Eight Things to Know about the 2019 In-Patient Proposed Rule (CMS-1694-P)

The 2019 Proposed Rule is over 1,880 pages, and covers topics such as Cost Reporting; Wage Index data corrections; Indirect and Direct medical education funding; Quality Reporting; Meaningful Use; Price Transparency & Out of Network billing.

The following are items that may be of interest to ASPS members:

1. **MS-DRG Reclassifications**

The Social Security Act mandates annual adjustments in the fee schedule to reflect changes in treatment protocols, technology and other factors that may change the relative use of hospital resources. For performance year 2019, one of several issues the Agency was asked to review was the six MS-DRGS* typically assigned to hospitalizations for corrosive burns. CPT Coding Guidance mandate the sequencing of a code from the "Toxic Effect" section of diagnosis codes as the primary code, with a code from the "corrosive burn" section of the diagnosis code set as the secondary code. This results in a DRG that is ranked lower than the five DRGs for Extensive or Full-Thickness burns. The requesting party noted that when corrosive burns are used as the primary diagnosis code, one of the Extensive or Full-Thickness DRGS, which result in higher reimbursement, are assigned.

Analysis of the relatively low volume of Medicare claims for corrosive burns reported in 2017 indicates the average costs and lengths of stay were equivalent across each of the eleven DRGs. As such, CMS has concluded there is no need to reclassify any of the DRGs for corrosive burns.

1a. Medicare Code Editor changes – the software edits the Agency uses to detect coding errors includes controls to ensure diagnosis codes match gender edits.

As an example, the Agency believes ICD-10-CM code Z98.891 (History of uterine scar from previous surgery) should only be reported for patients that are identified on the claims as female.

Likewise, codes from the N35 (Urethral Stricture) code family would also be flagged to compare patient gender to the gender descriptor included in the ICD-10-CM code.

These edits may negatively impact claims processing for gender-non-conforming individuals if billed without the KX modifier.*

2. **IME Payment Adjustment Factor**

In the regulations governing IME payment adjustments, the Agency identified an inadvertent omission of the calculations for a hospital's full-time equivalent cap for new medical residency training programs. Once enacted, the proposed revision will correct the calculations. *

3. **Payments for IME and DME**

The Agency is proposing to make changes to the Medicare GME Affiliated Group provisions to address new urban teaching hospitals to ensure they are consistent with the intent of the provisions.

Background information is available at the end of this document on items marked with an *

Specifically, an urban hospital that qualifies for an adjustment to its FTE cap will be permitted to be part of a Medicare GME affiliated group, and receive both decreases and increases in their FTE caps.*

This section of the Proposed Rule also calls out two teaching hospital closures, and the potential for redistribution of IME/DME funding.

4. **Hospital Inpatient Admission Orders Documentation**

CMS indicates it will be removing existing requirements that mandate written in-patient admission orders as a condition of participation. This change is in response to analysis of medical necessity audits, and the observation that other documents (e.g., lab or progress notes) can support the admission.

5. **In Patient Payment Programs**

To reduce administrative burden, the Agency proposes to make changes to the following in-patient payment programs to ensure there are no overlapping measures:

5a. Hospital Readmission Reduction Program – included in the Affordable Care Act (ACA) was a mandate to reduce payments under the Inpatient Prospective Payment System for those facilities that have excessive readmissions. Historically, the Agency has focused on six conditions. After review, CMS agrees these six measures continue to be relevant, and proposes to not add additional conditions/procedures in 2019.

5b. Hospital Value Based Purchasing (VBP) Program – the ACA also included a mandate to incentivize quality care to Medicare beneficiaries. The VBP program* is one of several quality strategies used in the inpatient setting to reform payment.

