Medicare Inpatient Prospective Payment System
Proposed Rule Impact Analysis
Federal Fiscal Year 2020

-Version 1-

Analysis Description

The federal fiscal year (FFY) 2020 Medicare Inpatient Prospective Payment System (IPPS) Proposed Rule Analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments will change from FFY 2019 to FFY 2020 based on the policies set forth in the FFY 2020 IPPS proposed rule. The analysis compares the year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes, including:

- potential payment penalties under the Inpatient Quality Reporting (IQR) and electronic health record (EHR) Incentive Programs;
- impact of CMS' proposal to adjust the wage index of hospitals in the top and bottom quartiles of wage index values nationally to reduce wage disparities;
- quality-based payment adjustments;
- Disproportionate Share Hospital (DSH) uncompensated care (UCC) payments; and
- CMS' use of solely Medicare Cost Report Worksheet S-10 for FFY 2020 UCC payments.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2020 IPPS Proposed Rule Changes Modeled in this Analysis:

- Provider Type Changes: Changes to inpatient payments resulting from a change in provider type. This includes adjustments to both hospital specific rate (if received) and changes to the traditional, rate-based DSH payment calculation for hospitals that change special status.
- Marketbasket Update: 3.2% operating marketbasket increase and 1.5% capital marketbasket increase. Budget neutrality factors increase the operating update by 0.1% and reduce the capital update by 0.3%.
- ACA Mandated Marketbasket Reduction: 0.5 percentage point (PPT) productivity reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.
- MACRA-Mandated Coding Adjustment: 0.5% increase to the federal operating rate to prospectively increase the rate after the American Taxpayer Relief Act (ATRA) of 2012 retrospectively adjusted for what CMS claimed to be over-payments due to coding improvements.
- Wage Index/GAF: Updated wage index and capital GAF values; including any impact due to new wage data; reclassifications; and other adjustments to the wage indexes. This value does not include CMS' proposal to increase the wage index values of hospitals in the bottom quartile of wage index values nationally.
- Reducing Wage Index Disparities: Reflects the estimated impact of CMS' proposal 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. This increase would be offset by reducing the wage index of hospitals above the 75th percentile wage index value by 4.3% of the difference between their individual wage index and the 75th percentile wage index value for all hospitals, while instituting a one-year stop-loss adjustment so that no hospital's FFY 2020 wage index could be less than 95% of that hospital's FFY 2019 wage index. The stop-loss adjustment would be made budget-neutral by a -0.17% adjustment to the IPPS operating rate and by a -0.23% adjustment to the IPPS capital rate. The impact of these individual components are broken out separately.
- DSH–UCC Payment Changes: Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2020 proposed rule DSH Supplemental File. Changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2020 DSH supplemental file. The impacts also include year-to-year changes in hospital-specific UCC payment factors (factor 3) for these hospitals, the impact of which is also displayed separately.
- Change in Hospital Specific Rate: Reflects the impact to special status hospitals (Sole-Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs), or Essential Access Community Hospitals (EACHs)) where there is a change in payment status (hospital-specific vs federal) or where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments.
- MS-DRG Updates: Changes due to updates to the DRG groupings and weights. The impact shown is the case-mix change resulting from running the FFY 2018 Medicare claims data through the two DRG Grouper software programs (Grouper Version 36.0 for FFY 2019 and Grouper Version 37.0 for FFY 2020) and assigning the respective MS-DRG weights for each year.
- Quality-Based Payment Adjustments: Year-to-year change in hospital-specific quality performance and subsequent adjustments under the Value Based Purchasing (VBP), Readmissions Reduction, and Hospital Acquired Condition (HAC) Reduction programs.
- Low Volume Adjustment Changes: Reflects the change in overall payments made as a result of the Low Volume Hospital (LVH) Adjustment program. The LVH adjustment factors are from FFY 2019 final rule and FFY 2020 IPPS proposed rule impact files. Distance eligibility for FFY 2019 was determined using the most recent 3 years of cost report data (2016, 2017 and 2018) as well as those determined to receive the adjustment in FFY 2020. If a hospital reported low volume payments in their most recent cost report, or had reported in its most recent year that the distance requirement had been met on Worksheet S-2, it is assumed that the hospital had

met the distance requirement of the low volume adjustment. It is worth noting that, due to the Bipartisan Budget Act of 2018, this adjustment is based on Medicare discharges for years prior to FFY 2019, and is based on total discharges for FFYs 2019-2022.

