. **The proposed Factor 1 amount is 75% of this, or $12.643 billion** — about $389 million more than the final Factor 1 for FFY 2019.

Proposed FFY 2020 Factor 2

Factor 2 adjusts Factor 1 based on the percent change in the uninsured since implementation of the ACA. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of Congressional Budget Office data as the source of change in the uninsured population. The NHEA estimate reflects the rate of uninsurance in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or the District of Columbia.

For FFY 2020, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14%; for calendar years (CYs) 2019 and 2020, that rate is estimated to be 9.4%. As required, the Chief Actuary of CMS certified these estimates.

Using these estimates, CMS calculates the proposed Factor 2 for FFY 2020 (weighting the portion of CYs 2019 and 2020 included in FFY 2020) as follows:

Percent of individuals without insurance for CY 2013: 14%
Percent of individuals without insurance for CY 2019: 9.4%
Percent of individuals without insurance for CY 2020: 9.4%
Percent of individuals without insurance for FY 2020 (0.25 times 0.094) + (0.75 times 0.094): 9.4%

Proposed Factor 2 = 1-|((0.094-0.14)/0.14)| = 1- 0.3286 = 0.6714 (67.14%)

CMS calculates Factor 2 for the FFY 2020 proposed rule to be 0.6714 or 67.14%, and the UCC amount for FFY 2020 to be $8.489 billion ($12.643 billion x 0.6714), about $216 million more than the FFY 2019 UCC total of about $8.273 billion; the percentage increase is 2.6%.

Proposed Factor 3 for FFY 2020

Factor 3 equals the proportion of hospitals' aggregate uncompensated care attributable to each IPPS hospital (including Puerto Rico hospitals). The product of Factors 1 and 2 determines the total pool available for UCC payments. This result multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

Proposal to Use Audited FFY 2015 Data

CMS discusses the feedback from commenters, including CHA, emphasizing the importance of audits to ensure data are reported accurately and consistently on Worksheet S-10. In response, CMS audited the cost reports for FFY 2015 Worksheet S-10 for 600 hospitals, representing a significant portion of UCC payments from August 2018 through January 31, 2019.

In the proposed rule, CMS expresses concern over using three years of data — which includes both audited and unaudited data — in calculating Factor 3 for FFY 2020, as this could result in fluctuation year over year. According to CMS, using three years of data could introduce unnecessary variability; in fact, its analysis indicates that about 10% of audited hospitals have a difference greater than $20 million between their audited FFY 2015 data and their unaudited FFY 2016 data. However, it is unclear to CHA whether the data CMS analyzed reflect the reversal of a recent MAC audit adjustment. This adjustment, known as the "expected vs. actual adjustment," was included in the HCRIS file submitted by MACs, but was later removed following successful advocacy by CHA and other hospitals around the country. CHA's letter on this issue is available on our website at www.calhospital.org/sites/main/files/file-attachments/verma_worksheet_s-10_january_2019_updated_013119_2.0.pdf.

Due to the concerns noted above, CMS proposes to use a single year of Worksheet S-10 data, from FFY 2015 cost reports, to calculate Factor 3 in the FFY 2020 methodology. CMS notes that audited hospitals account for about half of the proposed total UCC payments for FFY 2020. CMS uses the most recent HCRIS extract available — updated through February 15, 2019 — but plans to update these data using the March 2019 HCRIS file for the final rule. CHA's review of the proposed rule data file indicates that the HCRIS data have not been updated to reflect the "expected vs. actual" adjustment that was reversed and, as such, the impact analysis may vary greatly by hospital in the final rule.

Alternative Proposal

CMS asks for feedback on an alternative to its proposed use of audited FFY 2015 data, acknowledging that some hospitals have raised concerns about adjustments made to the FFY 2015 cost reports following the audits. In addition, CMS made important changes to lines 20-22 of Worksheet S-10 related

to reporting charity care charges; these are effective for cost reporting periods beginning on or after October 1, 2016.

CMS seeks public comment on whether the changes in the reporting instructions between the FFY 2015 cost reports and the FFY 2017 cost reports have resulted in a better hospital understanding of UCC cost reporting, as well as whether the changes improved relative consistency and accuracy across hospitals in reporting these costs. CMS seeks comment on whether it should, due to the changes in the reporting instructions, instead use a single year of UCC cost data from the FFY 2017 reports to calculate Factor 3 for FFY 2020.

CMS notes that if its final policy uses Worksheet S-10 data from the FFY 2017 cost reports to determine Factor 3 for FFY 2020, it would use the March 2019 update of HCRIS for the final rule. CMS further notes that the proposed methodology for Factor 3 would be unchanged, regardless of whether FFY 2017 or FFY 2015 cost report data are used.

All-Inclusive Rate Providers

CMS believes it is no longer necessary to propose specific Factor 3 policies for all-inclusive providers as it did in the FFY 2019 IPPS/LTCH PPS final rule. CMS states that it has examined the cost-to-charge ratios CCRs from the FFY 2015 cost reports and believes the risk that the data are aberrant is mitigated by the proposal to apply trim methodologies to potentially aberrant UCC costs for all hospitals.

Scaling Factor

CMS does not propose to scale Factor 3 of all DSH-eligible hospitals, which would account for the averaging effect of using three years of data, as this is unnecessary because CMS proposes to use only one year of cost report data.

Proposed Steps to Trim CCRs

Similar to the FFY 2018 and 2019 processes, CMS proposes a series of steps for trimming CCRs in FFY 2020. There is a discrepancy in the proposed rule about how CMS plans to treat all-inclusive rate providers. As noted above, CMS does not propose specific Factor 3 policies for all-inclusive rate providers. However, CMS does include them in the trimming process outlined in the proposed rule.

California Impact of Proposed Medicare DSH Cuts

CHA DataSuite analysis estimates the California impact of the increasing pool of Medicare DSH dollars for FFY 2020 as a result of the increased number of uninsured, as compared to FFY 2019. This analysis reflects the FFY 2015 cost report data.

	FFY 2019	FFY 2020	Change
Total Funding for UCC Payments	$12.254 Billion	$12.643 Billion	+$0.389 Billion
ACA-Mandated Reduction	-32.49%	-32.86%	-0.37%
Redistribution Pool	**$8.273 Billion**	**$8.489 Billion**	**+$0.216 Billion**
Hospital Specific Payment Factor	Hospital-Specific		
Hospital UCC Payment Amount	**$717,466,700**	**$524,991,500**	**($192,245,900)**

Request for Public Comments on Ways to Reduce Provider Reimbursement Review Board (PRRB) Appeals Related to a Hospital's Medicaid Fraction Used in the DSH Payment Adjustment Calculation

CMS states that, as part of its ongoing efforts to reduce regulatory burden on providers, it is examining the backlog of appeals cases before the Provider Reimbursement Review Board (PRRB). A large number of appeals relate to the calculation of a hospital's disproportionate patient percentage (DPP), which is used to calculate the DSH payment adjustment. According to CMS, many hospitals annually appeal their cost reports to the PRRB in an effort to use updated state Medicaid eligibility data to calculate the Medicaid fraction.

CMS explores options that may prevent the need for such appeals and thus reduce the backlog. One solution CMS suggests is to develop regulations governing the timing of the data for determining Medicaid eligibility, similar to its existing policy on entitlement to Supplemental Security Income (SSI) benefits, which is determined at a specific time. Under this solution, a provider would submit a cost report with Medicaid days based on the best available Medicaid eligibility data at the time of the filing and could request a "reopening" when the cost report is settled, without filing an appeal. CMS would direct MACs to open cost reports for this issue at a specific time and set a realistic period during which the provider could submit updated data.

Another option CMS is exploring is allowing hospitals to, once per cost reporting period, resubmit a cost report with updated Medicaid eligibility information. This would be similar to CMS' existing DSH policy allowing hospitals a one-time option to have their SSI ratios calculated based on their cost reporting period rather than the federal fiscal year.

CMS seeks comments on the viability of these options, as well as any alternative approaches that could help reduce the number of DSH-related appeals and inform its future rulemaking efforts. In particular — with respect to the reopening option — CMS is interested in the optimal time (e.g., two years after cost report submission) for review of data to occur, balancing accurate payment and CMS' and the MACs' desire to settle cost reports in a timely manner.

Graduate Medical Education Payments

Teaching hospitals receive payments from Medicare to compensate them for their indirect medical education (IME) and direct graduate medical education (DGME) costs. These payments are based on the number of full-time equivalent (FTE) residents trained by the hospital subject to a cap based on the number of residents the hospital claimed for IME and DGME payment in 1996. For both IME and DGME, hospitals can count residents who train in non-provider sites if they incur the costs of the resident's salary and fringe benefits, and the resident is providing patient care. A non-provider site does not include a critical access hospital (CAH).

Under current CMS policy, CAHs that train residents in approved programs are paid at 101% of reasonable cost. CMS has heard concerns that CAHs may be too small to support residency training programs or may not be in a financial position to incur the associated costs. In light of these concerns, CMS reexamined and proposes to modify the statutory language associated with its policy that a CAH cannot be considered a "non-provider site." Specifically, CMS proposes that — for cost reporting periods beginning October 1, 2019 — a hospital could include residents training in a CAH in its FTE count as long as it meets the requirements for counting residents in non-provider sites.

The IME adjustment factor will remain at 1.35 for FFY 2020.

Updates to MS-DRGs

Each year, CMS updates the Medicare Severity-Diagnosis Related Group (MS-DRG) classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes adopted for the FFY 2020 MS-DRGs would leave the number of payable DRGs at 761. Only 56% of DRG weights will change by less than +/- 5%, with 17% changing by +/- 10% or more. The five MS-DRGs with the greatest year-to-year change in weight are:

MS-DRG	Final FFY 2019 Weight	Proposed FFY 2020 Weight	Percent Change
MS-DRG 796: VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	2.4608	+67.6%
MS-DRG 779: ABORTION W/O D&C	0.7543	1.1521	+52.7%
MS-DRG 619: O.R. PROCEDURES FOR OBESITY W MCC	2.9207	4.2690	+46.2%
MS-DRG 837: CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	7.6525	+42.4%
MS-DRG 838: CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	3.2131	+36.6%

The full list of finalized FFY 2020 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-NPRM-Table-5.zip.

For comparison, the FFY 2019 DRGs are available in Table 5 on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-Table-5.zip.

CMS discusses specific changes to the MS-DRGs for FFY 2020. Highlights of CMS' discussion are summarized below; more specific details are available in the final rule.