For performance year 2019, CMS has proposed changes that could result in a very different VP program for payment year 2021. The Agency proposed to focus the VBP on the measurement priorities not covered by the Hospital Readmission Reduction Program or the HAC Reduction program. As such, multiple measures have been identified for removal, including the entire patient safety domain. This domain currently is responsible for 25% of a hospital's total VBP score and includes the PSI-90 patient safety composite plus five hospital-acquired infection measures.

In its place, the Agency proposes to fill the role of the patient safety domain by adjusting the weight of the clinical quality domain to 50 percent of the total performance score. This means that for a provider reporting every VBP quality measures, each measure would carry far greater weight than they do at present.

Additionally, lessons learned in past years have prompted the Agency to propose that rather than waiting for a Proposed Rule to remove measures that may pose a risk to patient safety, they will instead, and without Rulemaking, remove those measures. They are also proposing to add 10 measures to the 2019 VBP program.

5c. Hospital Acquired Condition (HAC) Reduction Program

Since 2014, CMS has reduced Medicare payments for hospitals that rank in the worst performing quadrant with respect to hospital acquired conditions. For 2019, the Agency proposes to equally

weigh all six measures* assessed under HAC, eliminating the distinction between the patient safety domain and the infection measures domain. The proposal is intended to lessen issues for some low-volume hospitals that are disproportionally assessed penalties.

5d. Hospital Inpatient Quality Reporting (IQR)

CMS has proposed a set of changes to the inpatient quality measure set to further ensure the IQR program focuses on measure topics not covered in the other program measures. While there will continue to be some overlap in the IQR and VBP measure set, the Agency is proposed to retire 21 measures* to begin addressing measure overlap. This represents the largest pruning of quality metrics in recent years.

The Agency is also proposing to eliminate 18 measures that are no longer deemed to be clear indicators of quality (i.e., "topped out") or have costs that outweigh the perceived benefits of reporting. CMS Also proposes to add two new measures to the IQR – a hospital-wide mortality measures and an electronic clinical quality measure to track opioid adverse events.

6. Publication of Standard Hospital Charges

The proposed rule discusses hospital price transparency at length. CMS indicates they will update current guidelines by requiring hospitals to publish a machine-readable list of their standard charges via public access sites on the internet by January 1, 2019. The lists will be required to be updated yearly.

The Agency seeks public comment on the following:

a. The definition of "standard charges." (Average versus Mean rates)
b. The type of information that would be most meaningful to patients
c. The need to discuss out-of-pocket costs prior to the furnishing of services
    i. What challenges are inherent in providing information to patients with Medigap?
d. What, if any, regulatory changes would be necessary to share Medicare payment rates
e. Thoughts on the best way to enforce transparency requirements

7. Promoting Interoperability and Electronic Health Information Exchange – Rebranding the Program

CMS often releases updates to Meaningful Use (MU) regulations throughout the year, but this proposed rule introduces an overhaul to incentives hospitals to adopt and effectively use EHRs. A series of proposals is offered which, if adopted, would modify the scoring methodology, measure requirements and the roster of measures. CMS is also proposing to move to a performance-based standard in lieu of the prior all-or-nothing-thresholds.

They are also including a proposal to rebrand "MU" as the "Promoting Interoperability" program for eligible hospitals, critical access hospitals and Medicaid providers. Additionally, CMS proposes to rename the Merit-Based Incentive Payment System's "Advancing care Information" performance category as the "PI Performance Category." The name change is intended to reflect a new programmatic emphasis on sharing information between providers and with patients.

The HITECH Act authorized payment incentives and successful demonstration of Certified Electronic Health Record Technology (CEHRT). It also authorized penalties for those hospitals not able to demonstrate CEHRT. In 2015, the Agency proposed to require technology certified to the 2015 Edition to demonstrate meaningful use for an EHR reporting period, but subsequently offered flexibility up to and including performance year 2018. The Agency believes the flexibility offered additional time to update, implement and optimize technology.

