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Medicare's FY 2019 Proposed IPPS Rules

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Proposed FY 2019 IPPS

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- **Copy at: https://www.gpo.gov/fdsys/pkg/FR-2018-05-07/pdf/2018-08705.pdf**
- **Tables for IPPS at:** http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- **Tables for LTCH at:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/LongTermCareHospitalPPS/index.html

Proposed FY 2019 IPPS Update

- **Comments**
  - **Rule is 1,883 pages (display copy)**
  - **Has lengthy but good regulatory analysis section**
  - **Display copy no longer available since reg is now published**
    - **Copy from webinar is available**
  - **Addendum is excellent to understand payment rate changes**

Proposed FY 2019 IPPS Update Market Basket Increase

- **MB is 2.8 percent –**
- **Offsets:**
  - **-0.8% for productivity**
  - **-0.75% for ACA mandate**
    - **Subtotal = 1.25 percent increase**
  - **+0.5 for documentation and coding per 21st Century Cures Act and MACRA**
  - **Net Increase 1.75%**

Proposed FY 2019 IPPS Update

- **CMS says overall increase of update factors to be 2.1percent – increase is 1.75 percent????**
- **Others would add 1.3 percent**
  - **Uncompensated Care**
  - **Capital**
  - **Low volume**
- **Final Increase 3.4 percent**
- **Increase of $4 billion**
- ***Bottom line – it's still a numbers game***

Proposed FY 2019 IPPS Update

- **Other major factor reduction items**
  - **VBP = 2.0 percent to all -- $1.9 billion (budget neutral)**
  - **HAC = 1.0 percent 25 worst [802 hospitals]**
  - **Readmissions = up to 3.0 percent [2,610 hospitals]**
  - **DSH = $1.483 billion increase over FY 2018**

Proposed FY 2019 IPPS Rates

- Following tables show how CMS arrives at proposed payment rates
- Tables are in Addendum

FY 2018 IPPS Rates

Hospital Submitted Quality Data and is a Meaningful EHR User		Hospital Submitted Quality Data and is NOT a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User	
Wage Index Greater Than 1.0000							
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,806.04	**$1,766.49**	$3,729.99	$1,731.20	$3,780.69	$1,754.73	$3,704.65	$1,719.43
Wage Index Equal to or Less Than 1.0000							
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,454.97	**$2,117.56**	$3,385.94	$2,075.25	$3,431.96	$2,103.46	$3,362.93	$2,061.15

Unadjusted FY 2018 IPPS Rates

Current FY 2018 Rates	Hospital Submitted Quality Data and is a Meaningful EHR User
Large Urban Areas	
Labor	$3,806.04
Non-Labor	$1,766.49
Total	**$5,572.53**
All Others	
Labor	$3,454.97
Non-Labor	$2,117.56
Total	**$5,572.53**

Labor Share

- **Unchanged from current**
- **Larger Urban at: 68.3 percent**
- **Other at: 62.0 percent**

Reductions for No Quality and/or No EHR

- **Regarding failures to report quality and be a meaningful EHR user**
  - **No Quality –**
    - **¼ of market basket [0.25 x 2.8 = -0.70]**
  - **No EHR**
    - **¾ of market basket [0.75 x 2.8 = -2.1]**
- **Failure to not report quality or be an EHR user is in effect a zero rate of increase w/o other adjustments**

Proposed 2019 IPPS Market Basket Increases

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	**2.8**	**2.8**	**2.8**	**2.8**
Adjustment for Failure to Submit Quality Data (1/4 of MB)	**0.0**	**0.00**	**-0.7**	**-0.7**
Adjustment for Failure to be a Meaningful EHR User (3/4 of MB)	**0.0**	**-2.1**	**0.0**	**-2.1**

Proposed 2019 IPPS Market Basket Increases

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Multi Factor Productivity (MFP) Adj	-0.8	-0.8	-0.8	-0.8
Statutory ACA Adjustment	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	**1.25**	**-0.85**	**0.55**	**-1.55**

Proposed FY 2019 IPPS Rate Changes

- CMS says **148** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they are identified as **not** meaningful EHR users
- CMS says that **54** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they **failed the quality** data submission
- CMS says **43** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2019 because they are identified as **both** not meaningful EHR users and do not submit quality data

Proposed FY 2019 IPPS Rates

- **Divide current 2018 rates as follows:**
  - **$5,572.53 = current total labor/ non-labor/ full update amount**

