CALIFORNIA HOSPITAL ASSOCIATION

Federal Regulatory Summary

from the California Hospital Association

SUMMARY OF FINAL RULE — SEPTEMBER 2019

FFY 2020 Medicare Inpatient Prospective Payment System

Overview

In the August 2 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its final 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 are effective for FFY 2020 discharges, beginning October 1.

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

The final 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. Though modified from the original proposal, this policy will adversely impact California hospitals, which stand to lose more than $22 million in hospital inpatient payments in FFY 2020 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

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 analyses were 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, DSH, etc.

	Final FFY 2019	Final FFY 2020	Percent Change
Federal Operating Rate	$5,646.08	$5,801.13	+2.75%
Federal Capital Rate	$459.41	$462.61	+0.70%

The table below provides details for 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	+3.0%		1.5%
ACA-Mandated Reductions 0.4 percentage point (PPT) productivity reduction	-0.4 PPT		—
MACRA-Mandated **Retrospective** Documentation and Coding Adjustment	+0.5%	—	—
Budget Neutrality Adjustments Related to FFY 2020 Wage Index Changes	-0.32		-0.36
Annual Budget Neutrality Adjustment	-0.04%		-0.43%
Net Rate Update	*+2.75%*	*+2.23%*	*+0.70%*

Retrospective Coding Adjustment

CMS will 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% Market Basket minus 0.4 PPT productivity)	+2.6%			
Penalty for Failure to Submit IQR Quality Data (25% of the base Market Basket Update of 3%)	—	-0.75 PPT	—	-0.75 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base Market Basket Update of 3%)	—	—	-2.25 PPT	-2.25 PPT
Adjusted Net Market Basket Update (prior to other adjustments)	*+2.6%*	*+1.85%*	*-0.35%*	*-0.4%*

CMS estimates certain hospitals will not receive the full market basket rate-of-increase, including 41 that failed the quality data submission process or chose not to participate in the IQR program, and 167 that are not meaningful EHR users. CMS also estimates 30 hospitals will be subject to both reductions.

Impact Analysis

CHA DataSuite analysis estimates that California hospitals will experience an increase of 2.1% in overall Medicare hospital inpatient payments in FFY 2020, as compared to FFY 2019. However, the impact will vary.

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2019 IPPS Payments	**$11,395,152,600**		**$859,412,800**		**$12,254,565,100**	
Provider Type Changes	$0	0.0%	($3,412,200)	-0.4%	($3,412,200)	0.0%
Marketbasket Update (Includes Budget Neutrality)	$318,266,300	2.8%	$9,102,600	1.1%	$327,367,900	2.7%
ACA-Mandated Marketbasket Reductions	($42,989,300)	-0.4%	*Not Applicable*		($42,989,300)	-0.4%
Forecast Error Adjustment	*Not Applicable*		$0	0.0%	$0	0.0%
MACRA-Mandated Coding Adjustment	$54,035,000	0.5%	*Not Applicable*		$54,035,000	0.4%
Wage Index/GAF (Wage Data and Reclassification)	$187,025,300	1.6%	$13,719,700	1.6%	$200,744,800	1.6%
Wage Index/GAF (Other Changes)	($88,553,200)	-0.8%	($7,164,600)	-0.8%	($95,718,100)	-0.8%
> Rural Reclasses Removed from Rural WI Calc	($54,288,300)	-0.5%	($4,097,900)	-0.5%	($58,386,000)	-0.5%
> Increasing Bottom Quartile Wage Index Values	$0	0.0%	$0	0.0%	$0	0.0%
> Bottom Quartile Increase BN Adjustment	($22,572,400)	-0.2%	($2,002,500)	-0.2%	($24,574,700)	-0.2%
> Application of 5% Stop Loss Adjustment	$1,311,500	0.0%	$89,600	0.0%	$1,401,100	0.0%
> 5% Stop-Loss BN Adjustment	($13,005,700)	-0.1%	($1,153,700)	-0.1%	($14,159,300)	-0.1%
DSH: UCC Payment Changes [1]	($217,377,300)	-1.9%			($217,377,300)	-1.8%
> DSH UCC Distribution Factor Change	($224,108,100)	-2.0%	*Not Applicable*		($224,108,100)	-1.8%
Change in Hospital Specific Rate	$0	0.0%			$0	0.0%
MS-DRG Updates	$32,309,400	0.3%	$2,537,600	0.3%	$34,847,100	0.3%
Quality Based Payment Adjustments [2]	$2,071,200	0.0%	$34,400	0.0%	$2,105,200	0.0%
Net Change due to Low Volume Adjustment	$2,187,700	0.0%	$149,600	0.0%	$2,337,500	0.0%
Estimated FFY 2020 IPPS Payments	**$11,642,128,400**		**$874,379,800**		**$12,516,506,600**	
Total Estimated Change FFY 2019 to FFY 2020¥	***$246,975,800***	***2.2%*** ▲	***$14,967,000***	***1.7%*** ▲	***$261,941,800***	***2.1%*** ▲

¥ 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 the impact of sequestration on FFY 2020 IPPS-specific payments will be: -$250,330,200.

