Fact sheet

Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System (CMS-1716-F)

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Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule
CMS-1716-F

On August 2, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that reflects the agency's efforts to transform the healthcare delivery system through competition and innovation to provide patients with better value and results. The final rule will update Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2020.

The policies in the final rule represent historic changes to the way many low wage index hospitals, which tend to be rural, are paid, and support the agency's priority of "Rethinking Rural Health." By improving the accuracy of the Medicare payments to these low wage hospitals, they will be able to increase what they pay their workers, and this will help ensure that patients, including those living in rural areas, continue to have access to high-quality, affordable healthcare. In addition, the new technology policies in this rule also help ensure

that Medicare beneficiaries continue to have access to potentially life-saving diagnostics and therapies by unleashing innovation and removing barriers to competition.

This fact sheet discusses major provisions of the final rule (CMS-1716-F), which can be downloaded from the *Federal Register* at: https://www.federalregister.gov/documents/2019/08/16/2019-16762/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Background on the IPPS and LTCH PPS

CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS. LTCHs are paid under the LTCH PPS. Under these two payment systems, CMS sets base payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge. The classification systems are:

- IPPS: Medicare Severity Diagnosis-Related Groups (MS-DRGs)
- LTCH PPS: Medicare Severity Long-Term Care Diagnosis-Related Groups (MS-LTC-DRGs).

The law requires CMS to update payment rates for IPPS hospitals annually, and to account for changes in the prices of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital "market basket." The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area. Payment rates to LTCHs are updated annually according to a separate market basket based on LTCH-specific goods and services.

The changes, which will affect approximately 3,300 acute care hospitals and approximately 390 LTCHs, apply to discharges occurring on or after October 1, 2019.

Innovation

New Technology Add-On Payment Pathway for Devices

The Food and Drug Administration (FDA) Breakthrough Devices Program can help expedite the development and review of transformative new devices that meet expedited program criteria (e.g., are intended to treat serious or life-threatening diseases or conditions

for which there are unmet medical needs). CMS believes it is appropriate to similarly facilitate access to new technology add on payments for these transformative technologies for Medicare beneficiaries. Marketing authorization (e.g., approval or clearance) of a medical device that is subject to this expedited program could lead to situations where the evidence base for demonstrating substantial clinical improvement in accordance with CMS's current new technology add-on payment policy has not fully developed at the time of FDA market authorization. To address this, CMS finalized an alternative new technology add-on payment pathway for a medical device that receives FDA marketing authorization and is part of the Breakthrough Devices Program.

This rule finalizes that if a medical device subject to the FDA's Breakthrough Devices Program has received marketing authorization from the FDA, CMS considers that product new and not substantially similar to an existing technology for purposes of the IPPS new technology add-on payment, and it is not subject to the substantial clinical improvement criterion. Under finalized policy, the medical device will need to meet the *cost* criterion to receive the add-on payment. This change begins with applications received for new technology add-on payments for FY 2021.

Calculation of the Add-On Payment
Under the current new technology add-on payment calculation, Medicare pays a marginal cost factor of 50 percent of the estimated costs of the case in excess of the full DRG payment, up to a maximum of 50 percent of the costs of the technology. CMS believes that setting the maximum add-on payment percentage at 50 percent may not result in an appropriate add-on payment. To address this issue, CMS is finalizing an increase to the add-on payment, beginning in FY 2020, from 50 percent to 65 percent, and additionally is increasing the add-on payment to 75 percent for certain antimicrobials.

Revising and Clarifying the New Technology Add-On Payment Substantial Clinical Improvement Criterion
Recent stakeholder feedback has indicated that it would be helpful for CMS to provide more guidance on what constitutes "substantial clinical improvement." We understand that clarity about this criterion would help the public, including innovators, better understand how CMS evaluates new technology applications for add-on payments and provide greater predictability about which applications will meet it. To provide greater clarity and predictability, in the final rule, CMS is revising and clarifying the policies for the substantial clinical

improvement criterion used to evaluate applications for the new technology add-on payment under the IPPS.

In addition, we will also consider in the future the longer range ideas and recommendations submitted by commenters in response to our request for public feedback on the type of additional detail and guidance the public and applicants for new technology add-on payments would find useful regarding 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. These comments will inform future rulemaking.

Applications for New Technology Add-on Payments for FY 2020
In FY 2020, CMS will be making new technology add-on payments for 18 technologies. After consideration of public comments on the proposed rule, CMS has approved 9 of the 13 applications for new technology add-on payment for FY 2020 discussed in the proposed rule where the technology received FDA approval by July 1, 2019. This final rule also finalizes the continuation of the new technology add-on payments for the 9 technologies currently receiving the add-on payment that will continue to be within their newness period in FY 2020. One of the technologies for which CMS finalized continued payments is the chimeric antigen receptor (CAR) T-cell therapies.