1. **Geographic BN 0.987985 = $5,640.30**
2. **Outlier BN 0.948998 = $5,943.43**

Proposed FY 2019 Rate Factors

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2018 Base Rate after removing: 1. FY 2018 Geographic Reclassification Budget Neutrality **(0.987985)** 2. FY 2017 Operating Outlier Offset **(0.948998)**	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor =* ***$5,943.43)***	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor =* ***$5,943.43)***	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor =* ***$5,943.43)***	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36 Nonlabor (31.7%) $1,884.07 *(Combined labor and nonlabor =* ***$5,943.43)***
FY 2018 Base Rate after removing: 1. FY 2018 Geographic Reclassification Budget Neutrality **(0.987985)** 2. FY 2017 Operating Outlier Offset **(0.948998)**	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor =* ***$5,943.43)***	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor =* ***$5,943.43***	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor =* ***$5,943.43***	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92 Nonlabor (38%): $2,258.50 *(Combined labor and nonlabor =* ***$5,943.43***

Proposed FY 2019 Rate Factors

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2018 Update Factor	1.0125	1.0125	1.0125	1.0125
Proposed FY 2019 MS-DRG Recalibration Budget Neutrality Factor	0.997896	0.997896	0.997896	0.997896
Proposed FY 2019 Wage Index Budget Neutrality Factor	1.001182	1.001182	1.001182	1.001182
Proposed FY 2019 Reclassification Budget Neutrality Factor	0.987084	0.987804	0.987804	0.987804
Proposed FY 2019 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999

Proposed FY 2019 Rate Factors

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed FY 2019 Rural Demonstration Budget Neutrality Factor	0.999325	0.999325	0.999325	0.999325
Adjustment for FY 2019 Required under Section 414 of Pub. L. 114-10 (MACRA	1.005	1.005	1.005	1.005
Total Proposed Rates	$5,656.18	$5,538.86	$5,617.07	$5,499.77

Proposed FY 2019 Rate Factors Large Urban

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
National Standardized Amount for FY 2019 **if Wage Index is Greater Than 1.0000;** Labor/Non-Labor Share Percentage (68.3/31.7)	**Labor: $3,863.17** **Non-labor: $1,793.01**	**Labor: $3,783.04** **Non-labor: $1,755.82**	**Labor: $3,836.46** **Non-labor: $1,780.61**	**Labor: $3,756.34** **Non-labor: $1,743.43**

Proposed FY 2019 Rate Factors Other Urban

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
National Standardized Amount for FY 2019 **if Wage Index is less than or Equal to 1.0000;** Labor/Non-Labor Share Percentage (62.0/38.0)	**Labor: $3,506.83**	**Labor: $3,434.09**	**Labor: $3,482.58**	**Labor: $3,409.86**
	Non-labor: $2,149.35	**Non-labor: $2,104.77**	**Non-labor: $2,134.49**	**Non-labor: $2,089.91**

IPPS Rate Comparison (w/Quality & MU)

FY 2018	FY 2019	Difference
Large		
$3,806.04	$3,863.17	
1,766.49	1,793.01	
$5,572.53	**$5,656.18**	**$83.65/ 1.50%**
Other		
$3,454.97	$3,506.83	
2,117.56	2,149.35	
$5,572.53	**$5,656.18**	**$83.65/ 1.50%**

Documentation & Coding

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
  - **Limits CMS reinstatement of offsets**
  - **CMS Offsets 3 years @ 0.8 = 2.4**
  - **CMS FY 2017@ 1.5 = 1.5**
  - **Total = 3.9 percent to add-back**
- **MARCA = 0.5 percent from FY 2018 through 2023**
  - **Would total 3.0 percent**
  - **Shortfall is 0.9 percent**

Documentation & Coding

- 21st Century Cures Act limited FY 2018 add-back
- Reduced FY 2018 from 0.5 to 0.4588
- Revised shortfall is now [0.9 + .0402 (0.5-0.4588) = 0.0412] = 0.9412 (0.9+.0412)

Proposed FY 2019 Capital

- **Rate would increase from $453.97 to $459.78**
- **Comment**
  - **Why is there still a separate add-on?**

Excluded Hospitals

- **Rate would increase to 2.8 percent – full market basket**
- **Affects**
  - **Children's Hospital**
  - **11 Cancer Hospitals**
  - **Hospitals outside 50 states & DC**
- Effective with cost reporting periods beginning on or after October 1, 2019, an IPPS-excluded hospital would be permitted to have an excluded psychiatric and/or rehabilitation unit

