
Medicare Inpatient Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2020

Overview and Resources

On August 2, 2019, the Centers for Medicare and Medicaid Services (CMS) released the final federal fiscal year (FFY) 2020 payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, this rule includes:

- A rate increase amount (+0.5%) for the Coding Offset adjustment;
- Changes intended to reduce the growing disparity between high-and-low-wage index hospitals;
- Changes to LUGAR county CBSA assignments;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies;
- Updates to the program rules for the Value-Based Purchasing (VBP), Readmission Reduction Program (RRP) and Hospital-Acquired Condition (HAC) programs; and
- Updates to the payment penalties for non-compliance with the Hospital IQR and Electronic Health Record (EHR) Incentive Programs.

Program changes are effective for discharges on or after October 1, 2019 unless otherwise noted.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page.html>.

An online version of the rule will be available at <https://www.federalregister.gov/d/2019-16762> on August 16, 2019.

A brief summary of the major hospital provisions of the IPPS final rule is provided below.

Note: Text in italics is extracted from either the May 3, 2019 *Federal Register* (Proposed Rule) or the August 2, 2019 Display Copy of the Final Rule.

IPPS Payment Rates

DISPLAY pages 17, 55 – 60, 926 – 934, 1217 – 1220, 1975 – 2043, and 2052 – 2066

The table below lists the federal operating and capital rates adopted for FFY 2020 compared to the rates currently in effect for FFY 2019. These rates include all marketbasket increases and reductions as well as the application of an annual budget neutrality factor. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

	Final FFY 2019	Final FFY 2020	Percent Change
Federal Operating Rate	\$5,646.08	\$5,801.13 <i>(proposed at \$5823.30)</i>	+2.75%
Federal Capital Rate	\$459.41	\$462.61 <i>(proposed at \$463.81)</i>	+0.70%

The table below provides details for the adopted annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2020.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	+3.0%		+1.5%
ACA-Mandated Reductions 0.4 percentage point (PPT) productivity reduction	-0.4 PPT		—
MACRA-Mandated <u>Retrospective</u> Documentation and Coding Adjustment	+0.5%	—	—
Budget Neutrality Adjustments Related to FFY 2020 Wage Index Changes	-0.32%		-0.36%
Annual Budget Neutrality Adjustments	-0.04%		-0.43%
Net Rate Update	+2.75%	+2.23%	+0.70%

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs (DISPLAY pages 926 – 934):** Beginning in FFY 2015, the IQR MB penalty changed from -2.0 percentage points to a 25% reduction to the full MB, and the EHR Meaningful Use (MU) penalty began its phase-in over three years, starting at 25% of the full MB. Beginning FFY 2017, the EHR MU penalty has capped at 75% of the MB; hence the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2020 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Marketbasket Update (3.0% MB less 0.4 PPT productivity)	+2.60%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.0%)	—	-0.75 PPT	—	-0.75 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.0%)	—	—	-2.25 PPT	-2.25 PPT
Adjusted Net Marketbasket Update (prior to other adjustments)	+2.60%	+1.85%	+0.35%	-0.40%

- **Retrospective Coding Adjustment (DISPLAY page 17, 57-60):** CMS will apply a retrospective coding adjustment of +0.5% to the federal operating rate in FFY 2020 as part of the third year of rate increases (of six) tied to the American Taxpayer Relief Act (ATRA). The coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by \$11 billion over a 4-year period, resulting in a cumulative rate offset of approximately -3.2%.
- **Outlier Payments (DISPLAY pages 2000 – 2039):** Due to prior concerns over CMS' decision to not consider outlier reconciliation in the outlier threshold development for a given fiscal year, CMS now believes that using a methodology that incorporates historic cost report outlier reconciliations to develop the threshold would be a reasonable approach and would provide a better predictor for upcoming fiscal year. Therefore, for FFY 2020, CMS will incorporate total outlier reconciliation dollars from the FFY 2014 cost reports into the outlier model.

To maintain outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of \$26,473 for FFY 2020. The adopted threshold is 2.73% higher than the current (FFY 2019) outlier threshold of \$25,769.

Wage Index

DISPLAY pages 770 – 917

For FFY 2020, CMS is making several changes that would affect the wage index and wage index-related policies, including:

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals (DISPLAY pages 864 – 917):** CMS had noted that many comments from the Wage Index RFI in the FFY 2019 IPPS proposed rule reflected “a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals.” Another common thread was the concern over the rural floor calculation allowing a limited number of hospitals to manipulate the system to achieve a higher rural floor for the state, at the expense of other states, leading to increased wage index disparities. Due to these comments, CMS is adopted a variety of proposals to reduce the disparity between high and low wage index hospitals as follows:

- **Providing Low Wage Index Hospitals an Opportunity to Increase Employee Compensation (DISPLAY pages 865 – 876):** CMS will increase the wage index for hospitals with a wage index value in the bottom quartile of the nation. This increase would be half of the difference between the hospital’s pre-adjustment wage index, and the 25th percentile wage index value across all hospitals. Effective FFY 2020, this policy will be in effect for at least four years in order to give hospitals time to increase employee compensation, as this is the minimum amount of time necessary for the data to be reflected in the Medicare cost report for use in calculating the wage index. For FFY 2020, the value of the 25th percentile wage index is 0.8457.

