The Centers for Medicare & Medicaid Services (CMS) Aug. 2 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2019. Select highlights of the proposed rule related to the inpatient PPS follow. Highlights of the proposals related to the LTCH PPS are covered in a separate Special Bulletin.

AHA Take: Several policies CMS finalized in this rule will reduce regulatory burden and help ensure America’s hospitals and health systems can continue to provide high-quality, efficient care for the patients and communities they serve. For example, CMS will implement the Administration’s “Meaningful Measures” initiative, a streamlined approach to quality measurement, as well as the Promoting Interoperability Program, which includes a more performance-based approach to determine whether a hospital has met meaningful use requirements. We also appreciate CMS’s approval of two chimeric antigen receptor t-cell (CAR T) products for new technology add-on payments, but remain concerned about the extraordinary costs incurred by hospitals to provide these life-saving therapies.

Key takeaways from the rule follow; a detailed Regulatory Advisory will be issued in the coming weeks.
HIGHLIGHTS OF THE INPATIENT PPS FINAL RULE

Inpatient PPS Payment Update: The final rule will increase inpatient PPS rates by 1.85 percent in FY 2019, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.9 percent, less 0.8 percentage points for productivity and 0.75 percentage points mandated by the Affordable Care Act (ACA). In addition, CMS finalizes an increase of 0.5 percentage points to partially restore cuts made as a result of the American Taxpayer Relief Act (ATRA) of 2012. Table 1 below details the factors CMS includes in its calculation.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Average Impact on Payments</th>
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<tbody>
<tr>
<td>Market-basket update</td>
<td>+ 2.9%</td>
</tr>
<tr>
<td>Productivity cut mandated by ACA</td>
<td>- 0.8%</td>
</tr>
<tr>
<td>Additional cut mandated by ACA</td>
<td>- 0.75%</td>
</tr>
<tr>
<td>Partial restoration of documentation and coding cut for FYs 2010, 2011 and 2012 mandated by ATRA</td>
<td>+ 0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>+1.85%</strong></td>
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The ACA and ATRA adjustments will be applied to all hospitals. Additionally, hospitals not submitting quality data will be subject to a one-quarter reduction of the initial market basket (for a new market-basket rate of 2.175 percent) and, thus, will receive an update of 1.125 percent. Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2017 will be subject to a three-quarter reduction of the initial market basket (for a new market-basket rate of 0.725 percent) and, thus, will receive an update of -0.325 percent. Hospitals that fail to meet both of these requirements will be subject to a full reduction of the initial market-basket rate (for a new market-basket rate of 0 percent), thus, receiving an update of -1.05 percent.

With respect to ATRA, the law requires CMS to recoup $11 billion for what the agency claims is the effect of documentation and coding changes from FYs 2010 through 2012 that CMS says do not reflect real changes in case mix. The agency instituted these cuts in FYs 2014 through 2017. The Medicare Access & CHIP Reauthorization Act and the 21st Century Cures Act then required CMS to restore most of these cuts over a six-year period, beginning in FY 2018.

Disproportionate Share Hospital (DSH) Payment Changes: Under the DSH program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.
In FY 2019, CMS will increase the amount of the 75 percent pool to reflect increases in the percentage of uninsured. Specifically, the agency will distribute roughly $8.3 billion in DSH payments, an increase of about $1.5 billion in FY 2019 compared to FY 2018.

In addition, CMS finalizes its proposal to, in FY 2019, implement the second year of a three-year phase in of incorporating hospitals’ Worksheet S-10 data into the methodology for determining uncompensated care payments. Specifically, CMS will continue to use data from a rolling three-year period to estimate uncompensated care costs. For FY 2019, it will use Worksheet S-10 data on uncompensated care costs from FY 2014 and 2015 cost reports in combination with inpatient days of Medicaid patients, plus inpatient days of Medicare Supplemental Security Income (SSI) patients from FY 2013 to determine the distribution of uncompensated care payments.

CMS notes in this rule that the agency will implement a full audit of S-10 data, expected to begin in the fall of 2018, and that instructions for Medicare Administrative Contractors (MACs) are currently under development. The AHA applauds CMS for committing to work with stakeholders to address concerns regarding the accuracy and consistency of Worksheet S-10 data. We appreciate the agency’s decision to offer further education to providers, refine Worksheet S-10 instructions, and implement a full audit of Worksheet S-10 data beginning in fall 2018.

**Wage Index:** CMS finalizes its proposal to allow the imputed rural floor to expire for all-urban states, which includes Delaware, New Jersey and Rhode Island. The agency also restates that a new occupational mix adjustment, based on calendar year (CY) 2016, will be applied beginning in FY 2019, per statutory requirement to collect data every three years.

**Promoting Interoperability Program:** CMS finalizes changes in the reporting period, objectives and scoring methodology for the Promoting Interoperability Program for hospitals and critical access hospitals (CAHs) beginning in CY 2019. CMS reiterates that renaming the Medicare and Medicaid EHR Incentive Program increases the program focus on interoperability and improving patient access to health information.

