Medicare Inpatient Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2020

Overview and Resources

On May 3, 2019, the Centers for Medicare and Medicaid Services (CMS) released the proposed federal fiscal year (FFY) 2020 payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed 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;
- Proposals 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 proposed 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-Proposed-Rule-Home-Page.html. Comments on all aspects of the proposed rule are due to CMS by June 24, 2019 and can be submitted electronically at https://www.regulations.gov/ by using the website's search feature to search for file code "1716-P".

An online version of the rule is available at https://www.federalregister.gov/d/2019-08330.

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

IPPS Payment Rates

FR pages 19170 – 19171, 19400 – 19403, 19452 – 19453, and 19585 – 19609

The table below lists the federal operating and capital rates proposed 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 <u>not</u> 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	Proposed FFY 2020	Percent Change
Federal Operating Rate	**$5,646.08**	**$5,823.30**	**+3.14%**
Federal Capital Rate	**$459.41**	**$463.81**	**+0.96%**

The table below provides details for the proposed 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	**+3.2%**		**+1.5%**
ACA-Mandated Reductions 0.5 percentage point (PPT) productivity reduction	**-0.5 PPT**		**—**
MACRA-Mandated <u>Retrospective</u> Documentation and Coding Adjustment	**+0.5%**	**—**	**—**
Annual Budget Neutrality Adjustment	**-0.07%**		**-0.53%**
Net Rate Update	***+3.14%***	***+2.63%***	***+0.96%***

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** ***(FR pages 19400 – 19403)***: 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 proposed update scenarios for FFY 2020 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Marketbasket Update (3.2% MB less 0.5 PPT productivity)	**+2.7%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.2%)	**—**	**-0.8 PPT**	**—**	**-0.8 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.2%)	**—**	**—**	**-2.4 PPT**	**-2.4 PPT**
Adjusted Net Marketbasket Update (prior to other adjustments)	***+2.7%***	***+1.9%***	***+0.3%***	***-0.5%***

- **Retrospective Coding Adjustment** ***(FR page 19161)*****:** CMS is proposing to 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** ***(FR pages 19591 – 19599)*****:** 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 is proposing to 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 proposing an outlier threshold of $26,994 for FFY 2020. The proposed threshold is 4.75% higher than the current (FFY 2019) outlier threshold of $25,769.

Wage Index

FR pages 19373 – 19399

For FFY 2020, CMS is proposing 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** ***(FR pages 19393 – 19399)*****:** CMS has 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 proposing to reduce the disparity between high and low wage index hospitals as follows:

- **Providing Low Wage Index Hospitals an Opportunity to Increase Employee Compensation** ***(FR pages 19394 – 19395)*****:** CMS is proposing to 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 would 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.
- **Budget Neutrality Offset for the Opportunity to Increase Employee Compensation** ***(FR pages 19395 – 19396)*****:** For the four years to which CMS' proposal to increase payments to hospitals in the lowest quartile of wage index values would apply, CMS is proposing to create a budget neutrality adjustment to offset these increases.

  To accomplish this, CMS is proposing 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.
- **Preventing Inappropriate Payment Increases Due to Rural Reclassifications** ***(FR pages 19396 – 19398)*****:** 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 proposing 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** ***(FR pages 19398 – 19399)*****:** As the proposed changes to the FFY 2020 wage index calculation could lead to large decreases in the wage index values of some hospitals, CMS is proposing 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, should the proposals go forward.

  In addition, CMS is proposing to apply a budget neutrality adjustment of 0.998349 to the FFY 2020 IPPS rate to account for this transition.