- **Budget Neutrality Offset for the Opportunity to Increase Employee Compensation (DISPLAY pages 876 – 889):** For the four years to which CMS’ will increase payments to hospitals in the lowest quartile of wage index values would apply, CMS is adopting a budget neutrality adjustment to offset these increases.

To accomplish this, CMS had proposed to identify hospitals above the 75th percentile wage index value as “high wage index hospitals.” These hospitals would each then have their wage index reduced by 4.3% of the difference between their individual wage index and the 75th percentile wage index value for all hospitals.

However, due to comments received, CMS is adopting a budget neutrality adjustment to the national standardized amount, instead of to the wage index values of the top 25% of hospitals. The value of the adjustment factor to be applied the operating rate will be 0.997987.

- **Preventing Inappropriate Payment Increases Due to Rural Reclassifications (DISPLAY pages 889 – 906):** In order to ensure that the rural floor policy remains as one “designed to address anomalies of some urban hospitals being paid less than the average rural hospital in their States,” CMS is adopting the proposal to remove wage index data from urban hospitals that reclassify as rural when calculating each state’s rural floor beginning FFY 2020.
- **Transition for Hospitals Negatively Impacted by the Budget Neutrality Offset (DISPLAY pages 906 – 915):** As the adopted changes to the FFY 2020 wage index calculation could lead to large decreases in the wage index values of some hospitals, CMS has adopted the proposal that a hospital’s FFY 2020 wage index be no less than 95% of its final FFY 2019 wage index. Hospitals will then be fully affected by these decreases in FFY 2021.

In addition, CMS will apply a budget neutrality adjustment of 0.998838 to the FFY 2020 IPPS rate to account for this transition.

- **Computing the FFY 2020 Unadjusted Wage Index (DISPLAY pages 784 – 798):** CMS is making adjustments to the calculation of the unadjusted wage index:

- For FFYs 2020 and subsequent years, CMS will modify the calculation of the Overhead Rate on cost report Worksheet S-3, Part II by no longer subtracting the sum of the overhead contract hours from Revised Total Hours as they are not included in the calculation of Revised Total Hours.
- In order to reduce confusion and to better align the wage index calculations of CMS and stakeholders, CMS will change the rounding methodology applied to the component values of the wage index calculation. For “Raw data” (e.g. cost report worksheet S-3, Parts II and III; occupational mix survey data), CMS will use “as is” and not round any of the data. For dollar values within the wage index calculations (e.g. sums, average hourly wages) CMS will round to two decimals. For hour values within the wage index calculation, CMS will round to the nearest whole number. For numbers not expressed as either dollars or hours (e.g. ratios, percentages, and inflation factors), CMS will round these to five

decimals. Finally, CMS will continue to round the actual adjusted and unadjusted wage indexes to four decimals.

- CMS has adopted that for FFYs 2020 and subsequent years, for urban labor market areas (i.e. CBSAs) for which CMS has no hospital wage data, that wage index of hospitals located in these CBSAs be set to the average urban wage index value of the state in which those hospitals are located (total urban hospital wages divided by total urban hospital hours, further divided by the national average hourly wage).
- **Wage Index Development Timetable for FFY 2021 (DISPLAY pages 818 – 820):** Applications for FFY 2021 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 3, 2019.
- **Elimination of Copy Requirement to CMS (DISPLAY pages 820 – 822):** Currently, hospitals applying for a wage index reclassification must submit the applications and supporting documentation to the MGCRB in the method prescribed by the MGCRB, with an electronic copy sent to CMS. As the MGCRB requires such documentation to be submitted electronically through the Office of Hearings Case and Document Management System (OH CDMS) for FFY 2020 and subsequent reclassifications; CMS is adopting its proposal to eliminate the requirement to send a copy to CMS, in order to reduce administrative burden on hospitals.
- **Lugar Status (DISPLAY pages 823 – 833, 844 – 848):** CMS clarified that when a Lugar hospital elects to receive an outmigration adjustment (in lieu of its Lugar wage reclassification) during the 45 day period following the display date of the proposed IPPS rule, and the county in which the hospital is located is no longer eligible for an outmigration adjustment when the final IPPS rule (or a correction notice that follows) wage index is completed, that hospital will be denied the outmigration adjustment and will be automatically reassigned the deemed-urban status. In addition, hospitals wishing to request a cancellation of rural reclassification must do so at least 120 days prior to the end of a Federal fiscal year.

