

HFMA's Regulatory Sound Bites

An Overview of the Final 2019 Inpatient Prospective Payment System Rule

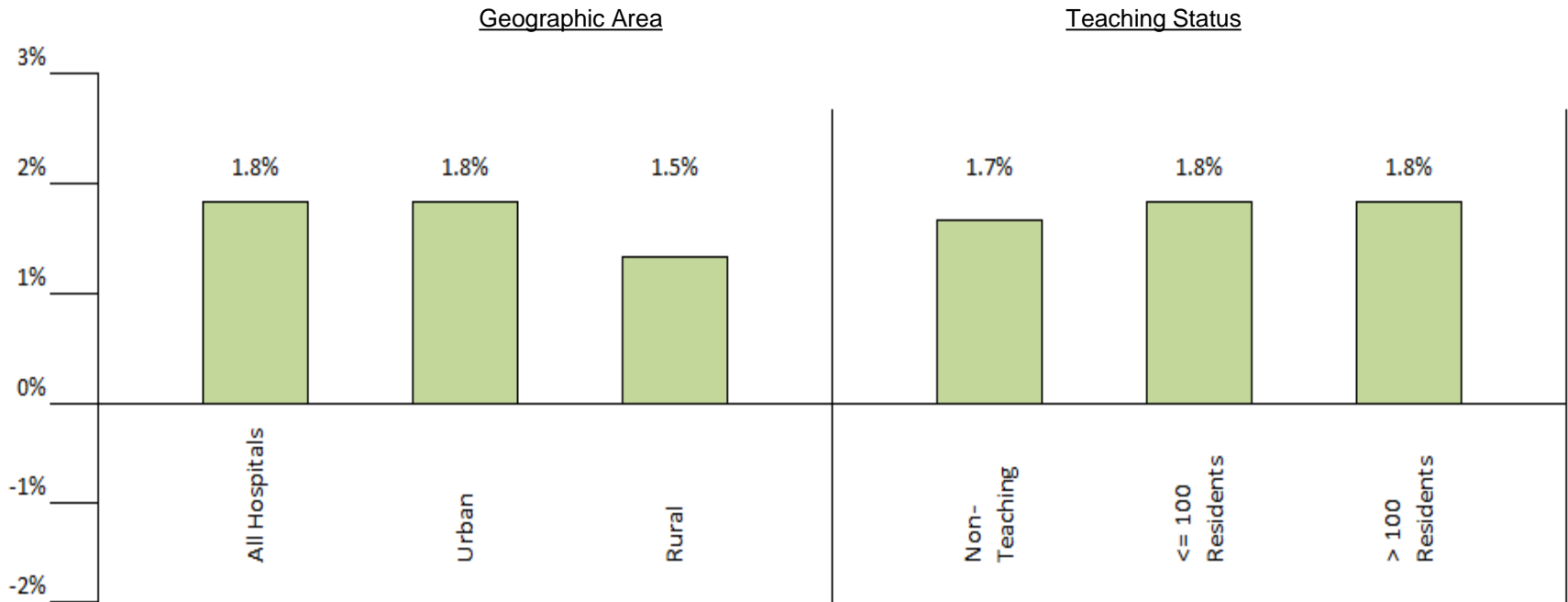
Presentation Objectives

- Review the 2019 Final Medicare Inpatient Prospective Payment System (IPPS) Rule
 - Published per Federal Register / Vol. 83, No. 160 / Friday, August 17, 2018 / Rules and Regulations
- Touch on the 2019 Proposed Medicare Outpatient Prospective Payment System (OPPS) Rule
 - Published per Federal Register / Vol. 83, No. 160 / Friday, July 27,, 2018 / Rules and Regulations

Modest Increase

The Final Rule Increases Payments to the Following Facilities

Reimbursement Impact of the 2019
Final IPPS Rule



Source: <https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf> pgs. 41744-41746

Operating Base Rates

CMS Is Adjusting the Market Basket Update

IPPS Provisions

- The FY18 market basket update is **2.9%**

The payment rate update factors are summarized below:

- -0.80 % multifactor productivity adjustment
- -0.75% Affordable Care Act (ACA) update adjustment mandate
- +0.50 documentation and coding adjustment required by 21st Century Cures Act

Resulting in a net increase in national standardized amounts (before application of budget neutrality factors of **1.85 %**)

See **Appendix 1** for final IPPS FY19 base and operating rates.