CMS' detailed impact estimates are displayed in Table I (pages 42, 657 - 42, 659) of the final rule, which is partially reproduced below.

Hospital Type	All Final Rule Changes
All Hospitals	2.9%
Urban	2.9%
Urban – Pacific Region	3.6%
Rural	2.8%
Rural – Pacific Region	2.4%
Major Teaching	2.9%

Outlier Payments

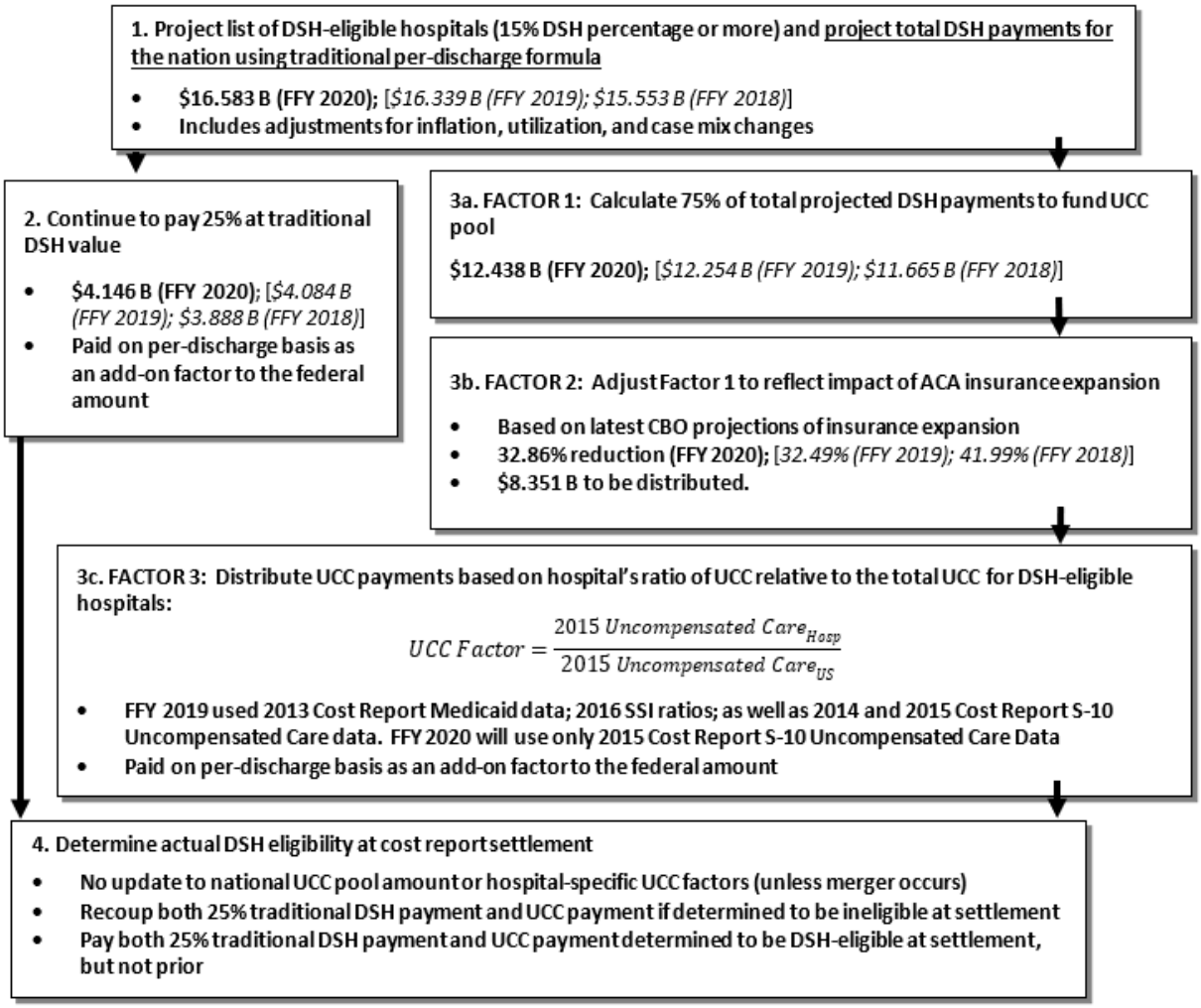
Due to prior concerns over CMS' decision not to consider outlier reconciliation in the outlier threshold development for a given fiscal year, CMS now believes incorporating historic cost report outlier reconciliations when developing the threshold is a reasonable approach and would provide a better predictor for the upcoming fiscal year. Therefore, for FFY 2020, CMS will 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 adopts an outlier threshold of $26,473 for FFY 2020. The threshold is 2.73% 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 details and background information follow.