Due to a reinterpretation of the Lugar statute, CMS will include outlying counties in the commuting analysis for the determination of those that qualify as Lugar counties. Due to this, for FFY 2020, CMS will change the CBSA assignments for the ten Lugar counties below:

County Name	FIPS County Code	Current Lugar CBSA	Current CBSA Name	Adopted Lugar CBSA	Adopted CBSA Name
Cleburne, AL	01029	11500	Anniston-Oxford-Jacksonville, AL	12060	Atlanta-Sandy Springs-Roswell, GA
Talladega, AL	01121	11500	Anniston-Oxford-Jacksonville, AL	13820	Birmingham-Hoover, AL
Polk, GA	13233	40660	Rome, GA	12060	Atlanta-Sandy Springs-Roswell, GA
Pearl River, MS	28109	25060	Gulfport-Biloxi-Pascagoula, MS	35380	New Orleans-Metairie, LA
Champaign, OH	39021	44220	Springfield, OH	18140	Columbus, OH
Susquehanna, PA	42115	13780	Binghamton, NY	42540	Scranton—Wilkes-Barre—Hazleton, PA
Lee, SC	45061	44940	Sumter, SC	17900	Columbia, SC
Grimes, TX	48185	17780	College Station-Bryan, TX	26420	Houston-The Woodlands-Sugar Land, TX
Henderson, TX	48213	46340	Tyler, TX	19124	Dallas-Plano-Irving, TX
Madison, VA	51113	16820	Charlottesville, VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV

- **Urban to Rural Reclassification (DISPLAY pages 836 – 848):** Currently, hospitals wishing to apply for an urban to rural reclassification must mail the application to the CMS Regional Office, and not submit through fax or other

electronic means. CMS is eliminating this restriction and thus will allow these applications to be submitted by mail, fax, or other electronic methods.

CMS is adopting its proposal to revise the requirements for an RRC to cancel their rural reclassification. Currently, an RRC must have been paid as a rural facility for at least one 12-month cost reporting period before they may request a cancellation, which would not take effect until the following fiscal year after the request is made. As RRCs can now simultaneously receive MGCRB and rural reclassifications, CMS will no longer apply this restriction for cancellation requests submitted during FFY 2020 and subsequent years. In addition, CMS is adopting, as general policy, that a hospital's rural reclassification *"will be considered cancelled effective for the next Federal fiscal year when a hospital opts (by submitting a request to CMS within 45 days of the date of public display of the proposed rule for the next Federal fiscal year...) to accept and receive its county out-migration wage index adjustment... in lieu of its geographic reclassification... If the hospital wishes to once again obtain a... rural reclassification, it would have to reapply through the CMS Regional Office... and the hospital would once again be ineligible to receive its out-migration adjustment."*

- **Labor-Related Share** (*DISPLAY pages 860 – 863*): The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2020, CMS will continue applying a labor-related share of 68.3% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

