

CMS Releases FY 2020 IPPS Proposed Rule: Calls for Increased Payments to Rural Hospitals and for New Technologies



On April 23, 2019, the Centers for Medicare and Medicaid Services (CMS) released the Inpatient Prospective Payment System (IPPS) proposed rule for fiscal year (FY) 2020. The proposed update includes changes that will affect all hospitals, with particular benefit to hospitals in rural areas at the expense of hospitals in large metropolitan centers. The proposed changes, if finalized, also would substantially benefit developers of new technologies and would potentially improve beneficiary access to those technologies.

A CMS factsheet on the [proposed rule](#) is available [here](#). Comments are due on June 24, 2019.

Key Takeaways

- + CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about \$4.7 billion in FY 2020.
- + CMS proposes to address payment disparities between rural and urban facilities through changes to the Medicare wage index.
- + To help improve beneficiary access to emerging technology, CMS sets out a number of proposals to revise policies related to new technology add-on payments and increase payment rates (maximum new technology add-on payment increased from \$186,500 to \$242,450).
- + The proposed rule includes a number of changes to the IPPS quality programs, including changes to measures and reporting requirements, with an eye towards burden reduction.
- + For the Medicare and Medicaid Interoperability Programs, CMS will continue a minimum 90-day reporting period. CMS proposes new measures and seeks comments on improving the use of electronic health records (EHRs), among other topics.

CMS Proposes to Increase Inpatient Hospital Rates by 3.2% in FY 2020

CMS proposes to increase inpatient hospital rates by 3.2% in FY 2020 compared to FY 2019, for hospitals that are meaningful users of EHRs and submit quality measure data.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 3.5% overall. When combined with proposed changes in uncompensated care payments, new technology add-on payments, low-volume hospital payments and capital payments, which are expected to increase payments by an additional 0.2%, CMS estimates a total increase in IPPS payments of approximately 3.7%.

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CMS Proposes \$8.5 Billion in 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 nationally. In this rule, CMS proposes to distribute roughly \$8.5 billion in uncompensated care payments in FY 2020, an increase of approximately \$216 million from FY 2019.

CMS is also seeking comments on a number of proposals related to how the agency collects data to calculate uncompensated care payments.

Streamlined Process and Increased Reimbursement for Some New Technology Add-On Payments

Under the new technology add-on payment (NTAP) program, CMS provides additional payment for breakthrough technologies in the inpatient hospital environment. New technologies meeting specific cost thresholds and demonstrating substantial clinical improvement over existing services qualify for an add-on payment under this program.

With the intent to support and improve beneficiary access to new technology, the 2020 IPPS proposed rule includes a number of policies streamlining and facilitating access to the add-on payments.

- + **Proposed NTAP Alternative Pathway for Devices:** Under this proposal, medical devices that receive US Food and Drug Administration (FDA) marketing authorization and are part of an FDA expedited program for medical devices (i.e., Breakthrough Devices Program) would have a lower bar to be eligible for an add-on payment. Under this proposal, the medical device would only need to meet the cost criterion to receive the add-on payment (and not the substantial clinical improvement criterion). This change would begin with applications received for NTAPs for FY 2021.
- + **Proposed Calculation of NTAP:** Currently, Medicare pays a marginal cost factor of 50% of the estimated costs of the case in excess of the full diagnosis-related group payment, up to a maximum of 50% of the costs of the technology. Because of increasing costs of new medical technologies, CMS is concerned that 50% may not be adequate. CMS proposes to increase the add-on payment beginning in FY 2020 from 50% to 65%. As a result, the maximum add-on payment in the proposed rule would increase from \$186,500 to \$242,450 for CAR T-cell therapy.
- + **Request for Information on the NTAP Substantial Clinical Improvement Criterion:** Stakeholders have indicated that they would like to better understand how CMS evaluates new technology applications for add-on payments, and would like the agency to provide greater predictability about which applications will meet the criterion for substantial clinical improvement. CMS is considering potential revisions to the substantial clinical improvement criterion under the IPPS NTAP policy and the hospital outpatient transitional pass-through payment policy for devices. CMS seeks comments on the type of additional detail and guidance that would be useful to the public and NTAP applicants for NTAPs would find useful. These comments will be used to inform future rulemaking.
- + **Applications for NTAPs for FY 2020:** CMS addresses applications for NTAPs under the IPPS by presenting its evaluation and analysis of the applications. In this proposed rule, CMS presents 17 new applications for FY 2020 NATPs, and proposes to continue the NTAPs for 10 of the 13 technologies currently receiving the add-on payment (the remaining three technologies will no longer be within their newness period in FY 2020 and therefore lose their add-on).

Addressing Rural Disparities Through Proposals to Change the Calculation of the Wage Index

The Medicare wage index seeks to adjust payments to account for how much labor costs vary in different areas of the United States. In the 2019 IPPS proposed rule, CMS sought suggestions on potential

reforms to the wage index, and commenters raised concern that the current wage index system perpetuates and exacerbates disparities between high and low wage index hospitals, which largely fall along urban and rural lines. Some commenters also expressed concern that the rural floor policy has allowed some states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities. In the 2020 IPPS proposed rule, CMS proposes the following changes to how it calculates and applies the Medicare wage index to address this disparity and improve payments to rural facilities.

Reduce Differences Between High and Low Wage Index Hospitals

CMS proposes to increase wage index values for certain hospitals with low wage index values and decrease wage index values for certain hospitals with high wage index values to promote equity and maintain budget neutrality. Specifically, CMS proposes to increase the wage index for hospitals with a wage index value below the 25th percentile. Using data from the proposed rule, CMS projects that the 25th percentile wage index value across all hospitals for FY 2020 is 0.8482. CMS proposes to increase the wage index for hospitals with a wage index value below 0.8482 to a value equal to half the difference between the hospital's applicable wage index value and the 25th percentile wage index value (0.8482). As an example, a hospital with a current wage index value of 0.6663 would receive a wage index value of 0.7573 (*i.e.*, $0.6663 + (0.8482 - 0.6663)/2$).