Final Operating Rates

	Standardized Operating Amounts Wage Index > 1		Standardized Operating Amounts Wage Index < 1	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User	\$3,858.62	\$1,790.90	\$3,502.70	\$2,146.82
Did Not Submit Quality Data and Is a Meaningful User	\$3,831.02	\$1,788.09	\$3,477.65	\$2,131.46
Submitted Quality Data and Is Not a Meaningful User	\$3,775.81	\$1,752.47	\$3,427.53	\$2,100.75
Did Not Submit Quality Data and Is a Not Meaningful User	\$3,748.21	\$1,739.65	\$3,402.48	\$2,085.39
Puerto Rico	N/A	N/A	\$3,502.70	\$2,146.82

Capital Base Rates and Payments

- CMS established a national capital federal rate of **\$459.72** for FY19.
- For FY19, the national capital federal rate will increase by **1.27%**, compared to the FY18 national capital federal rate (**\$453.97**).

See **Appendix 2** for FY19 standard federal capital rates

Outlier Payments

- For FY19, the final outlier fixed-loss threshold will be **\$25,769**.
 - This is an decrease from **\$ 26,601** in FY18 which will increase outlier payments.
- To qualify for outlier payments for high cost cases, a case must have costs greater than the sum of the prospective payment rate for the DRG, plus IME, DSH, and new technology add-on payments, plus the “outlier threshold” or “fixed-loss” amount.
- The sum of these components is the outlier “fixed-loss cost threshold” applicable to a case. To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital’s total covered charges billed for the case are converted to estimated costs using the hospital’s cost-to-charge ratio.

Wage Index

- For FY19, CMS applies the wage index to the labor-related share of 62 percent of the national standardized amount for hospitals with wage indices less than 1, and 68.3 percent of the national standardized amount for hospitals with wage indices greater than 1.0.
 - Tables 1A, 1B, and 1C reflect the national labor-related share, which is also applicable to Puerto Rico hospitals.
 - These tables are also found in Appendix I of this presentation
 - No changes to CBSA System
 - FFY 2019 wage index used info form cost report beginning in FFY 2015.
 - Shut down of “Other” wage related cost, Cost to be included MUST be reported on employees’ or contractor W-2 or 1099 forms

Occupational Mix

This year's Occupational Mix is using the Calendar Year 2016 Surveys

The FFY 2019 Occupational mix national average hourly wage is \$42.95 which is up from FY 2018 hourly amount of \$42.06 (Increase of 2.14%)

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	\$41.66
National LPN & Surgical Techs.	\$24.74
National Nurse Aide, Orderly & Attendants	\$16.97
National Medical Assistants	\$18.13
National Nurse Category	\$35.04

Disproportionate Share

- CMS continues to make interim DSH payments equal to 25 percent of what the DSH payment would have been absent the ACA changes.
- Based on the June 2018 estimate, the estimate for empirically justified Medicare DSH payments for FY18, with the application of section 1886(r)(1) of the Act, is approximately **\$4.085 billion** (or 25 percent of the total amount of estimated Medicare DSH payments for FY19).
- Therefore, in the final rule, Factor 1 for FY18 is **\$12.254 billion**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY18 (\$16.339 billion - \$4.085 billion).