Beginning with the 2109 performance year, CMS will, in accordance with HITECH, require the 2015 edition of CEHRT. Their rationale is that the more up-to-date standards will improve clinical workflows and better support the interoperable exchange of health information.

8. **Payments will increase in 2019**

The Agency indicates an overall inpatient payment rate increase of 1.75 percent for payment year 2019. This is the result of a strong market basket increase and fewer downward adjustments than in recent years. Under current proposals, inpatient payment would rise by roughly $4 billion in FY19.

This is however, a proposed rule, and a wide range of outcomes may ultimately be included in the final version, which we anticipate will be released in early August.

BACKGROUND INFORMATION

Item 1 - MS-DRGs for Burns

927	Extensive Burns or Full Thickness Burns with MV 96+ Hours with Skin Graft
933	Extensive Burns or Full Thickness Burns with MV 96+ Hours without Skin Graft
928-929	Full Thickness Burn with Skin Graft or Inhalation Injury
934-1	Full Thickness Burn without Skin Graft or Inhalation Injury
935	Non-Extensive Burns

Item 1A - Gender edits

CURRENT MEDICARE POLICY

I. GENERAL INFORMATION

A. Background: As the result of an increasing number of claims that are denied due to sex/diagnosis and sex/procedure edits, claims for some transgender and hermaphrodite beneficiaries are rejecting out of the Integrated Outpatient Code Editor (IOCE) and the Common Working File (CWF).

B. Policy: For Part A claims processing, institutional providers shall report condition code 45 (Ambiguous Gender Category) on any outpatient claim related to transgender or hermaphrodite issues. This claim level condition code should be used by providers to identify these unique claims and also allows the sex related edits to be by-passed. The CWF shall override any gender specific edits when condition code 45 is present and allow the service to continue normal processing.

For Part B claims processing, **the KX modifier** shall be billed on the detail line with any procedure code(s) that are gender specific. The definition of the KX modifier is: Requirements specified in the medical policy have been met. Use of the KX modifier will alert the MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, but should have such editing by-passed for the beneficiary. The CWF shall override any gender specific edits for procedure codes billed with the KX modifier and allow the service to continue normal processing.

Item 2 – IME Adjustment Factor

The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a multiplier, which is represented as c, in the following equation: c x [(1 + r).405 - 1]. The multiplier c is set by Congress. Thus, the amount of IME payment that a hospital receives is dependent upon the number of residents the hospital trains and the current level of the IME multiplier.

Item 3 – IME/DME Funding Caps

Two or more hospitals may form a Medicare GME affiliated group if the hospitals are located in the same urban area or rural area or in contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsor or major participating institutions in the same program.

Current regulations allow hospitals that are part of the same Medicare GME affiliated group to apply their IME and Direct GME FTE caps on an aggregated basis, and to temporarily adjust each hospital's cap to reflect rotations of residents amongst the affiliated hospitals during an academic year. However, under current regulations, a new urban teaching hospital may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase to its direct GME and IME FTEs.

Item 5B – Hospital Value-Based Purchasing

Hospital Value-Based Purchasing (VBP)

A hospital's performance in Hospital Value-Based Purchasing (VBP) is based on measures/dimensions for the domains per fiscal year (FY). In 2017, the hospital's Total Performance Score (TPS) is composed of the following:

2017 Domain	**2017 Weight**
Clinical Care (e.g., Mortality for AMI, HF, Pneumonia; Fibronolytic therapy w/in 30 minutes of arrival, etc.)	25%
Patient- and Caregiver-Centered Experience of Care/Care Coordination (e.g., HCAHPS)	25%
Safety (e.g., MRSA infections, C-difficile infections)	25%
Efficiency and Cost Reduction (e.g., Medicare spending per beneficiary)	25%

Background information is available at the end of this document on items marked with an *