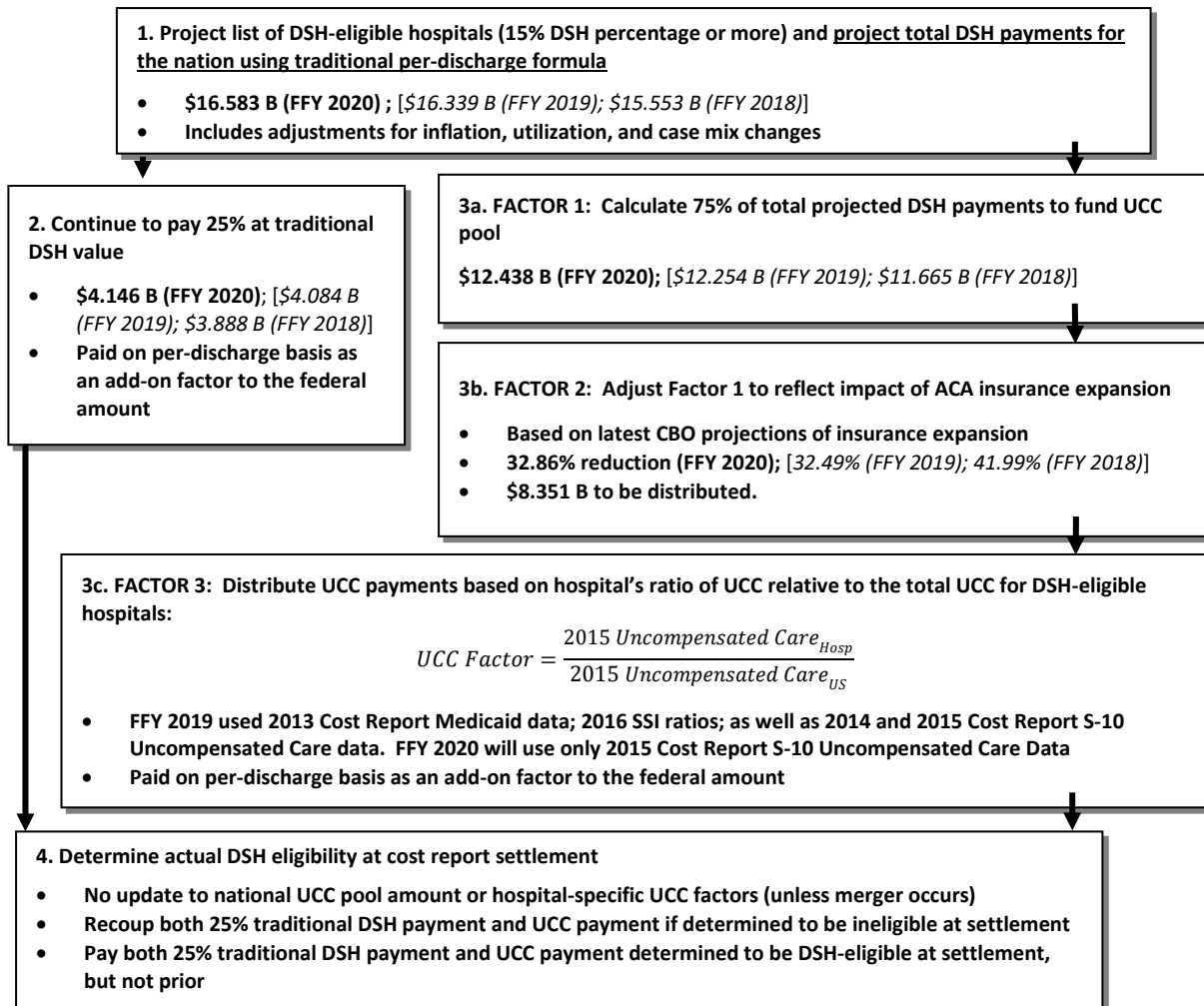
A complete list of the adopted wage indexes for payment in FFY 2020 is available on Table 2 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-FR-Tables-2-3-4.zip>.

DSH Payments

DISPLAY pages 950 – 1072

The ACA mandates the implementation of Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds, referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is to be distributed to hospitals based on each hospital’s proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2020** (DISPLAY pages 961 –1072): The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2019 to FFY 2020:



The DSH dollars available to hospitals under the ACA’s payment formula will increase by \$78 million in FFY 2020 due to an increase in the pool from projected DSH payments.

- **Eligibility for FFY 2020 DSH Payments** (DISPLAY pages 955 - 960): CMS is projecting that 2,432 hospitals will be eligible for DSH payments in FFY 2020 based on audited FFY 2015 S-10 data. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2020. CMS has made a file available that includes DSH eligibility

status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-FR-DSH-Supplemental-Data-File.zip>.

- **Adjustment to Factor 3 Determination** (*DISPLAY pages 984 – 1072*): CMS had been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014, due to concerns regarding data variability and lack of reporting experience with Worksheet S-10. However, in the FFY 2018 IPPS final rule, CMS again stated that it has been seeing an improving correlation between Factor 3 values calculated using data on uncompensated care from Worksheet S-10 and those calculated using data from the IRS Form 990. CMS began to phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the UCC payment factor (Factor 3), starting with FFY 2014 cost reports for DSH payments in FFY 2018.

For FFY 2020, CMS is adopting its proposal to utilize a single year of Medicare cost report data from the audited FFY 2015 S-10 Worksheet, and to not continue the three year averaging process for Factor 3. However, due to large number of comments received, CMS may consider returning to the use of a 3-year average in the future.

Additionally, as CMS is no longer using three years of data, a scaling factor will no longer be applied to the Factor 3 values due to a single data year being used.

Due to reporting requirements, CMS will continue to not utilize Worksheet S-10 for the calculation of Factor 3 for Puerto Rico or IHS/Tribal hospitals. Instead, Factor 3s for these providers will be calculated by applying a triple-weight to the FFY 2013 data due to the effects of Medicaid expansion on data reported for FFYs 2014 and 2015. For all-inclusive rate hospitals, which had previously been exempt from the S-10 version of Factor 3, CMS has determined that as the trim methodology will mitigate any aberrant CCRs, for FFY 2020 CMS will determine these hospitals' Factor 3 values using the audited FFY 2015 S-10 data.