Chimeric Antigen Receptor (CAR) T-Cell Therapy

CAR T-cell therapy is a cell-based gene therapy in which a patient's T-cells are genetically engineered to add a chimeric antigen receptor on the T-cells that will bind to a certain protein on the patient's cancerous cells. The CAR T-cells are then administered to the patient by infusion. Procedures involving CAR T-cell therapy drugs are currently identified with ICD-10-PCS procedure codes XW033C3 (Induction of engineered autologous CAR T-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 3) and XW043C3 (Induction of engineered autologous CAR T-cell immunotherapy into central, percutaneous approach, new technology group 3).

In the proposed rule, CMS notes that it has received a request to create a new MS-DRG for procedures involving CAR T-cell therapies. The requestor suggested CMS modify its existing payment mechanisms to use a CCR of 1.0 for charges associated with CAR T-cell therapy and provided additional thoughts on the development of future billing and cost reporting guidelines and instructions.

In the FFY 2019 IPPS/LTCH final rule, CMS stated it would collect more comprehensive clinical and cost data before considering assignment of a new MS-DRG for these therapies. CMS reviewed the FFY 2018 MedPAR data file and found some claims that identify CAR T-cell therapies, but the number of cases was limited and the submitted costs varied widely. CMS still believes it may be premature to consider creation of a new MS-DRG for this therapy and thus does not propose to modify the current MS-DRG assignment for cases reporting CAR T-cell therapy for FFY 2020. CMS notes that, consistent with section 1886(d)(4)(C)(iii) of the Act, any new MS-DRG would be established in a budget-neutral manner.

CMS requests public comments on payment alternatives for CAR T-cell therapies, including payment under any potential new MS-DRG. CMS is interested in how these payment alternatives would affect both access to care and incentives to encourage lower drug prices.

Specifically, CMS requests comments on the following questions:

1. What is the most appropriate way to develop the relative weight of a new MS-DRG?
    - Should the current methodology for setting relative weights be used? CMS states it may be operationally possible to create a relative weight by dividing the average costs of cases including CAR T-cell procedures by the average costs of all cases.
    - Should cases in clinical trials be excluded? CMS states that the absence of drug costs on claims for cases involving clinical trials could have a significant impact on the relative weight.
    - Should an alternative relative weight be developed using the average sales price (ASP) instead of the costs involved in treating patients with CAR T-cell therapies?

2. Would it be appropriate to geographically adjust payment under a new MS-DRG?
   CMS discusses the current methodology for determining the federal payment rate for operating costs under the IPPS. Using this methodology, the labor-related proportion of the national standardized amounts is adjusted by the wage index to reflect the relative differences in labor costs among geographic areas. The IPPS federal payment rate for operating costs is calculated as the MS-DRG relative weight x [(labor-related applicable standardized amount x applicable wage index) + (nonlabor-related applicable standardized amount x cost-of-living adjustment)].

CMS' understanding is that the costs for CAR T-cell therapy do not vary among geographic areas and, given that the costs for the therapy would be an extremely high portion of the costs of the MS-DRG, a geographic adjustment might not be appropriate. CMS acknowledges that other drug costs might not vary among geographic areas, but these do not represent as significant a percentage of the average costs for the case.

- Should CMS geographically adjust the payment for cases assigned to a new MS-DRG?
- Should CMS apply the geographic adjustment to a lower proportion of payments under a new MS-DRG? If yes, how should that lower portion be determined?
- CMS requests comments on the use of its exceptions and adjustments authority under section 1886(d)(5)(I) of the Act (or other relevant authorities) to implement any changes in the geographic adjustment.

3. What, if any, adjustments should be made for IME and DSH payments for cases assigned to a new MS-DRG?

   CMS discusses the additional payments under both the IME adjustment and the Medicare DSH adjustment. CMS states that these add-on payments could result in unreasonably high additional payment for CAR T-cell therapy cases unrelated in any significant, empirical way to the costs of providing care. For example, for a teaching hospital that has an IME adjustment factor of 0.25 and a DSH adjustment factor of 0.10, CMS calculates that — in a new MS-DRG for CAR T-cell therapies that resulted in an average IPPS federal payment rate for operating costs of $400,000 — the hospital would receive an IME payment of $100,000 and a DSH payment of $40,000. In this example, the total IPPS federal payment rate for operating costs including IME and DSH payments would be $540,000.
   - Should the IME and DSH payments be made for cases assigned to any new MS-DRG for CAR T-cell therapy?
   - Should the applicable percentage used to determine IME and DSH payments be reduced? If yes, how should those lower percentages be determined?
   - CMS requests comments on the use of its exceptions and adjustments authority under section 1886(d)(5)(I) of the Act (or other relevant authorities) to implement any changes in the geographic adjustment.

CMS also requests **comments about establishing a specific CCR** for reporting procedures involving the use of CAR T-cell therapies. For example, stakeholders have suggested a CCR of one for determining outlier payments and for the purposes of a new technology add-on payment. This change would result in a higher outlier payment, higher new technology add-on payment, or the determination of higher costs for IPPS-excluded cancer hospital cases. CMS notes that, in Section II.G.7 of the preamble, it also requests comments about other payment alternatives, including eliminating the use of the CCR in calculating the new technology add-on payments for KYMRIAH and YESCARTA by making a uniform add-on payment that is 65% of the cost of the technology (consistent with the proposed increase in the calculation of the maximum new technology add-on payment discussed in section II.H.9).

New Technology Payments

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. In this proposed rule, CMS:

- Proposes to discontinue add-on payments for three medical services/technologies
- Proposes continued new technology add-on payments for nine technologies
- Seeks comment on implementation of add-on payments for 17 technologies detailed in the proposed rule

In addition, CMS has issued a request for information (RFI) about the "New Technology Add-On Payment Substantial Clinical Improvement" criterion. Commenters have requested that CMS provide greater clarity on what constitutes "substantial clinical improvement" in order to better understand the new technology application process and to better predict which applications will meet the criterion. As such, CMS is considering revisions to this criterion under both the IPPS new technology and the OPPS transitional pass-through payment policies and is seeking public comment on additional guidance and details that would be useful.

Lastly, due to stakeholder concerns that the current new technology add-on payment policy does not adequately reflect the costs of new technology, or support health care innovation, CMS proposes to raise the current 50% cap on new technology add-on payments. For discharges beginning October 1, 2019, CMS proposes:

> If the costs of a discharge involving a new technology… exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 65 percent of the costs of the new medical service or technology; or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment. Unless the discharge qualifies for an outlier payment, the additional Medicare payment would be limited to the full MS-DRG payment plus 65 percent of the estimated costs of the new technology or medical service.

FFY 2020 Area Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index (AWI). Additional details about this methodology can be found in the regulation. Proposed rule wage index tables 2, 3, and 4 can be found at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020- IPPS-Proposed-Rule-Home-Page-Items/FY2020-IPPS-Proposed-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Due to the significant proposed changes to the hospital AWI, outlined below, CHA hosted an executive briefing on May 13. A recording and the presentation slides are available to members at https://www.calhospital.org/awi-briefing-participant-info.

CHA strongly opposes the CMS FFY 2020 AWI policies outlined below and urges member hospitals to join CHA's IPPS member forum on June 11 to learn about these policies and the next steps in our advocacy with CMS. Registration is available online at www.surveymonkey.com/r/TBR3NC3.

Hospital Exclusions

CMS calculates the proposed FFY 2020 wage index based on wage data of 3,221 hospitals from Worksheet S-3, Parts II and III of the cost report for cost reporting periods beginning in fiscal year 2016 (referred to as FFY 2016 wage data); the data file used to construct the proposed wage index includes FFY 2016 data submitted to CMS as of February 7, 2019.

General wage index policies are unchanged from prior years. CMS notes that it excludes 81 providers due to excessively aberrant data, but indicates that — if the data could be corrected in time — it intends to include some of those providers in the final wage index for FFY 2020.

The proposed rule indicates that eight of the excluded hospitals are part of a 38-hospital health system where salaries reflect union-negotiated agreements rather than prevailing wages in the local labor market. CMS indicates there is a large gap between the average hourly wage of each of these eight hospitals and the next closest average hourly wage in their respective CBSAs. Notably, CMS states that the data submitted by these hospitals are accurate. The proposed rule argues that section 1886(d)(3)(E) of the Act provides the Secretary with discretion to remove hospital data from the wage index that is not reflective of the relative hospital wage level in the hospitals' geographic area compared to the national average. CMS recently updated its public use files and now seven of the eight hospitals remain excluded; all seven are in California. CHA is extremely concerned about this precedent-setting policy and will advocate strongly for the inclusion of those seven hospitals.

CMS further indicates that it has previously removed hospitals from the wage index because their average hourly wages are either extraordinarily high or extraordinarily low compared to their labor market areas, even though their data were properly documented. Examples include wage data from government-owned hospitals and hospitals providing unique or niche services that affect their average hourly wages.

Occupational Mix Adjustment

Section 1886(d)(3)(E) of the Act requires CMS to collect data every three years on the occupational mix of employees for each Medicare-participating short-term, acute care hospital to construct an occupational mix adjustment to the wage index. The current occupational mix survey data from 2016 are used for the occupational mix adjustment applied to the FFY 2018 through FFY 2020 IPPS wage indexes. CMS proposes only a change to the rounding rules applied in the calculation of occupational mix adjustment, as described above. CMS reports having occupational mix data for 97% of hospitals (3,119 of 3,221) used to determine the FFY 2020 wage index. The proposed FFY 2020 national average hourly wage, unadjusted for occupational mix, is $44.03. The proposed occupational mix adjusted national average hourly wage is $43.99.

Rural Floor

The rural floor is a provision of statute that prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates that the rural floor will increase the FFY 2020 wage index for 166 hospitals — 87 fewer than were receiving the rural floor in FFY 2019. This impact is due, in part, to CMS' proposal to no longer include urban to rural reclassifications in the calculation of the rural wage index; this proposal is described below.

CMS calculates a proposed national rural floor budget neutrality adjustment factor of 0.996316 (negative 0.37%), applied to hospital wage indexes.

Frontier Floor Wage Index

The Affordable Care Act requires a wage index floor for hospitals in the low population density states of Montana, Nevada, North Dakota, South Dakota, and Wyoming. CMS indicates that 45 hospitals will receive the frontier floor value of 1.0000 for FFY 2020. This provision is not budget neutral, and CMS estimates an increase of approximately $63 million in IPPS operating payments.

Revisions to the Wage Index Based on Hospital Reclassifications

Geographic reclassification describes a process where hospitals apply to use another area's wage index. To do so, the applying hospital must be within a specified distance and have wages comparable to that area. The Medicare Geographic Classification Review Board (MGCRB) decides whether hospitals meet the criteria to receive the wage index of another hospital. CMS does not propose any changes to the geographic reclassification criteria. However, it proposes to make technical changes to the regulations to clarify that mileage and percentage standards are not rounded when determining whether a hospital meets reclassification criteria. The regulations explicitly specify using unrounded figures in some situations but not others. Under CMS' proposal, unrounded figures must be used in all situations.