Data Sources

Estimated FFYs 2019 and 2020 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2020 IPPS proposed rule Impact File and data from CMS' DSH Supplemental files. These files are available on CMS' website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Proposed-Rule-Home-Page.html.

The inpatient federal operating and capital rates are from the FFY 2019 final and FFY 2020 proposed rules, as published in the *Federal Register*.

Medicare cases and case-mix indices are from the CMS FFY 2020 proposed rule Impact File and include cases, case-mix indices, and transfer-adjusted cases resulting from running the FFY 2018 Medicare claims data through the two DRG Grouper software programs (Grouper Version 36.0 for FFY 2019 and Grouper Version 37.0 for FFY 2020).

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFY 2019 final and FFY 2020 proposed rule Impact Files and the wage index tables in the *Federal Register*. Impacts of CMS' three alternative wage index considerations are based on the "Wage Index Alternatives Considered" PUF that came with the FFY 2020 IPPS proposed rule.

The DSH impact estimates are based on the Impact and DSH Supplemental files published with the final FFY 2019 and proposed FFY 2020 IPPS rules. The DSH Supplemental file includes: an indicator of DSH-eligible hospitals for FFY 2020, the national UCC pool dollars, and hospital-specific UCC factors/payment amounts. Estimates of a continuing the three year data averaging for FFY 2020 Factor 3 values are calculated utilizing data from the 1Q2019 update of the Medicare cost reports for FFYs 2014 and 2016, and the audited FFY 2015 S-10 data from the FFY 2020 IPPS proposed rule DSH Supplemental file. Due to more recent data being included in this estimate (FFY 2016) than in CMS' main proposal, Factor 3 values are determined based on the eligibility flags provided with CMS' FFY 2017-based estimates.

The impact of the quality-based payment adjustments are based on the following: the FFY 2020 Readmissions adjustment factors are from FFY 2020 IPPS proposed rule impact file, and are based on the final adjustment factors that were applicable for FFY 2019. The list of hospitals that could potentially be subject to the FFY 2020 HAC Reduction Program penalty is derived from hospital quality data available with the 4th quarter 2018 update of Hospital Compare (CMS did not provide this list with the rule). The FFY 2020 VBP adjustment factor is estimated based on hospital quality data available with the 4th quarter 2018 update of Hospital Compare (CMS' FFY 2020 VBP proxy adjustment factors are based on a prior program year). The FFY 2019 VBP and Readmissions adjustment factors are from the FFY 2019 IPPS final rule correction notice, final FFY 2019 HAC flags are from Hospital Compare.

Note: This analysis was developed to measure the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, DSH eligibility, factors used to calculate the DSH and IME adjustments and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2020 proposed rule Impact File and DSH Supplemental File. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating FFY 2019 payments. Estimated FFY 2019 payments reflect the wage index, labor-share, DSH, IME and quality-adjusted federal payment amount (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated FFY 2019 payments, the adopted policy changes to the IPPS payment rates are applied. Then, the effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are calculated by substituting FFY 2019 values with FFY 2020 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the marketbasket update is applied to estimated FFY 2019 payments. Then, the change to the ACA-mandated marketbasket reduction is applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. marketbasket, ACA, etc.).

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding.

Hospitals with Special Status

MDH/SCH status and federal/hospital-specific payment determinations for MDH/SCHs are based on the status predicted by CMS in its FFY 2020 proposed rule impact and DSH Supplemental files. If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, IME, and transfer adjustments), payments based on the hospital-specific rate are used in this analysis.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the hospital-specific rate is more beneficial, these hospitals are paid at 100% of the hospital-specific rate. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate.