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Executive Summary: CMS FY 2020 IPPS Proposed Rule
Key Financial and Operational Impacts from the Proposed FY 2020 IPPS Rule

The 2020 IPPS (Inpatient Prospective Payment System) Proposed Rule was made available on April 24, 2019. A detailed summary of the rule will be available on the HFMA Regulatory Summary Page shortly. CMS estimates that the total impact of all proposed policy changes will increase payments to IPPS hospitals by $4.7 billion in FY 2020 (3.5% increase compared to the 2019 IPPS final rule).

1) **Base Operating Rate**: The proposed base operating rate is increased by approximately 2.7% (3.2% market basket update reduced by .5% productivity factor mandated by the ACA) for hospitals that successfully participate in the Inpatient Quality Reporting Program (IQR) and are meaningful users of electronic health records (EHRs).

FY 2020 PROPOSED 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 (2.7% Update)	$3,977.31	$1,845.99	$3,610.45	$2,212.85
Did Not Submit Quality Data and Is a Meaningful User (1.9% Update)	$3,946.33	$1,831.61	$3,582.32	$2,195.62
Submitted Quality Data and Is Not a Meaningful User (.3% Update)	$3,884.36	$1,802.85	$3,526.07	$2,161.14
Did Not Submit Quality Data and Is Not a Meaningful User (-.5% Update)	$3,853.38	$1,788.47	$3,497.95	$2,143.90
Puerto Rico	N/A	N/A	$3,610.45	$2,212.85

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

2) **National Capital Rate**: The proposed national capital rate for FY2020 is $463.81.

3) **Wage Index:** CMS proposes multiple changes to the wage index to address "disparities" between high- and low-wage index hospitals. First, the rule proposes to increase 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 proposes to decrease the wage index values for hospitals with wage index values above the 75th percentile. As a result of this proposal[1], urban hospitals in the Pacific (-.7%) and Mid-Atlantic (-.4%) regions would be most negatively impacted. Urban hospitals in East South-Central (+.9%) region and rural hospitals in the East South Central (+1.1%), West South Central and South Atlantic (+.7%) regions benefit most from the policy.

   CMS is also proposing to remove 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.

   Finally, CMS proposes a transitional 5% cap, relative to the FY 2019 wage index value, to limit decreases in an impacted hospital's wage index. It will also apply an adjustment to the standardized amount to ensure that the transitional policy is applied in a budget-neutral manner.

4) **Changes to Calculation for New Technology Add-On Payment (NTAP):** The rule proposes to increase the maximum amount of the NTAP to 65% for qualifying items. Specifically, if the costs of a discharge involving a new technology exceed the full DRG payment, Medicare would make an add-on payment equal to the lesser of: 65% of the costs of the new medical service or technology; or 65% of the amount by which the costs of the case exceed the standard DRG payment. Currently, the maximum NTAP payment is 50% of the costs or amount described in items one and two above. CMS estimates that this will increase NTAP payments by approximately $110 million in FY 2020 if finalized.

5) **Alternative NTAP Qualifying Pathway:** The rule proposes 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 FDA's 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 proposes that the medical device would not need to meet the requirement that it represent an advance that substantially

[1] 2020 IPPS Proposed, Table I – Impact Analysis of Proposed Changes to the IPPS for Operating Costs for FY 2020

improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

Disproportionate Share Hospitals (DSH): The rule proposes to use a single year of data on uncompensated care costs from Worksheet S-10 for FY 2015 to determine Factor 3 for FY 2020. In addition, CMS seeks public comments on whether it should, due to changes in the reporting instructions that became effective for FY 2017, alternatively use a single year of Worksheet S-10 data from the FY 2017 cost reports, instead of the FY 2015 Worksheet S-10 data, to calculate Factor 3 for FY 2020. CMS projects the uncompensated care pool will increase by $216 million in FY 2020 compared to what was distributed in FY 2019. The increase is a result of increased base rates in the proposed rule and slight projected increases in Medicare discharges and case mix. The proposed rule assumes that the uninsured rate will remain approximately the same in 2020 (9.3%) as in 2019 (9.4%).

6) **Outlier Threshold**: The proposed fixed loss outlier threshold increases to $26,994 (compared to the FY 2019 final threshold of $25,769), which will decrease outlier payments.

7) **Documentation and Coding**: CMS continues a six-year add-back related to prior year documentation and coding reductions by increasing operating payments by .5%.

8) **Hospital Readmissions Reduction Penalty (HRRP)**: Hospitals with higher-than-expected readmissions rates over a three-year period for AMI, heart failure, pneumonia, COPD, elective knee/hip replacement and CABG will be subject to a maximum 3% penalty. The proposed rule estimates that in FY 2020 2,599 hospitals will be subject to the HRRP. This will result in $550 million in savings to the Medicare program.

9) **Value Based Purchasing (VBP) Program**: The proposed 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).

10) **Inpatient Quality Reporting Program:** The proposed rule would make the following changes:

    a. Adopt two new opioid-related eCQMs – Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e) and Hospital Harm – Opioid-Related Adverse Events eCQM, beginning with the CY 2021 reporting period/FY 2023 payment determination.
    b. Adopt the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (NQF #2879), beginning with two years of voluntary reporting periods before requiring reporting of the measure for the reporting period that would run from July 1, 2023 through June 30, 2024, impacting the FY 2026 payment determination and subsequent years.

c. Remove the Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789) (HWR claims-only measure) beginning with the FY 2026 payment determination.
d. Extend 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.
e. Change 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 proposed Safe Use of Opioids – Concurrent Prescribing eCQM.
f. Continue 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.

11) **Promoting Interoperability**: CMS is proposing the following changes to the Medicare Promoting Interoperability program:

a. 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.
b. 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 attesting to CMS.
c. Require that the Medicare Promoting Interoperability Program measure actions must occur within the EHR-reporting period beginning with the EHR-reporting period in CY 2020.
d. 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.
e. 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 PDMP measure.
f. 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.
g. Revise the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to more clearly capture the previously established policy regarding CEHRT use.

12) **Long-Term Care Hospital (LTCH) PPS Standard Federal Rate:** CMS proposes an update to the standard federal rate of 2.7% ($42,950.91) for LTCHs that submit quality data. The reduced rate,

for those that don't submit quality data is $42,114.47 (.7% increase). CMS estimates this and other proposed changes will increase payments to LTCHs by $37 million in 2020.

13) **Long-Term Care Hospital Quality Reporting Program:** The rule proposes moving the implementation date of the LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS) from April to October to align with other post-acute care programs beginning October 1, 2020.