Geographic Reclassifications

The MGCRB approved 357 hospitals for a geographic reclassification starting in FFY 2020. Because reclassifications are effective for three years, a total of 963 hospitals are in a reclassification status for FFY 2020, including those initially approved by the MGCRB for FFY 2018 (332 hospitals) and FFY 2019 (274 hospitals). **The deadline for withdrawing or terminating a wage index reclassification for FFY 2020 approved by the MGCRB is June 17, 2019. Applications for FFY 2021 reclassifications or canceling a previously approved reclassification are due to the MGCRB by September 3, 2019.**

Requests must be received by the MGCRB through its electronic system at www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic- Filing.html. CMS proposes to dispense with the requirement that applications and other information furnished to the MGCRB also be provided to CMS electronically by email, believing that it is burdensome and no longer necessary as the electronic system will facilitate coordination between CMS and the MGCRB.

Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process will be incorporated into the final FFY 2020 wage index values.

Provisions Relating to Lugar Hospitals

Interactive Effects of a Lugar Reclassification and the Out-Migration Adjustment

A "Lugar" hospital is located in a rural county adjacent to one or more urban areas that is automatically reclassified to the urban area where the highest number of its workers commute. The out-migration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Out-migration adjustments are fixed for three years. A hospital can either be reclassified or receive the out-migration adjustment, but not both. Lugar status is

automatic and must be declined through an urban to rural reclassification application for the hospital to receive an out-migration adjustment to its home area wage index.

CMS permits a Lugar hospital to submit a single notice to automatically waive its deemed urban status for the three-year period of the out-migration adjustment, though the hospital is permitted before its second or third year of eligibility to notify CMS that it no longer seeks the out-migration adjustment and instead elects to return to its deemed urban (Lugar) status. A Lugar hospital that qualifies for and accepts the out-migration adjustment (or that no longer wants to accept the out-migration adjustment) must notify CMS within 45 days of publication of the proposed rule. A request to waive Lugar status that is timely received is valid for the full three-year period for which the out-migration adjustment applies; however, the hospital may reinstate its urban status for any fiscal year during that three-year period. Due to various factors, including hospitals withdrawing or terminating MGCRB reclassifications, reclassifying as rural, or corrections to hospital wage data, a newly proposed (first year) out-migration adjustment value may fluctuate between the proposed rule and the final rule (and subsequent correction notices). In certain circumstances, after processing varying forms of reclassification, wage index values may change so that a county would no longer qualify for an out-migration adjustment. In particular, when changes in wage index reclassification status alter the state rural floor so that multiple CBSAs would be assigned the same wage index value, an out-migration adjustment may no longer apply as there would be little, if any, differential in nearby wage index values. This can lead to a situation where a hospital has opted to receive a nonexistent out-migration adjustment.

CMS clarifies that it will deny the hospital's request to waive its Lugar status in the final rule in this situation. Final rule wage index values would be recalculated to reflect the hospital's Lugar reclassification, and in some instances, after taking into account this reclassification, the out-migration adjustment for the county in question could be restored in the final rule. However, as the hospital is assigned a Lugar reclassification, it would be ineligible to receive the county out-migration adjustment for that year. However, because the out-migration adjustment, once finalized, is locked for a three-year period under section 1886(d)(13)(F) of the Act, the hospital would be eligible to accept its out-migration adjustment in either the second or third year.

Change to the Determination of a Lugar County

CMS indicates that determination of Lugar county status is based on commuting patterns from the rural county to a central county or counties of an urban area. CMS proposes to revise that standard to include commuting patterns to outlying counties as well, based on an alternative interpretation of the statute from a Henderson, Texas hospital. The proposed rule indicates the revised policy would affect 10 counties in Alabama, Georgia, Mississippi, Ohio, Pennsylvania, Texas, and Virginia that include a total of four IPPS hospitals.

Out-Migration Adjustment

CMS proposes to use the same policies, procedures, and computation that were used for the FFY 2012 out-migration adjustment and estimates increased payments of approximately $40 million in FFY 2020 for 171 hospitals receiving the out-migration adjustment. This provision is not budget neutral.

Reclassification from Urban to Rural

Allowing Electronic Applications

A qualifying IPPS hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Regulations require that the application must be mailed to the CMS Regional Office and may not be submitted by facsimile or other electronic means. CMS proposes to revise § 412.103(b)(3) to allow a requesting hospital to submit an application to the CMS Regional Office by mail or by facsimile or other electronic means.

Cancelling a Rural Reclassification

Under current regulations, an urban hospital that reclassifies as rural to become a rural referral center (RRC) must maintain rural status and be paid as rural for at least one 12-month cost reporting period. This requirement was established to provide a disincentive for hospitals to receive a rural reclassification, obtain RRC status to take advantage of special MGCRB reclassification rules, and then terminate their rural status. However, as a result of adverse litigation, CMS has since changed its rules to allow a hospital to reclassify from urban to rural and then apply for geographic reclassification under the less restrictive rules for rural hospitals. As a hospital can now have a simultaneous urban to rural and MGCRB reclassification, CMS indicates that its rule requiring an RRC to maintain rural status for at least 12 months no longer has any practical effect. Accordingly, CMS proposes to revise § 412.103(g) effective October 1, 2019, to eliminate the requirement that an RRC must be paid as rural for at least one 12-month cost reporting period before it can cancel rural status.

CMS further proposes to set forth uniform requirements, applicable to all hospitals, for cancelling rural reclassifications. For all hospitals, cancellation of an urban to rural reclassification will be effective on the basis of a federal fiscal year rather than the hospital's cost reporting period. CMS proposes this change because the end dates of cost reporting periods vary among hospitals and cancellation requests may not be processed in time to be accurately reflected in the IPPS final rule appendix tables. For a cancellation request to be effective the following fiscal year, CMS proposes that the request must be made not fewer than 120 days prior to the end of a federal fiscal year. CMS believes 120 days is sufficient time for hospitals to assess and review reclassification options, and provides CMS adequate time to incorporate the cancellation into the wage index development process.

In addition, CMS proposes to codify into regulations a longstanding policy related to canceling an urban to rural reclassification when a hospital opts to accept and receives its county out-migration adjustment in lieu of its Lugar reclassification. Just as a hospital cannot simultaneously have an MGCRB or Lugar reclassification and out-migration adjustment, a hospital cannot simultaneously have an urban to rural reclassification and an out-migration adjustment. In FFY 2012, CMS adopted a policy to allow waiving of Lugar status for the out-migration adjustment to simultaneously waive the hospital's urban to rural reclassification. CMS adopted this policy in the context of hospitals wishing to obtain or maintain SCH or MDH status, but its application of the policy has not been limited to these cases. CMS proposes to codify this policy in regulation at § 412.103 by specifying that an urban to rural reclassification will be considered cancelled effective for the next federal fiscal year when a hospital opts to accept and receives its county out-migration wage index adjustment in lieu of an MGCRB geographic reclassification. Once an urban to rural reclassification is cancelled, the hospital would have to reapply to again acquire rural status.

CMS notes that, in a case where an urban hospital reclassified as rural wishes to receive its out-migration adjustment but does not qualify for a Lugar reclassification, the hospital would need to formally cancel its rural reclassification by written request to the CMS Regional Office consistent with the procedures in the regulations. Finally, CMS indicates that the hospital must not only opt to accept, but also **receive**, its county out-migration wage index adjustment to trigger cancellation of rural reclassification. In such cases where an out-migration adjustment is no longer applicable based on the wage index in the final rule, a hospital's rural reclassification remains in effect unless otherwise cancelled by written request to the CMS Regional Office.

Process for Requests for Wage Index Data Corrections

CMS posts the wage index timetable on its website at www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2020-Wage-Index-Home-Page.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending. This website also includes all of the public use files that CMS has made available during the wage index development process.

Labor-Related Share

The Secretary is required to update the labor-related share from time to time, but no less often than every three years. CMS is currently using a national labor-related share of 68.3%. If a hospital has a wage index of less than one, its IPPS payments will be higher with a labor-related share of 62%. If a hospital a wage index that is higher than 1, its IPPS payments will be higher using the national labor-related share. The 68.3 labor share will be effective through the end of FFY 2020.

FFY 2020 Proposals to Address Wage Index Disparities

CMS reviews comments received as part of the RFI in the FFY 2019 IPPS/LTCH PPS proposed rule concerning wage index disparities. One concern expressed by hospitals is the disparity in wage index values between high and low wage index areas. CMS presented a comment typical of this view that was critical of relying exclusively on hospital cost reports as the source to calculate the wage index. The comment indicated that relying on hospital-reported data allows higher wage index hospitals to, in turn, pay higher wages to continue a high wage index. Low wage areas cannot afford to pay wages that would allow their hospitals to approach median wage index. Over time, this condition of circularity has increased the gap between the high and low wage indexes. CMS refers to this system as the "downward spiral," as that term has been used by some stakeholders to describe the issue.

Some commenters recommended that CMS create a wage index floor for low wage hospitals and that, to maintain budget neutrality, CMS reduce the wage index values for high-wage hospitals through the creation of a wage index ceiling. There was also concern about opportunist gaming, especially in the area of urban to rural reclassifications and the rural floor. Providers in some urban areas are able to reclassify to a rural area and substantially raise the rural floor for an entire state. These respondents stated that CMS has the regulatory authority to determine how it calculates the rural floor and suggested CMS only consider geographically rural providers to calculate a state's rural floor.

Other commenters were not critical of wage index disparities. The typical comment representing this view argued that there are disparities in the cost of labor and cost of living between different parts of the country recognized by the wage index. The commenters urged to CMS to continue to adequately account for these resource differences in its payment systems.

Some commenters indicated that further analysis and study of the wage index are needed. A comment typical of this view indicated that a consensus solution to the wage index's shortcomings has not yet been developed and further analysis of alternatives is needed to identify approaches that promote payment adjustments that are accurate, fair, and effective.

Proposal 1 – Allow Time for Low-Wage Hospitals to Raise Wages

CMS and others have indicated in the past that comprehensive wage index reform would require both statutory and regulatory changes, and could require new data sources. However, CMS indicates that addressing this systemic issue does not need to wait for comprehensive wage index reform given growing wage index disparities and that some hospitals, particularly rural hospitals, are in financial distress facing potential closure.

In response to these concerns, CMS proposes to increase the wage index values for hospitals with a wage index in the lowest quartile. CMS acknowledges that there is no set standard for identifying hospitals as having a low or high wage index but indicates that the proposed quartile approach is reasonable given quartiles are a common way to divide distributions. Based on FFY 2020 proposal rule wage index data, the 25th percentile wage index value is 0.8482. CMS proposes to increase wage indexes below this amount by one-half the difference between a low wage index hospital's wage index and the 25th percentile. CMS will update the 25th percentile wage index based on FFY 2020 final rule data.