- **Computing the FFY 2020 Unadjusted Wage Index** ***(FR pages 19376 – 19380)*****:** CMS is proposing to make adjustments to the calculation of the unadjusted wage index:
  - For FFYs 2020 and subsequent years, CMS is proposing to 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 is proposing to 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 is proposing to 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 is proposing to round to two decimals. For hour values within the wage index calculation, CMS is proposing to round to the nearest whole number. For numbers not expressed as either dollars or hours (e.g. ratios, percentages, inflation factors), CMS is proposing to round these to five decimals. Finally, CMS is proposing to continue rounding the actual adjusted and unadjusted wage indexes to four decimals.
  - CMS is proposing 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** ***(FR pages 19382 - 19383)*****:** 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** ***(FR page 19383)*****:** 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 proposing to eliminate the requirement to send a copy to CMS, in order to reduce administrative burden on hospitals.
- **Lugar Status** ***(FR pages 19383 - 19387)*****:** CMS wishes to clarify 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, CMS is proposing that 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 is proposing to include outlying counties in the commuting analysis for the determination of those that qualify as Lugar counties. Due to this, for FFY 2020, CMS is proposing to change the CBSA assignments for the ten Lugar counties below:

County Name	FIPS County Code	Current Lugar CBSA	Current CBSA Name	Proposed Lugar CBSA	Proposed 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** ***(FR pages19387 - 19389)*****:** Currently, hospitals wishing to apply for an urban to rural reclassification must mail the application to the CMS Regional Office, and to not submit through fax or other electronic means. CMS is proposing to eliminate this restriction and thus allow this applications to be submitted by mail, fax, or other electronic methods.

CMS is proposing 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 is proposing that this restriction will no longer apply for cancellation requests submitted during FFY 2020 and subsequent years. In addition, CMS is proposing, 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 receives 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** ***(FR pages 19392 – 19393)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2020, CMS is proposing to 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 proposed 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-NPRM-Tables-2-3-4.zip.

DSH Payments

FR pages 19406 – 19423

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** ***(FR pages 19406 –19423)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program is proposed to change from FFY 2019 to FFY 2020:

1. Project list of DSH-eligible hospitals (15% DSH percentage or more) and <u>project total DSH payments for the nation using traditional per-discharge formula</u>

- **$16.857 B (FFY 2020) ;** [*$16.339 B (FFY 2019); $15.553 B (FFY 2018)*]
- **Includes adjustments for inflation, utilization, and case mix changes**

2. Continue to pay 25% at traditional DSH value

- **$4.214 B (FFY 2020)**; [*$4.084 B (FFY 2019); $3.888 B (FFY 2018)*]
- **Paid on per-discharge basis as an add-on factor to the federal amount**

3a. FACTOR 1: Calculate 75% of total projected DSH payments to fund UCC pool

$12.643 B (FFY 2020); [*$12.254 B (FFY 2019); $11.665 B (FFY 2018)*]

3b. FACTOR 2: Adjust Factor 1 to reflect impact of ACA insurance expansion

- **Based on latest CBO projections of insurance expansion**
- **32.86% reduction (FFY 2020);** [*32.49% (FFY 2019); 41.99% (FFY 2018)*]
- **$8.489 B to be distributed.**

3c. FACTOR 3: Distribute UCC payments based on hospital's ratio of UCC relative to the total UCC for DSH-eligible hospitals:

$$UCC\ Factor = \frac{2015\ Uncompensated\ Care_{Hosp}}{2015\ Uncompensated\ Care_{US}}$$

- **FFY 2019 used 2013 Cost Report Medicaid data; 2016 SSI ratios; as well as 2014 and 2015 Cost Report S-10 Uncompensated Care data. FFY 2020 proposed to use only 2015 Cost Report S-10 Uncompensated Care Data**
- **Paid on per-discharge basis as an add-on factor to the federal amount**

4. Determine actual DSH eligibility at cost report settlement

- **No update to national UCC pool amount or hospital-specific UCC factors (unless merger occurs)**
- **Recoup both 25% traditional DSH payment and UCC payment if determined to be ineligible at settlement**
- **Pay both 25% traditional DSH payment and UCC payment determined to be DSH-eligible at settlement, but not prior**

The DSH dollars available to hospitals under the ACA's payment formula will increase by $216 million in FFY 2020 due to an increase in the pool from projected DSH payments.