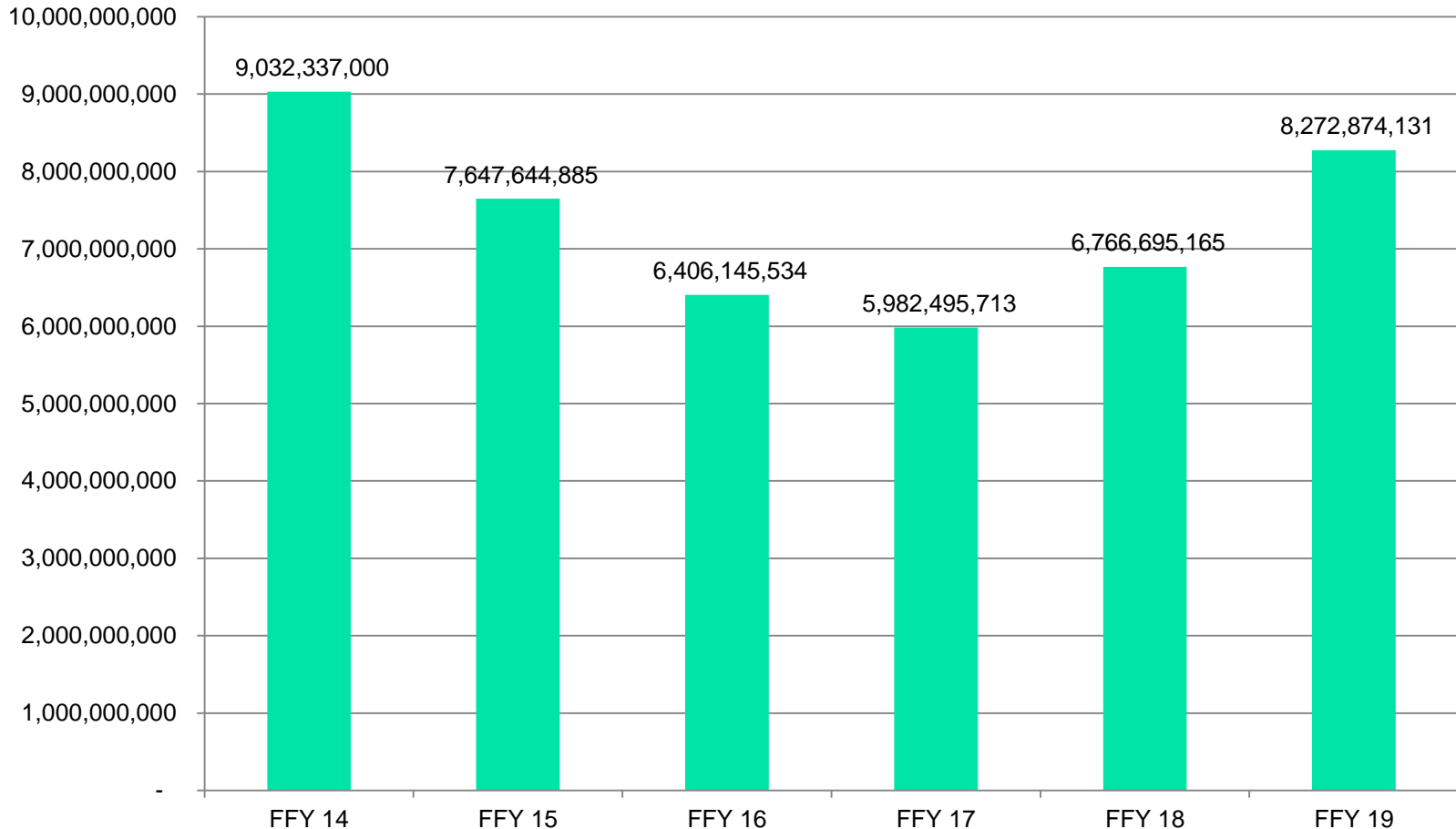
The uncompensated care portion of the DSH payment amount for each DSH hospital is the product of three factors:

- ❖ Factor 1 equals 75 percent of the aggregate DSH payments that would be made under section 1886(d)(5)(F) without application of the DSH changes made by the ACA
- ❖ Factor 2 reduces the amount based on the ratio of the percent of the population who are insured in the most recent period following implementation of the ACA to the percent of the population who were insured in a base year prior to ACA implementation
- ❖ Factor 3 is determined by a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percentage.