Proposed FY 2019 Outliers

- **Outlier fixed-loss cost threshold** for FY 2019 would equal the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus **$27,545**
  - The current amount is $26,601
  - CMS says FY 2017 outliers estimated to be 5.53 percent

Proposed FY 2019 Wage Index

- **No new/ additional changes to CBSA system**
  - Creates new CBSA for Idaho Falls, ID
  - Has a single hospital

Proposed FY 2019 Wage Index

- **Request for Public Comments on Wage Index Disparities**
- CMS is soliciting comments regarding changes to improve the wage index
- The section extends some 25 pages and rehashes previous research into alternative area wage index construction
- ***Caveat – is this a precursor to something new???***

Proposed FY 2019 Wage Index

- Using info from cost reports in **FY 2015**
- To use “other” wage related costs, costs ***MUST*** now be reported on employees’ or contractors’ W-2 or 1099 forms
- CMS to allow only “core” wage related costs effective FY 2020
- No change to the statewide budget neutrality adjustment factor – federal versus state specific
- CMS estimates that **255** hospitals would receive an increase in their FY 2019 proposed wage index due to the application of the rural floor.

Proposed FY 2019 Wage Index Rural Floor

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FY 2019 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals	Number of Hospitals That Would Receive the Rural Floor	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality	Difference (in $ millions)
Connecticut	30	17	5.5	$90
California	297	63	0.4	$48
Massachusetts	56	35	1.4	$49

Proposed FY 2019 Wage Index Rural Floor

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FY 2018 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals	Number of Hospitals That Would Receive the Rural Floor	Percent Change in Payments due to Application of Rural Floor with Budget Neutrality	Difference (in $ millions)
Florida	168	8	-0.2	-$17
New York	149	18	-.03	-$16
Pennsylvania	150	3	-0.3	-$14
New Jersey	64	10	-0.4	-$13
Texas	311	14	-0.2	-$12
Illinois	125	2	-0.3	-$12
North Carolina	84	0	-0.2	-$9
Missouri	72	0	-0.2	-$6

Proposed FY 2019 Floors

- **Frontier Floor**
  - Would benefit Montana, North Dakota, South Dakota, and Wyoming, covering 50 providers, would receive a frontier floor value of 1.0000
- **Imputed Floor**
  - CMS would eliminate imputed floor
  - Three states have no rural areas
  - Currently affects 17 providers in New Jersey,10 providers in Rhode Island, 6 providers in Delaware

Proposed FY 2019 Occupational Mix

- Using FY 2016 survey
- FY 2019 occupational mix adjusted national average hourly wage is **$42.990625267** – current is $42.0564

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$41.67064907
National LPN and Surgical Technician	$24.68950438
National Nurse Aide, Orderly, and Attendant	$16.96671421
National Medical Assistant	$18.1339666
National Nurse Category	$35.05256013

FY 2019 Reclassifications

- FY 2019 – 337 approved
- FY 2018 – 345 approved
- FY 2017 – 259 approved
- CMS says there are **941** hospitals reclassified for FY 2019
- Applications for FY 2020 to MGCRB due by September 4th

Out-Migration

- **Out-Migration Adjustment**
  - CMS is adding a new Table 4, “List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2019

Proposed FY 2019 RRCs

- **Proposed FY 2019 – Case-Mix**
- **National CMI 1.66185 for FY 2017 cost reporting periods or regional, if lower**

New England (CT, ME, MA, NH, RI, VT)	1.4071
Middle Atlantic (PA, NJ, NY)	1.4694
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5486
East North Central (IL, IN, MI, OH, WI)	1.5765
East South Central (AL, KY, MS, TN)	1.5289
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6387
West South Central (AR, LA, OK, TX)	1.6872
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7366
Pacific (AK, CA, HI, OR, WA)	1.6619

Proposed RRCs continued

- **From cost reports that began during FY 2016 – Discharges – 5,000**
  - **National or regional, if lower**
  - **None Lower**

Proposed SCH and MDH Updates

- The FY 2019 applicable percentage increase, except for the hospital-specific rate for SCHs) is, the same update factor as for all other hospitals subject to the IPPS

Proposed MDH

- **MDH program was terminated 9/30/2017**
- **Reinstated through September 30, 2022**
  - Defined as:
    - (1) a hospital located in a State with no rural area that meets certain statutory criteria,
    - (2) has not more than 100 beds,
    - (3) is not an SCH, and
    - (4) has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years)

