

FY 2020 IPPS/LTCH Final Rule



HFMA Executive Summary

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Overall Impact

- CMS estimates that the total impact of all policy changes will increase payments to IPPS hospitals by \$3.8 billion in FY 2020 (a 3.0% increase compared to the 2019 IPPS final rule).

Estimated Impact of All IPPS Policies on Medicare Inpatient Payments

	2020 Impact
All Hospitals	2.9%
Urban Hospitals	2.9%
Rural Hospitals	2.8%
Major Teaching	2.9%
Minor Teaching	2.9%
Non-Teaching	2.9%
DSH >= 100 Beds	2.2%
DSH <100 Beds	3.9%
Non-DSH	2.7%
Ownership	
Voluntary	1.8%
Proprietary	3.0%
Government	1.9%

- This is down from a proposed increase of \$4.7 billion (a 3.7% increase compared to the 2019 IPPS final rule).

IPPS Operating Payment Rates to Increase 3.1%

- The final base operating rate is increased by approximately 3.1%* for hospitals that successfully participate in the Inpatient Quality Reporting Program (IQR) and are meaningful users of electronic health records.
- This increase is the net result of a market basket update of 3.0%, less a .4% annual multi-factor productivity adjustment mandated by the ACA, and an adjustment of +0.5 % for prior reductions for documentation and coding.

Factor	% Change
FY 2020 Market Basket Update	3.0
Multi-factor productivity adjustment mandated by ACA	-0.4
MACRA Documentation and Coding Adjustment	+0.5
Net increase before budget neutrality factors applied	3.1

* Before budget neutrality and other adjustments

Sources:

- 1) CMS IPPS Final Rule Fact Sheet, Aug 2, 2019
- 2) IPPS Final Rule Display Version, pages 974, 2145

FY 2020 Final Rule Tables 1a-1c

	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 (2.6% Update)	\$3,962.17	\$1,838.96	\$3,596.70	\$2,204.43
Did Not Submit Quality Data and Is a Meaningful User (1.85% Update)	\$3,933.21	\$1,825.52	\$3,570.41	\$2,188.32
Submitted Quality Data and Is Not a Meaningful User (.35% Update)	\$3,875.28	\$1,798.63	\$3,517.82	\$2,156.09
Did Not Submit Quality Data and Is Not a Meaningful User (-.4% Update)	\$3,846.32	\$1,785.19	\$3,491.54	\$2,139.97
Puerto Rico	N/A	N/A	\$3,596.70	\$2,204.43

Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013.

Program and Policy Impacts on Payments

- **Hospital Readmissions Reduction Program (HRRP):** Hospitals with higher-than-expected readmissions rates over a three-year period for acute myocardial infarction, heart failure, pneumonia, COPD, elective knee/hip replacement and coronary artery bypass grafting will be subject to a maximum 3% penalty. The rule estimates that in FY 2020, 2,583 hospitals will be subject to the HRRP. This will result in \$563 million in savings to the Medicare program.
- **Value Based Purchasing (VBP) Program:** The final FY 2020 IPPS rule will redistribute approximately \$1.9B in operating payments through the VBP program. All hospitals will be subject to a 2% reduction in base operating DRG payments. Starting with the CY 2020, data collection the Hospital VBP Program will use the same data used by the HAC Reduction Program for purposes of calculating the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) Healthcare-Associated Infection (HAI).

Program and Policy Impacts on Payments

- **Medicare DSH:** The uncompensated care pool will increase by \$78 million in FY 2020, compared to what was distributed in FY 2019. The increase is a result of increased base rates in the final rule and slight projected increases in Medicare case mix. The final rule assumes the uninsured rate will remain the same in 2020 (9.4%) as in 2019 (9.4%).
- **National Capital Rate:** The final national capital rate for FY2020 is \$462.61.
- **Outlier Threshold:** The final fixed loss outlier threshold increases to \$26,473 (compared to the FY 2019 final threshold of \$25,769), which will decrease outlier payments.

Program and Policy Impacts on Payments

- **Documentation and Coding:** CMS continues a six-year add-back related to prior year documentation and coding reductions by increasing operating payments by .5% for FY 2020. Absent changes in legislation, this increase will continue annually through FY 2023.
- **New Technology Add-On Payment (NTAP):** CMS estimates that increases to the maximum amount of the NTAP will increase payments by approximately \$94 million in FY 2020.

NTAP



Changes to Calculation for New Technology Add-On Payment (NTAP)

- The final rule increases the maximum amount of the NTAP (for devices other than those that receive Qualified Infectious Disease Program (QIDP) status) to 65% for qualifying items. Specifically, if the costs of a discharge involving a new technology exceed the full DRG payment, Medicare will make an add-on payment equal to the lesser of:
 1. 65% of the costs of the new medical service or technology; or
 2. 65% of the amount by which the costs of the case exceed the standard DRG payment. This is a 15-percentage point increase from the current maximum NTAP payment, which is 50% of the costs or amount described above.

Changes to Calculation for New Technology Add-On Payment (NTAP)

- For qualifying new technologies that receive Qualified Infectious Disease Program (QIDP) status, Medicare will make an add-on payment equal to the lesser of:
 1. 75% of the costs of the new medical service or technology; or
 2. 75% of the amount by which the costs of the case exceed the standard DRG payment.
- These policies are effective for discharges beginning on October 1, 2019.

Alternative NTAP Qualifying Pathway

- The final rule adopts a policy for NTAP applications received for IPPS new technology add-on payments for FY 2021 and subsequent fiscal years, that if the medical device is part of the U.S. Food & Drug Administration's (FDA) Breakthrough Devices Program and receives marketing authorization, the device would be considered new and not substantially similar to an existing technology for purposes of new technology add-on payment under the IPPS.
- Because the technology may not have a sufficient evidence base to demonstrate substantial clinical improvement at the time of FDA-marketing authorization, CMS also finalizes that the medical device would not need to meet the requirement that it represent an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.
- CMS adopts the same policy for add-ons related to new technology products that have received the FDA's qualified infectious disease product (QIDP) designation.

Disproportionate Share Hospitals (DSH)

- The final rule uses a single year of data on uncompensated care costs from Worksheet S-10 for FY 2015 to determine Factor 3 for FY 2020.
- In response to comments, CMS states it may return to using multiple years of uncompensated care data from the S-10 in the future.
- CMS will only 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 hospitals in Puerto Rico and Indian Health Service and Tribal hospitals.
- The final rule assumes the uninsured rate will remain the same in 2020 (9.4%) as in 2019 (9.4%).

Disproportionate Share Hospitals (DSH)

- Following the publication of the final rule, hospitals will have until August 31, 2019, to review and submit comments on the accuracy of the impact table and supplemental data file published in conjunction with the final rule.
- CMS believes the supplemental data file reflects the most recent available data in Healthcare Cost Report Information System (HCRIS) (June 30, 2019 extract) at the time of development of the final rule.

Inpatient Quality Reporting Program

- The final rule:
 - Adopts a new opioid-related electronic clinical quality measure (eCQM)
 - **Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)**, beginning with the CY 2021 reporting period/FY 2023 payment determination.
 - CMS did not finalize the proposed Hospital Harm – Opioid-Related Adverse Events eCQM.
 - Adopts **Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (NQF #2879)**, beginning with two years of voluntary reporting periods running from July 1, 2021 through June 30, 2022, and from July 1, 2022 through June 30, 2023, before requiring reporting of the measure for the reporting period that will run from July 1, 2023, through June 30, 2024, impacting the FY 2026 payment determination and for subsequent years.

Inpatient Quality Reporting Program

- Removes the Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789) (HWR claims-only measure) beginning with the FY 2026 payment determination.
- Extends the current eCQM reporting and submission requirements for the CY 2020 reporting period/FY 2022 payment determination and CY 2021 reporting period/FY 2023 payment determination.
- Changes the eCQM reporting and submission requirements for the CY 2022 reporting period/FY 2024 payment determination, such that hospitals would be required to report one self-selected calendar quarter of data for three self-selected eCQMs, and the Safe Use of Opioids – Concurrent Prescribing eCQM, for a total of four eCQMs.
- Continues requiring that EHRs be certified to all available eCQMs used in the Hospital IQR Program for the CY 2020 reporting period/FY 2022 payment determination and subsequent years.

Promoting Interoperability

- For FY 2020, CMS finalizes the following changes to the Medicare Promoting Interoperability programs:
 - Eliminate the requirement that for the FY 2020 payment adjustment year, for an eligible hospital that has not successfully demonstrated it is a meaningful EHR user in a prior year, the EHR-reporting period in CY 2019 must end before and the eligible hospital must successfully register for, and attest to meaningful use, no later than the October 1, 2019, deadline.
 - Establish 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 and attest to CMS.
 - Require that the Medicare Promoting Interoperability Program measure actions must occur within the EHR-reporting period beginning with the EHR-reporting period in 2020.
 - Revise the Query of PDMP measure to make it an optional measure worth five bonus points in CY 2020, remove the exclusions associated with this measure in CY 2020, require a yes/no response instead of a numerator and denominator for CY 2019 and CY 2020 and clearly state CMS's intended policy that the measure is worth a full five bonus points in CY 2019 and CY 2020.

Promoting Interoperability

- Change the maximum points available for the e-Prescribing measure to 10 points beginning in CY 2020, in the event CMS finalizes the proposed changes to the Query of prescription drug monitoring program (PDMP) measure.
- Remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 and clearly state CMS's intended policy that this measure is worth a full five bonus points in CY 2019.
- Revise the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to more clearly capture the previously established policy regarding certified electronic health record technology (CEHRT) use

Promoting Interoperability

- Further, the final rule aligns the Promoting Interoperability Programs reporting requirements for CQMs with the requirements under the hospital IQR. Specifically, these are:
 - Adopt one opioid-related CQM (Safe Use of Opioids – Concurrent Prescribing CQM beginning with the reporting period in CY 2021 (CMS does not finalize its proposal to add the Hospital Harm – Opioid-Related Adverse Events CQM).
 - Extend current CQM reporting and submission requirements for the reporting periods in CY 2020 and CY 2021.
 - Establish CQM reporting and submission requirements for the reporting period in CY 2022, which will require all eligible hospitals and CAHs to report on the Safe Use of Opioids – Concurrent Prescribing eCQM beginning with the reporting period in CY 2022.

Long-Term Care Hospital (LTCH) PPS Standard Federal Rate

- The final rule increases the standard federal rate by 2.5%* to \$42,677.63 for LTCHs that submit quality data.
- The reduced rate, for those that don't submit quality data is \$41,844.89 (.5% increase*). CMS estimates this and other changes will increase payments to LTCHs by \$43 million in 2020.

*Before budget neutrality and other adjustments.

Wage Index

- CMS finalizes multiple changes to the wage index to address “disparities” between high- and low-wage index hospitals:
 1. First, the rule increases the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals.
 - The policy would be effective for at least four years to allow employee compensation increases implemented by these hospitals enough time to be reflected in the wage index calculation.
 - To offset the cost of increasing payments to low-wage index hospitals, the rule applies a uniform budget neutrality adjustment to the standardized amount.

Wage Index

2. CMS will remove urban-to-rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.
3. Finally, to protect hospitals from significant decreases in wage index (and therefore payments), CMS is implementing a 5% cap on any decrease in a hospital's wage index in a budget neutral manner. This will also result in a budget neutrality adjustment to the standardized amount.

Medicare for All



For More Information

- Read an [executive summary](#) of the final rule.
- Read the [full text](#) of the final rule, made available on August 2, 2019.

CY 2020 OPPS/ASC Proposed Rule



HFMA Executive Summary

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Overall Impact

- CMS estimates that, compared to CY 2019, OPPS payments in CY 2020 will increase by approximately \$6 billion.
- This estimate excludes the estimated changes in enrollment, utilization, and case-mix.
- Below is a breakdown of how the proposed rule will impact specific types of hospitals or markets.

	Projected 2020 Impact
All Facilities*	2.0%
All Hospitals	2.0%
Urban Hospitals	2.0%
Rural Hospitals	2.0%
Major Teaching	1.3%
Minor Teaching	2.1%
Non-Teaching	2.3%
Ownership	
Voluntary	1.8%
Proprietary	3.0%
Government	1.9%

*Excludes hospitals permanently held harmless and CMHCs

Payment Impacts

- **Conversion Factor:** In CY 2020, CMS is proposing a conversion factor of \$81.398. This is an increase from \$79.490 in CY 2019. Hospitals failing to meet the Outpatient Quality Reporting Program requirements will see a reduced CY 2020 conversion factor of \$79.770.
- **Outlier Threshold:** CMS proposes to increase the outpatient fixed loss outlier threshold for CY 2020 to \$4,950 (compared to \$4,825 in CY 2019). This is expected to reduce outpatient outlier payments in CY 2020 relative to CY 2019.