CMS proposes to make the policy effective for at least four years, to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. CMS selected this duration because there is a four-year lag between the cost report year used for the wage index and the payment year when that wage index is applied (FFY 2016 for FFY 2020). Therefore, four years is the minimum time before increases in employee compensation included in the Medicare cost report could be reflected in the wage index data. CMS indicates the policy may need to be in place for additional time and intends to revisit the duration of the policy in future rulemaking.

Proposal 2: Make Proposal Budget Neutral by Lowering Wage Index for High Wage Hospitals

CMS declines to establish a wage index floor as some commenters suggested because it believes that rank order generally reflects meaningful distinctions between employee compensation costs faced by hospitals in different geographic areas but is exacerbated by the circularity of using hospital-reported data for the wage index. However, CMS does believe that it should maintain budget neutrality for increases to low wage index hospital through an adjustment to the wage index of high wage index hospitals.

CMS considered three options for budget neutrality: 1) a uniform adjustment for budget neutrality to the standardized amount; 2) reducing wage indexes over the 75th percentile by half of the difference between the hospital's wage index and the 75th percentile wage index; 3) applying a uniform reduction to hospital wage indexes above the 75th percentile. CMS proposed the third option. Compressing the wage index for hospitals on the high and low ends increases the impact on existing wage index disparities more than by simply addressing one end. Further, such a methodology ensures those hospitals whose wage index is not considered high or low do not have their wage index values affected by the proposed policy.

Accordingly, to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile, CMS proposes to apply a uniform reduction of 3.4% to the portion of a hospital's wage index above the 75th percentile. Based on proposed rule data, the 75th percentile wage index value is 1.0351. Under CMS' proposal, the portion of a hospital's wage above 1.0351 will be reduced by 3.4% to maintain budget neutrality for the proposed wage index increases. **Notably, CMS has confirmed that the 3.4% is incorrect, and the tables reflect a reduction of 4.3%.**

CMS states that it is undertaking the proposed policy under 1886(d)(3)(E) of the Act, which gives the Secretary broad authority to adjust for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Section 1886(d)(3)(E) requires those adjustments to be budget neutral. CMS also indicates that it has authority for the proposed policy using its exceptions and adjustments authority under section 1886(d)(5)(I) of the Act.

Examples of Proposed Wage Compression – Year 1

Low-Wage Hospital Increase	**High-Wage Hospital Decrease**
• FFY 2020 the 25th percentile across all hospitals is 0.8482 • Proposed increase would be **half of the difference between current wage index and the 25th percentile across all hospitals** **Example**: Alabama Hospital 0.6663 (08482-0.6663)/2 = half the difference 0.0910 **0.6663+0.0910 = 0.7573 New AWI for Alabama Hospital**	• FFY 2020 the 75th percentile across all hospitals is **1.0351** **Example**: **Hospital A** – AWI 1.7351 (1.7351-1.0351) = 0.700 CMS proposes a uniform multiplicative BN factor to reduce the distances (0.7 and 0.2) to offset the payments needed to fund the low wage adjustments. CMS estimates BN factor **at 3.4**** ** CMS has confirmed the 3.4% is incorrect, it is 4.3% **Example**: **Hospital A** **Step 1** (0.7*0.043) = 0.0301 **Step 2** (1.7351-0.0301) = 1.705 **OLD AWI 1.7351** **NEW AWI AFTER WAGE COMPRESSION ONLY – 1.705**

Proposal 3: Prevent Urban to Rural Reclassifications from Raising the Rural Floor

Public commenters indicated that another contributing systemic factor to wage index disparities is the rural floor. Section 4410(a) of the Balanced Budget Act (BBA) of 1997 provides that, for discharges on or after October 1, 1997, 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 of that state. Section 3141 of the Affordable Care Act also requires that a national budget neutrality adjustment be applied in implementing the rural floor.

The proposed rule states wage index disparities associated with the rural floor significantly increased in FFY 2019 with the urban to rural reclassifications of hospitals in Arizona, Connecticut, and Massachusetts. CMS states the rural floor policy was meant to address anomalies of some urban hospitals being paid less than the average rural hospital in their states, not to raise the payments of many hospitals to the high wage level of a geographically urban hospital within the state.

CMS believes that urban to rural reclassifications have stretched the rural floor provision beyond a policy designed to address such anomalies and goes beyond the general criticisms of the rural floor policy by MedPAC, CMS, OIG, and many stakeholders**. Therefore, CMS proposes to remove urban to rural reclassifications from the calculation of the rural floor beginning in FFY 2020.**

Proposal 4: Transitioning Wage Index Reductions and Budget Neutrality

Following past practice when large changes to wage indexes have been transitioned, CMS proposes a transition to mitigate any significant decreases in the wage index values of hospitals compared to their final wage indexes for FFY 2019. For FFY 2020 only, CMS proposes to place a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FFY 2019. CMS seeks public comments on alternative levels for the cap, with accompanying rationale.

Following past practice, CMS invokes section 1886(d)(5)(I) of the Act to propose making the 5% cap on wage index reductions budget neutral. CMS proposes to apply a budget neutrality adjustment to ensure that estimated aggregate payments under the proposed transition for hospitals negatively impacted by proposed wage index policies would equal what estimated aggregate payments would otherwise have been absent the transition policy. The proposed budget neutrality adjustment is 0.998349 (negative 0.17%) to the FFY 2020 standardized amount.

Post-Acute Care Transfer and Special Payment MS-DRGs

A post-acute transfer is a discharge from a hospital to certain facilities — including a rehabilitation hospital or unit, a psychiatric hospital or unit, a skilled-nursing facility, or home with a written plan for home health services from a home health agency — where services begin within three days after the discharge date. If that transfer occurs prior to the geometric mean length of stay and the patient is grouped to an MS-DRG subject to the post-acute transfer policy, CMS makes payment to the transferring hospital using one of two methodologies: (1) payment at twice the per diem amount for the first day with each subsequent day paid at the per diem amount up to the full MS-DRG payment; or (2) payment of 50% of the full MS-DRG payment, plus the single per diem payment, for the first day of the stay, as well as a per diem payment for subsequent days up to the full MS-DRG payment. The second methodology is known as the "special payment methodology" and is specifically for cases that exhibit exceptionally high costs very early in the hospital stay.

If the MS-DRG's total number of discharges to post-acute care equals or exceeds the 55th percentile for all MS-DRGs and the proportion of short-stay discharges to post-acute care to total discharges in the MS-DRG exceeds the 55th percentile for all MS-DRGs, CMS will apply the post-acute care transfer policy to that MS-DRG and to any other MS-DRG that shares the same base MS-DRG. CMS does not revise the list of DRGs subject to the post-acute care transfer policy annually, unless it is also making a change to a specific MS-DRG.

Changes for FFY 2020

CMS proposes to make changes to a number of MS-DRGs effective for FFY 2020 and reviewed the new and revised MS-DRGs for application of the post-acute care transfer policy and special payment methodology. As a result of its review, CMS proposes to:

- Reassign procedure codes from MS-DRGs 216 through 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, CC and without CC/MCC, respectively), and MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with and

without MCC, respectively) and create new MS-DRGs 319 and 320 (Other Endovascular Cardiac Valve Procedures with and without MCC, respectively).
- Delete MS-DRGs 691 and 692 (Urinary Stones with ESW Lithotripsy with CC/MCC and without CC/MCC, respectively) and revise the titles for MS-DRGs 693 and 694 to 'Urinary Stones with MCC' and 'Urinary Stones without MCC', respectively.
- Remove MS-DRGs 273 and 274 from the post-acute care transfer policy list.

Low-Volume Hospital Adjustment

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the adjustment amounts. The Bipartisan Budget Act of 2018 had extended the relaxed low-volume adjustment criteria (>15-mile/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-22 and changed the discharge criteria to require that a hospital have fewer than 3,800 total discharges, rather than 1,600 Medicare discharges. The new payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} * \frac{Total\ Discharges}{13{,}200}$$

Beginning in FFY 2023, the criteria for the low-volume hospital adjustment will return to more restrictive levels. At that point, in order to receive a low-volume adjustment, subsection (d) hospitals would need to:

- Be located more than 25 road miles from another subsection (d) hospital
- Have fewer than 200 total discharges (all payer) during the fiscal year

For a hospital to acquire low-volume status for FFY 2020, CMS will require — consistent with historical practice — that a hospital have submitted a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that it meets the applicable mileage and discharge criteria. The MAC must have received a written request by September 1, 2019, for the adjustment to be applied to payments for discharges beginning on or after October 1, 2019. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Under this process, a hospital receiving the adjustment for FFY 2019 will continue to receive it without reapplying if it continues to meet the mileage and discharge criteria.

Rural Referral Centers: Annual Updates to Case-Mix Index and Discharge Criteria

CMS provides updated criteria for determining RRC status, including updated minimum national and regional case-mix index (CMI) values and updated minimum national and regional numbers of discharges. To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2019, CMS proposes that a rural hospital with fewer than 275 beds available for use meet specific geographic criteria, and:

- Have a CMI value for FFY 2018 that is at least 1.6855 (national—all urban) or the median CMI value (not transfer-adjusted) for urban hospitals (excluding those with approved teaching programs) calculated by CMS for the census region in which the hospital is located
- Have at least 5,000 discharges for the cost reporting period that began during FFY 2017; for osteopathic hospitals, this threshold is 3,000

A hospital seeking to qualify as an RRC should obtain its hospital-specific (not transfer-adjusted) CMI value from its MAC.

CAH Payment for Ambulance Services

A CAH can be paid 101% of reasonable costs for ambulance services if it is the only provider or supplier of ambulance services within a 35-mile drive of the CAH. The CAH can be paid 101% of reasonable costs for ambulance services even if its ambulance company is more than a 35-mile drive from the CAH, as long as it is the closest provider or supplier of ambulance services to the CAH. Otherwise, the CAH is paid for its ambulance services using the ambulance fee schedule (AFS).

CMS has been advised of a situation where a non-CAH owned ambulance service is within a 35-mile drive of the CAH, but is not legally authorized to transport individuals to or from the CAH because it is in another state. Under this scenario, the CAH is paid for its ambulance services using the AFS even though there is no ambulance other than the CAH's own available to transport patients. CMS does not believe this result is consistent with the intent of the CAH program to provide access to care to individuals living in remote and rural areas, particularly in emergency situations and when individuals have no other mode of transportation due to hazardous traveling conditions.

