April 25, 2019

To: Strategic Health Care Clients

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Re: Summary of CMS' Proposed 2020 Inpatient Prospective Payment System (IPPS) Rule

Below is a summary of the proposed IPPS rule released this past Tuesday. The 1,824 page rule is at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08330.pdf. It will be published in the Federal Register on May 3rd.

Proposed Changes to Payment Rates
CMS projects an operating payment rate increase of approximately 3.7%. Hospitals may be subject to other payment adjustments under the IPPS, including: penalties for excess readmissions; penalties for the worst-performing quartile under the Hospital Acquired Condition Reduction Program; and, adjustments made under the Hospital Value-Based Purchasing Program. In sum, CMS projects total Medicare spending on inpatient hospital services will increase by about $4.7 billion in FY 2020.

Medicare Uncompensated Care Payments (pg. 25, ff)
CMS proposes distributing roughly $8.5 billion in uncompensated care (disproportionate share) payments in FY 2020, an increase of approximately $216 million from FY 2019.

Wage Index Disparities (pg. 24, ff)
CMS is proposing to increase the wage index for hospitals with a wage index value below the 25th percentile. These hospitals' wage indexes would be increased by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals. This proposed policy would be effective for at least four years beginning in FY 2020. To maintain budget neutrality CMS is proposing to decrease the wage index for hospitals above the 75th percentile. To mitigate payment decreases CMS proposes a 5% cap on any decrease in a hospital's wage index comparted to FY 2019. CMS is also proposing changes to the wage index "rural floor" calculation, i.e., the wage index value. To address this, CMS proposes removing urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.

Outlier Fixed-Loss Cost Threshold (pg. 1561, ff)
CMS proposes to incorporate an estimate of outlier reconciliation dollars based on actual outlier reconciliation amounts reported in historical cost reports to provide a better estimate and

predictor of outlier reconciliation for the upcoming fiscal year. No proposals were made with respect to FY 2021 methodology and subsequent FYs, however, CMS notes that the proposed methodology could advance by one year the cost reports used to determine the historical outlier reconciliation (for example, for FY 2021, the FY 2015 outlier reconciliations would be expected to be complete). The outlier fixed-loss cost threshold for FY 2020 is equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $26,994 (up from $25,769 in FY 2019).

<u>Hospital Readmissions Reduction Program (HRRP) (pg. 935, ff)</u>
The 21st Century Cures Act requires CMS assess payment reductions based on a hospital's performance relative to other hospitals with a similar proportion of patients dually eligible for Medicare and full-benefit Medicaid. CMS is proposing to: adopt eight factors CMS would use when deciding whether a measure should be removed from HRRP; update the definition of "dual eligible"; and, adopt a sub-regulatory process to address potential non-substantive changes to the payment adjustment factor components.

<u>Hospital Value-Based Purchasing (VBP) Program (pg. 955, ff)</u>
CMS is proposing the VBP would use the same data as the HAC Reduction Program to calculate the National Health Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures beginning with CY 2020 data collection, which is when the Hospital IQR Program will cease collecting data on those measures. CMS is also proposing that the VBP would rely on the process used by the HAC Reduction Program to validate the NHSN HAI measures to ensure that the measure rates are accurate for use in the Hospital VBP Program.

<u>Hospital-Acquired Conditions (HAC) Reduction Program (pg. 983, ff)</u>
CMS is proposing to: specify the dates to collect data used to calculate hospital performance for the FY 2022 HAC Reduction Program; adopt eight factors CMS would use when deciding whether a measure should be removed from the HAC Reduction Program; and, clarify administrative processes for validating National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) data submitted by hospitals to the CDC.

<u>Hospital Inpatient Quality Reporting (IQR) Program (pg. 1111, ff)</u>
The rule proposes to remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace it with the proposed Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data measure and require reporting beginning with the FY 2026 payment determination after 2 years of voluntary reporting of the Hybrid HWR measure and establish reporting and submission requirements for the hybrid measures. Proposes to adopt two new opioid-related electronic clinical quality measures (eCQMs) beginning with the CY 2021 reporting period/FY 2023 payment determination: Safe Use of Opioids – Concurrent Prescribing eCQM; and, Hospital Harm – Opioid-Related Adverse Events eCQM. CMS is also proposing three changes for reporting eCQMs. These proposals align with the Promoting Interoperability Program's Clinical Quality Measure proposals.
CMS also invites public comment on three potential new measures for the Hospital IQR Program: Hospital Harm—Severe Hypoglycemia eCQM; Hospital Harm—Pressure Injury eCQM; and, Cesarean Birth eCQM.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (pg. 1210, ff)

CMS is proposing to adopt one new claims-based outcome measure, the Surgical Treatment Complications for Localized Prostate Cancer measure, beginning with the FY 2022 program year. CMS is proposing to remove the External Beam Radiotherapy for Bone Metastases measure, beginning with the FY 2022 program year, remove the current pain management questions from the version of the Hospital CAHPS used in PCHQR Program beginning with October 1, 2019 discharges, begin publicly reporting the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure in CY 2020, begin publicly reporting data for the Colon and Abdominal Hysterectomy Surgical Site Infection, Methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (CDI) and Healthcare Personnel Vaccination measures beginning with the October 2019 Hospital Compare release and conduct confidential national reporting for four end-of-life measures and one unplanned readmissions measure to prepare hospitals for the public reporting of these measures.