Addressing Antimicrobial Resistance

CMS understands the serious impact that antimicrobial resistance represents for Medicare beneficiaries and public health overall. To address this, after consideration of public comments received on our proposals related to new technology add-on payment policies. CMS is finalizing an alternative new technology add-on payment pathway for antimicrobial products designated by FDA as Qualified Infectious Disease Products (QIDPs). Similar to the alternative pathway for certain breakthrough devices, under this policy, a QIDP will be considered new and will not need to demonstrate that it meets the substantial clinical improvement criterion (it will only need to meet the cost criterion). We are also increasing the new technology add-on payment percentage to 75 percent for an antimicrobial designated by the FDA as a QIDP.

Additionally, to address this concern, while we are continuing to examine the implementation of broader comprehensive changes to the MS-DRG severity level designation overall, after consideration of public comments CMS increased the MS-DRG severity level designation for

the diagnosis codes that specify antimicrobial drug resistance beyond those included in the proposal. Under this change, those antimicrobial drug resistance ICD-10-CM diagnosis codes will be designated as a complication or comorbidity (CC), the presence of which generally results in assignment to a higher severity MS-DRG due to the relatively higher resources associated with diagnoses with such designation.

Rethinking Rural Health

Addressing Wage Index Disparities

In last year's proposed rule, we invited comments, suggestions, and recommendations for changes to the Medicare wage index. Many responses reflected a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. To help address these wage index disparities, we are finalizing changes to improve the accuracy of the wage index calculation, including a methodology to increase the wage index for certain low wage index hospitals and to change how the statutory rural floor wage index values are calculated.

To address the impact of disparities on low wage index hospitals, CMS is finalizing our proposal to increase the wage index for hospitals with a wage index value below the 25th percentile. These hospitals' wage indexes will 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 policy will be effective for at least 4 years, beginning in FY 2020, in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. In response to public comments, CMS is modifying the budget neutrality adjustment for the policy. Overall Medicare spending will still not increase as a result of this policy, but CMS is accomplishing this through a budget neutrality adjustment to the standardized amount that is applied across all IPPS hospitals, rather than a decrease to the wage index for hospitals above the 75th percentile as proposed.

CMS is also finalizing changes to the wage index "rural floor" calculation. Under the law, the IPPS wage index value for an urban hospital cannot be less than the wage index value applicable to hospitals located in rural areas in the state. This is known as the "rural floor" provision. It appears that hospitals in a limited number of states have used urban to rural hospital reclassifications to inappropriately influence the rural floor wage index value. To address the unanticipated effects of rural reclassifications on the rural floor and the

resulting wage index disparities created by urban to rural hospital reclassifications, CMS will remove urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.

In conjunction with these policies, CMS is finalizing a transition of a 5-percent cap for FY 2020 on any decrease in a hospital's wage index from its final wage index for FY 2019 to help mitigate any significant decreases in the wage index values of hospitals for FY 2020. That is, a hospital's final wage index for FY 2020 will not be less than 95 percent of its final wage index for FY 2019.

Changes to Payment Rates under IPPS

The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 3.1 percent. This reflects the projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage point productivity adjustment. This also reflects a +0.5 percentage point adjustment required by legislation.

CMS projects the rate increase, together with other changes to IPPS payment policies, will increase IPPS operating payments by approximately $3.4 billion, and payments for new technologies will increase by 70 percent, or $0.2 billion. Combined with changes in uncompensated care payments, low-volume hospital payments, and capital payments, CMS projects total Medicare spending on inpatient hospital services, including capital, will increase by about $3.8 billion, or 3.0 percent, in FY 2020.

Individual hospitals may be subject to other payment adjustments under the IPPS, including:

- Penalties for excess readmissions, which reflect an adjustment to a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid
- Penalty (1 percent) for worst-performing quartile under the Hospital Acquired Condition Reduction Program
- Upward and downward adjustments under the Hospital Value-Based Purchasing Program.

Medicare Uncompensated Care Payments
CMS distributes a prospectively determined amount of uncompensated care payments to "Medicare disproportionate share hospitals" based on their relative share of uncompensated care. As required under law, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured people. In this rule, CMS will distribute roughly $8.4 billion in uncompensated care payments in FY 2020, an increase of approximately $78 million from FY 2019.