Therefore, CMS proposes to exclude consideration of ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals either to or from the CAH in applying the 35-mile distance criterion. CMS believes its proposed policy is reasonable under the statute because it retains the requirement that the CAH be the only provider or supplier of ambulance services within (or beyond a 35-mile drive of the CAH as long as there is no closer ambulance service) that is available to transport individuals either to or from the CAH.

Hospital Inpatient Quality Reporting Program

CMS proposes to add three new measures for the hospital IQR program. Specifically, CMS proposes two new opioid-related electronic clinical quality measures (eCQMs) beginning with the FFY 2023 payment determination. CMS also proposes to require mandatory reporting of the currently voluntary Hybrid Hospital-Wide Readmission measure beginning with the FFY 2026 payment determination, and would remove two existing claims-based readmission measures. In addition, CMS discusses future measures under consideration for the program and confidential reporting of stratified outcome measures to account for social risk factors.

Table 1 in the appendix to this summary shows the previously adopted and proposed measure sets for FFY 2019 through FFY 2023. Technical specifications for hospital IQR program measures are available from the CMS QualityNet website at www.qualitynet.org and for eCQMs at http://ecqi.healthit.gov/.

Proposed New Opioid-Related eCQMs

CMS proposes to add two eCQMs related to opioids beginning with the FFY 2021 reporting period/FFY 2023 payment year. CMS also proposes to add both eCQMs to the measure set for the Medicare and Medicaid Promoting Interoperability Program, discussed later in this summary.

- Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)
  This proposed measure calculates the proportion of patients age 18 and older who are prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from

a hospital-based encounter (inpatient, observation stays, emergency department). The measure excludes patients with an active diagnosis of cancer or order for palliative care during the encounter, in alignment with the 2016 Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain. CMS states that the measure's goal is to help systems identify and monitor patients at risk, rather than score a measure rate of zero. CMS notes that concurrent prescribing rates of 18.2% for inpatients and 6.1% in emergency department settings are consistent with rates in the clinical literature. The measure is endorsed by the National Quality Forum (NQF). For the measure specifications, CMS refers readers to the NQF fall 2017 final technical report on patient safety issued in July 2018.

CMS proposes that, beginning with the 2022 reporting period/FFY 2024 payment determination, all hospitals participating in the IQR program be required to report this eCQM and two additional eCQMs of their choosing. Additional details on proposed eCQM reporting requirements are provided later in this summary.

- Hospital Harm – Opioid-Related Adverse Events eCQM
  This proposed measure assesses the proportion of an acute care hospital's patients with an opioid-related adverse event during an admission, as indicated by the administration of naloxone. The denominator is the number of patients age 18 or older who were discharged during the measurement period and had an admission that was initiated in the emergency department or on observational status. The numerator is the number of patients who received naloxone outside the operating room after 24 hours from hospital arrival **or** during the first 24 hours after hospital arrival with evidence of hospital opioid administration prior to naloxone administration. This is intended to exclude patients who receive naloxone within 24 hours of arrival due to an opioid overdose that occurred in the community prior to hospital arrival. CMS notes that the measure was refined in response to concerns raised by the Measures Applications Partnership (MAP) and submitted for NQF endorsement in spring 2019. Measure specifications are available at www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/measure-methodology.html.

Proposed Mandatory Reporting of Hybrid Hospital-Wide Readmission Measure (NQF #2879)

In the FFY 2018 IPPS final rule, CMS adopted the Hybrid Hospital-Wide Readmission (HWR) measure, which combines claims data with patient data extracted from hospital EHRs. CMS adopted an initial six-month voluntary reporting period for the EHR-derived data elements used in the measure. CMS states that about 80 hospitals submitted the EHR data and will receive a confidential, hospital-specific report in early summer 2019 that includes Hybrid HWR measure results of merging the submitted electronic data with claims data for the same set of index admissions.

In this rule, CMS proposes a stepped approach to mandating the Hybrid HWR measure and replacing the existing claims-based HWR measure. CMS proposes to establish two new expanded voluntary data collection periods: July 1, 2021, through June 30, 2022, and July 1, 2022, through June 30, 2023. Beginning with the FFY 2026 payment determination, CMS proposes mandatory reporting from July 1, 2023, through June 30, 2024.

Hospitals would use Quality Reporting Data Architecture (QRDA) Category I files to report the core clinical data elements for each Medicare FFS beneficiary who is 65 years and older during the annual

measurement period. In addition, hospitals would be required to submit six linking variables that would allow CMS to merge the EHR core clinical data elements with claims data for the patient: CMS certification number, health insurance claims number or Medicare beneficiary identifier, date of birth, sex, admission date, and discharge date. For CMS to reliably calculate the Hybrid HWR measure results, the hospital would have to report the core clinical data element vital signs for at least 90% of the Medicare FFS aged beneficiary discharges and the laboratory test results for at least 90% of non-surgical patients. CMS notes that the six variables required for linking EHR and claims data should be submitted for 100% of discharges in the measurement period, but hospitals would meet Hospital IQR Program requirements if they submit linking variables on 95% or more of discharges with a Medicare FFS claim for the same hospitalization during the measurement period.

Initial electronic specifications for the proposed voluntary data collection periods would be provided in spring of 2020 as part of the 2021 annual update issued by the Electronic Clinical Quality Improvement (eCQI) Resource Center. Confidential feedback reports would be provided for the two proposed new voluntary reporting periods, the first of which would be delivered to hospitals in the spring of 2023. No public reporting of the Hybrid HWR measure would occur during the voluntary reporting periods. CMS proposes to begin public reporting of the Hybrid HWR measure on the Hospital Compare website for the first mandatory data collection period (July 1, 2023-June 30, 2024).

Removal of Claims-Based Hospital-Wide Readmission Measure

CMS proposes to remove the current Claims-Based HWR measure, contingent on finalizing its proposal to adopt mandatory reporting of the Hybrid HWR measure beginning with the FFY 2026 payment determination.

Future Hospital IQR Program Measures

CMS seeks comment on the potential adoption of three specific eCQMs in both the IQR and Promoting Interoperability programs. CMS specifically seeks comment on potential unintended consequences that might result from the future adoption of each measure.

- Hospital Harm – Severe Hypoglycemia eCQM: This eCQM measures the proportion of patients who experienced a severe hypoglycemic event (low glucose test result of <40mg/dL) within 24 hours of the administration of an antihyperglycemic agent. This indicates harm to a patient and CMS discusses the clinical issues and gaps in measurement for how often these events occur in the inpatient setting. The proposed measure is a re-specification of an NQF-endorsed measure. The new version has received support from the MAP, conditioned on NQF review and re-endorsement. The measure was submitted to the NQF for review in the spring of 2019.
- Hospital Harm – Pressure Injury eCQM: This eCQM measures the rate at which new hospital-acquired pressure injuries occur during an acute care hospitalization. The numerator is the number of admissions where a patient has a newly-developed stage 2, 3, or 4 pressure injury; a deep tissue pressure injury; or an unstageable pressure injury that was not documented as present in the first 24 hours of hospital arrival. The denominator is all patients age 18 and older discharged during the measurement period. The MAP made several recommendations for modifying this measure, which CMS says will be considered during the NQF review of the measure, scheduled for June 2019.
- Cesarean Birth (PC-02) eCQM (NQF #0471e): This eCQM assesses the rate of nulliparous women (those who have never given birth) with a term singleton baby in a vertex position delivered by

cesarean birth. The Joint Commission is the measure steward and maintains the measure specifications. The MAP supported the measure, conditioned on NQF review and endorsement.

Confidential Reporting of Stratified Data for Hospital Quality Measures

As a first step to addressing disparities due to social risk factors, CMS in its FFY 2019 IPPS final rule adopted plans to include stratified data on the Pneumonia Readmission measure (NQF #0506) data for dually eligible patients in hospitals' confidential feedback reports beginning in August 2018, using two methods: a within-hospital disparity method that compares readmission rates for dually eligible and other beneficiaries within a hospital, and an outcome measure that compares care performance for dually eligible patients across hospitals.

In this proposed rule, CMS states that it plans to expand these reports to include five additional measures in the spring of 2020: acute myocardial infarction (AMI) readmission measure, coronary artery bypass grafting (CABG) readmission measure, chronic obstructive pulmonary disease (COPD) readmission measure, heart failure readmission measure, and total hip arthroplasty/total knee arthroplasty (THA/TKA) readmission measure. CMS seeks comments on this plan. In the future, CMS will include hospitals' disparity results in the regular annual confidential hospital-specific reports on claims-based measures that are made available to hospitals each spring for download through the QualityNet security portal. CMS has not yet determined future plans for public reporting of the stratified data and intends to continue to engage with hospitals and other stakeholders on these issues.

Form, Manner, and Timing of Data Submission

CMS does not propose changes to policies involving procedural requirements, data submission for chart-abstracted measures, data submission deadlines, sampling and case thresholds, HCAHPS administration and submission requirements, data accuracy and completeness acknowledgement, public display of measures on Hospital Compare, reconsideration and appeals, and the extraordinary circumstances exception policy. However, the agency does propose to establish eCQM reporting and submission requirements for FFYs 2022-24 payment determinations (FFY 2020 through 2022 reporting periods).

For the FFY 2022 and 2023 payment determinations, CMS proposes to continue to require that hospitals report one self-selected calendar quarter of data for four self-selected eCQMs. Beginning with the FFY 2024 payment determination (2022 reporting period), CMS proposes to require all hospitals to report one self-selected calendar quarter of data for the proposed Safe Use of Opioids Concurrent Prescribing eCQM plus three additional self-selected eCQMs. CMS said it considered allowing hospitals to choose one of the two new proposed opioid measures, but believes that approach would be more complicated and that the concurrent prescribing measure is more closely related to combatting the current opioid epidemic.

CMS proposes to continue its requirement that hospitals use the 2015 Edition Certified Electronic Health Record Technology (CEHRT) for the CY 2020 reporting/FFY 2022 payment period and subsequent years. No changes are proposed to previously adopted policies regarding use of the 2015 Edition Certification Criteria, eCQM file format requirements, and submission deadlines for eCQM data.

Hospital Value-Based Purchasing Program

As required by law, the available funding pool for the hospital VBP program is equal to 2% of the base operating diagnosis-related group (DRG) payments to all participating hospitals. CMS estimates the total

amount available for VBP payments to be $1.9 billion. In FFY 2020, CHA estimates that overall California hospitals will earn approximately $6.3 million in hospital VBP payments, with some hospitals seeing a positive and others a negative impact. Table 2 in the appendix of this summary lists previously adopted measures for the program.