Site-Neutral Payment for E&M Services

- In CY 2019, CMS applied a 30% reduction factor for E&M services (described by HCPCS code G0463), when they were provided at an excepted off-campus hospital outpatient department (HOPD).
 - This was half of the payment differential between E&M services provided in the HOPD and freestanding settings under a two-year phase-in policy to implement site-neutral payment.
- For 2020, CMS proposes to implement the full 60% reduction to payments for E&M services described by HCPCS code G0463 provided in exempted HOPDs.
- Similar to CY2019, this will be implemented in a non-budget neutral manner.

Inpatient Only List - Total Hip Arthroplasty (THA)

- CMS proposes to remove total hip arthroplasty (CPT Code 27130) from the inpatient only list in CY 2020, allowing these procedures to be performed in hospital outpatient departments.
 - It will be assigned to C-APC 5115 with a status indicator of J1.
- CMS states that if the proposal is finalized, it will prohibit Quality Improvement Organizations (QIOs) from referring THA cases performed in the inpatient setting to Recovery Audit Contractors (RACs) for patient status reviews for one year.
- The rule does not add THA to the ASC covered procedure list.

Payment for Part B Drugs Acquired Under the 340B Program

- Despite its loss in court, CMS proposes to continue paying for separately payable Part B drugs acquired under the 340B program at ASP minus 22.5%.
- CMS also is soliciting comments on appropriate remedies for CY 2018 and CY 2019 claims should the ruling in the case be upheld on appeal.
 - Specifically, CMS is requesting input on the appropriate OPPS payment rate for 340B-acquired drugs, including whether a rate of ASP plus +3% could be an appropriate payment amount for these drugs, both for CY 2020 and for purposes of determining the remedy for CYs 2018 and 2019.

Non-Exempt Provider Based Clinics

- CMS will continue to pay for services provided in non-exempted hospital outpatient departments (new clinics that were not in process by November 2, 2015) at 40% of the OPPS rate.

General Supervision of Hospital Outpatient Therapeutic Services

- For CY 2020, CMS proposes to change the minimum required level of supervision from direct supervision to general supervision for all hospital outpatient therapeutic services provided by all hospitals and critical access hospitals (CAHs).

Additional Comprehensive APCs

- CMS proposes to create two new comprehensive APCs (C-APCs). These proposed new C-APCs include the following:
 1. C-APC 5182 (Level 2 Vascular Procedures)
 2. C-APC 5461 (Level 1 Neurostimulator and Related Procedures).
- This proposal increases the total number of C-APCs to 67.

Prior Authorization Process for Certain OPD Services

- CMS proposes that a provider must submit a prior authorization request for any service on its list of outpatient department services requiring prior authorization.
- The five categories of proposed services are:
 - Blepharoplasty
 - botulinum toxin injections
 - Panniculectomy
 - rhinoplasty
 - vein ablation

Prior Authorization Process for Certain OPD Services

- Additionally, any claims associated with or related to a service included on the prior authorization list that is denied will also be denied as well since these services are unnecessary. These associated services include, but are not limited to, services such as anesthesiology services, physician services and/or facility services.
- CMS is proposing that this requirement would begin for dates of service on or after July 1, 2020, to allow more time for provider education and process implementation.

Outpatient Quality Reporting Program

- For the Hospital OQR Program, CMS does not propose adding new measures.
- The rule proposes (beginning with October 2020 encounters) removing OP-33: External Beam Radiotherapy for Bone Metastases for the CY 2022 payment determination and subsequent years due to the cost associated with the measure relative to its benefits.

Price Transparency

- In response to the President's executive order on price transparency, CMS expands its prior interpretations of section 2718 of the Public Health Service Act.
- The proposed rule would require all hospitals to make a list of both gross charges and negotiated rates for all services in the hospital charge description master (CDM), as well as a set of shoppable services publicly available.
 - The rule specifies the manner and format in which the lists are to be made publicly available.
- Hospitals that do not comply with the requirement may be subject to civil monetary penalty (CMP) of up to \$300 per day.
- HFMA's detailed summary of the proposed price transparency provisions is available [here](#).