To maintain budget neutrality in the system, CMS proposes to decrease the wage index for hospitals above the 75th percentile (estimated by CMS to be 1.0351) by applying a uniform discount factor (proposed to be 3.4%) to the difference between the hospital's otherwise applicable wage index and the 75th percentile wage index value. In an example provided by CMS, a hospital with a wage index value of 1.7351 would have that value reduced by 0.0238 (*i.e.*, $1.7351 - (1.7351 - 1.0351) * 0.034$).

CMS has applied these adjustments to hospitals qualifying for wage index reclassification and is using the reclassified (applicable) wage index for purposes of making adjustments. CMS states that this proposed policy would be effective for four years, beginning in FY 2020, which CMS believes allows time for hospitals to increase wages using additional funds from this policy change, and to have those increases reflected in the wage index. CMS projects that this change will increase payments to rural hospitals by 0.4%, while reducing payments to hospitals in large urban areas by 0.2%.

Changes to Rural Floor Calculation

Under current 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 same state. This policy is known as the "rural floor." In FY 2018, 366 urban hospitals (11% of hospitals) benefitted from the rural floor policy. According to CMS, this policy perpetuates disparities by increasing wage index values for select urban hospitals, while decreasing wage index values for all other hospitals, because CMS offsets the resulting increased payments with broadly applicable budget neutrality adjustments. CMS also asserts that some states use the reclassification process to manipulate and take advantage of the rural floor policy.

To address these concerns, CMS proposes to remove wage data from hospitals that undergo urban-to-rural reclassifications from the calculation of the rural floor. Beginning in FY 2020, the rural floor would be calculated without including the wage data of hospitals that have reclassified as rural pursuant to 42 CFR § 412.103. While not expressly stated, it appears that CMS will continue to include wage data from urban hospitals reclassifying as rural under 42 CFR § 412.103 in the calculation of the rural wage index of the state, but will not use that wage data to determine the rural floor.

CMS estimates that if this proposal is finalized, 166 hospitals would receive the rural floor in FY 2020 (200 fewer than in FY 2018, but only 87 fewer than in FY 2019). Hospitals in Arizona and Massachusetts would experience the greatest consequence, with Massachusetts hospitals losing approximately \$100

million in Medicare payments as a result of this policy. Some (but not all) hospitals in California would see a net payment increase of more than \$60 million as a result of this policy.

Cap on Wage Index Decreases

For FY 2020, CMS proposes to place a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2019. This cap will help mitigate the impact of the wage index proposals described above. Accordingly, if finalized, a hospital's final wage index for FY 2020 would not be less than 95% of its final wage index for FY 2019. CMS proposes to implement this stop-loss in a budget neutral manner by adjusting the FY 2020 standardized amount by a factor of 0.998349. CMS proposes that this be a one-time adjustment, applicable just for FY 2020.

While not expressly stated, it is likely that if these proposals are finalized, CMS would extend these same changes to the Hospital Outpatient Prospective Payment System, and use these same wage index values to adjust payments for outpatient services.

IPPS Quality Programs

The proposed rule includes a number of changes to the IPPS quality programs, including changes to measures and reporting requirements with an eye towards burden reduction.

Quality Program	Proposals
Hospital-Acquired Conditions (HAC) Reduction Program	<ul style="list-style-type: none"> • Adopt criteria for a measure removal policy that aligns with other quality programs • Clarify administrative policies for validation of the Centers for Disease Control National Healthcare Safety Network health-care-associated infection measures • Establish the data collection period for the FY 2022 program year
Hospital Readmissions Reduction Program (HRRP)	<ul style="list-style-type: none"> • Adopt criteria for a measure removal policy that aligns with other quality programs • Update the definition of "dual eligible" • Adopt a subregulatory process to address potential nonsubstantive changes to the payment adjustment factor components • Establish the data collection period for the FY 2022 program year
Hospital Inpatient Quality Reporting (IQR) Program	<ul style="list-style-type: none"> • Remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace with the proposed Hybrid Hospital-Wide All-Cause Readmission Measure • Adopt two new opioid-related electronic clinical quality measures (eCQMs) beginning with the CY 2021 reporting period and FY 2023 payment determination • Propose adopting three changes for reporting eCQMs
Hospital Value-Based Purchasing (VBP) Program	<ul style="list-style-type: none"> • No proposals to remove or add any measures • Proposals related to aligning data collection and processes with the HAC Reduction Program for certain measures

Quality Program	Proposals
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	<ul style="list-style-type: none"> • Adopt one claims-based outcome measure for prostate cancer • Remove a bone metastases measure and pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems survey • Begin publicly reporting the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure in CY 2020

Medicare and Medicaid Interoperability Programs

The Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established in 2011. CMS includes a number of policies related to these program in the 2020 proposed rule.

CMS proposes:

- + An EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and critical access hospitals)
- + To continue for CY 2020 the Query of Prescription Drug Monitoring Program measure as optional and available for bonus points, instead of being required as finalized last year, because of unforeseen implementation challenges
- + To remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 because of feedback from stakeholders that this measure presents significant implementation challenges, leads to an increase in burden and does not further interoperability

CMS also requests information on including more meaningful measures to combat the opioid epidemic, engaging vendors and providers in improving efficiency of EHRs, and integrating data into the Hospital Compare website, among other topics.

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