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.

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) June 2019 Medicare DSH estimates, which were based on the March 2019 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 June 2019 Medicare estimate of DSH is $16.583 billion. **The proposed Factor 1 amount is 75% of this, or $12.438 billion** — about $184 million more than the final Factor 1 for FFY 2019.

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 CMS chief actuary certified these estimates.

Using these estimates, CMS calculates 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 final rule to be 0.6714 or 67.14%, and the UCC amount for FFY 2020 to be $8.350 billion ($12.438 billion x 0.6714), about $77 million more than the FFY 2019 UCC total of about $8.273 billion; the percentage increase is 0.94%.

FFY 2020 Factor 3

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.

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 expressed 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.

Due to the concerns noted above, CMS had proposed to use a single year of Worksheet S-10 data, from FFY 2015 cost reports, to calculate Factor 3 in the FFY 2020 methodology. However, acknowledging that some hospitals have raised concerns about adjustments made to the FFY 2015 cost reports following the audits, as well as important changes to lines 20-22 of Worksheet S-10 related to reporting charity care charges, CMS sought feedback on an alternative proposal. Specifically, CMS sought feedback 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.

Despite comments from CHA and other commenters, who raised concerns about the use of a single year of data rather than a three-year average, and the challenges of using both audited and unaudited FFY 2015 data, **CMS finalized its proposal to use the audited FFY 2015 Worksheet S-10 cost report data in the methodology to determine Factor 3.** Due to feedback from commenters emphasizing the importance of audits in ensuring the accuracy and consistency of data, CMS believes that the FFY 2017 Worksheet S-10 data should be audited before being used in the uncompensated care distribution. CMS states, and CHA has confirmed, that the audits of a limited number of hospitals' FFY 2017 Worksheet S-10 data are currently in process. CHA encourages all member hospitals selected for a FFY 2017 audit to respond in a timely fashion to the requests for information from the contractors and to contact CHA with concerns.

In the proposed rule, CMS indicated that it would use the March 2019 extract of the HCRIS for the final rule. However, commenters were concerned that audit adjustments made to the FFY 2015 were not included in the proposed rule Worksheet S-10s that went into determining the FFY 2020 Factor 3 and expressed concern those audit adjustments would not be included in the March HCRIS extract used for the final rule.

CMS recognizes that some hospitals' data in the March HCRIS update may not have reflected all corrections and/or adjustments made to Worksheet S-10 data in response to CMS' hospital outreach and auditing efforts. Given those circumstances and consistent with the historical practice of using the best data available, CMS is using a June 30, 2019, HCRIS extract, the most recent available for the final rule, to calculate Factor 3 for FFY 2020. CHA continues to identify challenges in the data, and hospitals had until August 31, 2019, to review and submit comments on the accuracy of their uncompensated care data and Factor 3.

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 policy to apply trim methodologies to potentially aberrant UCC costs for all hospitals.

Scaling Factor

CMS will not 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 finalizes its proposal to use only one year of cost report data.

Steps to Trim CCRs

Similar to the FFY 2018 and 2019 processes, CMS finalized a series of steps for trimming CCRs in FFY 2020. In response to comments that raised a discrepancy in the proposed rule about how CMS plans to treat all-inclusive rate providers, CMS provides a clarification. Specifically, CMS states that there are two trims. One trim applies when a hospital's uncompensated care costs are more than 50 percent of its total costs. All-inclusive rate providers are subject to this trimming methodology. However, no hospitals (all-inclusive rate providers or other hospitals) were excluded based on this trim point. The second trimming methodology applies to aberrant CCRs. CMS excludes all-inclusive rate providers from the determination and application of the trim point for aberrant CCRs.

The final rule provides the four-step process for determining statistical trim methodologies, which is the same as was provided in prior years:

Methodology for Trimming CCRs	
Step 1	Remove Maryland hospitals and all-inclusive rate providers.
Step 2	For FY 2015 cost reports, calculate a CCR ceiling by dividing the total costs on Worksheet C, Part I, Line 202, Column 3 by the charges reported on Worksheet C, Part I, Line 202, Column 8. The ceiling is calculated as three standard deviations above the national geometric mean CCR for the applicable fiscal year. Remove all hospitals that exceed the ceiling. In the proposed rule, this step removed eight hospitals that have a CCR above the calculated ceiling of 0.925 for FY 2015. In the final rule, CMS removed six hospitals.
Step 3	Using the CCRs for the remaining hospitals in Step 2, determine the urban and rural statewide average CCRs for FY 2015 for hospitals within each state (including non-DSH eligible hospitals), weighted by the sum of total inpatient discharges and outpatient visits from Worksheet S-3, Part I, Line 14, Column 14.
Step 4	Assign the statewide average CCR (urban or rural) calculated in Step 3 to all hospitals, excluding all-inclusive rate providers, with a CCR greater than three standard deviations above the corresponding national geometric mean (that is, the CCR "ceiling"). For the proposed rule, the statewide average CCR would, therefore, by applied to eight hospitals, of which four had Worksheet S-10 data. There is no indication of this figure for the final rule.