Proposed MDH

- To qualify for rural reclassification or SCH, RRC, or MDH status, CMS is proposing that a hospital with remote locations must demonstrate that both the main campus and its remote location(s) satisfy the relevant qualifying criteria.
- Example, If the main campus of a hospital has 75 beds and its remote location has 30 beds, the bed count exceeds 100 beds and the hospital would not satisfy
  - MDHs paid based on the IPPS Federal rate **or**, if higher, the IPPS Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate

Proposed MDH

- Generally, a provider that was classified as an MDH as of September 30, 2017, was reinstated as an MDH effective October 1, 2017, with no need to reapply for MDH classification
- If the MDH had re-classified as an SCH or cancelled its rural classification under § 412.103(g) effective on or after October 1, 2017, the effective date of MDH status may not be retroactive to October 1, 2017
- These hospitals need to reapply for MDH status

Proposed MDH

- Because MDHs are paid based on the IPPS Federal rate, they continue to be eligible to receive empirically justified Medicare Disproportionate Share (DSH) payments and uncompensated care payments if their disproportionate patient percentage (DPP) is at least 15 percent

Proposed SCH

- **SCH proposed** prospective payment rate for FY 2019 equals the higher of the applicable Federal rate, or the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge

Proposed Low-Volume Hospitals

- **Low Volume adjustment reinstated from FY 2019 through 2022**
  - Hospital must be 15 miles from another section (d) hospital
  - Hospital must have 3,800 or fewer beds, but at least 500 beds

Proposed Low-Volume Hospitals

- **Low-Volume Hospital Payment Adjustment** = 0.25 – [0.25/3300] x (number of total discharges - 500) = (95/330) x (number of total discharges/13,200)
- CMS estimates that **622** providers would receive approximately **$417** million compared to CMS' estimate of 606 providers receiving approximately $345 million in FY 2018

Proposals to Codify Policies Regarding Multicampus Hospitals

- To qualify for rural reclassification or SCH, RRC, or MDH status, CMS is proposing that a hospital **with remote locations** must demonstrate that both the main campus and its remote location(s) satisfy the relevant qualifying criteria
- CMS is proposing that a main campus of a hospital cannot obtain a SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s) and vice versa

IME / GME

- **IME multiplier unchanged at 1.35 – by law**

MS-DRGs

MS-DRGs

- **The following items are some of the major MS-DRG proposed changes for FY 2019:**
  - ***Laryngectomy***
  - ***Pacemaker Insertions***
  - ***Benign Lipomatous Neoplasm of Kidney***
  - ***Systemic Inflammatory Response Syndrome (SIRS) of Non-Infectious Origin***

MS-DRGs

- **CMS is proposing to:**
  - Assign CAR-T therapy procedure codes to MS-DRG 016 (proposed revised title: Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy);
  - Delete MS-DRG 685 (Admit for Renal Dialysis) and reassign diagnosis codes from MS-DRG 685 to MS-DRGs 698, 699, and 700 (Other Kidney and Urinary Tract Diagnoses with MCC, with CC, and without CC/MCC, respectively);
  - Delete 10 MS-DRGs (MS-DRGs 765, 766, 767, 774, 775, 777, 778, 780, 781, and 782) and create 18 new MS-DRGs relating to Pregnancy, Childbirth and the Puerperium (MS-DRGs 783 through 788, 794, 796, 798, 805, 806, 807, 817, 818, 819, and 831 through 833);
  - Assign two additional diagnosis codes to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator);

MS-DRGs

- **CMS is proposing to:**
  - Reassign 12 ICD-10-PCS procedure codes from MS-DRGs 329, 330 and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 344, 345, and 346 (Minor Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively); and
  - Reassign ICD-10-CM diagnosis codes R65.10 and R65.11 from MS-DRGs 870, 871, and 872 (Septicemia or Severe Sepsis with and without Mechanical Ventilation >96 Hours with and without MCC, respectively) to MS-DRG 864 (proposed revised title: Fever and Inflammatory Conditions).