After consideration of public comments on the alternative discussed in the proposed rule, we determined that the best available data on uncompensated care costs are from Worksheet S-10 of the FY 2015 cost report, in part because we have conducted audits of this data. Accordingly, for FY 2020, CMS will use a single year of data on uncompensated care costs from Worksheet S-10 of the Medicare cost report for FY 2015 to distribute these funds. We will also continue to use data regarding low-income insured days (Medicaid days for FY 2013 and FY 2017 SSI days) to determine the amount of uncompensated care payments for Puerto Rico hospitals and Indian Health Service and Tribal hospitals.

Hospital-Acquired Conditions (HAC) Reduction Program
The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to reduce payment by one percent for applicable hospitals, which are subsection (d) hospitals that rank in the worst-performing quartile for HACs. In the FY 2020 IPPS/LTCH PPS final rule, CMS is finalizing our proposals to:

- Specify the dates to collect data used to calculate hospital performance for the FY 2022 HAC Reduction Program;
- Adopt eight removal factors CMS would use when deciding whether a measure should be removed from the HAC Reduction Program; all of these factors were previously adopted by the Hospital IQR and Hospital VBP Programs; and
- Clarify administrative processes for validating National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) data submitted by hospitals to the Centers for Disease Control and Prevention (CDC).

Hospital Readmissions Reduction Program (HRRP)
The Hospital Readmissions Reduction Program (HRRP) reduces

payments to hospitals with excess readmissions. The program includes six claims-based outcomes measures. The 21st Century Cures Act requires CMS to 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. For the FY 2020 IPPS/LTCH PPS final rule, CMS is finalizing our proposals to:

- Establish the performance period for the FY 2022 program year;
- Adopt eight removal factors CMS would use when deciding whether a measure should be removed from the Hospital Readmissions Reduction Program; all of these factors were previously adopted by the Hospital IQR and Hospital VBP Programs;
- Update the definition of "dual eligible," and the definitions of "aggregate payments for excess readmissions," "applicable condition," "base operating DRG payment amount," and limitations on administrative and judicial review to align with previously finalized policies; and
- Adopt a sub-regulatory process to address potential non-substantive changes to the payment adjustment factor components.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital IQR Program is a pay-for-reporting quality program which reduces payment to hospitals that fail to meet program requirements. In the FY 2020 IPPS/LTCH PPS final rule, CMS is updating the Hospital IQR Program's measure set, among other changes. Specifically, CMS is finalizing its proposals to:

- Remove the Claims-Based Hospital-Wide All-Cause Readmission measure (NQF #1789) beginning with the July 1, 2023 through June 30, 2024 reporting period, for the FY 2026 payment determination, and replace it with the newly adopted Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data measure (NQF #2879); require reporting of the Hybrid HWR measure beginning with the FY 2026 payment determination, following 2 years of voluntary reporting beginning July 1, 2021; and establish reporting and submission requirements for hybrid measures; and
- Adopt the Safe Use of Opioids – Concurrent Prescribing electronic clinical quality measure (eCQM), with a clarification and update, beginning with the CY 2021 reporting period/FY 2023 payment determination.

CMS is not finalizing its proposal to adopt the Hospital Harm – Opioid-Related Adverse Events eCQM.

Also, CMS is finalizing its proposals related to eCQM reporting requirements. These finalized proposals align with the Promoting Interoperability Program's Clinical Quality Measure requirements:

- For the CY 2020 reporting period/FY 2022 payment determination and CY 2021 reporting period/FY 2023 payment determination, to extend the current eCQM reporting and submission requirements finalized for the CY 2019 reporting period, such that hospitals submit one, self-selected calendar quarter of discharge data for four self-selected eCQMs in the Hospital IQR Program measure set;
- For the CY 2022 reporting period/FY 2024 payment determination, to require hospitals to report one, self-selected calendar quarter of data for: (1) three self-selected eCQMs, and (2) the finalized Safe Use of Opioids – Concurrent Prescribing eCQM, for a total of four eCQMs; and
- To continue requiring EHR technology be certified to all eCQMs available to report for the CY 2020 reporting period/FY 2022 payment determination and subsequent years.

CMS also responded to public comments on three potential new measures for the Hospital IQR Program: Hospital Harm—Severe Hypoglycemia eCQM; Hospital Harm—Pressure Injury eCQM; and Cesarean Birth (PC-02) eCQM. In addition, CMS provided an update on continuing and expanding confidential reporting of outcome measures data stratified by patients' dual eligibility status using two disparity methods in order to account for social risk factors in quality measurement.