California Impact of Proposed Medicare DSH Cuts

CHA DataSuite analysis has estimated 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. These data remain preliminary.

	FFY 2019	FFY 2020	Change
Total Funding for UCC Payments	$12.254 Billion	$12.438 Billion	+$0.183 Billion
ACA-Mandated Reduction	-32.49%	-32.86%	-0.37%
Redistribution Pool	**$8.273 Billion**	**$8.351 Billion**	**+$0.078 Billion**
Hospital Specific Payment Factor	Hospital-Specific		
Hospital UCC Payment Amount	**$716,868,700**	**$499,244,900**	**($217,377,300)**

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 adopts its proposal to modify the statutory language associated with its policy that a CAH cannot be considered a "non-provider site." Specifically, for cost reporting periods beginning October 1, 2019, a hospital can 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. Eighty percent of DRG weights will change by less than +/- 5%, with 5% 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	Final FFY 2020 Weight	Percent Change
MS-DRG 779: ABORTION W/O D&C	0.7543	1.1418	+51.4%
MS-DRG 886: BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	1.3456	+36.1%
MS-DRG 796: VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	1.9723	+34.3%
MS-DRG 951: OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	0.5865	-26.5%
MS-DRG 770: ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	0.7863	-26.4%

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-FR-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).

CMS notes that it has received a request to create a new MS-DRG for procedures involving CAR T-cell therapies. 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 is premature to consider creation of a new MS-DRG for this therapy, so modified the current MS-DRG assignment for cases reporting CAR T-cell therapy for FFY 2020.

In the proposed rule, CMS requested public comments on payment alternatives for CAR T-cell therapies, including payment under any potential new MS-DRG. Specifically, CMS asked for responses to the following questions:

- What is the most appropriate way to develop the relative weight of a new MS-DRG?
- Would it be appropriate to geographically adjust payment under a new MS-DRG?
- What, if any, adjustments should be made for IME and DSH payments for cases assigned to a new MS-DRG?

In comments on the proposed rule, CHA urged the agency to finalize a method of determining the cost of the CAR T-cell therapy that ensures the agency captures that cost accurately, such as using the therapy's average sales price (ASP) as a proxy for its cost. CMS also requested comments about establishing a specific CCR for reporting procedures involving the use of CAR T-cell therapies. CMS notes that several commenters suggested a CCR of 1.0 for CAR T-cell products for all payment purposes, including new technology add-on payments, outlier payments, and payments to IPPS-excluded cancer hospitals. In comments, CHA expressed concern that the assumption that hospitals are charging their actual acquisition cost may be incorrect, since hospitals are required to have a set of uniform charges and payments made to providers under contract to private plans also dictate how the charge is set. CMS states that it will consider all the comments in any future rulemaking related to the MS-DRG assignment for CAR-T cell therapy.

Finally – as described below – CMS finalized its proposal to raise its current cap on New Technology Add-on Payments (NTAPs). According to CMS, the cost of administering either of the current CAR-T products approved for NTAPs, KYMRIAH™ or YESCARTA™, is $373,000; thus, the finalized policy will increase the maximum NTAP for CAR-T from $186,500 to $242,450 per case for FFY 2020. CMS estimates the FFY 2020 add-on payments at approximately $93,585,700, based on 386 patients.

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. CMS finalized policies to:

- Discontinue add-on payments for three medical services/technologies
- Continue new technology add-on payments for nine technologies
- Implement add-on payments for nine technologies

In addition, in the proposed rule, CMS issued a request for information (RFI) about the "New Technology Add-On Payment Substantial Clinical Improvement" criterion. Commenters have previously 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 provides a summary of public comments in response to the RFI in the final rule.

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 finalized its proposal to raise the current 50% cap on new technology add-on payments. Specifically, for discharges beginning October 1, 2019, CMS finalized the following:

> *"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. For a new technology that is a medical product designated by the FDA as a QIDP* [Qualified Infectious Disease Products]*, beginning with discharges on or after October 1, 2019, 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) 75 percent of the costs of the new medical service or technology; or (2) 75 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 will be limited to the full MS-DRG payment plus 65 percent (or 75 percent for a medical product designated by the FDA as a QIDP) 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. Final rule wage index tables 2, 3, and 4 can be found at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Despite significant opposition from CHA and other stakeholders, CMS finalized changes to the wage index that will result in a reduction in payments to California hospitals by approximately $22 million in FFY 2020. The finalized policy – described in more detail below - presents a dangerous precedent: that CMS can choose to increase payments to one group of hospitals by decreasing payments to another group. Although CMS modified the policy since its initial proposal, we remain concerned about this dangerous precedent and have begun the process to initiate legal action on behalf of CHA members. Additional information on the AWI ligation, including the process for member hospitals to join the legal challenge, important documents, and key contacts, is available on CHA's website.