CMS finalizes a reporting period of a minimum of any continuous 90 days for both the CY 2019 and 2020 reporting periods. The AHA strongly supports this policy. CMS also reiterates that eligible hospitals, CAHs and eligible professionals must use 2015 Edition Certified EHR beginning in CY 2019.

CMS finalizes a new scoring methodology that allows hospitals and CAHs to receive points for measures under four objectives – e-prescribing, health information exchange, provider to patient exchange, and public health and clinical data exchange. CMS finalizes that attaining a minimum of 50 points is sufficient to meet the scoring requirement. The new methodology eliminates specific performance thresholds for each measure, and allows hospitals to build up points in areas of strong performance while also earning points in areas where performance is being improved. The AHA supports the flexible, performance-based approach to meeting promoting interoperability requirements.
CMS finalizes two new e-prescribing measures related to opioid treatment available for optional reporting and bonus points in CY 2019. The query of the prescription drug monitoring program measure will be a required measure for CY 2020. CMS finalizes a new health information exchange measure that combines two previously separate measures. CMS finalizes the requirement to connect any app of the patient choice, but clarifies that the agency does anticipate that hospitals, CAHs and their technology vendors will take reasonable steps to protect the privacy and security of their patients’ information. Such measures might include vetting and registering apps, or deactivating apps that function in anomalous or malicious ways. The AHA remains concerned about the timeline for adoption of these new approaches that will be required in 2019.

CMS finalizes that the performance-based scoring methodology is available to eligible hospitals and CAHs that participate in Medicare, or in both Medicare and Medicaid. CMS finalizes flexibility to the states to decide to adopt the performance-based scoring methodology and finalized measures for the Medicaid Promoting Interoperability Program.

Price Transparency: CMS finalizes its proposal to require hospitals to publicly post their charges in a machine readable format. Hospitals will be required to update this information at least annually, or more often as appropriate. The agency also recognized that many commenters had responded to its Request for Information on how to make pricing information more available and user-friendly for patients and indicated that it is considering this input for future rulemaking.

Post-acute Care Transfer Policy: The Bipartisan Budget Act (BiBA) of 2018 required that, beginning in FY 2019, the inpatient PPS post-acute care transfer policy also applies to discharges to hospice care. Accordingly, CMS finalizes its proposal that, if a discharge is assigned to one of the Medicare Severity Diagnosis Related Groups (MS-DRGs) subject to the post-acute care transfer policy and the individual is transferred to hospice care by a hospice program, the discharge will be subject to payment as a transfer case. Specifically, this includes Patient Discharge Status codes 50 and 51. The agency estimates that this will reduce Medicare payments by approximately $240 million in FY 2019.

Major Diagnostic Category (MDC) 14 (Pregnancy, Childbirth and the Puerperium): CMS finalizes its proposal to restructure MDC 14 by deleting 10 MS-DRGs and creating 18 new MS-DRGs.

Chimeric Antigen Receptor (CAR) T-Cell Therapy: CAR T-cell therapy is a cell-based gene therapy in which a patient’s own T-cells are genetically engineered in a laboratory and administered to the patient by infusion to assist in the patient’s treatment to attack certain cancerous cells. Currently, the procedures are described by two ICD-10-PCS procedure codes that have no impact on MS-DRG assignment. However, for FY 2019, CMS will assign CAR-T therapy procedure codes to MS-DRG 016 (under the revised title “Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy”). CMS plans to collect more comprehensive clinical and cost data and may consider assigning CAR T to a new MS-DRG in the future.
In addition, CMS approved the new technology add-on payment (NTAP) applications for two CAR T therapies, KYMRIAH™ and YESCARTA™, with a maximum payment of $186,500 per case. These NTAPs are approved for FY 2019 and can be extended two to three years under the statute. The agency declined to finalize any further payment-related proposals, but states that it is soliciting comments in the [CY 2019 outpatient PPS/ambulatory surgery center proposed rule](https://www.cms.gov/OutpatientPPS/OutpatientHospitalPpsOutpatientSurgeryCenterProposedRule/index.html) on a potential demonstration model to test competition and private market strategies that improve quality and reduce costs related to drugs. Specifically, in the OPPS proposed rule, CMS states that the agency is “interested in how best to handle Medicare payment for the new high-cost therapies, and whether a potential Competitive Acquisition Program (CAP)-like model could be an appropriate payment and delivery structure for these drugs and biologicals.” However, this solicitation relates to “Authority for the CAP for Part B Drugs and Biologicals” and does not explicitly address inpatient use.

**The AHA appreciates CMS’s approval of CAR T products for NTAPs. However, we are concerned that NTAPs alone do not sufficiently offset the extraordinary costs associated with providing these therapies, including because they are temporary. Furthermore, while a demonstration model may be informative, the potential model referenced in the final rule is not specific – and possibly not applicable – to unique characteristics of CAR T given its provision in the inpatient setting. We maintain that a more appropriate and longer-term approach is needed to more precisely estimate the costs of CAR T for Medicare payments. We are analyzing constructive alternatives that offer promise for sustaining beneficiary access to such new, life-saving technologies.**

**Low-volume Hospitals:** The BiBA retroactively extended the enhanced low-volume payment adjustment. The FY 2019 final rule finalizes the FY 2018 low-volume adjustment policy, which was addressed in a separate notice. Specifically, for FY 2018, low-volume hospitals will continue to be defined as those that are more than 15 road miles from another comparable hospital and that have up to 1,600 Medicare discharges. In order to receive the enhanced payments for FY 2018, a hospital must have notified its MAC that it qualifies by May 24, per the instructions outlined in the notice. In **Transmittal 4046**, CMS issued guidance on the manner in which it will make low-volume payments for FY 2018, given that a portion will be made retroactively.