MS-DRGs

- Changes to the Medicare Code Editor (MCE)
- Changes to Surgical Hierarchies
- Operating Room (OR) and non OR issues

MS-DRGs

- **Post Acute Care Transfer Policy**
  - MS-DRGs 023, 329, 330, 331, 698, 699, 700, 870, 871, and 872 are currently subject to the postacute care transfer policy
  - These MS-DRGs, are proposed to be revised, and would continue to qualify to be included on the list of MS-DRGs that are subject to the postacute care transfer policy

MS-DRG Changes

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LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS)				
RELATIVE WEIGHTING FACTORS – Proposed FY 2019 Rule				
MS-DRG	**MS-DRG Title**	**Proposed 2019 Weights**	**Final FY 2018 Weights**	**Percentage Change**
65*	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0043	1.0313	-2.62%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2332	1.2198	1.10%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1900	1.1528	3.23%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3048	1.3733	-4.99%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.8949	0.9333	-4.11%
291	HEART FAILURE & SHOCK W MCC	1.3424	1.4761	-9.06%
292	HEART FAILURE & SHOCK W CC	0.9143	0.9589	-4.65%
378	G.I. HEMORRHAGE W CC	0.9849	0.9704	1.49%

MS-DRG Changes

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LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2019 Proposed Rule				
MS-DRG	**MS-DRG Title**	**Proposed FY 2019 Weights**	**Final FY 2017 Weights**	**Percentage Change**
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7532	0.7594	-0.82%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9995	2.0522	-2.57%
603	CELLULITIS W/O MCC	0.8445	0.8503	-0.68%
682	RENAL FAILURE W MCC	1.5024	1.4845	1.21%
683	RENAL FAILURE W CC	0.9074	0.9293	-2.36%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7846	0.7946	-1.26%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8418	1.8231	1.03%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0390	1.0547	-1.49%

MS-DRG Changes

- 16 above MS-DRGs account for 3.2 million discharges
- Total discharges = 9.6 million
- Result 16 = 34 percent

New Technology Add-ons

- **For FY 2019 – discontinuing:**
  - EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
  - GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE)
  - Praxbind® Idarucizumab
  - Vistogard™ (Uridine Triacetate)

New Technology Add-ons

- **For FY 2019 continuing:**

  - Defitelio® (Defibrotide). The maximum payment will remain at $75,900.
  - Ustekinumab (Stelara®). The maximum payment for a case involving Stelara® would remain at $2,400 for FY 2019.
  - Bezlotoxumab (ZINPLAVA™) The maximum new technology add-on payment amount for a case involving the use of ZINPLAVA™ is $1,900.

New Technology Add-ons

- **For FY 2019, received following applications, so far, none approved:**

  - KYMRIAH™ (Tisagenlecleucel) and YESCARTA™ (Axicabtagene Ciloleucel)
  - VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection)
  - VABOMERE™ (meropenem-vaborbactam)
  - DURAGRAFT® Vascular Conduit Solution
  - remedē® System
  - Titan Spine nanoLOCK® (Titan Spine nanoLOCK® Interbody Device)
  - Plazomicin
  - GIAPREZA™
  - GammaTile™
  - Supersaturated Oxygen (SSO2) Therapy (DownStream® System)
  - Cerebral Protection System (Sentinel® Cerebral Protection System)
  - AZEDRA® (Ultratrace® iobenguane Iodine-131) Solution
  - The A QUAB EAM System (Aquablation)
  - AndexXa™ (Andexanet alfa)

IPPS DSH Formula

IPPS DSH Formula

- Mandated by Section 3133 of ACA
- Splits system
  - 25 percent remains as old formula
  - 75 percent new
  - Uses 3 factors

IPPS DSH Formula

- CMS says it will distribute **$6.767** billion in uncompensated care payments in FY 2018, *an increase of approximately $1.0 billion from the FY 2017* amount (factor 2 monies)
- This change reflects CMS' adoption to incorporate data from its National Health Expenditure Accounts into the estimate of the percent change in the rate of uninsurance, which is used in calculating the total amount of uncompensated care payments available to be distributed

DSH Factor One

- Determines 75 percent of what would have been paid under the old methodology
- Excluded hospitals
  - MD waiver
  - SCHs paid on a hospital-specific basis
  - Hospitals in Rural Community Demo

DSH Factor One

- The December 2017 ***Office of the Actuary*** estimate for Medicare DSH payments for FY 2019, without regard to the application of section 1886(r)(1) of the Act, is approximately **$16.295 billion**
- The estimate for empirically justified Medicare DSH payments for FY 2019, with the application of section 1886(r)(1) of the Act, is approximately **$4.074 billion** (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2019)
- **Factor One is $12,221,027,954.27**
  - **($16,294,703,939 – 4,073,675,985)**

DSH Factor Two

- The calculation of the Factor 2 for FY 2019 using a weighted average of OACT's projections for CY 2018 and CY 2019 is as follows:

  - Percent of individuals without insurance for CY 2013: 14.0 percent.
  - Percent of individuals without insurance for CY 2018: 9.1 percent.
  - Percent of individuals without insurance for CY 2019: 9.6 percent.
  - Percent of individuals without insurance for FY 2019 (0.25 times 0.091) + (0.75 times 0.096): **9.48** percent

  Number of uninsured is increasing

DSH Factor Two

- Formula;
  - 1-|((0.0948-0.14)/0.14)| = 1- 0.3229 = 0.6771 (67.71 percent)
  - 0.6771 (67.71 percent) - .002 (***0.2 percentage points*** for FY 2019 under section 1886(r)(2)(B)(ii) of the Act) = 0.67.51 or 67.51 percent
- **Factor 2 = 67.51**
  - 0.7619 = was Factor 2 for FY 2015
  - 0.6369 = was Factor 2 for FY 2016
  - 0.5674 = was Factor 2 for FY 2017
  - 0.5801 = is factor for FY 2018

DSH Factor Two

- The amount available for uncompensated care payments for FY 2019 would be **$8,250,415,972.16**
  - ($12,221,027,954.62 x 0.6751 = **$8,250,415,972.16**

  - The FY 2014 “pool” was $9.033 billion
  - The FY 2015 “pool” was $7.648 billion
  - The FY 2016 “pool” was $6.406 billion
  - The FY 2017 “pool” was $6.054 billion
  - The FY 2018 “pool” is $6.767 billion

DSH Factor Three

- Factor 3 is “equal to the percent, for each subsection (d) hospital, that represents the quotient of (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data)”
- Based on each hospital’s share of total uncompensated care costs across all PPS hospitals that received DSH payments
  - So the numerator is <u>all</u> PPS hospitals, but denominator is just DSH hospitals

DSH Factor Three & S-10

- For this FY 2019 proposed rule, hospitals had to submit their amended FY 2014 and FY 2015 cost reports containing the revised Worksheet S-10 (or a completed Worksheet S–10 if no data were included on the previously submitted cost report) to the MAC no later than January 2, 2018
- CMS is proposing to advance the time period of the data used in the calculation of Factor 3 forward by 1 year and to use data from FY 2013, FY 2014, and FY 2015 cost reports to determine Factor 3 for FY 2019
- For FY 2019, in addition to the Worksheet S–10 data for FY 2014 and FY 2015, CMS is proposing to use Medicaid days from FY 2013 cost reports and FY 2016 SSI ratios

Readmissions, HVBP, and HAC

Readmissions

- **The Hospital Readmissions Reduction Program currently includes the following six applicable conditions:**
  - acute myocardial infarction (AMI);
  - heart failure (HF);
  - pneumonia (PN);
  - total hip arthroplasty/total knee arthroplasty (THA/TKA);
  - chronic obstructive pulmonary disease (COPD); and
  - coronary Artery Bypass Graft (CABG) Surgery

Readmissions

- **Aggregate payments for excess readmissions** =
  - [sum of base operating DRG payments for **AMI** x (Excess Readmissions Ratio for AMI-1)] +
  - [sum of base operating DRG payments for **HF** x (Excess Readmissions Ratio for HF-1)] +
  - [sum of base operating DRG payments for **PN** +
  - [sum of base operating DRG payments for **COPD**) x (Excess Readmissions Ratio for COPD-1)] +

Readmissions

- **Aggregate payments for excess readmissions** =
  - [sum of base operating DRG payments for **THA/TKA** x (Excess Readmissions Ratio for THA/TKA-1)] +
  - [sum of base operating DRG payments for **CABG** x (Excess Readmissions Ratio for CABG-1)]
- **Aggregate payments for all discharges** = sum of base operating DRG payments for all discharges

Readmissions

- Ratio = 1-(Aggregate payments for excess readmissions/Aggregate payments for all discharges)

- **Readmissions Adjustment Factor for FY 2019 is the higher of the ratio or 0.9700**
  - **Maximum reduction = 3 percent**
- **CMS estimate that 2,610 hospitals will be impacted**

Value Based Purchasing

- **Withhold amount will be 2.0 percent for all hospitals**
- Total amount available for performance-based incentive payments for FY 2019 will be approximately $1.9 billion
- Supposed to be budget neutral
- Would remove 10 measures for FY 2020
  - Part of CMS initiative to reduce overlapping data elements in the various quality programs

Value Based Purchasing

- **CMS proposes the following deletions:**
  - Elective Delivery (NQF #0469) (PC-01) beginning with the FY 2021 program year;
  - National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138) (CAUTI) Program beginning with the FY 2021 program year;
  - National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139) (CLABSI) Program beginning with the FY 2021 program year;
  - American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) (Colon and Abdominal Hysterectomy SSI) Program beginning with the FY 2021 program year;
  - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) (MRSA Bacteremia) Program beginning with the FY 2021 program year;