Due to the significant changes finalized to the hospital AWI, outlined below, CHA hosted an executive briefing on August 16. A recording and the presentation slides are available to members at www.calhospital.org/awi-member-briefing.

Hospital Exclusions

CMS calculates the FFY 2020 wage index based on the wage data of 3,239 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 final wage index includes FFY 2016 data submitted to CMS as of June 19, 2019.

General wage index policies are unchanged from prior years. In the proposed rule, CMS excluded 81 providers due to excessively aberrant data, but indicated that — if the data could be corrected in time — it would include some of those providers in the final wage index for FFY 2020. In the final rule, CMS restores data to the wage index calculation for 16 of these hospitals. An additional three hospitals were deleted for having aberrant data, and an additional three hospitals were dropped from the wage index calculation because they converted to CAH status.

The proposed rule also excluded eight California hospitals that are part of a 38-hospital health system where salaries reflect union-negotiated agreements and reflect prevailing wages in the local labor market. CMS indicated 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 stated that the data submitted by these hospitals are accurate. In response to comments from CHA – who strongly opposed the exclusion of these hospitals from the wage index data – CMS included data from these

eight hospitals in the FFY 2020 final rule wage index data. CMS responded that it will allow more time to consider the appropriateness of including or excluding the wage data of this unique health care chain in the future.

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 reports having occupational mix data for 97% of hospitals (3,136 of 3,239) used to determine the FFY 2020 wage index. The FFY 2020 national average hourly wage, unadjusted for occupational mix, is $44.19. The occupational mix adjusted national average hourly wage is $44.15.

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 164 hospitals — 99 fewer than were receiving the rural floor in FFY 2019. This impact is due, in part, to CMS' policy, described below, to no longer include urban to rural reclassifications in the calculation of the rural wage index.

CMS calculates a national rural floor budget neutrality adjustment factor of 0.997081 (negative 0.29%), 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 did not propose any changes to the geographic reclassification criteria. However, it did finalize 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 the finalized policy, unrounded figures must now be used in all situations.

Geographic Reclassifications

The MGCRB approved 294 hospitals for a geographic reclassification starting in FFY 2020. Because reclassifications are effective for three years, a total of 859 hospitals are in a reclassification status for FFY 2020, including those initially approved by the MGCRB for FFY 2018 (290 hospitals) and FFY 2019 (275 hospitals). **The deadline for withdrawing or terminating a wage index reclassification for FFY 2020 approved by the MGCRB was June 17, 2019. Applications for FFY 2021 reclassifications or canceling a previously approved reclassification were due to the MGCRB by September 3, 2019.**

Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process were 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 received in time 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 finalizes its proposal 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 revised policy will affect 10 counties in Alabama, Georgia, Mississippi, Ohio, Pennsylvania, Texas, and Virginia that include a total of four IPPS hospitals.

Out-Migration Adjustment

CMS will use the same policies, procedures, and computation that were used for the FFY 2012 out-migration adjustment and estimates increased payments of approximately $44 million in FFY 2020 for 176 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 finalizes its proposal 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.

Canceling 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 revises § 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 finalizes uniform requirements, applicable to all hospitals, for canceling 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 made 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, 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 codifies 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 codifies 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.

Finally, CMS expresses concern about a hospital reclassifying from urban to rural after the lock-in date in order to get a higher wage index without affecting the rural wage index calculation. CMS says that it will monitor this situation over the course of FFY 2020 to determine if it is necessary to prevent this type of gaming in future rulemaking. This may occur in the situations where the rural wage index is higher than the rural floor and the urban hospital's wage index is between these two amounts. Prior to FFY 2020, the rural wage index and the rural floor were the same. However, CMS' policy to exclude urban to rural reclassifications from the rural floor could make the rural wage index different and higher than the rural floor, as is occurring in Massachusetts in FFY 2020.

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 Policies to Address Wage Index Disparities

Policy 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. For additional background on the concerns expressed in previous rulemaking we refer readers to CHA's IPPS proposed rule summary.

In response to these concerns, CMS finalizes its proposal 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 believes that the quartile approach is reasonable given quartiles are a common way to divide distributions. Based on FFY 2020 final rule wage index data, the 25th percentile wage index value is 0.8457. CMS will 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 finalizes its proposal to make the policy effective for at least four years, to allow for employee compensation increases to be implemented by these hospitals and provide 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.

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

CMS declined 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 hospitals through an adjustment to the wage index of high wage index hospitals.

In the proposed rule, CMS stated it 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 would have ensured those hospitals whose wage index is not considered high or low do not have their wage index values affected by the proposed policy.