NHSN HAI Measure Data

CMS proposes one administrative change for the hospital VBP program, related to the specific data used in the program for the CDC National Healthcare Safety Network (NHSN) Healthcare Associated Infection (HAI) measures. To date, the NHSN HAI measure data used for the VBP program has been the same data used to calculate these measures for the IQR program. However, CMS removed these measures from the IQR program in the FFY 2019 IPPS final rule. To address this, CMS proposes to use the same data to calculate the NHSN HAI measures for the VBP program that it uses to calculate these measures for the HAC reduction program. The proposal would begin with data collection on January 1, 2020, for the FFY 2022 VBP program performance period, which is the effective date of the removal of these measures from the IQR program and the beginning of reporting of these measures for the HAC reduction program. The review and correction and data validation processes adopted for these data for the HAC reduction program would also apply. CMS believes this proposal would provide a seamless shift from the use of IQR program data for the VBP program.

Previously Adopted Performance and Baseline Periods

CMS does not propose changes to previously adopted performance and baseline periods for the program measures, the specific time periods of which are automatically updated each year. The proposed rule includes tables, on pages 19433-19435, that display the baseline and performance periods for each fiscal year from 2022 through 2025.

Previously Adopted Performance Standards

The proposed rule includes a series of tables that display the previously and newly adopted numeric performance standards for VBP program measures for FFYs 2022-25.The tables are listed on pages 19436-19439 of the proposed rule.

Hospital-Acquired Conditions Reduction Program

Under the HAC reduction program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. CMS does not propose any change to the measure set for the HAC reduction program. Table 3 in the appendix of this summary lists previously adopted measures for the HAC reduction program. CMS does propose to establish factors for removal of program measures, establish the data collection period for the FFY 2022 program year, clarify certain data validation and data collection policies finalized in the FFY 2019 IPPS final rule, and change regulatory text to update references to domains that were previously removed from the scoring calculation effective with the FFY 2020 payment year.

CMS estimates that 795 hospitals will fall into the worst-performing quartile and be penalized in FFY 2020 under the program. However, CMS provides no aggregate dollar amount of the penalties in its impact analysis. CHA DataSuite analysis estimates that California hospitals will lose approximately $52 million under this program for FFY 2020.

Removal Factors for HAC Reduction Program Measures

CMS proposes a set of eight factors it would use to determine whether a measure should be removed from the HAC reduction program; no measures are proposed for removal at this time. The proposed factors are the same as those already adopted for the IQR program, the hospital VBP program, and other hospital quality reporting programs. As is the case in these other programs, the factors would not be used for automatic removal of measures but would be applied on a case-by-case basis.

Performance Period for FFY 2022 Program Year

Consistent with previous policies, CMS proposes that the HAC reduction program performance period for FFY 2022 will be the 24-month period from July 1, 2018, through June 30, 2020, for the PSI-90 measure and January 1, 2019, through December 31, 2020, for the NHSN measures.

HAC Reduction Program Data Validation

In the FFY 2019 IPPS final rule, CMS finalized a HAC reduction program data validation process that replaced the IQR data validation process, following the removal of HAC reduction program measures from the IQR program. Under the policy, the five chart-abstracted NHSN measures will be subject to validation under the HAC reduction program beginning with third quarter 2020 discharges for FFY 2023 payment. The HAC reduction program data validation period will include the four middle quarters of the program's two-calendar year performance period for NHSN measures.

As previously finalized, all hospitals will be eligible for random selection for the data validation sample because they are all subject to the HAC reduction program. The sample sizes were carried over from the IQR program: 400 randomly selected hospitals and 200 hospitals selected using targeting criteria. However, in this rule, CMS proposes to modify the number of hospitals targeted from exactly 200 hospitals to "up to 200 hospitals," which it says will provide flexibility to avoid selection of hospitals simply to meet the 200 number. Hospitals eligible for targeted selection are those that failed validation in the previous year; submit data to NHSN after the data submission deadline has passed; have not been randomly selected in the past three years; passed validation in the previous year but had a two-tailed confidence interval that included 75%; or failed to report to NHSN at least half of actual infection events detected, as determined through the previous year's validation.

Further, CMS clarifies its provider selection process to reduce the likelihood that hospitals could be selected for validation under the IQR program and the HAC reduction program during the same reporting period. Specifically, CMS clarifies that it will randomly select one pool of 400 hospitals for validation of chart-abstracted measures in both programs. All the hospitals will be included for the HAC reduction program, whereas CMS will remove any hospitals without an active notice of participation in the IQR program. The process will begin with third quarter 2020 infectious events, which is the beginning of the HAC reduction program validation process. After the random selection of 400 hospitals, CMS will select the targeted sample of up to 200 hospitals for validation under both programs.

In addition, CMS proposes to use a filtering method to better target "true events," or those that meet NHSN HAI criteria. The proposed filtering method would eliminate cases from the validation pool for which the positive cultures were collected on the first or second day following admission. CMS believes that this approach will increase the number of true events for validation without having to increase the sample size. CMS believes that this would help it better understand the overreporting and underreporting of such events and that, by improving the power of the validation methodology, CMS

could select fewer cases for validation and reduce hospital burden. CMS is considering a similar filtering approach to apply to the SSI measures, which also have a low yield rate. For the Methicillin-Resistant Staphylococcus Aureus Bacteremia (MRSA) and Clostridium difficile Infection (CDI) measures, CMS notes that the validator agreement rates for these measures have been lower than for central line-associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI), and that these events are overreported due to missing laboratory record information. CMS will provide additional training to hospitals with the hope of improving hospital validation performance on these measures.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program (HRRP) reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor that is between 1 (no reduction) and 0.9700, for a greatest possible reduction of 3% of base operating DRG payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

While CMS does not propose changes to its previously adopted HRRP measure set, it does proposes several other changes to HRRP policies for FFY 2020 in this rule. Specifically, CMS would establish factors for removal of HRRP measures, update the definition of "dual eligible" used for creating peer groups, create a subregulatory process for making nonsubstantive changes to the HRRP adjustment factor components, and change regulatory text to align with these proposals and to codify other parts of the HRRP.

CMS estimates that 2,599 hospitals will be penalized under the HRRP in FFY 2020. CHA DataSuite analysis estimates that the HRRP will result in a Medicare payment reduction for California hospitals of approximately $43 million for FFY 2020.

Removal Factors for HRRP Measures

CMS proposes a set of eight factors it would use to determine whether a measure should be removed from the HRRP; no measures are proposed for removal at this time. The proposed factors are the same as those adopted for the IQR program, the Hospital VBP program, and other hospital quality reporting programs. As is the case in these other programs, the factors would not be used for automatic removal of measures but would be applied on a case-by-case basis.

Definition of Dually Eligible Beneficiary

Beginning with FFY 2021, CMS proposes to modify the definition of "dual eligible" to avoid undercounting the status of beneficiaries who die within a month of hospital discharge. For these beneficiaries, a one-month lookback period would be used. CMS reports that this change would affect a small number of beneficiaries and would not have a "substantive impact." However, CMS believes it should use the most accurate information available in counting dually eligible patients for purposes of the HRRP adjustment. The proposed new definition (new language italicized) is:
"Dual-eligible is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in the State Medicare Modernization Act (MMA) files for the month the beneficiary was discharged from the hospital, *except for those patient beneficiaries who die in the*

month of discharge, who will be identified using the previous month's data sourced from the State MMA files."

Subregulatory Process for Changes to Payment Adjustment Factor Components

Currently, a subregulatory process exists for making nonsubstantive modifications to HRRP measures. CMS proposes a similar process for nonsubstantive modifications to other components of the HRRP adjustment — such as updated naming or locations of data files or other minor discrepancies that do not change the policy's intent — so that minor changes can be rapidly adopted. Substantive changes — those that impact the payment adjustment factor component so significantly that it could no longer be considered to be the same as the previously finalized component — would continue to go through notice and comment rulemaking.

Applicable Periods for FFY 2020

Consistent with current policies, CMS proposes that, for FFY 2022, the applicable period from which data would be collected for calculating the readmission payment adjustment factor would be the three-year period from July 1, 2017, through June 30, 2020. The proportion of dually eligible individuals, excess readmissions ratios, and the payment adjustment factors (including aggregate payments for excess readmissions and aggregate payments for all discharges) are based on claims data from the applicable period. Previously finalized periods are shown with this proposal below.

Previously Finalized and *Proposed* HRRP "Applicable Period"	
Payment Year	**Discharge Dates**
FFY 2019	July 1, 2014-June 30, 2017
FFY 2020	July 1, 2015-June 30, 2018
FFY 2021	July 1, 2016-June 30, 2019
FFY 2022	*July 1, 2017-June 30, 2020*

Payment Adjustment Methodology for FFY 2020

CMS proposes no changes to its previously finalized methodology for calculating the HRRP payment adjustment for FFY 2020. Using MedPAR data for the three-year applicable period from July 1, 2015, through June 30, 2018, hospitals will be grouped by quintiles (five peer groups) based on their proportion of dually eligible patients. The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio to the median excess readmission ratio (ERR) for the hospital's peer group. "Payment" refers to base operating DRG payments, "dx" refers to an HRRP condition (i.e., AMI, HF, PN, COPD, THA/TKA or CABG), and "NMM" is a budget neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions. For additional information on the methodology, CHA refers readers to our FFY 2018 IPPS final rule summary.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

Confidential Reporting of Stratified Readmissions Data

As early as the spring of 2020, CMS will include — in confidential hospital-specific reports — data on the six readmissions measures stratified by patient dual eligible status. Results will be provided using two disparity methodologies as described in the IQR section of this summary. These methods differ from the HRRP stratification and will not be used for any payment calculations. CMS is providing the data because it believes that they allow for a more meaningful comparison and will provide additional perspectives on health care equity.

Revisions to Regulatory Text

CMS proposes a series of revisions to the regulatory text involving the HRRP. Specifically, CMS proposes to update the definition of dual eligible as described above. Two other proposals also involve modifying definitions. First, "aggregate payments for excess readmissions" would be modified to reflect the peer grouping methodology now in use. Second, the definition of "base operating DRG payment amount" would be modified to reflect changes in Medicare-dependent hospital policy.

Additionally, CMS proposes to add the neutrality modifier and the proportion of dually eligible patients to the list of specific items for which no administrative and judicial review is permitted. The current list prohibits this review for (1) the determination of base operating DRG payment amounts; (2) the methodology for determining the HRRP adjustment factor, including the excess readmissions ratio, aggregate payments for excess readmissions, and aggregate payments for all discharges; (3) the applicable period; and (4) the applicable conditions.

PPS-Exempt Cancer Hospital Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a quality reporting program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting Program (QRP) follows many of the policies established for the hospital IQR program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking. Five initial measures were adopted for FFY 2014, and subsequent rulemaking has added and removed measures. A total of 15 measures were previously adopted for FFY 2021.