For FYs 2019 through 2022, the discharge thresholds will be modified to reflect *total* discharges. Specifically, payment adjustments will be made on a sliding scale ranging from 25 percent adjustment for low-volume hospitals with 500 or fewer *total* discharges to zero percent additional payment for those with more than 3,800 *total* discharges, based on a formula provided in the rule. To receive the payments for FY 2019, a hospital must notify its MAC that it qualifies by Sept. 1, per the instructions outlined in the rule.

**Medicare Dependent Hospitals (MDH):** The BiBA also retroactively extended the MDH program through FY 2022. CMS states that a provider that was classified as an MDH as of Sept. 30, 2017 was automatically reinstated as an MDH effective Oct. 1, 2017, with no need to reapply for MDH classification. However, as outlined in detail in its separate notice, if the MDH had classified as a sole community hospital or cancelled its rural
classification effective on or after Oct. 1, 2017, the effective date of MDH status may not be retroactive to Oct. 1, 2017. In Transmittal 4046, CMS issued guidance on the exact manner in which it will make MDH payments for FY 2018, given that a portion will be made retroactively.

Hospital Quality Reporting and Value Programs: The AHA applauds CMS for taking significant steps to streamline and prioritize the measures used in its hospital quality reporting and value programs. CMS used its “Meaningful Measures” framework to identify a limited list of measure priority areas and used them to review all of the programs. Most of the priority areas are ones that the AHA has consistently recommended to the agency. CMS adopts the following changes in the final rule:

- **Inpatient Quality Reporting (IQR).** CMS will remove 39 measures from the IQR program. Of that total, 18 will be removed from hospital quality programs altogether because they are “topped out,” no longer relevant or have costs that outweigh their value. The remaining 21 measures will be “de-duplicated;” that is, they will be removed from the IQR program, but retained in other programs. CMS states that this approach should remove the burden and complexity of tracking measure performance in multiple programs.

- **IQR Electronic Clinical Quality Measure (eCQM) Reporting.** For FY 2021, CMS finalizes the submission of one, self-selected calendar quarter of data on four self-selected eCQMs for the CY 2019 reporting period. CMS finalizes the removal of seven of the 15 eCQMs currently available for IQR reporting for the FY 2022 program and subsequent years. Hospitals and CAHs will be required to use the 2015 edition certified EHR for eCQM reporting beginning in CY 2019. These changes are aligned with eCQM reporting requirements under the Medicare and Medicaid Promoting Interoperability programs.

- **Hospital Value-based Purchasing (VBP).** CMS finalizes the removal of four measures from the VBP program, all of which will be retained in the IQR. However, CMS did not finalize its proposal to remove the safety measure domain from the VBP. As a result, hospitals will continue to be scored on the same safety measures in both the VBP and the Hospital Acquired Condition (HAC) Reduction Program. The AHA remains concerned by the potential for inconsistent performance and “double penalties” that can result from using the measures in both programs.

- **HAC Reduction Program.** The HAC Reduction Program measure set is unchanged. However, starting with the FY 2020 program, CMS will eliminate HAC measure domains and assign an equal weight to all six measures in the program when determining hospital performance.

- **Hospital Readmissions Reduction Program (HRRP).** The HRRP program measure set is unchanged. However, CMS codifies the statutorily-mandated socioeconomic adjustment approach that it adopted in last year’s IPPS final rule. Starting with the FY 2019 HRRP, CMS will place hospitals into one of five peer groups (quintiles) based on their proportion of dual-eligible Medicare fee-for-
service and Medicare Advantage patients. Hospitals will have their performance compared to others within their quintile. As required by statute, the peer grouping approach will be implemented in a budget-neutral manner.

**Burden Reduction:** CMS finalizes several proposals to alleviate documentation burdens and provide more flexibility, which include:

- Removing the requirement that certification statements detail where in the medical record the required information can be found.
- Removing the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment.
- Providing more flexibility for new urban teaching hospitals to enter into Medicare Graduate Medical Education affiliation agreements, allowing hospitals to share full-time equivalent cap slots to accommodate the cross training of residents.
- Allowing those hospitals that wish to reclassify to a higher wage index area and are the only hospital in their metropolitan statistical area to use average hourly wage data from the current year’s IPPS final rule to demonstrate they are the only hospital in their labor market area.

**Next Steps**

The final rule will be published in the Aug. 17 Federal Register and provisions will take effect Oct. 1. Watch for a more detailed analysis of the proposed rule in the coming weeks.

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