Medicare and Medicaid Promoting Interoperability Programs (pg. 1410, ff)

CMS is proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and CAHs). CMS is proposing to continue for CY 2020 the Query of PDMP measure as optional and available for bonus points instead of being required as was finalized last year. CMS is proposing to convert this measure from a numerator/denominator response to a yes/no attestation beginning with the EHR reporting period in CY 2019. CMS is proposing to remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 from the Promoting Interoperability Program. CMS is seeking comment on the inclusion of more meaningful measures to combat the opioid epidemic.

CMS also seeks comment on the following topics: opioid measures based on existing efforts by NQF and the CDC for potential inclusion in the Promoting Interoperability Program; measures to engage vendors and clinicians in improving the efficiency of healthcare providers use of EHRs; Inclusion of Medicare Promoting Interoperability Program data on the CMS Hospital Compare website; integration of Patient-Generated Health Data into EHRs using CEHRT; activities that promote the safety of the EHR; and, measures requiring the use of an open application programming interface (API), including reporting of such a measure as an alternative to the patient access measure.

Proposed New Technology Add-On Payment Pathway for Devices (pg. 730, ff)

CMS is proposing an alternative new technology add-on payment pathway for a medical device that receives FDA marketing authorization and is part of an FDA expedited program for medical devices, which is currently the Breakthrough Devices Program. CMS is proposing that if a medical device subject to one of the FDA's expedited programs has received marketing authorization from the FDA, CMS would consider that product new and not substantially similar to an existing technology for purposes of the IPPS new technology add-on payment. Under this proposal, the medical device would only need to meet the cost criterion to receive the add-on payment. This change would begin with applications received for new technology add-on payments for FY 2021. CMS proposes increasing the add-on payment beginning in FY 2020 from 50 percent to 65 percent.

Potential Revisions to the New Technology Add-On Payment Substantial Clinical Improvement Criterion

CMS is considering potential revisions to the substantial clinical improvement criterion under the IPPS new technology add-on payment policy and the OPPS transitional pass-through payment policy for devices policy. The agency is seeking public comment on the type of additional detail and guidance applicants for new technology add-on payments would find useful.

Applications for New Technology Add-on Payments for FY 2020

CMS proposes to continue the new technology add-on payments for 10 of the 13 technologies currently receiving the add-on payment. Add-on payments for CAR T-cell therapy for FY 2020, under the proposal to increase the maximum new technology add-on payment from 50 percent of the estimated costs of the case to 65 percent, would increase from $186,500 to $242,450.

Peripheral Extracorporeal Membrane Oxygenation (ECMO) (pg. 64, ff)

CMS is proposing to reassign the following procedure codes describing peripheral ECMO procedures from their current MS-DRG assignments to Pre-MDC MS-DRG 003 (ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedure). If this proposal is finalized, CMS would also make conforming changes to the titles for MS-DRGs 207, 291, 296, and 870 to no longer reflect the "or Peripheral Extracorporeal Membrane Oxygenation (ECMO)" terminology in the title. CMS notes that this proposal includes maintaining the designation of these peripheral ECMO procedures as non-O.R. Therefore, if finalized, the procedures would be defined as non-O.R. affecting the MS-DRG assignment for Pre-MDC MS-DRG 003.

LTCH PPS Payment Rate Changes (pg. 1049, ff)

CMS expects LTCH-PPS payments to increase by approximately 0.9% or $37 million which reflects the continued statutory implementation of the revised LTCH PPS payment system. LTCH PPS payments for FY 2020 for discharges paid using the standard LTCH payment rate are expected to increase by 2.3% after accounting for the proposed annual standard federal rate update for FY 2020 of 2.7% and an estimated decrease in outlier payments and other factors. LTCH PPS payments for cases continuing to transition to the site neutral payment rates are expected to decrease by approximately 4.9%. This accounts for the LTCH site neutral payment rate cases that will no longer be paid a blended payment rate as the rolling statutory transition period ends for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

LTCH Quality Reporting Program (QRP) (pg. 1249, ff)

In response to the IMPACT ACT CMS is proposing to adopt two new quality measures pertaining to transferring health information as well as a number of standardized patient assessment data elements that assess either functional status, cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, or social determinants of health. CMS is also proposing to modify the previously-adopted Discharge to Community measure to exclude nursing home residents who already reside in the nursing home, to move the implementation date of future versions of the LTCH CARE Data Set from April to October, to adopt data collection and public display periods for various measures and to no longer publish a list of compliant LTCHs on the LTCH QRP website.