In this rule, CMS proposes to remove the pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care measure effective October 1, 2019; remove the measure External Beam Radiotherapy for Bone Metastases; and add the measure Surgical Treatment Complications for Localized Prostate Cancer.

Removal of Pain Management Questions from HCAHPS Survey

CMS has previously removed the three HCAHPS pain management questions from the HCAHPS survey for purposes of the IQR program and the inpatient VBP program. The rationale for removal has raised concern among stakeholders that the questions might incentivize providers to prescribe more opioids to achieve higher scores on the pain management dimension. CMS removed the questions out of an abundance of caution, in light of the national opioid epidemic. For the same reasons, and for alignment across programs, CMS proposes to remove these questions from the PCH QRP beginning with the FFY 2022 payment determination. Under the proposal, data collected on these questions, beginning with October 2018 discharges, would not be publicly reported. CMS would provide performance results to PCHs in confidential preview reports as early as July 2019.

Removal of External Beam Radiotherapy for Bone Metastases Measure

CMS proposes to remove this measure from the PCH QRP beginning with the FFY 2022 payment based on previously adopted removal Factor 8: the costs associated with a measure outweigh the benefit of its continued use in the program. Specifically, the radiation delivery current procedural terminology codes used for the measure, which were part of a respecification after the measure was finalized, have required additional exclusions and proven burdensome for PCHs. In addition, CMS notes that the measure lost NQF endorsement in 2018 and is no longer being maintained by the measure steward.

Addition of Surgical Treatment Complications for Localized Prostate Cancer Measure

CMS proposes to add this measure, which uses claims data to calculate hospital-specific rates of urinary incontinence and erectile dysfunction among patients undergoing localized prostate cancer surgery, beginning with the FFY 2022 payment determination. Claims data for July 1, 2019, through June 30, 2020, would be used to calculate measure rates.

Public Reporting of Measures

CMS proposes two changes with respect to public display of PCH QRP measures. First, public display of performance on the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure would begin in 2020. CMS has recently provided a first round of confidential reports to PCHs on this measure, and another round is planned before public display would be effective. Second, CMS previously deferred public display of the CDC NHSN infection measures. In this rule, it proposes that public display of the MRSA, CDI, colon/abdominal hysterectomy surgical site infection measures, and the influenza vaccine for health care personnel measure would begin with the October 2019 Hospital Compare release. CMS believes that additional time is needed with respect to the updated risk-adjusted versions of the CLABSI and CAUTI measures. CMS expects that the earliest public display possible for these measures is 2022.

To prepare for public reporting, CMS proposes to conduct two confidential reporting periods of measure results on five measures: the four end-of-life care measures and the Unplanned Readmissions for Cancer Patients measure. Confidential reporting is intended to educate PCHs and other stakeholders about the measures, allow PCHs to review their measure results prior to public reporting, test the reporting process, and identify technical changes to measure specifications that might be needed. The data collection periods used for calculating the confidential reports are July 1, 2019, through June 30, 2020, for the end-of-life care measures and fiscal year 2020 for the readmissions measure. Table 4 in the appendix of this summary details the previously adopted and proposed public reporting dates for each measure.

Medicare and Medicaid Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction of 2.4% in the update factor for FFY 2020. In the proposed rule, CMS establishes reporting periods through 2021, clarifies actions that must occur during the reporting period, proposes changes to previously adopted measures, and proposes to add new eCQMs to align with the hospital IQR program.

Certification Requirements

CMS proposes no changes to its policy previously finalized in the FFY 2019 IPPS final rule, under which eligible hospitals and CAHs must use EHR technology certified to the 2015 Edition of CEHRT in 2019 and subsequent years.

Reporting Periods

CMS previously adopted a continuous 90-day reporting period for the Medicare Promoting Interoperability Program for 2019 and 2020. CMS proposes to extend this continuous 90-day reporting period for 2021.

CMS' previously adopted policies required, for the FFY 2020 payment adjustment year, an eligible hospital that had not demonstrated meaningful use in a prior year to use a continuous 90-day reporting period that ends before the October 1, 2019, deadline for registering and attesting to meaningful use. In this rule CMS conditionally proposes to eliminate the October 1, 2019, reporting period deadline for hospitals that had not previously demonstrated meaningful use. These hospitals would then have all of 2019 to complete the reporting requirement for the FFY 2020 payment adjustment. This proposal is contingent on CMS finalizing its proposal to modify the Query of Prescription Drug Monitoring Program (PDMP) measure, described later in this summary.

CMS proposes that eligible hospitals that have not previously demonstrated meaningful use would be required to use a continuous 90-day reporting period in CY 2021 that would apply for the FFY 2022 and 2023 payment adjustment years. For the FFY 2022 payment year, the self-selected reporting period would be required to end before the October 1, 2021, deadline for registering and attesting to meaningful use.

Actions Must Occur During Reporting Period

In response to questions, CMS previously issued an FAQ (number 8231) indicating that, when reporting a numerator value, the hospital is not constrained to the EHR reporting period unless it is expressly required in the measure's numerator statement. Currently, measures associated with the public health and clinical data exchange objective do not contain this limitation. In these cases, actions outside the EHR reporting period could be counted in the numerator if they occurred after the start of the reporting year and before the date of attestation.

CMS now proposes a different policy in light of the new scoring methodology adopted in the FFY 2019 IPPS final rule. Because hospitals may elect an EHR reporting period that is 90 consecutive days or up to an entire calendar year, CMS proposes, beginning with reporting periods in 2020, to require both the numerators and denominators of measures to be based on actions that occurred during the hospital's chosen EHR reporting period. Under the proposal, an exception would apply to the Security Risk Analysis measure because actions included in that measure may occur at any time during the calendar year in which the EHR reporting period occurs. All other measures would be subject to the limitation.

The proposals would not apply to the Medicaid Promoting Interoperability Program, because some measures that were removed from the Medicare Promoting Interoperability Program remain in the Medicaid program. For those measures, CMS believes it is appropriate to continue to allow hospitals to report actions in the numerators outside the EHR reporting period.

Proposals Related to Previously Adopted Measures

CMS proposes changes to the two opioid-related measures previously adopted in the FFY 2019 IPPS final rule. As discussed further below, CMS also includes in this proposed rule several RFIs intended to help it develop better measures in the future to support prevention and treatment of substance use disorder.

- **Changes to Query of PDMP Measure:** CMS proposes to modify this measure in three ways: (1) the measure would remain optional for 2020 reporting and eligible for five points, (2) beginning with 2019 reporting, it would be changed to a yes/no measure instead of a numerator/denominator measure, and (3) as an optional measure the exclusion for this measure would be removed. As currently defined, the measure assesses the number of Schedule II opioid prescriptions for which CEHRT data are used to conduct a query of a PDMP for prescription drug history (except where prohibited and in accordance with applicable law) as a percentage of the number of all Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or CAH during the EHR reporting period. Under the proposal, hospitals electing to report this optional measure would report "yes" if for at least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH used data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. CMS further proposes that if the changes to the Query of PDMP measure are finalized, the e-Prescribing measure would be worth up to 10 points for reporting in 2020 and subsequent years.
- **Removal of Verify Opioid Treatment Measure:** CMS proposes to remove this optional measure from the Medicare Promoting Interoperability Program beginning with 2020 reporting. The measure was previously finalized as an optional measure beginning with 2019 reporting. It assesses the percentage of patients for whom a Schedule II opioid was prescribed during the EHR reporting period and for whom the eligible hospital or CAH sought to identify a signed opioid treatment agreement and incorporated any agreement found into CEHRT. The measure would apply to patients who received an opioid prescription for at least 30 cumulative days within a six-month lookback period. In proposing to remove this measure, CMS cites ongoing stakeholder concerns related to the lack of defined data elements, structure, standards, and criteria for the electronic exchange of opioid agreements; calculating the 30-day lookback period; and the burden caused by lack of a definition for an "opioid treatment agreement." CMS also clarifies that, for 2019 reporting, this measure is worth five points — not "up to" five points as was stated in some places in the FFY 2019 final rule.
- **Clarification for Support Electronic Referral Loops by Receiving and Incorporating Health Information:** CMS proposes to modify the regulatory text to match the measure to require that the electronic summary of care must be received using CEHRT and that clinical information reconciliation for medication, medication allergy, and current problem list must be conducted using CEHRT.

Scoring Methodology for 2020 Reporting Period

As previously finalized, to be considered a meaningful user of EHR technology, an eligible hospital or CAH must:

- Report on all the required measures across all four objectives, unless an exclusion applies.
- Report "yes" on all required yes/no measures, unless an exclusion applies.
- Attest to completing the actions included in the Security Risk Analysis measure.
- Achieve a total score of at least 50 points.

CMS proposes to modify the scoring for the 2020 reporting period to reflect the proposed changes to measures as described above. The table below compares the previously adopted measures and points with those proposed in this rule.

Current and Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in 2020			
Objectives	**Measures**	**Maximum Points**	
		Current	**Proposed**
e-Prescribing	e-Prescribing	5 points	10 points*
	Query of Prescription Drug Monitoring Program (PDMP)	5 points	5 points (bonus)
	Verify Opioid Treatment Agreement	5 points (Bonus)	Removed
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	40 points
Public Health and Clinical Data Exchange	Choose any two of the following: Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points	10 points

*This change in points is conditional on CMS finalizing the Query of PDMP measure as optional.

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

As previously finalized, for the 2019 reporting period, hospitals participating in the Medicare and Medicaid Promoting Interoperability programs must report on four self-selected measures (from an available eight) for one self-selected quarter of data during the calendar year. CMS proposes to continue these reporting requirements for the 2020 and 2021 reporting years. These requirements align with those under the hospital IQR program.

As is proposed for the hospital IQR program, CMS proposes to add two new eCQMs to the list of those available for reporting beginning with the 2021 reporting period: Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e) and Hospital Harm – Opioid Related Adverse Events eCQM. Additional information on both measures is available in the hospital IQR section of this summary. Beginning with the 2022 reporting period — and aligned with the IQR program — CMS proposes that reporting of the new Concurrent Prescribing eCQM would be mandatory, with hospitals and CAHs self-selecting three other eCQMs to report.

The previously adopted requirements that EHRs be certified to all CQMs adopted for the Promoting Interoperability Program would be extended for the 2020 reporting period and subsequent years. No changes are proposed to previously adopted policies related to use of 2015 CEHRT and data submission using QRDA-1 and the QualityNet Portal. More information on the form and manner of reporting is available on the eCQI Resource Center web page at: https://ecqi.healthit.gov/.

Beginning with the 2023 reporting period, CMS proposes that hospitals would be required to submit eCQM data electronically; attestation would be eliminated as a method of reporting for the Medicare Promoting Interoperability Program. CMS notes that attestation is currently only permitted where electronic reporting is not feasible, and it believes that the proposed timing would allow an adequate transition period for hospitals and CAHs to move to electronic reporting.