Disproportionate Share

- In FY19 the Office of the Actuary is calculating the Factor 2 amount. In the earlier years this would have come from the office CBO.
- CMS uses uninsured estimates produced by the Office of the Actuary as part of the development of the National Health Expenditure Accounts in the calculation of Factor 2. *This explains the second time increase in the DSH-UC payment pool.*
- For FY19, CMS also incorporates data from Worksheet S-10 in the calculation of hospitals' share of uncompensated care, by combining data on uncompensated care costs from the Cost Reports Worksheet S-10 for FYs 2014 and 2015 along with hospital's share of low-income insured days for FY 2013, to determine Factor 3.
 - CMS will continue to use data from three cost reporting periods to calculate Factor 3, next year will be 100% uncompensated care data from Worksheet S-10.
 - Worksheet S-10 audits have begun with CMS directing MACs to have corrections in HCRIS by 1/31/2019.

UC Amount by Year



Documentation & Coding Adjustment

- In FY19, CMS is in year 2 of it's six-year process required by statute to restore prior payment adjustments removed from the IPPS rates to recoup \$11 billion in additional IPPS payments attributable to documentation and coding.
- As required by the 21st Century Cures Act, CMS proposed and is finalizing an adjustment of **+0.50** percentage points as the FY18 installment in the six-year process to restore prior payment adjustments to the IPPS standardized amounts.
- This adjustment represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized until FY13.

Two Midnight Policy

- CMS has made no changes to this policy for FY 2019
 - Noted change: Revises the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment. Specifically, a written inpatient admission order (including physician admission and progress notes) will no longer be required to be present in the medical record as a specific condition of Medicare Part A payments;

Quality Based Payment Adjustments

- Value-Based Purchasing Program (VBP)
Budget neutral, +/- 2%, \$1.9B,
Winners and Losers
 - In efforts to reduce duplication, CMS has removed 4 measures:
 1. AMI Payment-2019
 2. HF Payment-2019
 3. PN Payments-2019
 4. Safety Measure (PC-01) - 2021

Quality Based Payment Adjustments

- Readmission Reduction (RRP)

Not Budget neutral, up to - 3%,
CMS est. 2,600 Hospitals, 85% Impacted

- The FFY 2019 RRP will evaluate hospitals on 6 conditions/procedures:

1. Acute myocardial infarction (AMI)
2. Heart failure (HF)
3. Pneumonia (PN) (expanded in FFY 2017 to include diagnoses of sepsis with a secondary diagnosis of pneumonia, and aspiration pneumonia),
4. Chronic obstructive pulmonary disease (COPD),
5. Elective total hip arthroplasty (THA) & total knee arthroplasty (TKA),
6. Coronary artery bypass graft (CABG).

Quality Based Payment Adjustments

- Hospital Acquired Conditions (HAC)

Not Budget neutral, - 1%,
4th Quartile – 804 Hospitals Impacted

- The FFY 2019 RRP will evaluate hospitals on 6 conditions/procedures:

1. AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures),
2. Central Line-Associated Bloodstream Infection (CLABSI) rates,
3. Catheter-Associated Urinary Tract Infection (CAUTI) rates,
4. Surgical Site Infection (SSI) Pooled Standardized Infection Ratio,
5. Methicillin-resistant Staphylococcus Aurea (MRSA) rates ,
6. Clostridium difficile (C.diff.) rates.

CMS has stated that it expects to release the list of hospitals subject to the HAC penalty for FFY 2019 in Fall of 2018.

GME & IME Payments

- Sharing of cap room:
 - Hospitals that are part of the same Medicare GME affiliated group are permitted to apply their IME and direct GME FTE caps on an aggregate basis, and to temporarily adjust each hospital's caps to reflect the rotation of residents among affiliated hospitals during an academic year. For a new urban teaching hospital that qualifies for an adjustment to its FTE cap, this hospital may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase to its direct GME and IME FTE caps.
 - In order to promote flexibility, CMS will revise the regulations to specify that new urban teaching hospitals may form a Medicare GME affiliated group and therefore be eligible to receive both decreases and increases to their FTE caps, beginning with affiliation agreements entered into for the July 1, 2019 – June 30, 2020 residency training year.
 - The *(DISPLAY pages 967 – 969 and 1,329 – 1,357)*
- The Indirect Medical Education (IME) adjustment factor will remain at 1.35 for FFY

