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FY 2020 IPPS and LTCH Final Rule

OVERVIEW

On August 2nd, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2020. CMS is making a 0.5 percentage point adjustment to the standardized amount of Medicare payments to acute care hospitals. Payment rates for acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users will increase by approximately 3.1%, or $3.4 billion nationally. Combined with changes in uncompensated care payments, capital payments and other changes, CMS projects total Medicare spending on inpatient hospital services and capital will increase by about $3.8 billion in FY 2020.

LTCH aggregate payments for FY 2020 will increase by approximately 1%, or $43 million. This is the result of an increase of 2.7% in LTCH PPS payments under the standard payment rate and a decrease of 5.9% in LTCH PPS payments for cases continuing to transition to the site neutral payment rate.

The final rule is available here.

FINALIZED POLICIES TO ADDRESS WAGE INDEX DISPARITIES

CMS is finalizing, with modifications, a proposal to increase the wage index for hospitals with a wage index below the 25th percentile by half the difference between the otherwise applicable wage index value for those hospitals and the 25th percentile wage index value across all hospitals. This policy will be in effect for at least four years beginning in FY 2020. In order to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile, CMS is applying a uniform budget neutrality factor to the standardized amount applied to all hospitals, rather than reduce the wage index only for hospitals above the 75th percentile as originally proposed. Additionally, CMS is removing urban to rural hospital reclassifications from the calculation of the rural floor wage index value. CMS is finalizing a 5% cap on any decrease in a hospital’s wage index from FY 2019 to FY 2020.

UNCOMPENSATED CARE PAYMENTS

CMS will distribute about $8.4 billion in uncompensated care payments in FY 2020, an increase of $78 million from FY 2019, and will use a single year of data on uncompensated care costs from Worksheet S-10 of the Medicare cost report for FY 2015 to distribute these funds. CMS is continuing to use the following established policies:

1. A provider with multiple cost reports beginning in the same fiscal year will continue to use the longest cost report and annualize Medicaid data and uncompensated care data if a hospital’s cost report does not equal 12 months of data.

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2. If a provider has multiple cost reports beginning in the same fiscal year, but one report also spans the entirety of the following fiscal year, such that the hospital has no cost report for that fiscal year, the provider should use the cost report that spans both fiscal years for the latter fiscal year.
3. CMS will continue to apply statistical trim methodologies to potentially aberrant cost-to-charge ratios (CCRs) and potentially aberrant uncompensated care costs reported on the Worksheet S-10.

INPATIENT NEW TECHNOLOGY ADD-ON PAYMENTS

CMS is adopting an alternative pathway for the inpatient new technology add-on payment for medical devices that receive Food and Drug Administration (FDA) marketing authorization and are part of the FDA Breakthrough Devices Program. CMS is also finalizing an alternative inpatient new technology add-for Qualified Infectious Disease Products (QIDPs). Medical devices that have received marketing authorization under the FDA Breakthrough Devices Program will be considered new and not substantially similar to an existing technology, will not be subject to the substantial clinical improvement criterion, and will only need to meet the cost criterion to receive the IPPS new technology add-on payment beginning in FY 2021. Under the final rule, 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 new medical devices, and 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 for certain QIDPs, beginning in FY 2020.

ADVERSE EVENT REDUCTION PROGRAMS

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS is establishing the following policy changes to the Hospital Readmissions Reduction Program (HRRP):

- Hospitals with higher-than-expected readmissions rates over a three-year period for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective knee/hip replacement and coronary artery bypass grafting will be subject to a maximum 3% penalty.
- CMS is adopting a measure removal policy and eight removal factors for deciding whether a measure should be removed from the HRRP. The removal factor policies were previously adopted by the Hospital Inpatient Quality Reporting (IQR) and Hospital Value Based Payment (VBP) Programs.
- CMS is updating the HRRP definition of "dual-eligible," beginning with the FY 2021 program year to allow for a 1-month lookback period in data sourced from the State Medicare Modernization Act (MMA) files to determine dual-eligible status for beneficiaries who die in the month of discharge. CMS is also updating the definitions of "aggregate payments for excess

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readmissions," "applicable condition," "base operating diagnosis-related group (DRG) payment amount," and limitations on administrative and judicial review to align with previously finalized policies.