CHA and other commenters strongly opposed the proposed wage compression. In the final rule, CMS states that the vast majority of commenters argued that CMS did not have the statutory authority for its budget neutrality proposal and that it arbitrarily results in an inaccurate wage index for high wage hospitals. Commenters claimed this selective budget neutrality – whereby a small subset of hospitals bears the entire burden of budget neutrality for a given CMS policy change – is unprecedented, and that it violates both the statutory purpose of the wage index and CMS' own long-standing policy of spreading the cost of payment adjustments across all hospitals equally. CMS furnished no evidence to suggest that

the high wage indexes being reduced are inaccurate. Further, CHA and others argued that CMS is not under a requirement to make the wage index increases budget neutral.

Despite CMS' continued belief that it has the statutory authority to address budget neutrality as proposed, CMS acknowledged that commenters presented reasonable policy arguments regarding the relationship between its proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of IPPS hospitals. For this reason, CMS did not finalize the proposed budget neutrality adjustment. Instead, CMS finalizes the application of a uniform budget neutrality adjustment of 0.997987 (-0.2 percent) to the national standardized amounts for all hospitals.

Policy 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.

In the rule, CMS 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 finalizes its proposal to remove urban to rural reclassifications from the calculation of the rural floor beginning in FFY 2020.**

Policy 4: Transitioning Wage Index Reductions and Budget Neutrality

Following past practice when large changes to wage indexes have been transitioned, CMS finalizes its proposal of a transition to mitigate any significant decreases in the wage index values of hospital's compared to their final wage indexes for FFY 2019. For FFY 2020 only, CMS will place a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FFY 2019.

Following past practice, CMS invokes section 1886(d)(5)(I) of the Act to make the 5% cap on wage index reductions budget neutral. CMS will apply a budget neutrality adjustment to ensure that estimated aggregate payments under the transition for hospitals negatively impacted by new wage index policies will equal what estimated aggregate payments would otherwise have been absent the transition policy. The budget neutrality adjustment is 0.998838 (negative 0.12%) to the FFY 2020 standardized amount.

Post-Acute Care Transfer and Special Payment MS-DRGs

CMS finalized 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 will:

- 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 finalizes 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 1.68645 (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 finalizes its proposal 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 the 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 adopts two new measures for the hospital IQR program. Specifically, CMS adopts new opioid-related electronic clinical quality measures (eCQMs) beginning with the FFY 2023 payment determination, and will require mandatory reporting of the currently voluntary Hybrid Hospital-Wide Readmission measure beginning with the FFY 2026 payment determination. The existing claims-based readmission measures will be removed at that time. Notably, in response to comments from CHA and other stakeholders CMS did not finalize the addition of a second opioid-related eCQM, Hospital Harm—Opioid Related Adverse Events eCQM.

Table 1 in the appendix to this summary shows the previously adopted and finalized 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/.

Safe Use of Opioids – Concurrent Prescribing eCQM

CMS finalized the addition of the Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e) beginning with the FFY 2021 reporting period/FFY 2023 payment year. As discussed later in this summary, CMS also finalized this eCQM for the Medicare and Medicaid Promoting Interoperability Program.

This 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 an 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.

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

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 finalizes a stepped approach to mandating the Hybrid HWR measure and replacing the existing claims-based HWR measure. CMS adopts two new expanded voluntary data collection periods: July 1, 2021, through June 30, 2022, and July 1, 2022, through June 30, 2023. Mandatory reporting will be required beginning with the FFY 2026 payment determination, with a data collection period of July 1, 2023, through June 30, 2024.

Hospitals will 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 will 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 must 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 will 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 will 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 will be provided for the two proposed new voluntary reporting periods, the first of which will be delivered to hospitals in the spring of 2023. No public reporting of the Hybrid HWR measure will occur during the voluntary reporting periods. CMS will 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

In conjunction with the adoption of mandatory reporting of the Hybrid HWR measure, CMS finalizes its proposal to remove the current Claims-Based HWR measure beginning with the FFY 2026 payment determination.

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 final rule, CMS describes 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. 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 did not make any 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 establish eCQM reporting and submission requirements for FFYs 2022 through 2024 payment determinations (FFY 2020 through 2022 reporting periods).

For the FFY 2022 and 2023 payment determinations, CMS will 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 will 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 continues 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 were made to previously adopted policies regarding use of the 2015 Edition Certification Criteria, eCQM file format requirements, and submission deadlines for eCQM data.
For reporting of the Hybrid HWR measure finalized in this rule, updated implementation guidance, schematrons, and sample files will be made available on the eCQI Resource Center website. Current zero-denominator declaration and case threshold exemption policies for eCQMs will also apply to hybrid measure reporting. If a hospital's EHR is capable of reporting hybrid measure data, but the hospital does not have patients that meet the measure's denominator criteria, the hospital may submit a zero in the denominator and that will count as a successful submission for the hybrid measure. Similarly, hospitals that have five or fewer inpatient discharges per quarter or 20 or fewer inpatient discharges per year, as defined by a hybrid measure's denominator population, are exempted from reporting on that hybrid measure.

The deadline for submission of the Hybrid HWR core clinical data elements and linking variables will be three months following the end of the applicable reporting period. For example, for the first voluntary reporting period (July 1, 2021 through June 30, 2022) the deadline for submitting the core clinical data is September 30, 2022.

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 $6.14 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 adopts 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 will 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. This will 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 will also apply.

Previously Adopted Performance and Baseline Periods

CMS did not make changes to previously adopted performance and baseline periods for the program measures, the specific time periods of which are automatically updated each year. The final rule

includes tables, on pages 42394-42395, that display the baseline and performance periods for each fiscal year from 2022 through 2025.

Previously Adopted Performance Standards

The final 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 42396-42399 of the final 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 did not make any changes 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. In the final rule, CMS establishes factors for removal of program measures, establishes the data collection period for the FFY 2022 program year, clarifies certain data validation and data collection policies finalized in the FFY 2019 IPPS final rule, and updates regulatory text to reflect previously adopted policies effective with the FFY 2020 payment year.

CMS estimates that 792 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 $50 million under this program for FFY 2020.

Removal Factors for HAC Reduction Program Measures

CMS finalizes its proposal to adopt a set of eight factors it will use to determine whether a measure should be removed from the HAC reduction program; no measures are removed at this time. The 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 will not be used for automatic removal of measures but will be applied on a case-by-case basis.

Performance Period for FFY 2022 Program Year

Consistent with previous policies, CMS establishes 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 modifies 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 finalizes its proposal to use a filtering method to better target "true events," or those that meet NHSN HAI criteria. The filtering method will 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 will 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 did not make any changes to its previously adopted HRRP measure set, it does finalize several other changes to HRRP policies for FFY 2020 in this rule. Specifically, CMS establishes factors for removal of HRRP measures, updates the definition of "dual eligible" used for creating peer groups, creates a subregulatory process for making nonsubstantive changes to the HRRP adjustment factor

components, and changes regulatory text to align with these policies and to codify other parts of the HRRP.

CMS estimates that 2,583 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 finalizes its proposal to adopt a set of eight factors it will use to determine whether a measure should be removed from the HRRP; no measures are removed at this time. The 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 will not be used for automatic removal of measures but will be applied on a case-by-case basis.

Definition of Dually Eligible Beneficiary

Beginning with FFY 2021, CMS modifies 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 will be used. CMS believes that this change would affect a small number of beneficiaries and would not have a "substantive impact." In response to comments urging CMS to provide more detail on its estimated impact, CMS states that the new definition increases the number of dual eligible stays by 16,756 or 0.2 percent for the period July 1, 2014 through June 30, 2017.

The finalized 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 establishes 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.

In response to comments from CHA and other stakeholders seeking additional clarity on when this policy will be used, CMS says that the policy is intended to make minor and technical changes that would not substantively impact previously finalized policies. Nonsubstantive changes would not be expected to impact internal hospital monitoring policies or result in hospital burden. CMS understands the concerns of commenters who indicated that the example of the change in the dual eligible definition is substantive and would not be appropriate for a subregulatory process. However, it believes that when minor and previously unknown data discrepancies are discovered that frustrate but do not change the stated intent of existing policies, a subregulatory process may be the best approach for a timely

solution. CMS further notes that in FFY 2020 it will begin providing additional details regarding the payment adjustment factors in the technical appendix of the Hospital Specific Reports User Guide to provide greater insight and detail about the HRRP payment methodology. This information includes details about how CMS processes data, such as the removal of duplicate stays, and the files it uses to produce the final payment adjustment factors. CMS sought flexibility to amend and update the nonsubstantive standard processing rules and data processing to ensure that quality data are used for the payment adjustment calculations, rather than have to delay data improvements.

Applicable Periods for FFY 2020

Consistent with current policies, CMS finalizes that, for FFY 2022, the applicable period from which data will be collected for calculating the readmission payment adjustment factor will 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.

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 made 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 finalizes a series of revisions to the regulatory text involving the HRRP. Specifically, CMS updates the definition of dual eligible as described above. CMS also finalizes two other proposals involving modifying definitions. First, "aggregate payments for excess readmissions" is modified to reflect the peer grouping methodology now in use. Second, the definition of "base operating DRG payment amount" is modified to reflect changes in Medicare-dependent hospital policy.
Additionally, CMS adds 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 removes the pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care measure effective October 1, 2019; removes the measure External Beam Radiotherapy for Bone Metastases; and adds the measure Surgical Treatment Complications for Localized Prostate Cancer beginning with FFY 2022.

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 finalizes its proposal to remove these questions from the PCH QRP beginning with the FFY 2022 payment determination. Data collected on these questions, beginning with October 2018 discharges, will not be publicly reported. CMS will provide performance results to PCHs in confidential preview reports as early as July 2019.