For FFY 2020, any hospitals with a CCN created on or after October 1, 2015, due to the lack of FFY 2015 cost report data, these hospitals will not receive interim FFY 2020 DSH UCC payments. However, CMS states that the MACs will make final determinations as to DSH eligibility for these hospitals at cost report settlement and, if eligible, they shall receive UCC payments using a Factor 3 based on their FFY 2020 cost report S-10 data as the numerator, set over the established national value for the FFY 2015 cost report S-10 data as the denominator.

In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS will continue its FFY 2019 trimming methodology targeting the cost to charge ratio (CCR).

GME Payments

DISPLAY pages 949 – 950 and 1178 – 1197

Under current CMS policy, Critical Access Hospitals (CAHs) that train residents in approved programs are paid at 101% of reasonable cost. CMS has heard concerns over CAHs not being considered as nonprovider sites for DGME and IME payments, including that current policy is creating barriers to training residents in rural areas as well as hindering collaborative efforts between hospitals and CAHs to recruit and retain physicians in rural areas. The ACA made several changes to the requirements that must be met to include residents training in a nonprovider setting as part of a hospital's FTE count, including incurring the cost of residents' salaries and fringe benefits. However, while a CAH is considered to be a provider, the term "nonprovider" is not explicitly stated in statute, leading to ambiguity regarding the training of hospital residents at a CAH.

CMS has adopted the proposal that, for cost reporting periods beginning October 1, 2019, *"a hospital may include FTE residents training at a CAH in its FTE count as long as it meets the nonprovider setting requirements currently included at 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g). [CMS did not] change [their] policy with respect to CAHs incurring the costs of training residents."*

The Indirect Medical Education (IME) adjustment factor will remain at 1.35 for FFY 2020.

Notice of Teaching Hospital Closure and Opportunity to Apply for Available Slots

The ACA authorizes the redistribution of residency slots after a hospital that trained residents in an approved medical residency program closes. This final rule is being used to notify hospitals of one such closure, and the opportunity to obtain additional residency slots. Hospitals that wish to apply for these slots must submit their applications by October 31, 2019. The closed teaching hospital is:

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap (including +/- MMA Sec. 422 and ACA Sec. 5503 Adjustments)	Direct GME FTE Resident Cap (including +/- MMA Sec. 422 and ACA Sec. 5503 Adjustments)
090006	Providence Hospital	Washington, D.C.	47894	4/30/2019	50.50	52.12

Updates to the MS-DRGs

DISPLAY pages 60 – 370, 390 – 396

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes adopted for the FFY 2020 MS-DRGs leave the total number of payable DRGs at 761. 80% of DRG weights will change by less than +/- 5%, and 5% change by +/- 10% or more. The five MS-DRGs with the greatest year-to-year change in weight are:

MS-DRG	Final FFY 2019 Weight	Final FFY 2020 Weight	Percent Change
MS-DRG 779: ABORTION W/O D&C	0.7543	1.1418	+51.4%
MS-DRG 886: BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	1.3456	+36.1%
MS-DRG 796: VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	1.9723	+34.3%
MS-DRG 951: OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	0.5865	-26.5%
MS-DRG 770: ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	0.7863	-26.4%

The full list of adopted FFY 2020 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-FR-Table-5.zip>.

For comparison purposes, the FFY 2019 DRGs are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-Table-5.zip>.

- Chimeric Antigen Receptor (CAR) T-Cell Therapies (DISPLAY pages 100 – 114 and 390 – 396):** CAR T-cell treatments are eligible for new technology add-on payments for FFY 2020, assuming that CMS adopts the proposal to continue such payments for these treatments. There had been a request to create a new MS-DRG specifically for CAR T-cell treatments, however CMS is not making any changes for FFY 2020 due to the limited number of cases in which they are used, which make the creation of a CAR T-cell therapy-specific MS-DRG appear premature.

In the proposed rule, CMS had sought public comment on payment alternatives for CAR-T cell therapies. Comments received may be found on DISPLAY pages 106-114, and were in response to the following topics:

- the most appropriate method to use to develop a relative weight should CMS propose a CAR T-cell therapy MS-DRG in the future;
- to what extent it would be appropriate to apply the wage index to such an MS-DRG as CMS's understanding of the therapy is that the costs do not vary among geographic areas;
- if IME and DSH adjustment add-on percentages should be reduced for these treatments due to their already high payments;

- elimination of the use of CCR in calculating new technology add-on payments for the existing CAR T-cell treatments, by making the add-on payment amount capped at 65% of the marginal cost of the technology, vs. the current 50%; and
- if CMS should consider using a specific CCR for ICD-10-PCS procedure codes used to report the performance of procedures involving CAR T-cell therapies.