- CMS is adding a sub-regulatory process to address any potential non-substantive changes to the payment adjustment factor components.
- CMS is establishing the performance period for the FY 2022 program year as the 3-year period from July 1, 2017 through June 30, 2020. The applicable period for dual-eligibles for FY 2022 would similarly be the 3-year period from July 1, 2017 through June 30, 2020.

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

CMS is adopting a measure removal policy previously adopted by the Hospital Inpatient Quality Reporting (IQR) and Hospital Value Based Payment (VBP) Programs and eight removal factors for deciding whether a measure should be removed from the HAC Reduction Program. CMS is clarifying administrative policies for validation of the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) healthcare-associated infection (HAI) measures and adopting the data collection periods for the FY 2022 program year for the CMS PSI 90 as the 24-month period from July 1, 2018 through June 30, 2020, and the applicable period for CDC NHSN HAI measures as the 24-month period from January 1, 2019 through December 31, 2020.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

The rule will redistribute approximately $1.9 billion in operating payments through the VBP program, funded by a 2% reduction in base operating DRG payments. CMS is establishing that the Hospital VBP Program will use the same data used by the HAC Reduction Program for purposes of calculating CDC NHSN HAI measures beginning with CY 2020 data collection, and will rely on HAC Reduction Program validation to ensure the accuracy of CDC NHSN HAI measure data used in the Hospital VBP Program.

CMS is also finalizing the following changes to the Promoting Interoperability Program:

- Eliminating the requirement that, for the FY 2020 payment adjustment year, for an eligible hospital that has not successfully demonstrated it is a meaningful EHR user in a prior year, the EHR reporting period in CY 2019 must end before and the eligible hospital must successfully register for and attest to meaningful use no later than the October 1st, 2019 deadline.
- Establishing a new EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants in the Medicare Promoting Interoperability Program attesting to CMS and is requiring that the Medicare Promoting Interoperability Program measure actions must occur within the EHR reporting period, beginning with the EHR reporting period in CY 2020.
- Revising the Query of Prescription Drug Monitoring Program (PDMP) measure to make it an optional measure worth five bonus points in CY 2020 among other revisions and is changing the

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maximum points available for the e-Prescribing measure from five points to ten points beginning in CY 2020.

- Removing the Verify Opioid Treatment Agreement measure beginning in CY 2020 and clearly stating that the measure is worth a full five bonus points in CY 2019 and is revising the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to more clearly capture the previously established policy regarding CEHRT use.

For CQM reporting under the Medicare and Medicaid Promoting Interoperability Programs, CMS is aligning program requirements with requirements under the Hospital IQR Program.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

CMS is making the following changes to the IQR Program:

- Adopting the Safe Use of Opioids – Concurrent Prescribing electronic clinical quality measure (eCQM) beginning with the CY 2021 reporting period/FY 2023 payment determination. CMS did not finalize the Hospital Harm – Opioid-Related Adverse Events eCQM identified in the proposed rule.
- Adopting the Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) measure beginning with two voluntary reporting periods which will run from July 1st, 2021 through June 30th, 2022, and from July 1st, 2022 through June 30th, 2023. CMS will require reporting of the measure for the reporting period that will run from July 1st, 2023 through June 30th, 2024, impacting the FY 2026 payment determination and subsequent years.
- Removing the Claims Based Hospital-Wide All-Cause Unplanned Readmission Measure (HWR claims-only measure), beginning with the FY 2026 payment determination.
- Changing the eCQM reporting and submission requirements for the CY 2022 reporting period FY 2024 payment determination, requiring hospitals to report one self-selected calendar quarter of data for three self-selected eCQMs and the Safe Use of Opioids – Concurrent Prescribing eCQM.