Requests for Information on Future of Promoting Interoperability Program

The proposed rule includes a number of RFIs on potential future measures and policies under the promoting interoperability programs.

- **RFI on Potential Future Opioid Measures:** CMS seeks comment on new measures for opioid use disorder prevention and treatment that could be included in future years of the Promoting Interoperability Program.
- **RFI on National Quality Forum and CDC Opioid Quality Measures:** CMS specifically seeks comments on the development measures for the Promoting Interoperability Program that are based on existing efforts to measure clinical and process improvements. CMS cites three existing measures endorsed by the NQF and 16 CDC Quality Improvement opioid measures.
- **RFI on a Metric to Improve Efficiency of Providers within EHRs:** CMS requests comments on a potential metric to assess provider efficiency using EHRs. Comments are sought on how implementation of efficient workflows and technologies can be effectively measured and how to measure and incentivize efficiency as it relates to the meaningful use of CEHRT and the furtherance of interoperability.
- **RFI on Including Medicare Promoting Interoperability Program Data on the Hospital Compare Website:** CMS seeks comment on posting the performance of eligible hospitals and CAHs on Medicare Promoting Interoperability Program measures on Hospital Compare, including which measures CMS should consider posting and the process by which hospitals should review data prior to publication.
- **RFI on the Provider to Patient Exchange Objective:** CMS discusses its efforts to improve patient access to information and the recent proposed rule issued by the Office of the National Coordinator for Health Information Technology (ONC) that would establish new standards for application programming interfaces (APIs) as part of the 2015 Edition of CEHRT requirements. CMS seeks comments on whether hospitals should be required to make patient health information available immediately through the open, standards-based API, no later than one business day after it is available to the eligible hospital or CAH in their CEHRT. CMS also seeks information on the barriers to more immediate access to patient information, and if there are any specific data elements that are more or less feasible to share no later than one business day. In addition, CMS seeks comment on whether the current Provide Patients Electronic Access to their Health Information measure should be more specific with respect to the experience patients should have regarding their access and whether stakeholders would support bonus point scoring for early adoption of a certified FHIR-based API if the ONC proposal is finalized. Finally, CMS seeks comment on an alternative measure under the Provider to Patient Exchange objective that would require health care providers to use technology certified to the electronic health information export criteria — if finalized by the ONC — to provide patients their complete electronic health data contained within an EHR.
- **RFI on Integration of Patient-Generated Health Data into EHRs Using CEHRT:** CMS seeks comments on ways that the Promoting Interoperability Program could adopt new elements

related to patient-generated health data (PGHD) that represent clearly defined uses of health IT; are linked to positive patient outcomes; and advance the capture, use, and sharing of PGHD.

- **RFI on Engaging in Activities that Promote the Safety of the EHR:** CMS seeks comments on ways that the Promoting Interoperability Program could reward hospitals for engaging in activities that can help to reduce errors associated with EHR implementation. CMS is particularly interested in comments about whether to award points under the program for hospitals that attest to performance of an assessment based on one of the ONC SAFER Guides.

Appendix — Quality Reporting Program Tables

Table 1

IQR Program Measures by Payment Determination Year X= Mandatory Measure, *Proposed Measures in Italics*	2019	2020	2021	2022	2023
Chart-Abstracted Process of Care Measures					
STK-4 Thrombolytic therapy for acute ischemic stroke	Removed				
VTE-5 VTE discharge instructions	Removed				
VTE-6 Incidence of potentially preventable VTE			Removed		
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X	X
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF #0495)	X	X	Removed		
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)	X	X	X	Removed	
IMM-2 Immunization for influenza (NQF #1659)	X	X	Removed		
PC-01 Elective delivery < 39 weeks gestation (NQF#0469)	X	X	X	X	X
Healthcare-Associated Infection Measures					
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X	Removed	
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	X	Removed	
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	Removed	
MRSA Bacteremia	X	X	X	Removed	
Clostridium Difficile (C. Diff)	X	X	X	Removed	
Healthcare Personnel Influenza Vaccination	X	X	X	X	X
Claims-Based Measures					
Mortality					
AMI 30-day mortality rate	X	Removed			
Heart Failure (HF) 30-day mortality rate	X	Removed			
Pneumonia 30-day mortality rate	X	X	Removed		
Stroke 30-day mortality rate	X	X	X	X	X
COPD 30-day mortality rate	X	X	Removed		
CABG 30-day mortality rate	X	X	X	Remove	

Readmission/ Coordination of Care					
AMI 30-day risk standardized readmission	X	Removed			
Heart Failure 30-day risk standardized readmission	X	Removed			
Pneumonia 30-day risk standardized readmission	X	Removed			
TKA/THA 30-day risk standardized readmission	X	Removed			
Hospital-wide all-cause unplanned readmission	X	X	X	X	X**
Stroke 30-day risk standardized readmission	X	Removed			
COPD 30-day risk standardized readmission	X	Removed			
CABG 30-day risk standardized readmission	X	Removed			
Hybrid (claims+EHR) hospital-wide readmission		Voluntary			
Excess days in acute care after hospitalization for AMI	X	X	X	X	X
Excess days in acute care after hospitalization for HF	X	X	X	X	X
Excess days in acute care after hospitalization for PN	X	X	X	X	X
Patient Safety					
PSI-90 Patient safety composite (NQF #0531)	X	Removed			
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X	X
THA/TKA complications	X	X	X	X	Removed
Efficiency/Payment					
Medicare Spending per Beneficiary	X	Removed			
AMI payment per 30-day episode of care	X	X	X	X	X
Heart Failure payment per 30-day episode of care	X	X	X	X	X
Pneumonia payment per 30-day episode of care	X	X	X	X	X
THA/TKA payment per 30-day episode of care	X	X	X	X	X
Kidney/UTI clinical episode-based payment	X	Removed			
Cellulitis clinical episode-based payment	X	Removed			
Gastrointestinal hemorrhage clinical episode- based payment	X	Removed			

Aortic Aneurysm Procedure clinical episode-based payment	X	Removed			
Cholecystectomy/Common Duct Exploration episode-based payment	X	Removed			
Spinal Fusion clinical episode-based payment	X	Removed			
Patient Experience of Care					
HCAHPS survey + 3-item Care Transition Measure	X	X	X	X	X
Structural Measures					
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Removed				
Participation in a Systematic Clinical Database Registry for General Surgery	Removed				
Safe Surgery Checklist Use	X	Removed			
Hospital Survey on Patient Safety Culture	X	Removed			

Electronic Clinical Quality Measures

Measure	Payment Years				
	2019	2020	2021	2022	2023
STK-2 Antithrombotic therapy for ischemic stroke STK-3 Anticoagulation therapy for Afib/flutter STK-5 Antithrombotic therapy by end of hospital STK-6 Discharged on statin (NQF #0439) STK-8 Stroke education STK-10 Assessed for rehabilitation services (NQF #0441) VTE-1 VTE prophylaxis (NQF #0371) VTE-2 ICU VTE prophylaxis (NQF #0372) AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) (NQF #0163) CAC- 3 Children's asthma care – 3 ED-1 Median time from ED arrival to departure from the emergency room for ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497) EDHI-1a Hearing screening prior to hospital discharge PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469) PC-05 Exclusive breast milk feeding (NQF #0480)	Report 4 of the following 15 eCQMs: AMI-8a CAC-3 ED-1 ED-2 EHDI-1a PC-01 PC-05 STK-02 STK-03 STK-05 STK-06 STK-08 STK-10 VTE-1			Report 4 of the following 8 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2	Report 4 of the following 10 eCQMs ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 *Opioid-related Adverse Events* *Safe use of Opioids**

*As proposed, beginning with the FY 2024 payment determination, hospitals would be required to report this eCQM and 3 other self-selected eCQMs

**As proposed, beginning with the FY 2026 payment determination, this measure would be replaced by the Hybrid HWR measure.

Table 2

VBP-1 Program Measures and Domains by Payment Year					
Measure	**2018**	**2019/2020**	**2021**	**2022**	**2023**
Clinical Care – *Renamed "Clinical Outcomes" beginning 2020*					
Acute Myocardial Infarction (AMI) 30-day mortality rate	X	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty		X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate			X	X	X
CABG 30-day mortality rate				X	X
Safety					
PSI-90 Patient safety composite (NQF #0531)	X	Removed			
Patient Safety and Adverse Events composite					X
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X	X	X
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
MRSA Bacteremia	X	X	X	X	X
Clostridium Difficile (C.Diff)	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation	X	X	Removed		
Patient and Caregiver Centered Experience of Care/Care Coordination (Person and Community Engagement)					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Management (before 2018)* Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital 3-Item Care Transition measure	X	X	X	X	X
Efficiency and Cost Reduction					
Medicare Spending per Beneficiary	X	X	X	X	X
AMI Payment per 30-day episode			Removed		
HF Payment per 30-day episode			Removed		
PN Payment per 30-day episode				Removed	

*The pain management component of HCAHPS was removed beginning with the FY 2018 payment determination.

Table 3

HAC Reduction Program Measures and Performance Periods for Payment Determination in FFYs 2018-2020			
Measure	**FFY 2018**	**FFY 2019**	**FFY 2020**
Domain 1			
PSI-90 Patient Safety & Adverse Events Composite	X	X	X
Performance Period	7/1/14-9/30/15	10/1/15-6/30/17	7/1/16-6/30/18
Domain 2			
NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	X
NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X
NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X
NHSN Methicillin-Resistant Staphylococcus Aureus Bacteremia (MRSA) Outcome Measure (NQF #1716)	X	X	X
Colon/Abdominal Hysterectomy Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753)	X	X	X
Performance Period	1/1/15-12/31/16	1/1/16-12/31/17	1/1/17-12/31/18

Table 4

PCH QRP Measures for 2022 (*Proposals in Italics)*	
Measure	**Public Display**
Safety and Healthcare-Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	*Proposed 2019**
NHSN CDI (NQF #1717)	*Proposed 2019**
NSHN MRSA bacteremia (NQF #1716)	*Proposed 2019**
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	*Proposed 2019**
NHSN CLABSI (NQF #0139)**	*Deferred until 2022*
NHSN CAUTI (NQF #0138)**	*Deferred until 2022*
Clinical Process/Oncology Care	
Oncology: Plan of Care for Pain (NQF #0383)	2016
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)	
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	
Patient Experience of Care	
HCAHPS (NQF #0166)	2016
Clinical Effectiveness	
Proposed for Removal: External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	*Proposed 2020*
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	
Proposed: Surgical Treatment Complications for Localized Prostate Cancer	
**Public display, previously deferred, is proposed to begin with the October 2019 Hospital Compare update.*	