- **Eligibility for FFY 2020 DSH Payments** ***(FR pages 19407 - 19408)*****:** CMS is projecting that 2,430 hospitals will be eligible for DSH payments in FFY 2020 if audited FFY 2015 S-10 data is used, or 2,443 with FFY 2017 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 (Tables 18A and 18B) are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-NPRM-Table-18.zip.

- **Adjustment to Factor 3 Determination** ***(FR pages 19413 – 19422)*****:** 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 proposing 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. Additionally, CMS is seeking public comment on whether FFY 2017 S-10 data should be used in lieu of the audited FFY 2015 S-10 data.

  Additionally, as CMS is proposing to no longer use three years of data, they are proposing to no longer apply a scaling factor to the Factor 3 values as it would no longer be necessary due to a single data year being used.

  Due to reporting requirements, CMS is proposing to 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, CMS is proposing for FFY 2020 to determine these hospitals' Factor 3 values using the audited FFY 2015 S-10 data.

  CMS is proposing for FFY 2020, for any hospitals with a CCN created on or after October 1, 2015, that due to the lack of FFY 2015 cost report data, these hospitals will not receive interim FFY 2020 DSH UCC payments. However, CMS is proposing 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 is proposing to continue its FFY 2019 trimming methodology targeting the cost to charge ratio (CCR).

GME Payments

FR pages 19406 and 19446 – 19448

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 is proposing 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 is] *not proposing to 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

FR pages 19448 – 19449

The ACA authorizes the redistribution of residency slots after a hospital that trained residents in an approved medical residency program closes. This proposed 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)
360052	Good Samaritan Hospital	Dayton, OH	19380	7/23/2018	62.60	62.03

Updates to the MS-DRGs

FR pages 19171 – 19273

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 proposed for the FFY 2020 MS-DRGs would leave the total number of payable DRGs at 761. Only 56% of DRG weights will change by less than +/- 5%, with 17% changing by +/- 10% or more. The five MS-DRGs with the greatest year-to-year change in weight are:

MS-DRG	Final FFY 2019 Weight	Proposed FFY 2020 Weight	Percent Change
MS-DRG 796: VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	2.4608	+67.6%
MS-DRG 779: ABORTION W/O D&C	0.7543	1.1521	+52.7%
MS-DRG 619: O.R. PROCEDURES FOR OBESITY W MCC	2.9207	4.2690	+46.2%
MS-DRG 837: CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	7.6525	+42.4%
MS-DRG 838: CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	3.2131	+36.6%

The full list of proposed 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-NPRM-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** ***(FR pages 19180 – 19182 and 19278 – 19279)*****:** 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 proposing this change for FFY

2020 due to the limited number of cases in which they are used, thus making the creation of a CAR T-cell therapy-specific MS-DRG appear premature.

CMS is seeking public comment on payment alternatives for CAR-T cell therapies, including:

- o the most appropriate method to use to develop a relative weight should CMS propose a CAR T-cell therapy MS-DRG in the future;
- o 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 no vary among geographic areas;
- o if IME and DSH adjustment add-on percentages should be reduced for these treatments due to their already high payments;
- o 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
- o 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

FR pages 19272 – 19373

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

- Proposing to discontinue add-on payments for three medical services/technologies;
- Proposing continued new technology add-on payments for nine technologies; and
- Seeking comment on implementation of add-on payments for 17 technologies.

CMS has issued a Request for Information (RFI) regarding the "New Technology Add-On Payment Substantial Clinical Improvement" criterion. Commenters have 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 are seeking public comment on what sort of additional guidance and details would be useful. The RFI may be found on pages 19367-19373 of the proposed 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 is proposing to raise the current 50% cap on new technology add-on payments. Specifically, CMS is proposing that, 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. Unless the discharge qualifies for an outlier payment, the additional Medicare payment would be limited to the full MS-DRG payment plus 65 percent of the estimated costs of the new technology or medical service."*

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

FR pages 19399 – 19401

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 proposed 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

FR pages 19404 – 19406

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:

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

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 is proposing to 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

FR pages 19403 – 19404

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 proposed FFY 2020 minimum case-mix and discharge values are available on the pages listed above.

Quality-Based Payment Adjustments

FR pages 19423 – 19446

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 *(FR pages 19428 – 19440)*:** The FFY 2020 program will include hospital quality data for 19 measures in 4 domains: safety of care; clinical outcomes; person and community engagement; and efficiency. 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 proposed 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) *(FR pages 19423 – 19428)*:** 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. CMS expects to release the final FFY 2020 RRP factors in the fall of 2019.

  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 *(FR pages 19440 – 19446)*:** 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 has stated that it expects to release the list of hospitals subject to the HAC penalty for FFY 2020 in fall of 2019.

CMS previously adopted a continuous program 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 proposing new policies and measures for its quality-based payment programs.

- **VBP Program–FFYs 2021 through 2025** ***(FR pages 19428 – 19440)*****:** CMS has already adopted VBP program rules through FFY 2021 and some program policies and rules beyond FFY 2021. CMS is proposing 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** ***(FR pages 19423 – 19428)*****:** CMS is proposing to adopt a measure removal policy for RRP, similar to those previously adopted in other quality programs (8 removal factors).

  Beginning FFY 2021, CMS is also proposing 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 proposing a process to address any potential future insignificant changes to the payment adjustment factor components outside of the rule making process. CMS also proposed 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 are early as spring 2020.
- **HAC Reduction Program–FFY 2021** ***(FR pages 19440 – 19446)*****:** CMS is proposing specifications for the FFY 2021 program such as time periods used to calculate performance scores. CMS is also proposing to adopt 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

FR pages 19473 – 19500

Beginning with the CY 2021 reporting period (FFY 2023 payment determination), CMS is proposing to adopt two opioid-related eCQMs:

- Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e); and
- Hospital Harm – Opioid Related Adverse Events eCQM

CMS is also proposing 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 would 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 proposing to require 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 proposing to remove the Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789) with the FFY 2026 program determination. This proposal is contingent on the adoption of the mandatory measure.

CMS is soliciting comments on three potential measures for inclusion in the future (pages 1161 – 1176):

- Hospital Harm – Severe Hypoglycemia eCQM;
- Hospital Harm- Pressure Injury eCQM; and
- Cesarean Birth (PC-02) eCQM (NQF #0471e).

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 considering providing these hospital specific reports for additional outcome measures in spring of 2020.

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

Tables in the proposed rule on Federal Register pages 19485 - 19487 outline the previously adopted Hospital IQR Program measure set for the FFYs 2022 – 2023 payment determination and subsequent years.

IPPS-Excluded Hospital Policies

FR pages 19453 – 19458

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** ***(FR pages 19453 – 19454)*****:** 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.

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

- **TEFRA Adjustments to the Rate of Increase Ceiling** ***(FR pages 19454 – 19455)*****:** 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 is seeking 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.

- **CAH Payment for Ambulance Services** ***(FR pages 19455 – 19456)*****:** 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 is proposing 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 the proposal, such services would continue to be considered outside of the 35-mile zone.

Promoting Interoperability Program

FR pages 19554 – 19569

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 new program has fewer measures and moves away from the threshold-based methodology currently in use.

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

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

Objectives	Measures	2020: Maximum Points
Electronic Prescribing	e-Prescribing*	10 points
	Query of Prescription Drug Monitoring Program (PDMP)*	5 point (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Heath 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 proposed changes to scoring are denoted with an asterisk (*).

For CY 2021 reporting and CY 2023 payment, CMS is proposing to add two new opioid-related clinical quality measures:

- Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e); and
- Hospital Harm – Opioid Related Adverse Events eCQM

CMS is also seeking comment on whether to propose to adopt the Hybrid Hospital-Wide Readmission measure beginning CY 2023 with Claims and EHR Data in future rulemaking.

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