New Technology

DISPLAY pages 371 – 769

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. In this final rule, CMS will:

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

With the proposed rule, CMS had issued a Request for Information (RFI) regarding the “New Technology Add-On Payment Substantial Clinical Improvement” criterion. Commenters had previously requested that CMS provide greater clarity on what constitutes “substantial clinical improvement” in order to better understand the New Technology application process and to better predict which applications will meet the criterion. As such, CMS is considering revisions to this criterion under both the IPPS new technology and the OPPS transitional pass-through payment policies and sought public comment on what sort of additional guidance and details would be useful. Comments on the RFI may be found on DISPLAY pages 725-758 of the final rule.

Additionally, due to stakeholder concerns that the current new technology add-on payment policy based does not adequately reflect the costs of new technology, nor support healthcare innovation, CMS will raise the current 50% cap on new technology add-on payments. Specifically, CMS is adopting, for discharges beginning October 1, 2019:

“if the costs of a discharge involving a new technology... exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 65 percent of the costs of the new medical service or technology; or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment. For a new technology that is a medical product designated by the FDA as a QIDP [Qualified Infectious Disease Products], beginning with discharges on or after October 1, 2019, if the costs of a discharge involving a new technology... exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 75 percent of the costs of the new medical service or technology; or (2) 75 percent of the amount by which the costs of the case exceed the standard DRG payment... unless the discharge qualifies for an outlier payment, the additional Medicare payment will be limited to the full MS-DRG payment plus 65 percent (or 75 percent for a medical product designated by the FDA as a QIDP) of the estimated costs of the new technology or medical service.”

Changes to the MS-DRG Postacute Care Transfer and Special Payment Policies

DISPLAY pages 918 – 926

When a patient is transferred from an acute care facility to a post-acute care or hospice setting, the transferring hospital receives a per diem payment, with a total payment capped at the full MS-DRG amount. For MS-DRGs subject to the post-acute care transfer policy that CMS deems to be high cost, CMS applies a special payment methodology so that the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with total payment capped at the full MS-DRG amount. Each year CMS, using established criteria, reviews the lists of MS-DRGs subject to the post-acute care transfer policy and special payment policy status.

Effective FFY 2020, CMS has adopted changes to a number of MS-DRGs affected by these policies, including:

- *“Reassign procedure codes from MS-DRGs 216 through 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, CC and without CC/MCC, respectively), and MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively) and create new MS-DRGs 319 and 320 (Other Endovascular Cardiac Valve Procedures with and without MCC, respectively);*

- Delete MS-DRGs 691 and 692 (Urinary Stones with ESW Lithotripsy with CC/MCC and without CC/MCC, respectively) and revise the titles for MS-DRGs 693 and 694 to 'Urinary Stones with MCC' and 'Urinary Stones without MCC', respectively"; and
- Remove MS-DRGs 273 and 274 from the postacute care transfer policy list.

Low-Volume Hospital Adjustment

DISPLAY pages 939 – 949

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Bipartisan Budget Act of 2018 had extended the relaxed low volume adjustment criteria (>15-mile/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 total discharges (rather than 1,600 Medicare discharges). The current payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

$$\text{Low Volume Hospital Payment Adjustment} = \frac{95}{330} - \frac{\text{Total Discharges}}{13,200}$$

Beginning with FFY 2023, the criteria for the low-volume hospital adjustment will return to the more restrictive levels. At that point, in order to receive a low-volume adjustment, subsection (d) hospitals would need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status for FFY 2020, consistent with historical practice, CMS will require that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria. The MAC must receive a written request by September 1, 2019 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2019. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Under this process, a hospital receiving the adjustment for FFY 2019 may continue to receive it without reapplying if it continues to meet the mileage and discharge criteria.

RRC Status

DISPLAY pages 934 – 939

Hospitals that meet certain case-mix and discharge criteria may be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and special treatment with respect to geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The adopted FFY 2020 minimum case-mix and discharge values are available on the pages listed above.

Quality-Based Payment Adjustments

DISPLAY pages 1074 – 1177

For FFY 2020, IPPS payments to hospitals will be adjusted for quality performance under the Value Based Purchasing (VBP) Program, Readmissions Reduction Program (RRP), and the Hospital-Acquired Conditions (HAC) Reduction Program. Detail on the FFY 2020 programs and payment adjustment factors are below (future program year program changes are addressed at the end of this Brief):

- **VBP Adjustment** (*DISPLAY pages 1115 – 1145*): The FFY 2020 program will include hospital quality data for 19 measures in 4 domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP Program must be budget neutral and the FFY 2020 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at \$1.9 billion). Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0% reduction.

While the data applicable to the FFY 2020 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the current year's (FFY 2019) program. Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors published with the final rule are available in Table 16A on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-NPRM-Table-16.zip>

CMS anticipates making actual FFY 2020 VBP adjustment factors available in the Fall of 2019. Details and information on the program currently in place for FFY 2019 and FFY 2020 program are available on CMS' QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937>.