Removal of External Beam Radiotherapy for Bone Metastases Measure

CMS finalizes its proposal 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 finalizes its proposal 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, will be used to calculate measure rates.

Public Reporting of Measures

CMS adopts 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 is finalized to begin as soon as feasible. CMS had proposed to begin public display in 2020, but other changes to the *Hospital Compare* website may delay its ability to publicly report the measure. CMS has recently provided a first round of confidential reports to PCHs on this measure, and another round is planned before public display is effective. Second, CMS previously deferred public display of the CDC NHSN infection measures. CMS finalizes that public display of the MRSA, CDI, colon/abdominal hysterectomy surgical site infection measures, and the influenza vaccine for health care personnel measure will begin as soon as feasible, with a target date of January 2020. CMS had proposed to begin public display with the October 2019 *Hospital Compare* release. CMS continues to believe 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 will 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 — as well as 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 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 2.25% in the update factor for FFY 2020. In the final rule, CMS establishes reporting periods through 2021, clarifies actions that must occur during the reporting period, implements changes to previously adopted measures, and adds one new eCQM to align with the hospital IQR program.

Certification Requirements

CMS did not make 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 finalizes its proposal to extend this continuous 90-day reporting period for 2021.

For the FFY 2020 payment adjustment year, CMS' previously adopted policies required 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 eliminates the October 1, 2019, reporting period deadline for hospitals that had not previously demonstrated meaningful use. These hospitals will have all of 2019 to complete the reporting requirement for the FFY 2020 payment adjustment.

CMS also finalizes that eligible hospitals that have not previously demonstrated meaningful use will be required to use a continuous 90-day reporting period in CY 2021 that will apply for the FFY 2022 and 2023 payment adjustment years. For the FFY 2022 payment year, the self-selected reporting period will 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 finalizes 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, beginning with reporting periods in 2020, CMS will require both the numerators and denominators of measures to be based on actions that occurred during the hospital's chosen EHR reporting period. An exception applies 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 are subject to the limitation.

These policies will 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.

Changes to Previously Adopted Measures

CMS finalizes changes to the two opioid-related measures previously adopted in the FFY 2019 IPPS final rule.

- **Changes to Query of PDMP Measure:** CMS modifies this measure in three ways: (1) the measure will remain optional for 2020 reporting and eligible for five points, (2) beginning with 2019 reporting, it will be changed to a yes/no measure instead of a numerator/denominator measure, and (3) as an optional measure, the exclusion for this measure is 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 new policy, hospitals electing to report this optional measure will 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. With respect to scoring this optional measure, CMS clarifies that for 2019 reporting this measure is worth five points, not "up to" five points as was stated in the FFY 2019 final rule in some places. A hospital that responds "yes" on this measure will receive five points.

- **Removal of Verify Opioid Treatment Measure:** CMS finalizes its proposal 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. In removing 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 optional 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 modifies 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 modifies the scoring for the 2020 reporting period to reflect the changes to measures as described above. The table below compares the previously adopted measures and points with those finalized 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

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 continues these reporting requirements for the 2020 and 2021 reporting years. These requirements align with those under the hospital IQR program.

As is finalized for the hospital IQR program, CMS adds one new eCQM to the list of those available for reporting beginning with the 2021 reporting period: Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e). CMS did not finalize its proposal to adopt a second eCQM, Hospital Harm – Opioid Related Adverse Events eCQM. Beginning with the 2022 reporting period — and aligned with the IQR program — CMS will require mandatory reporting of the new Concurrent Prescribing eCQM, with hospitals and CAHs self-selecting three other eCQMs to report.

The previously adopted requirement that EHRs be certified to all CQMs adopted for the Promoting Interoperability Program is 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, hospitals will be required to submit eCQM data electronically; attestation will 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 2023 allows an adequate transition period for hospitals and CAHs to move

to electronic reporting. In response to a public comment, CMS notes that the Medicare Promoting Interoperability Program offers hardship exceptions for extreme and uncontrollable circumstances.

Appendix — Quality Reporting Program Tables

Table 1

IQR Program Measures by Payment Determination Year X= Mandatory Measure	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	Voluntary	Voluntary	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 Safe use of Opioids*

*Beginning with the FY 2024 payment determination, hospitals will be required to report this eCQM and 3 other self-selected eCQMs

**Beginning with the FY 2026 payment determination, this measure will be removed and mandatory reporting of the Hybrid HWR measure will be required

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	
Measure	**Public Display**
Safety and Healthcare-Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	As soon as feasible*
NHSN CDI (NQF #1717)	As soon as feasible*
NSHN MRSA bacteremia (NQF #1716)	As soon as feasible*
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	As soon as feasible*
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
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	As soon as feasible*
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	
Proposed: Surgical Treatment Complications for Localized Prostate Cancer	

*Public display, previously deferred, is targeted to begin in January 2020
** Beginning with October 1, 2018 discharges, responses to the Pain Management questions will not be public.