IPPS FY 2021 Final Rule

October 2, 2020

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Presenters

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Adventist Health Policy Association (AHPA)

AdventHealth

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Adventist HealthCare

LOMA LINDA UNIVERSITY

AdventistHealth

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What is IPPS?

- 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.

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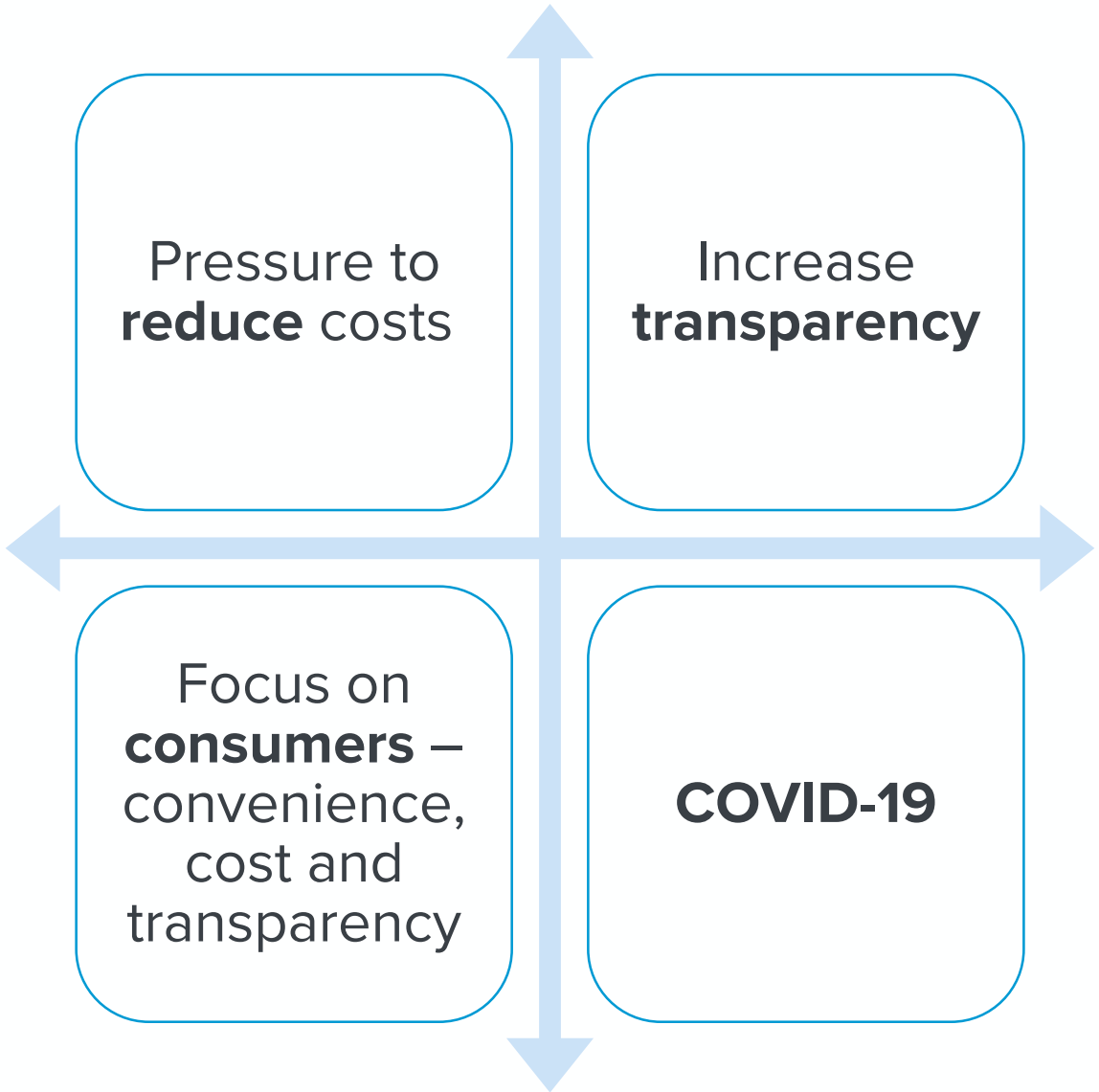
The Broader Policy Landscape



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Price Transparency

The New York Times

Many Hospitals Charge More Than Twice What Medicare Pays for the Same Care

The gap between rates set for private insurers and employers vs. those by the federal government stirs the debate over a government-run health plan.

Financial Management

ed Over the Years TIME Climate Change Policy

You can now look up charges at your local hospital. Good luck understanding them.

What "2-D ECHO TTE COMP NO CONTRST" tells you about modern health care.

By Sarah Kliff | sarah@vox.com | Jan 14, 2019, 2:20pm EST

SHARE

The Trump administration rang in 2019 by enacting a seemingly great health care policy: requiring all hospitals to **list the price** of their most common procedures on their websites.

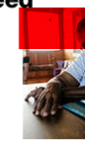
The whole idea was to make the American health care system more transparent, allowing patients to research the cost of care at thousands of hospitals across the country.

"We are just beginning on price transparency," Medicare Administrator Seema Verma said **when she announced** the policy last April. "We know that hospitals have this information and we're asking them to post what they have online."

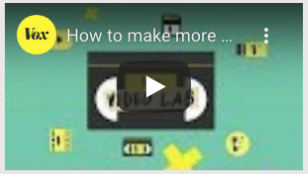
Her goal made a lot of sense: It is *really* hard for patients to research health care prices in our current system. One **2013 study** found that nearly all hospitals could give you their parking prices — but barely any could provide an estimate for the cost of their health care services.

The federal government has had this hospital charge data for a while now. I actually **wrote**

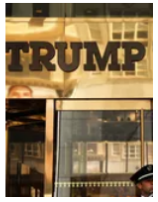
Helping stud in need



Join the Vox Video Lab



MOST READ



Hospital charges $67,957 for 4 vials of antivenin after snakebite: 6 things to know

Kelly Gooch - Tuesday, April 30th, 2019 Print | Email

Share Tweet

The family of a 2-year-old Indiana girl bitten by a venomous snake received a medical bill totaling $142,000

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Transparency in Public Policy

Executive Orders

- Publicly post charges and negotiated rates
- Surprise billing
- Modify Medicare FFS to reflect MA and private insurance rates

Final Price Transparency Rule

- Share negotiated rates
- Pay $300 CMP

Final IPPS Rule

- Report median negotiated charges for MA
- 2024 adjust hospital payments

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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

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Payment Changes

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Inpatient Payments

Contributing Factor	Change
Market Basket Update	+2.4% (instead of 3%)
ACA Productivity Cut (expired in FY 2020)	- 0.0%
DSH Payments	- 0.7% (instead of 6.4%) – Decrease of $61 million compared to FY 2020
MACRA Documentation and Coding Adjustment	+ 0.5%
LTCH Payments	+2.3%

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Price Transparency

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Price Transparency

Hospital Price Transparency Final Rule

Effective: January 1, 2021

Requires hospitals to:

1) Make standard charges for all items and services, including negotiated charges, publicly available in a single-machine readable format.
2) Make public a consumer-friendly list of negotiated charges for at least 300 shoppable services.
3) $300 a day civil monetary penalties.

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."

Proposed Inpatient Payment Methodology

1) For cost reporting periods ending on or after January 1, 2021, require hospitals to report their median negotiated charges with MA and all third-party payers by MS-DRG.
2) Requirement applies for all items and services provided in the inpatient setting.
3) Use the median negotiated charges reported to adjust Medicare payment rates beginning in FY 2024.

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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.

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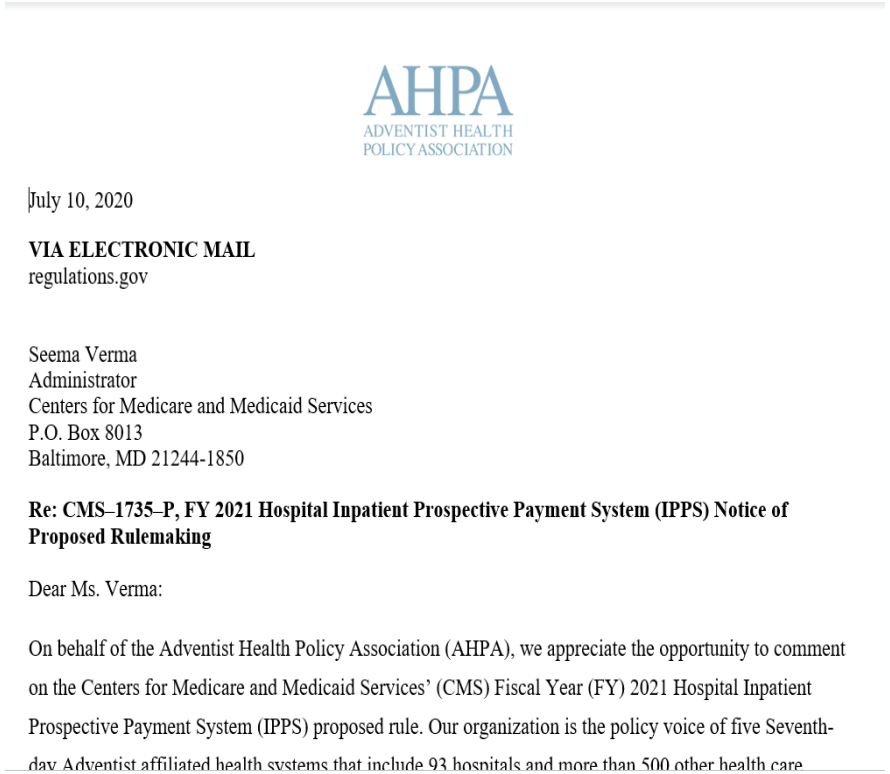
AHPA Position



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July 10, 2020

VIA ELECTRONIC MAIL
regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS–1735–P, FY 2021 Hospital Inpatient Prospective Payment System (IPPS) Notice of Proposed Rulemaking

Dear Ms. Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Fiscal Year (FY) 2021 Hospital Inpatient Prospective Payment System (IPPS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 93 hospitals and more than 500 other health care

"AHPA does *not* support the proposed policy. Charges paid to MA health plans are largely based on Medicare Fee-for-Service charges and are therefore reflective of traditional Medicare and not market costs. Relying on MA negotiated charges to change traditional Medicare charges would not achieve the Administration's goal of capturing market rates."

"AHPA recommends that CMS explore other payment mechanisms to better capture the cost of providing care to Medicare patients."

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Finalized Policy

- Hospitals will only be required to report the median negotiated charges for MA payers, instead of all third-party payers.
- Applies to cost reporting periods ending on or after January 1, 2021.
- Beginning in FY 2024, CMS will adjust inpatient payments based on data collected in hospital cost reports.

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Compliance

- **No civil monetary penalties**, compared to the 2019 Price Transparency Rule.

- **Potential withholding of inpatient payments if cost report does not include required information.**
  - Participating Medicare providers are required under 42 Code of Federal Regulations (CFR) Section 413.20(a) “to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. In accordance with Section 413.20(d), providers must furnish such information to Medicare contractors as necessary to assure proper payment.”

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Next Steps

“We will also conduct further analysis based on the market-based data received and provide an opportunity for public comment on that analysis, which may include consideration of any unknown impacts of the COVID–19 PHE on this data.”

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Disproportionate Share Hospital Payments (DSH)

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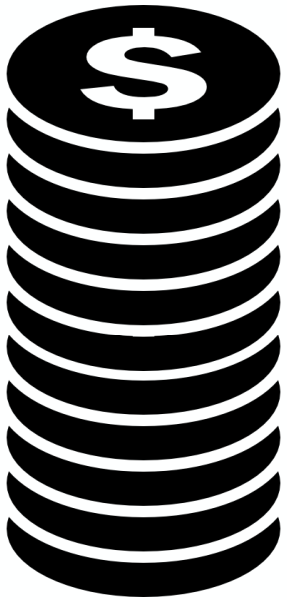
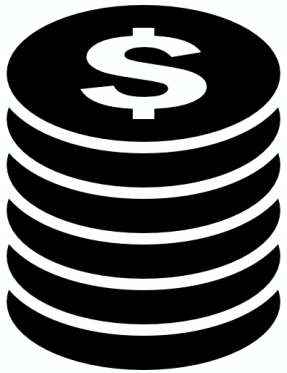
Disproportionate Share Hospital Payments



Base DRG Payment

+



DSH Supplemental Payment

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

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Finalized DSH Payments

Proposed Estimated Payment: $11.6 Billion

Finalized Estimated Payment: $12.1 Billion

CMS will continue to use a **single year** of Worksheet S-10 data to determine distribution in FY 2021.

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Medicare Severity Diagnosis-Related Groups (MS-DRGs)

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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*

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Proposed New 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

"**AHPA requests that CMS provide further details on how target prices within CJR will be calculated should this proposal be finalized,** as hospitals manage their model programs based on established target prices."

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Finalized Changes to MS-DRGs

MS-DRG 018

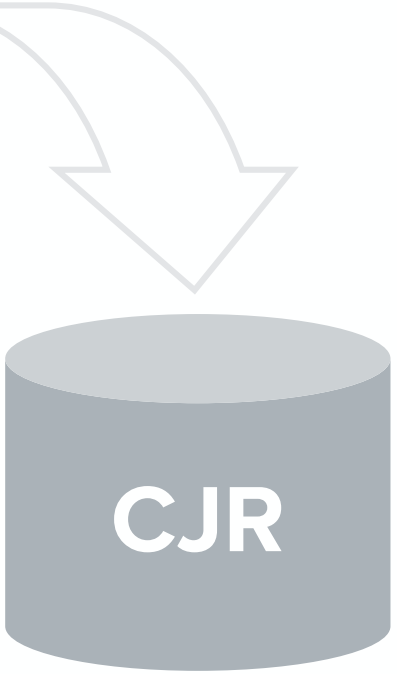
CAR T-Cell Therapy

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

MS-DRG 521

MS-DRG 522

Hip Replacements with Principal Diagnosis of Hip Fracture



Note: CMS is also implementing 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.

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ICD-10-CM Code Updates

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ICD-10-CM Code Updates

The final rule includes changes to nearly 600 ICD-10-CM codes.

Added: 490	Revised: 47	Deleted: 58

Tables 6A – 6K and 6P in the final rule.

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New Technology Add-On Payments (NTAP)

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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.

Newness

Cannot be "substantially similar" to existing tech

Must have FDA approval in past two or three years

Cost

Costly such that the applicable DRG rate is determined to be inadequate

Clinical Improvement

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

New Technology Add-On Payments

- Previously, eligible antimicrobial products could receive NTAPs after receiving FDA approval, provided the approval occurred before July 1st.
  - **Now, CMS will allow products to receive conditional add-on payments for those that do not receive FDA approval by July 1st**

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New Technology Add-On Payments

The IPPS final rule:

- Continues NTAPs for 10 products.
- Discontinues NTAPs for eight products. These products no longer meet the newness criteria.
- Approves nine products through the alternative NTAP pathway.
  - Three breakthrough devices; six antimicrobial products

Decisions on the new NTAP applications received for FY 2021 begin on page 58620 of the final rule.

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Quality Programs

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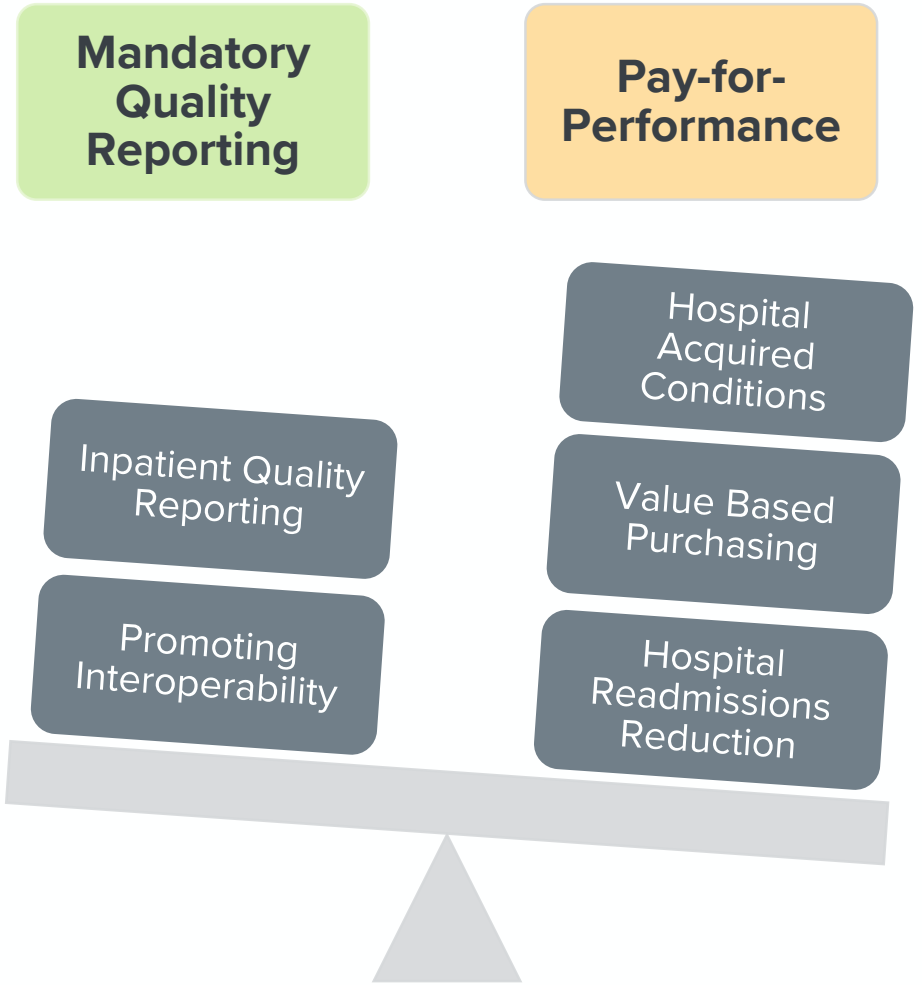
Hospital Quality Programs



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Overarching Proposals Across Programs

	IQR	HAC	HRRP	VBP	PI
Adopt an automatic performance period.		✓	✓		
Publicly report eCQM data beginning with the CY 2021 reporting period.	✓				✓
Increase the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data by CY 2023.	✓				✓
Align hospital selection for data validation.	✓	✓			

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Hospital Inpatient Quality Reporting (IQR) Program

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Overview

- The IQR program collects quality data.

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Reporting and Submission of eCQM Data

- Increase the number of quarters that hospitals must submit:
  - FY 2023 payment (CY 2021 reporting): report data for 2 self selected calendar quarters.
  - FY 2024 payment (CY 2022 reporting) report data for 3 self selected calendar quarters.
  - FY 2025 payment (CY 2023 reporting) and subsequent years, report data for all 4 calendar quarters.

- Beginning FY 2023, publicly report data to providers and consumers on the Hospital Compare website.

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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.

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Hospital-Acquired Conditions (HAC) Program

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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.

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HAC Program

- For FY 2021, require a PDF submission for medical record data validation.
- Beginning in FY 2023, the applicable period for both domains will be a 24-month period.
- Data submission quarters will be the same as IQR program.
  - For 2023 data validation, would include data from Q3 and Q4 2020.
  - For 2024 data validation, would include data from CY 2021 data.
- Beginning with data validation for FY 2024 payment, up to 400 hospitals could be selected.

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Hospital Readmissions Reduction Program (HRRP)

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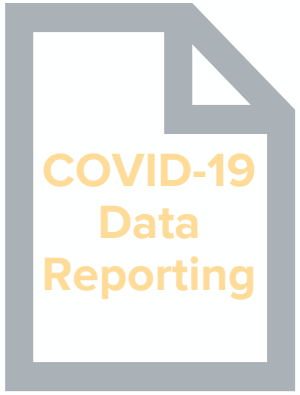
Overview

Program's Purpose: To incentivize hospitals to reduce their readmissions.

- Hospitals face a potential 3% reduction in payments if they have an excess of readmissions.



Stay tuned, AHPA members!

The first two quarters of 2020 data *may* be excluded from HRRP's performance calculations. CMS expects to include their final decision on this in the COVID-19 data reporting final rule.

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Value-Based Purchasing (VBP) Program

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Overview

Program's Purpose: To incentivize the highest-value care possible.

- Makes incentive payments to hospitals based on how well they perform or improve when compared to their peers.
- 2% of inpatient base operating payments are at risk.
- A budget-neutral program.

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Promoting Interoperability (PI) Program

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PI Program Overview

Program's Purpose: To promote the meaningful use of Certified Electronic Health Record Technology (CEHRT).

- Previously called the "Meaningful Use" program.
- Requires eligible hospitals to report on objectives and measures to be considered a meaningful EHR user.
- Those who do not comply face a Medicare payment reduction.

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PI Program Changes

- Extends the continuous 90-day reporting period to 2022.
- Maintains *Query of the PDMP* measure as voluntary for 2021.
- Renames the Health Information Exchange objective measure to *Support Electronic Referral Loops by Receiving and Reconciling Health Information*.

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PI Program Changes

- Progressively increases the number of quarters that hospitals must report eCQM data.

One Quarter of Data

Four Quarters of Data

(Over a three-year period)

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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 Reconciling 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 <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	10 points ***Total Points: 100***

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 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.

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Patient Records

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

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Questions?

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