Value Based Purchasing

- **CMS proposes the following deletions:**
  - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717) (CDI) Program beginning with the FY 2021 program year;
  - Patient Safety and Adverse Events (Composite) (NQF #0531) (PSI 90) Program effective with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
  - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction (NQF #2431) (AMI Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule;
  - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure (NQF #2436) (HF Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule; and
  - Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (NQF #2579) (PN Payment) with the effective date of the FY 2019 IPPS/LTCH PPS final rule.

Value Based Purchasing

- **CMS proposes the following deletions for FY 2021:**
- Safety domain (PC-01, CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI), as all of the HAI measures will be retained in the Hospital Acquired Condition (HAC) Reduction Program, and
- To remove the Safety domain itself, as there would be no measures remaining in the domain,
- Along with proposing to remove two measures from the Efficiency and Cost Reduction domain (AMI Payment and HF Payment)

HAC Reduction

- **Lowest-performing quartile get 1.0 percent reduction**

Quality

Hospital Inpatient Quality

- **For FY 2017 had finalized 62 measures for FY 2019 payment**

- CMS is proposing to adopt a new measure removal factor and to update the Hospital IQR Program's measure set as follows:
  - **Remove 18** previously adopted measures that are "topped out", no longer relevant, or where the burden of data collection outweighs the measure's ability to contribute to improved quality of care.
  - **De-duplicate 21 measures** to simplify and streamline measures across programs. These measures will remain in one of the other 4 hospital quality programs

Inpatient Quality Reporting

REIMBURSEMENT ALLIANCE GROUP, LLC
Strength In Numbers

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Structural Patient Safety Measures			
Safe Surgery Checklist	Safe Surgery Checklist Use	FY 2020	N/A
Patient Safety Culture	Hospital Survey on Patient Safety Culture	FY 2020	N/A
Patient Safety Measures			
PSI 90	Patient Safety and Adverse Events Composite	FY 2020	0531
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	FY 2021	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	FY 2021	1717

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Patient Safety Measures			
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	FY 2021	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	FY 2021	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	FY 2021	1716

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Coordination of Care Measures			
READM-30- AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0505
READM-30-CABG	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2020	2515
READM-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2020	1891
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization	FY 2020	0330

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Coordination of Care Measures			
READM-30-PNA	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	FY 2020	0506
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY 2020	1551
READM-30-STK	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	FY 2020	N/A

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Mortality Measures			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	FY 2020	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	FY 2020	0229
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	FY 2021	1893

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Mortality Measures			
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	FY 2021	0468
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	FY 2022	2558
Claims-Based Patient Safety Measure			
Hip/Knee Complications	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	FY2023	1550

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Payment Measures			
MSPB	Medicare Spending Per Beneficiary (MSPB) - Hospital Measure	FY 2020	2158
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment Measure	FY 2020	N/A
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	FY 2020	N/A
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	FY 2020	N/A
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	FY 2020	N/A
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	FY 2020	N/A

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
Claims-Based Payment Measures			
SFusion Payment	Spinal Fusion Clinical Episode-Based Payment Measure	FY 2020	N/A
Chart-Abstracted Clinical Process of Care Measures			
IMM-2	Influenza Immunization	FY 2021	1659
VTE-6	Incidence of Potentially Preventable VTE [Venous Thromboembolism]	FY 2021	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2021	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	FY 2022	0497

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
EHR-Based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))			
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	FY 2022	+
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	FY 2022	+
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	FY 2022	0495
EHDI-1a	Hearing Screening Prior to Hospital Discharge	FY 2022	1354
PC-01	Elective Delivery	FY 2022	0469

Inpatient Quality Reporting

Summary of Hospital IQR Program Measures Proposed for Removal			
Short Name	**Measure Name**	**First Payment Determination Year Proposed for Removal**	**NQF #**
EHR-Based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))			
STK-08	Stroke Education	FY 2022	+
STK-10	Assessed for Rehabilitation	FY 2022	0441

* Measure is proposed for removal in chart-abstracted form, but will be retained in eCQM form.
\+ NQF endorsement removed.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

- CMS is proposing to remove following with the FY 2021 program year because they are topped-out:
  - Oncology: Radiation Dose Limits to Normal Tissues (PCH-14/NQF #0382);
  - Oncology: Medical and Radiation – Pain Intensity Quantified (PCH-16/NQF #0384);
  - Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients (PCH-17/NQF #0390); and
  - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk
  - Patients (PCH-18/NQF #0389).

