

IPPS FY 2021 Proposed Rule

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Adventist Health Policy Association (AHPA)



Presenters



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What is IPPS?



Comments due July 10th

- The IPPS rule sets the reimbursement rate for Medicare **Inpatient** payments.
- It includes updates to Medicare quality programs.
 - Inpatient Quality Reporting (IQR) – incentive program to report quality measures.
 - Hospital-Acquired Conditions (HAC) – penalty program based on performance.
 - Hospital Readmissions Reduction (HRRP) – penalty program based on performance.
 - Value-Based Purchasing (VBP) – budget neutral incentive program based on performance and improvement.
 - Promoting Interoperability (PI) Program – measures of interoperability and exchange of information.

Overview

- Inpatient Payment Changes
- Price Transparency
- Add-On Payments
- Disproportionate Share Hospitals (DSH)
- CMS' Quality Programs
 - Inpatient Quality Reporting
 - Hospital-Acquired Conditions Program
 - Hospital Readmissions Reduction Program
 - Value-Based Purchasing Program
 - Promoting Interoperability Program

Payment Changes

Inpatient Payments

Contributing Factor	Change
Market Basket Update	+ 3% (\$1.98 billion)
ACA Productivity Cut (expired in FY 2020)	- 0.0%
DSH Payments	- 6.4% (\$534 million)
MACRA Documentation and Coding Adjustment	+ 0.5%
LTCH Payments	- \$36 million

Price Transparency

Price Transparency

Hospital Price Transparency Final Rule

Effective: January 1, 2021

Requires hospitals to:

- 1) Make standard charges for all items and services publicly available, including negotiated charges, in a single-machine readable format.
- 2) Make public a consumer-friendly list of negotiated charges for at least 300 shoppable services.



Executive Order 13890

Issued: October 3, 2019

“Modify Medicare FFS payments to more closely reflect the prices paid for services in MA and the commercial insurance market.”

New Proposed Inpatient Payment Methodology

- 1) For cost reporting periods ending on or after January 1, 2021, require hospitals to report the median negotiated charge by MS-DRG for MA organizations and third-party payers.
- 2) Use the median negotiated charges reported to adjust Medicare payment rates beginning in FY 2024.

Calculating Median Negotiated Rates

CMS' Example:

Hospital A has negotiated four different payer-specific charges with four MA organizations for hypothetical MS-DRG 123. The four payer-specific negotiated charges are \$7,300, \$7,400, \$7,600 and \$7,700.

The median negotiated charge for MS-DRG 123 would be \$7,400.

Proposed New Payment Methodology

The methodology being considered includes the following steps:

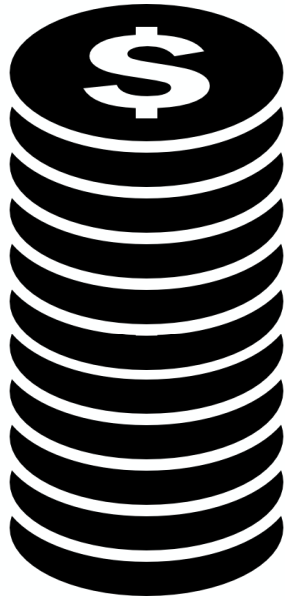
- 1) Standardize the median MA organizations payer-specific negotiated charges.
- 2) Create a single weighted average standardized median MA payer-specific negotiated charge by MS-DRG across hospitals.
- 3) Create a single national weighted average standardized payer-specific negotiated charge across all MS-DRGs.
- 4) Calculate the Market-based Relative Weights.
- 5) Normalize the Market-based Relative Weights.

Comment Solicitation

- The best way to calculate a single standardized median payer-specific negotiated charge across hospitals.
- Alternatives that would capture market-based information for the potential use in IPPS payments.
- The relative burden of calculating and submitting a median negotiated reimbursement amount.
- Whether to adopt a transition period before adopting the policy.

Disproportionate Share Hospital Payments (DSH)

Disproportionate Share Hospital Payments



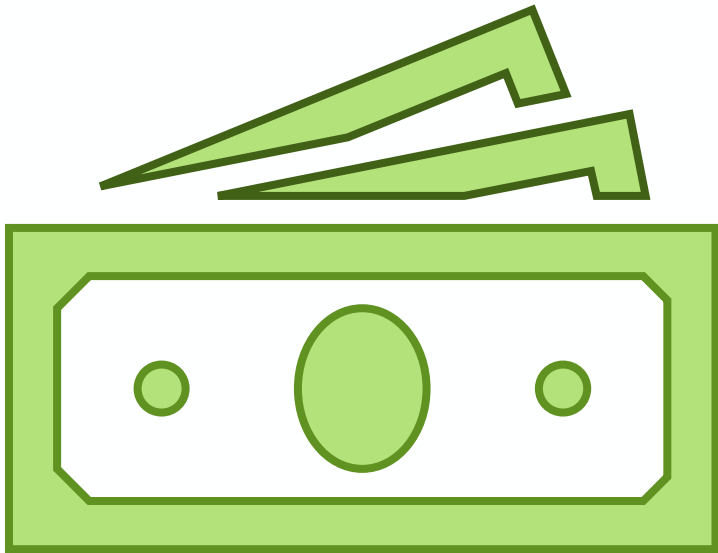
Base Payment



**DSH Supplemental
Payment**

- Percentage add-on to basic DRG payment
- Worksheet S-10 data

FY2021 DSH Payments



Estimated Payment: \$11.6 Billion

CMS proposes to continue to use a **single year** of Worksheet S-10 data to determine distribution.

Medicare Severity Diagnosis-Related Groups (MS-DRGs)

Proposed Adjustment for MS-DRGs

- Adopt a +0.5 adjustment to the standardized amount of Medicare payments for acute care hospitals.

*“Section 414 of the MACRA replaced the single positive adjustment we intended to make in FY 2018 with a **0.5 percentage point positive adjustment** to the standardized amount of Medicare payments to acute care hospitals **for FYs 2018 through 2023.**”*

- CMS

Changes to MS-DRGs

MS-DRG 018

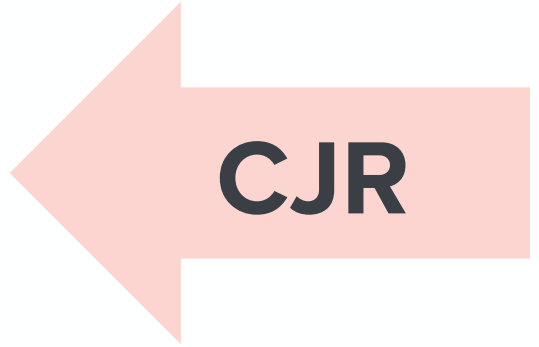
CAR T-Cell Therapy

- Now **ineligible** for NTAP in FY 2021.
- Proposed **relative weight adjustment of 0.15** for clinical trials.

MS-DRG 521

MS-DRG 522

*Hip Replacements with Principal
Diagnosis of Hip Fracture*



CJR

Note: CMS is also proposing a new deadline of **October 20th** of each year for requesting changes to MS-DRGs.

Principles for Severity-Level Changes

1. Represents end-of-life or near-death or has reached an advanced stage associated with systemic physiologic decompensation and debility.
2. Denotes organ system instability or failure.
3. Involves a chronic illness with susceptibility to exacerbations or abrupt decline.
4. Serves as a marker for advanced disease states across multiple different comorbid conditions.
5. Reflects systemic impact.
6. Post-operative condition/complication impacting recovery.
7. Typically requires higher level of care.
8. Impedes patient cooperation and/or management of care.
9. Recent change in best practice or in practice guidelines.

ICD-10-CM Code Updates

ICD-10-CM Code Updates

- CMS is proposing to change almost 600 ICD-10-CM codes.
 - Revised 47 codes
 - Deleted 58 codes
 - Added 490 new codes
 - Includes two new codes for CAR T-Cell Therapies (XW033C3 and XW043C3), drug misuse and more

New Technology Add-On Payments (NTAP)

New Technology Add-On Payments

- In FY 2020, CMS established an alternative New Technology Add-on Payments (NTAP) pathway for certain technologies and finalized higher payments.

NTAP Criteria (Must meet one to be eligible)

Newness

Cannot be substantially similar to existing tech

FDA approval in past two or three years

Cost

Must be costly such that applicable DRG rate is determined to be inadequate

Substantial Clinical Improvement

Meets the parameters outlined in the FY 2020 rulemaking to demonstrate substantial clinical improvement

- For FY 2021, CMS proposed to extend this pathway for antibacterial and antifungal drugs (LPAD pathway) starting in FY 2022 with a 75% higher NTAP rate.

New Technology Add-On Payments

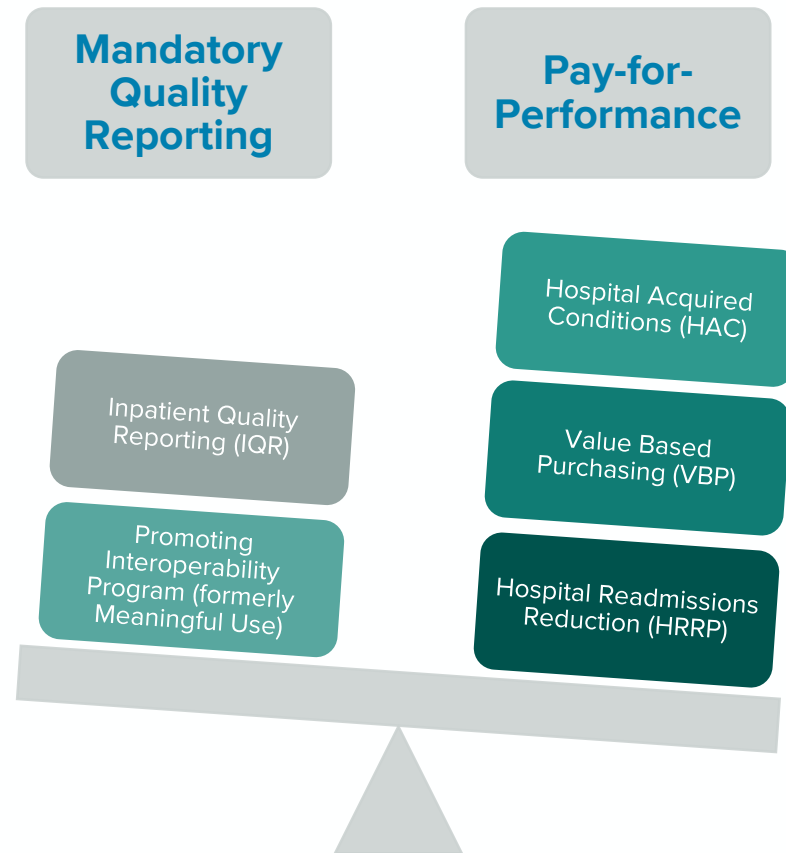
- Under the current rule, eligible antimicrobial products can receive NTAP after receiving FDA approval and considered in the final rule as long as the approval occurs before July 1st.
 - CMS proposes to allow products to receive conditional add-on payments for products that do not receive FDA approval by July 1st

New Technology Add-On Payments, Cont.

- CMS proposals for products in the NTAP Pathway:
 - Continue NTAPs for 10 products
 - Discontinue NTAPs for eight products that no longer meet the newness criterion
 - Approve nine products through the alternative NTAP pathway
 - Three breakthrough devices; six antimicrobial products
- The 15 new applications received for FY 2021 NTAPs will be determined in the final rule.

Quality Programs

Hospital Quality Programs



Overarching Proposals Across Programs

	IQR	HAC	HRRP	VBP	PI
Adopt an automatic performance period		✓	✓		
Align submission data so that by the CY 2021 reporting period, all four quarters are used	✓	✓			✓
Publicly report eCQM data beginning with the CY 2021 reporting period	✓				✓
Align data validation quarters so that by the CY 2021 reporting period, all four quarters are used	✓	✓			
Align hospital selection for data validation	✓	✓			

Hospital Inpatient Quality Reporting (IQR) Program

Overview

- The IQR program collects quality data.
- This data is made available to providers and consumers on the *Hospital Compare* website.

Proposed Changes: Reporting and Submission of eCQM Data

- Add EHR Submitter ID as a fifth key element for file identification.
- Require that all future hybrid measures use 2015 Edition CEHRT and submit using QRDA I file format.

Proposed Changes: Data Validation

- Align data validation process for both chart-abstracted measures and eCQMs
 - Require electronic file submission for chart-abstracted measure validation
 - Shift the weight of eCQMs in the future for data validation scoring process
 - Update educational review process to address eCQM validation results

Hospital-Acquired Conditions (HAC) Program

Overview

- Reduces total payments by 1% for the bottom quartile of hospitals.
- Two domains:
 - Domain 1: Agency for Healthcare Research and Quality measures (AHRQ PSI-90).
 - Domain 2: Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN- Hospital-Acquired Infections) measures.
- CMS is proposing that, for FY 2021, there will be a required PDF submission for medical record data validation.

Hospital Readmissions Reduction Program (HRRP)

Overview

- Purpose is to incentivize hospitals to reduce their readmissions.
- Hospitals receive reduced payments if they have excess readmissions.
- The payment reduction is capped at 3%.

Value-Based Purchasing (VBP) Program

Overview

- Budget neutral policy.
 - Makes incentive payments to hospitals based on how well they perform compared to other hospitals or how much they improve.
 - 2% of inpatient base operating payments are at risk.
-
- **No changes were proposed for FY 2021.**

Promoting Interoperability (PI) Program

PI Program Overview

- Originally created to incentivize the use of Certified Electronic Health Record Technology (CEHRT)
- Requires eligible hospitals to report on objectives and measures to be considered a meaningful EHR user and avoid a Medicare payment reduction

PI Program Proposed Changes

- CMS proposes to:
 - Extend the continuous 90-day reporting period that was extended in 2021 to 2022.
 - Continue Query of PDMP measure as voluntary for 2021
 - Update the Health Information Exchange Objective measure to “Support Electronic Referral Loops by Receiving and *Reconciling* Health Information”
 - Require that hospitals report on four of the eight available eCQMs for one self-selected quarter of data for the 2021 reporting period

Measures & Scoring: No Changes

OBJECTIVES	MEASURES	MAXIMUM POINTS
Prerequisite	Security Risk Analysis	REQUIRED – NOT SCORED
e-Prescribing	e-Prescribing	10 points
	Query of the Prescription Drug Monitoring Program	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider-to-Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting – REQUIRED	10 points
	<u>Choose one or more additional:</u> - Immunization Registry Reporting - Electronic Case Reporting - Public Health Registry Reporting - Clinical Data Registry Reporting - Electronic Reportable Laboratory Result Reporting	Total Points: 100

On June 24th, 2019, President Trump issued Executive Order 13877, *Improving Price and Quality Transparency in American Healthcare to Put Patients First*. The purpose of the executive order is to empower patients to make fully informed decisions about their healthcare, by facilitating the availability of appropriate and meaningful price and quality information. Section 4 of the executive order specifically directed the Secretaries of the Department of Health and Human Services (HHS), Department of Defense (DoD), and Department of Veterans Affairs (VA) to publish a Health Quality Roadmap detailing a strategy for establishing, adopting, and publishing common quality measurements; aligning inpatient and outpatient measures; and eliminating low-value¹ or counterproductive measures.

The purpose of this Roadmap is to improve patient² outcomes through enhanced effectiveness and efficiency of the healthcare quality system supported by federal investments. The federal government serves as a leader, and this Roadmap identifies policy and regulatory levers to drive change. True system advancement cannot occur without private sector stakeholders as equal partners in this endeavor, and the Roadmap implementation will be an opportunity for public-private partnership.

When implemented, this Roadmap will improve alignment of quality measures across federal programs and improve the value delivered by those measures. Improvements in the federal Quality Measurement Enterprise (QME)³ will equip patients with more meaningful information and enable greater patient engagement in their treatment and care planning.

Improvements in the federal QME will equip patients with more meaningful information and enable greater patient engagement in their treatment and care planning.

Introduction

The United States government is the largest provider of healthcare and health-related services to the American people. HHS administers healthcare programs that directly affect over 175 million Americans through Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and the Health Insurance Exchanges administered by the Centers for Medicare & Medicaid Services (CMS); the Indian Health Service (IHS) serving American Indians and Alaska Natives; and health services to people who are geographically isolated and/or economically or medically vulnerable, through the Health Resources and Services Administration (HRSA).⁴ Similarly, the DoD provides medical benefits to 9.5 million active duty personnel, military retirees, and their families through the Military Health System, and the VA serves

¹ For purposes of the Roadmap, value is defined as the ratio of healthcare quality, safety, and patient experience to the cost of care.

² This Roadmap uses the term "patient" to align with language in the Executive Order and is meant to include all consumers of healthcare services and their caregivers.

³ For purposes of this document, the quality measurement enterprise includes the broad array of organizations and individuals who develop and steward measures of health quality; collect and report data on those measures; and use quality measure information.

⁴ This number reflects 145 million Americans served by CMS programs (<https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2020-CJ-Final.pdf>), 30 million by HRSA (<https://data.hrsa.gov/data/factsheets/>), and 2.5 million by IHS (<https://www.ihs.gov/newsroom/factsheets/ihsprofile/>).

Quality Roadmap

“To improve the **alignment** of quality measures across federal programs and improve the **value** of those measures.”

- Principles to improve the health care quality system.
- Goals for improving governance and data collection.
- Recommendations for streamlining existing programs.

Actions to be completed by Dec. 31, 2020.

Clarifications to “Bad Debt” Standards

Reasonable Collection Efforts:

- Performed both **in-house** and by a **collections agency**, in the same fashion as private-payer collections policies.
- **Issue a bill** on or before 120 days following Medicare remittance advice or the a secondary payer’s remittance advice, whichever is later.
- **Additional steps** such as subsequent billings, letters, phone calls or “personal contacts”.
- Efforts must last at least **120 days**.
- Documentation must be made available for **MAC review** and include collection policies and proof of these efforts.

Patient Records

- Require providers to submit patient records to Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) in an electronic format.

Questions?

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