Hospital Value-Based Purchasing (VBP) Program
The Hospital VBP Program adjusts payments to hospitals under the IPPS in a fiscal year for inpatient services based on their performance on specified quality measures. CMS is finalizing that the Hospital VBP Program will 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 finalizing that the Hospital VBP Program will rely on the process used by the HAC Reduction Program to validate the NHSN HAI measures. In addition, CMS is establishing the performance standards that would apply to a number of measures in future program years.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
The PCHQR Program collects and publishes data on an announced set

of quality measures. CMS is finalizing the following proposals:

- Adoption of one new claims-based outcome measure, the Surgical Treatment Complications for Localized Prostate Cancer measure, beginning with the FY 2022 program year;
- Removal of one measure because the burden outweighs the benefit of its use, the External Beam Radiotherapy for Bone Metastases measure, beginning with the FY 2022 program year;
- Refining of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey used in the PCHQR Program by removing the pain management questions from the version of the survey, beginning with October 1, 2019 discharges;
- Begin publicly reporting the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure;
- Begin publicly reporting data for the Colon and Abdominal Hysterectomy SSI, MRSA, CDI and HCP measures; and
- Conduct confidential national reporting for four end-of-life measures and one unplanned readmissions measure to prepare PCHs for the public reporting of these measures.

Medicare and Medicaid Promoting Interoperability Programs
In 2011, the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT). As part of the Trump Administration's MyHealthEData initiative launched in 2018 to empower patients with control of their healthcare data, CMS continues to make changes to the Promoting Interoperability Programs, including changes intended to reduce the burden on providers of complying with program requirements.

We are finalizing 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) in the Medicare Promoting Interoperability Program attesting to CMS.

We are finalizing our proposal to continue for the CY 2020 EHR reporting period the Query of PDMP measure as optional and available for bonus points instead of being required as was finalized last year because of unintended and unforeseen challenges that arose from the stakeholder community citing implementation difficulties and provider burden. To minimize burden, we are also finalizing converting

this measure from a numerator/denominator to a yes/no attestation beginning with the EHR reporting period in CY 2019.

We are finalizing our proposal to remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 from the Promoting Interoperability Program based on received feedback from stakeholders that this measure presents significant implementation challenges, leads to an increase in burden, and does not further interoperability.

Additionally, we are finalizing our plan to continue to align the CQM reporting requirements for the Promoting Interoperability Programs with similar requirements under the Hospital IQR Program. This includes finalizing the adoption of the new opioid-related quality measure Safe Use of Opioids – Concurrent Prescribing CQM .

Changes to Payment Rates under LTCH PPS

Beginning in FY 2016, under the statutory dual-rate LTCH PPS payment system, only certain discharges receive the LTCH PPS standard Federal payment amount; the remaining discharges receive a relatively lower site neutral payment rate. The law also included a transition period, which ends after cost reporting periods that began in in FY 2019. Therefore, LTCH site neutral payment rate cases will begin to be paid exclusively on the site neutral payment rate, rather than the transitional blended rate, for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

Overall, under the changes included in this final rule, CMS projects that LTCH PPS payments will increase by approximately 1.0 percent or $43 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 LTCH PPS standard Federal payment rate are expected to increase by 2.7 percent after accounting for the annual update for FY 2020 of 2.5 percent, and an estimated increase in outlier payments and other factors.

LTCH PPS payments for cases continuing to transition to the site neutral payment rate are expected to decrease by approximately 5.9 percent. 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.

In addition, this final rule implements the statutory payment adjustment and reinstatement process for LTCHs that do not meet statutorily required threshold of discharges that meet the patient criteria. Under this policy, CMS has provided for a "cure period" before the payment adjustment would go into effect to address unusual circumstances in which an LTCH's percentage of discharges meeting the patient criteria in a cost reporting period is not being fully reflective of its LTCH typical mix discharges.

LTCH Quality Reporting Program (QRP)

The LTCH QRP was implemented in FY 2012. LTCHs must report standardized patient assessment data, as well as data on quality, resource use, and other measures, and CMS makes public the reported data. LTCHs that do not satisfy the requirements of the program for a fiscal year receive a two percentage point reduction to their annual update to the LTCH PPS standard Federal rate for discharges for that fiscal year.

In the FY 2020 final rule, CMS is finalizing the adoption of two new quality measures in satisfaction of the quality measure domain in the IMPACT Act pertaining to transferring health information, as well as a number of standardized patient assessment data elements (SPADE) that assess functional status, cognitive function and mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments, and social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation). CMS is finalizing its proposal to modify the previously adopted Discharge to Community measure to exclude nursing home residents, moving the implementation date of future versions of the LTCH CARE Data Set from April to October, adopting data collection and public display periods for various measures, and announcing that it will no longer publish a list of compliant LTCHs on the LTCH QRP website.

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