GME & IME Payments

- Interesting notice in this year's IPPS Final Rule

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

DISPLAY pages 1,357 – 1,360

The ACA authorizes the redistribution of residency slots after a hospital that trained residents in an approved medical residency program closes. This final rule is being used to notify hospitals of one such closure, and the opportunity to obtain additional residency slots. Hospitals that wish to apply for these slots must submit their applications by October 31, 2018. 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)
410001	Memorial Hospital of Rhode Island	Pawtucket, RI	39300	1/31/2018	73.66	72.62

EHR Incentive Program



- CMS is adopting its proposal to rename the current EHR Incentive Program to the Promoting Interoperability Program which reflects the finalized scoring and measurement policies for CYs 2019 and 2020 which focus on interoperability and improving patient access to health information.
 - Beginning CY 2019, CMS is adopting an updated EHR Incentive program performance-based scoring methodology for eligible hospitals and Critical Access Hospitals (CAHs), as opposed to the current Stage 3 methodology. CMS believes the new scoring methodology will 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. It applies to eligible hospitals and CAHs that submit an attestation to CMS under the Medicare EHR program beginning in CY 2019.
 - The adopted methodology groups measures into four objectives as opposed to the current 6 objectives and scores hospitals and CAHs based on performance and participation, rather than the threshold-based methodology currently in use.

Other Items:

- Effective January 1, 2019, CMS is updating its guidelines to require hospitals to make a list of their current standard charges available via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate. This could take the form of the chargemaster itself, or another form of the hospital's choice, as long as the information is in a machine readable format.

Tables

- Here is the link that will provide you access to the following IPPS tables:

Downloads
Table 1A-1E (Final Rule and Correction Notice) [ZIP, 14KB] 
Tables 2 and 3 (Wage Index Tables; Final Rule and Correction Notice) [ZIP, 1MB] 
Table 5 (Final Rule and Correction Notice) [ZIP, 116KB] 
Tables 6A-6M and Tables 6P.1a-6P.4p (Final Rule and Correction Notice) [ZIP, 7MB] 
Tables 7A and 7B (Final Rule and Correction Notice) [ZIP, 150KB] 
Tables 8A, 8B, and 8C [ZIP, 16KB] 
Table 10 (Final Rule and Correction Notice) [ZIP, 61KB] 
Table 15 [ZIP, 101KB] 
Tables 16A and 16B [ZIP, 317KB] 
Table 18 (Final Rule and Correction Notice) [ZIP, 240KB] 
CMS-1677-N Table 1 [ZIP, 54KB] 

- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

Questions???

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OPPS Proposed

Agenda

- Proposed Rule: CMS 1695-P
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-P.html>
- The Highlights:
 - Conversion Factor Update
 - Wage Index & Outliers
 - APC Groups & Weights
 - Update Inpatient only listing
 - Focus on Off-Campus Departments (G0463 w/ PO modifiers)
 - Update Quality Reporting
 - RFI) EHR, Pricing Transparency, CAP for Part B 7 Biologicals

OPPS Conversion Factor

☐	Final-CY-2018☐	Proposed-CY-2019☐	Percent-Change☐
OPPS-Conversion-Factor☐	\$78.636☐	\$79.546☐	+1.16%☐

Proposed-CY-2019-Update-Factor-Component☐	Value☐
<u>Marketbasket</u> -(MB)-Update☐	+2.80%☐
Affordable-Care-Act-(ACA)-Mandated-Productivity-MB-Reduction☐	-0.8-percentage-points-(PPT)☐
ACA-Mandated-Pre-Determined-MB-Reduction☐	-0.75-PPT☐
Wage-Index-BN-Adjustment☐	+0.04%☐
Pass-through-Spending-/Outlier-BN-Adjustment☐	-0.13%☐
Cancer-Hospital-BN-Adjustment☐	+0.00%☐
Overall-Proposed-Rate-Update☐	+1.16%☐

OPPS Wage Index & Outliers

- As in past years, for CY 2019 OPPS payments, CMS is proposing to use the federal fiscal year (FFY) 2019 inpatient PPS (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustment
- The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2019, CMS is proposing to continue to use a labor-related share of 60%.
- To maintain total outlier payments at 1.0% of total OPPS payments, CMS is proposing a CY 2019 outlier fixed-dollar threshold of \$4,600. This is an increase compared to the current threshold of \$4,150. Outlier payments will continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold are met.