- **Readmissions Reduction Program (RRP) (DISPLAY pages 1074 – 1114):** The FFY 2020 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) (expanded in FFY 2017 to include diagnoses of sepsis with a secondary diagnosis of pneumonia, and aspiration pneumonia), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare Fee-For-Service and Medicare Advantage patients during the same 3-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the 6 measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

The data applicable to the FFY 2020 RRP program is still being reviewed and corrected by hospitals, and therefore CMS did not yet post final factors for the FFY 2020 program in Table 15.

Details and information on the RRP currently are available on CMS' QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458>.

- **HAC Reduction Program (DISPLAY pages 1146 – 1177):** The FFY 2020 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments.

CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Beginning FFY 2020, CMS adopted a change to the domain weighting scheme in Total HAC score calculations that removes domains entirely and applies an equal weight to each measure for which a hospital has a score.

Details and information on the HAC currently are available on CMS' QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166>.

Quality-Based Payment Policies—FFYs 2021 and Beyond

For FFYs 2021 and beyond, CMS is adopting new policies for its quality-based payment programs.

- **VBP Program—FFYs 2021 through 2025** (*DISPLAY pages 1115 – 1145*): CMS has already adopted VBP program rules through FFY 2021 and some program policies and rules beyond FFY 2021. CMS is finalizing further program updates for FFYs 2021-2025, which include:
 - Beginning January 1, 2020 (FFY 2022 program year performance), use of the same data to calculate the HAI measures and review/correction processes that the HAC Reduction Programs currently uses for these measures; and
 - National performance standards for a subset of the FFY 2022, FFY 2024 and FFY 2025 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking).
- **Readmissions Reduction Program** (*DISPLAY pages 1074 – 1114*): CMS is adopting a measure removal policy for RRP, similar to those previously adopted in other quality programs (8 removal factors).

Beginning FFY 2021, CMS is also finalizing a change to the current definition of “dual eligible” for those beneficiaries who die in the month of discharge. These beneficiaries will be identified using the previous month’s data sourced from the State Medicare Modernization Act files.

In addition, CMS is adopting a process to address any potential future insignificant changes to the payment adjustment factor components outside of the rule making process. CMS also finalized a 3-year performance period for FFY 2022.

CMS plans to include data stratified by patient dual-eligible status for each individual measure in the RRP hospital-specific reports as early as spring 2020.
- **HAC Reduction Program—FFY 2021** (*DISPLAY pages 1146 – 1177*): CMS finalized specifications for the FFY 2021 program such as time periods used to calculate performance scores. CMS is also adopting a measure removal policy for HAC, similar to those previously adopted in other quality programs (8 removal factors).

Updates to the IQR Program and Electronic Reporting Under the Program

DISPLAY pages 1328 – 1556

Beginning with the CY 2021 reporting period (FFY 2023 payment determination), CMS is adopting one of the two proposed opioid-related eCQMs: Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e), with an update to the technical specifications, clarifying that the measure is only applicable to the inpatient setting for implementation under IQR.

CMS is not finalizing its proposal to adopt the Hospital Harm – Opioid Related Adverse Events eCQM in order to further assess recommendations made in public comments and potentially incorporate suggested changes into the measure for the future. The public comments can be found on *Display pages 1380 – 1395*.

CMS is adopting its proposal to expand the voluntary reporting of the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (Hybrid HWR measure) with mandatory reporting beginning with the FFY 2026 payment determination in a two-step process. First, hospitals will have the option to report data for four quarters (as opposed to the previous two voluntary reporting periods) from July 1, 2021 through June 30, 2022 and July 1, 2022 through June 30, 2023. Afterwards, CMS is requiring reporting of the measure beginning with the FFY 2026 payment determination for the period of July 1, 2023 through June 30, 2024.

In conjunction with the mandatory reporting of the Hybrid Hospital-Wide measure, CMS is adopting its proposal to remove the Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789) with the FFY 2026 program determination.

In the FFY 2020 proposed rule, CMS solicited comments on three potential measures for inclusion in the future. Public comments on these measures can be found on the following *Display pages*:

- Hospital Harm – Severe Hypoglycemia eCQM (pages 1468 – 1478);
- Hospital Harm- Pressure Injury eCQM (pages 1485 – 1494); and
- Cesarean Birth (PC-02) eCQM (NQF #0471e) (pages 1502 – 1505).

In late summer of 2018, CMS provided stratified hospital specific reports of the Pneumonia readmission and mortality measures using two disparity methods for comparison (within hospital method and across hospital method). CMS is planning to provide this same data in the regular annual confidential HSRs for claims-based measure results for an additional five measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0505);
- Hospital 30-Day, All-Cause, RSRR Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2515);
- Hospital 30-Day, All-Cause, RSRR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891);
- Hospital 30-Day, All-Cause, RSRR Following Heart Failure (HF) Hospitalization (NQF #0330); and
- Hospital-Level 30-Day, All-Cause, RSRR Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551).