Item 5C – FY 2018 HAC measures

1. **Domain 1 — Recalibrated Patient Safety Indicator (PSI) 90 Composite (15% of total score)**
   The Recalibrated PSI 90 Composite is calculated using Medicare fee-for-service claims for discharges from **July 1, 2014** through **December 31, 2015.** The Recalibrated PSI 90 Composite includes the following eight recalibrated PSIs:

   - PSI 03 — Pressure Ulcer Rate
   - PSI 06 — Iatrogenic Pneumothorax Rate
   - PSI 07 — Central Venous Catheter-Related Bloodstream Infections Rate
   - PSI 08 — Postoperative Hip Fracture Rate
   - PSI 12 — Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
   - PSI 13 — Postoperative Sepsis Rate
   - PSI 14 — Postoperative Wound Dehiscence Rate
   - PSI 15 — Accidental Puncture or Laceration Rate

2. **Domain 2 — Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures (85% of total score)**
   The following CDC NHSN HAI measures are calculated using hospitals' chart-abstracted surveillance data reported to NHSN for infections occurring from **January 1, 2015** through **December 31, 2016**:

   - Central Line-Associated Bloodstream Infection (CLABSI)
   - Catheter-Associated Urinary Tract Infection (CAUTI)
   - Surgical Site Infection (SSI) (colon and hysterectomy)
   - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
   - Clostridium difficile Infection (CDI)

Payment adjustments applied to hospital discharges from 10-1-2016 through 9-30-2018

Item 5D – IQR Measures Proposed for Removal

Measure Title	Beginning with Reporting Year
Hospital Survey on Patient Safety Culture	2018
Safe Surgical Checklist	2018
Patient Safety and Adverse Events Composite (PSI 90)	2018
Facility-wide Inpatient Hospital-onset Clostridium Difficile Infection Outcome measure (CDI)	2019
Catheter-Associated Urinary Tract Infection (CAUTI)	2019
Central Line-Associated Bloodstream Infection (CLABSI)	2019
Methicillin-Resistant Staphylococcus Aureus Bacteremia (MRSA) Outcome	2019
ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome	2019
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI)	2018
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG)	2018
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following COPD Hospitalization	2018

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Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization	2018
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	2018
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Total Hip Arthroplasty and/or Total Knee Arthroplasty	2018
Hospital 30-Day, All Cause, Risk-Standardized Readmission Rate Following Stroke Hospitalization	2018
Claims Based Mortality Measure – Mortality Rate Following Acute Myocardial Infarction Hospitalization	2018
Claims Based Mortality Measure - Mortality Rate Following Heart Failure Hospitalization	2018
Claims Based Mortality Measure - Mortality Rate Following COPD	2019
Claims Based Mortality Measure - Mortality Rate Following Pneumonia Hospitalization	2019
Claims Based Mortality Measure - Mortality Rate Following CABG Surgery	2020
Hospital-Level Risk-Standardized Complication Rate Following Elective THA/TKA	2021
Medicare Spending Per Beneficiary	2018
Cellulitis Clinical Episode-Based Payment Measures	2018
Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	2018
Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	2018
Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	2018
Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	2018
Spinal Fusion Clinical Episode-Based Payment Measure	2018
Chart Abstracted Measure: Influenza Immunization Measure	2019
Chart Abstracted Measure: Incidence of Potentially Preventable Venous Thromboembolism Measure	2019
Chart Abstracted Measure: Median Time from ED Arrival to ED Departure for Admitted ED Patients	2019
Chart Abstracted Measure: Admit Decision Time to ED Departure Time for Admitted Patients Measure	2020
ECQM: Primary PCI Received Within 90 Minutes of Hospital Arrival	2020
ECQM: Home Management Plan of Care Document Given to Patient/Caregiver	2020
ECQM: Median Time from ED Arrival to ED Departure for Admitted ED Patients	2020

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ECQM: Hearing Screen Prior to Hospital Discharge	2020
ECQM: Elective Delivery	2020
ECQM: Stroke Education	2020
ECQM: Assessed for Rehabilitation	2020

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