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

- CMS also is proposing to remove to two National Healthcare Safety Network (NHSN) chart-abstracted measures and, beginning with the FY 2021 program year

  - NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (PCH-5/NQF #0138)
  - NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (PCH-4/NQF #0139)

Long-Term Care Hospital (LTCH) Prospective Payment System (PPS)

- CMS is proposing to remove the following measures. These measures either have significant operational challenges with reporting or are duplicative of other measures in the program
-
  - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) (beginning with the FY 2020 LTCH QRP)
  - National Healthcare Safety Network (NHSN) Ventilator Associated Event (VAE) Outcome Measure (beginning with the FY 2020 LTCH QRP)
  - Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) (beginning with the FY 2021 LTCH QRP)

Proposed Changes to the Medicare and Medicaid EHR Incentive Programs (now referred to as the Medicare and Medicaid Promoting Interoperability Programs)

- Beginning with an EHR reporting period in CY 2019, CMS is reiterating that all eligible hospitals and CAHs under the Medicare and Medicaid EHR Incentive Programs are required to **use the 2015 Edition of CEHRT**
- CMS is proposing that EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020

Electronic Clinical Quality Measures (eCQMs)

- For eligible hospitals and CAHs that report CQMs electronically, the reporting period for the Medicare and Medicaid EHR Incentive Programs would be one, self-selected calendar quarter of CY 2019 data, reporting on at least 4 self-selected CQMs from a set of 16
- CMS proposes the submission period for the Medicare EHR Incentive Program would be the 2 months following the close of the calendar year, ending February 29, 2020
- In addition, beginning with the 2020 reporting period, CMS proposes to remove 8 of the 16 CQMs consistent with CMS' commitment to producing a smaller set of more meaningful measures and in alignment with the Hospital IQR Program

Electronic Clinical Quality Measures (eCQMs)

- **The eight eCQMs CMS is proposing to remove in CY 2020 are:**
  - Primary PCI Received Within 90 Minutes of Hospital Arrival (NQF #0163) (AMI-8a);
  - Home Management Plan of Care Document Given to Patient/Caregiver (CAC-3);
  - Median Time from ED Arrival to ED Departure for Admitted ED Patients (NQF #0495) (ED-1);
  - Hearing Screening Prior to Hospital Discharge (NQF #1354) (EHDI-1a);
  - Elective Delivery (NQF #0469) (PC-01);
  - Stroke Education (STK-08) (adopted at 78 FR 50807;
  - Assessed for Rehabilitation (NQF #0441) (STK-10); and
  - Median Time from ED Arrival to ED Departure for Discharged ED Patients (NQF 0496) (ED-3).

Proposed Revisions of the Supporting Documentation Required for Submission of an Acceptable Medicare Cost Report

- CMS is proposing to incorporate the Provider Cost Reimbursement Questionnaire, Form CMS-339, into the OPO and Histocompatibility Laboratory cost report, Form CMS-216. CMS says the incorporation of the Form CMS-339 into the Form CMS-216 will complete its incorporation of the Form CMS-339 into all Medicare cost reports

- CMS is proposing to require that the Medicare bad debt listing correspond to the bad debt amount claimed in the provider's cost report

- CMS is proposing, effective for cost reporting periods beginning on or after October 1, 2018, that in order to have an acceptable cost report submission, DSH eligible hospitals must submit this supporting data with their cost reports

Proposed Revisions of the Supporting Documentation Required for Submission of an Acceptable Medicare Cost Report

- CMS is proposing that, effective for cost reporting periods beginning on or after October 1, 2018, in order for a provider claiming costs on its cost report that are allocated from a home office or chain organization to have an acceptable cost report submission under § 413.24(f)(5), a Home Office Cost Statement completed by the home office or chain organization that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report must be submitted as a supporting document with the provider's cost report

Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet

- Effective January 1, 2019, CMS is updating its guidelines to require hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate. This could be in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format

LTCHs

- Update at 1.15 percent
- Area wage factor = of 0.999713
- Budget neutrality = 0.990535
- Results in Federal rate of **$41,482.98**
- Current rate of $41,415.11 x 1.0115 x 0.999713 x 0.990535
- Labor share will be 66.2 percent
- HCO Threshold -- **$30,639** ; site neutral $27,545,
- **Outlier = $26,601**

Questions