Currently, hospitals are required to report one, self-selected calendar quarter of data for four self-selected eQMs. CMS is finalizing that for CY 2022 reporting period (FFY 2024 payment determination), hospitals must report on Safe Use of Opioids – Concurrent Prescribing eQCM as one of the four required eQMs.

Tables in the final rule on *Display* pages 1456 - 1459 outline the previously adopted Hospital IQR Program measure set for the FFYs 2022 – 2023 payment determination and subsequent years.

IPPS-Excluded Hospital Policies

DISPLAY pages 1221 – 1246

Certain hospitals excluded from the inpatient prospective payment system, including critical access hospitals (CAHs), children’s hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico receive payment for inpatient hospital services they furnish on the basis of reasonable costs, subject to a rate-of-increase ceiling. A per-discharge limit is set for each hospital based on the hospital’s own cost experience in its base year, and updated annually. For FFY 2020, CMS is making the following policy changes that would affect hospitals excluded from the IPPS:

- **FFY 2020 Payment Rate of Increase for Excluded Hospitals** (*DISPLAY pages 1221 – 1225*): For each cost reporting period, an excluded hospital’s updated target amount is multiplied by total Medicare discharges during that period and applied as an aggregate upper limit of Medicare reimbursement for total inpatient operating costs for a hospital’s cost reporting period. CMS uses the percentage increase in the IPPS operating market basket to update the target amounts for children’s hospitals, cancer hospitals, and RNHCIs.

For cost reporting periods starting during FFY 2019, CMS will set the update to the target amount for long-term care neoplastic disease hospitals at 3.2 percent.

- **TEFRA Adjustments to the Rate of Increase Ceiling** (*DISPLAY pages 1225 – 1229*): Medicare pays under the Tax Equity and Fiscal Responsibility Act (TEFRA) system on a reasonable cost basis, with a ceiling determined from a hospital’s target amount, which uses updated Medicare inpatient operating costs per discharge from a base year. If a TEFRA hospital’s inpatient operating costs exceed the ceiling for a cost reporting period, a hospital may request either an increase to their Medicare payment ceiling, or a new base year to account for service or patient population changes.

In the proposed rule, for hospitals seeking a ceiling increase, CMS had sought public comment on the methodologies used to determine an appropriate adjustment amount, as well as for recommendations on possible criteria/documentation that would warrant a new base period. No comments with such suggestions were included in this final rule.

- **CAH Payment for Ambulance Services** (*DISPLAY pages 1230 – 1242*): Currently, Medicare pays for ambulance services provided by CAHs (or CAH-owned entities) at 101% of reasonable costs as long as that entity is the only provider of ambulance services within a 35-mile drive of the CAH, or if there are no ambulance services within a 35-mile drive of the CAH and that entity is the closest provider of ambulance services to the CAH. In all other cases, those services are paid under the Ambulance Fee Schedule. Ambulance service providers that are not legally authorized

to transport individuals to/from the CAH count towards these criteria under the current regulations, thus leading to such a CAH being unable to support the costs of providing ambulance services to its area.

CMS adopted its proposal to exclude ambulance service providers without legal authorization to transport individuals to/from a CAH from consideration of the criteria for ambulance services within 35 miles of the CAH. Under this change, such “third-party” ambulance services would continue to be considered outside of the 35-mile zone.

Promoting Interoperability Program

Display pages 1870 – 1915

Beginning CY 2019, CMS adopted an updated EHR Incentive program performance-based scoring methodology for eligible hospitals and Critical Access Hospitals (CAHs) to reduce burden on health care providers, EHR developers and vendors, as well as allow for flexibility on scoring. The program has fewer measures and moves away from the threshold-based methodology currently in use.

CMS is finalizing the continuation of an EHR reporting period minimum of any continuous 90-day period for CY 2021 for new and returning participants. CMS is also adopting changes to the scoring methodology and measures beginning CY 2020, outlined below.

Finalized Performance-Based Scoring Methodology Beginning with EHR Reporting Periods in CY 2020:

Objectives	Measures	2020: Maximum Points
Electronic Prescribing	e-Prescribing*	Finalized as 10 points
	Query of Prescription Drug Monitoring Program (PDMP)* (finalized as optional with yes/no response)	5 point (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	<u>Choose two measures:</u> Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points

Measures with changes to scoring are denoted with an asterisk ().

CMS is finalizing the removal of the Verify Opioid Treatment Agreement measure for the CY 2020 program.

For CY 2021 reporting and CY 2023 payment, CMS is adopting one of two proposed opioid-related clinical quality measures: Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e).

CMS is not finalizing its proposal to adopt the Hospital Harm – Opioid Related Adverse Events eCQM due to commenter’s concerns about the measure.

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