APC Groups & Weights

- As required by law, CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.
- The proposed payment weights and rates for CY 2019 are available in Addenda A and B of the proposed rule at <https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1695-P-OPPS-Addenda.zip>.
- CMS is not proposing to remove any codes from the CY 2019 bypass list.
- There is continued focus on packaging as opposed to paying separately.

Update to IP only Listing

- ▶ For CY-2019, CMS is proposing to make the following changes to the services included on the inpatient-only list:¶

Remove:¶

- CPT code 31241 — Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery [proposed assignment to APC 5153]; and¶
- CPT code 01402 — Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty.¶

Add:¶

- HCPCS code C9606 — Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, and combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel.¶

In addition, the public is asked to comment on whether CPT code 0266T (“Implantation or replacement of carotid sinus baroreflex activation device; total system {includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed}”) should also be removed from the inpatient only list.¶

Off-Campus Departments

- ED off-Campus Departments: Effective January 1, 2019, a HCPCS modifier “ER” (Items and services furnished by a provider-based off-campus emergency department) be reported with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. (worried over the Significant Growth)
- In CY 2019, in order to control what CMS deems an unnecessary increase in OPSS service volume for a basic clinic visit representing a large share of the services provided at off-campus PBDs, CMS is proposing to expand the MPFS payment methodology to excepted off-campus PBDs (currently paid under the OPSS rates), for HCPCS code G0463. These excepted PBDs would continue to bill HCPCS code G0463 with modifier “PO”. CMS is further proposing that this payment method would be implemented in a non-budget neutral manner. (reduce current payment by 60%)
- PO “provider old” = Did bill as a Hospital department prior to 11/2/2015 (OPSS)
- PN “provider new” = Did not bill as Hospital department prior to 11/2/2015. (MPFS)
- Locations that are PO will not be able to be paid OPSS on newer Services.

Update Quality Reporting

In the CY 2019 OPPS proposed rule, CMS is proposing the removal of ten measures from the Hospital Outpatient Quality Reporting Program:

The one measure to be removed for CY 2020 payment determinations is:

- OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431);

The nine measures to be removed for CY 2021 payment determinations are:

- OP-5: Median Time to ECG (NQF #0289);
- OP-31: Cataracts – Improvements in Patient’s Visual Function within 90 Days Following Cataract Surgery (NQF #1536);
- OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658);
- OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (NQF #0659);
- OP-9: Mammography Follow-up Rates;
- OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513);
- OP-12: The Ability for Providers with HIT (Health Information Technology) to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data;
- OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT; and
- OP-17: Tracking Clinical Results between Visits.

Request For Information (RFI)

- EHR - CMS is issuing an RFI on “Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid- Participating Providers and Suppliers.”
- Pricing Transparency - CMS is updating its guidelines to require hospitals to make a list of their current standard charges available via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate.
- CMS is seeking additional public feedback on a potential model design that would accelerate the move to a value-based health care system building on the Competitive Acquisition Program (CAP) for Part B and Biologicals

340B update

- CMS now pays a reduced rate of ASP - 22.5%, rather than the current rate of ASP + 6% for nonpass-through separately payable drugs and biosimilar biological products purchased under the 340B program. CMS believes that 22.5 percent below the ASP reflects the average minimum discount that 340B hospitals receive for drugs acquired under the 340B program.

Your Presenters Today

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FY19 IPPS Resources

- ❑ FY19 IPPS Final Rule, August 17, 2018, *(Federal Register)*
- ❑ THA Inpatient PPS-Summary *(DataGen)*
- ❑ THA Inpatient PPS-Analysis Description *(DataGen)*

FY19 OPSS Proposed Rule, July 25, 2018, *(Federal Register)*

- ❑ THA Outpatient PPS-Summary *(DataGen)*
- ❑ THA Outpatient PPS-Analysis Description *(DataGen)*