Negotiated Rate Posting Requirement

- CMS expanded its prior interpretations of section 2718 of the Public Health Service Act, requiring all hospitals to make a list of both gross charges and negotiated rates for all services in the hospital charge description master (CDM), as well as a set of shoppable services publicly available.
- All non-governmental hospitals (e.g. general acute hospitals including Critical Access Hospitals (CAHs) and Sole Community Hospitals (SCHs), psychiatric hospitals, rehabilitation hospitals and others previously identified in CMS guidance*) are covered under this requirement.
- The requirement does not apply to governmental hospitals (e.g. Veterans Affairs (VA), Department of Defense (DOD) or Indian Health Service (IHS) facilities). It also does not apply to entities such as ambulatory surgical centers (ASCs) or other non-hospital sites-of-care from which consumers may seek healthcare items and services.

* <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProposedMedicareFeeSvcPmtGen/Downloads/Additional-Frequently-Asked-Questions-Regarding-Requirements-for-Hospitals-To-Make-Public-a-List-of-Their-Standard-Charges-via-the-Internet.pdf>

Negotiated Rate Posting Requirement

- “Items and services” covered by the proposal are all items and services, including individual items and services and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge.
- Example items and services include, but are not limited to:
 - Supplies, procedures
 - Room and board
 - Use of the facility and other items (generally described as facility fees)
 - Services of employed physicians and employed non-physician practitioners (generally reflected as professional charges) provided in a hospital setting
 - Any other items or services for which a hospital has established a charge.

Negotiated Rate Posting Requirement

- The rule expands the definition of “standard charges” to two separate concepts:
 - **Gross Charge:** The charge for an individual item or service that is reflected on a hospital’s chargemaster (or outside the CDM in the case of pharmaceuticals), absent any discounts
 - **Payer-Specific Negotiated Charge:** Defined as all charges that the hospital has negotiated with third-party payers for an item or service.
- Hospitals will make public their standard charges in two ways:
 1. A comprehensive (one single, digital) machine-readable file that makes public all standard charge information for all hospital items and services, and
 2. A consumer-friendly display of common “shoppable” services derived from the machine-readable file. See below for additional details on the “consumer-friendly” file.

Negotiated Rate Posting Requirement

- If a hospital is found to be non-compliant, CMS proposes that it may take the following steps:
 1. CMS may provide a written warning notice to the hospital of the specific violation(s).
 2. CMS requests a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements.
 3. If the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP, CMS may impose a CMP on the hospital of up to \$300 per day for non-compliance. It may also publicize the penalty on a CMS website.
- The rule clarifies that it may deviate from this sequence of compliance actions at its discretion.

ASC Conversion Factor

- CMS increases the CY 2020 ASC conversion factor to \$47.827 for ASCs meeting the quality reporting requirements from the CY 2019 conversion factor of \$46.532.
- The proposed CY 2020 conversion factor for ASCs not meeting quality reporting requirements is \$46.895.

ASC Updates

- Additions to the ASC Surgical Covered Procedures List: CMS proposes adding total knee replacement (TKA), a mosaicplasty procedure, as well as six coronary intervention procedures to the list of surgical procedures covered when performed in an ASC (see Table I at the end of this presentation).
- ASC Quality Reporting Program: CMS proposes to adopt one new measure beginning with the CY 2024 payment determination and for subsequent years:
 - ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers.
- CMS is not proposing to remove any quality measures from the ASCQR program.
- ASC Impact: Including beneficiary cost sharing and estimated changes in enrollment, utilization and case-mix, and changes in the proposed rule, Medicare ASC payments for CY 2020 would be approximately \$4.89 billion, an increase of approximately \$200 million compared to estimated CY 2019.

Table I: Proposed Additions to the List of ASC Covered Surgical Procedures for CY 2020

CY 2020 CPT Code	CY 2020 Long Descriptor	Proposed CY 2020 ASC Payment Indicator
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	J8
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	J8
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	G2
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1

Medicare for All



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