

## Hospitals to See Big Changes in Reimbursement in 2020 & 2021

Hospitals are likely to see some significant changes in the way that Medicare reimburses for inpatient services in the next couple of years, according to the calendar year (CY) 2020 *Inpatient Prospective Payment System* (IPPS) final rule that was published on August 16, 2019,<sup>1</sup> and the announcement by the *Centers for Medicare & Medicaid Services* (CMS) on August 19, 2019 that it would change the quality “star ratings” system on Hospital Compare, beginning in 2021.

Hospitals that provide care to Medicare Part A beneficiaries are paid by CMS under the IPPS, which reimburses according to predetermined payment rates; these rates are determined by the patient’s needs, through Medicare severity diagnosis related groups (MS-DRGs), which classify patients based on the average per discharge cost of caring for their particular diagnosis.<sup>2</sup> The 2020 IPPS final rule, which will apply to discharges on or after October 1, 2019, will impact approximately 3,300 acute care hospitals, and increase payments to hospitals by \$3.8 billion (a 3% increase from 2019).<sup>3</sup>

Most importantly, the 2020 IPPS changes the rules by which “low wage” hospitals (most of which are rural) will be paid.<sup>4</sup> CMS utilizes the wage index in adjusting standardized amounts “for area differences in hospital wage levels by a factor...reflecting the relative hospital wage in the geographic area of the hospital compared to the national average hospital wage level.”<sup>5</sup> In response to the comments submitted last year by industry stakeholders, which signaled a shared concern that the current hospital wage index system “perpetuates and exacerbates the disparities between high and low wage index hospitals,” CMS is finalizing its proposal to increase the wage index for those hospitals below the 25<sup>th</sup> percentile.<sup>6</sup> These indices will be increased by half the amount between the hospital’s current index, and the 25<sup>th</sup> percentile index.<sup>7</sup> This change will commence in 2020, and continue for a length of four years, so that employee compensation (i.e., wages) has time to increase in response to this change, which will ultimately be reflected in the hospital’s wage index calculation.<sup>8</sup>

In its proposed rule, CMS suggested decreasing the wage index for hospitals above the 75<sup>th</sup> percentile, as a way to keep the program budget neutral. However, CMS ultimately revised this proposal, keeping the program’s overall budget neutrality, but through an adjustment to the standardized amount applied to all hospitals.<sup>9</sup> Additionally, CMS is implementing changes to the

calculation of the wage index “rural floor” (i.e., the wage index value for an urban hospital cannot be less than that of the rural hospitals in the same state).<sup>10</sup> Addressing concerns that some urban hospitals have inappropriately swayed the index via urban/rural reclassifications, CMS will remove such reclassifications from the calculation of the wage index rural floor going forward.<sup>11</sup>

In order to guard against any major decreases in any one hospital’s wage index in 2020, CMS is instituting a one-year 5% cap on the decrease of hospitals’ wage indices, so that no hospital’s final wage index for 2020 will be less than 95% of its 2019 wage index.<sup>12</sup>

Other notable changes to the IPPS for 2020 include:

- (1) An increase in the add-on payment for “new technology,” i.e., “medical services or technologies found to be 1) new; 2) disproportionately costly to the existing MS-DRG, and 3) a substantial clinical improvement.”<sup>13</sup> There are currently nine technologies that meet these requirements, and an additional nine were approved with the 2020 IPPS final rule.<sup>14</sup> The add-on payment for these technologies will be the lesser of either 50% of the cost of the new technology/service or 50% of the amount in excess of the MS-DRG payment.<sup>15</sup>
- (2) Clarifications and updates to the metrics included in the various quality programs, including the:
  - Hospital-Acquired Conditions (HAC) Reduction Program;
  - Hospital Readmissions Reduction Program (HRRP);
  - Hospital Inpatient Quality Reporting (IQR) Program;
  - Hospital Value-Based Purchasing (VBP) Program; and,
  - PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.<sup>16</sup>
- (3) Changes to the three factors included in the calculation of *Disproportionate Share Hospital* (DSH) payments.<sup>17</sup>

In addition to the announced payment updates and other changes, CMS announced on August 19, 2019 that it would be overhauling the methodology by which it determines hospital quality star ratings for the Hospital Compare website.<sup>18</sup> The Hospital Compare website allows patients to “[c]ompare hospitals based on their star rating, which summarizes a variety of quality measures...”<sup>19</sup> that are based upon “common conditions that hospitals treat, such as heart attacks or pneumonia.”<sup>20</sup> Based upon the over 800 comments received in response to CMS’s February 2019 public input request on this topic, CMS will revise the current methodology in early 2021 (for 2020, CMS will simply refresh the data utilizing current methodology).<sup>21</sup> Although exact details regarding the overhaul were not shared, the questions asked by CMS in its public input request are illuminating. The CMS request sought feedback on nine potential changes, including abandoning the latent variable model that assigns

hospital ratings.<sup>22</sup> Most commenters expressed opposition to the current model, stating that the model is too opaque in its approach, making it impossible for hospitals to predict their rating (and any impact that implemented quality-improvement activities may have on that rating).<sup>23</sup>

In its dual push toward transparency and value-based care, CMS is enacting a myriad of extensive reforms, in every sector of the healthcare delivery system. However, the reforms related to hospitals may be the most significant, as IPPS payments account for approximately 25% of Medicare spending, and these Medicare payments account for approximately 20% of hospital revenues.<sup>24</sup> This may mean that any change in hospital payments (or the strings attached thereto) may result in a paradigm shift in the healthcare industry, affecting insurers, providers, and patients.

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1 Note that, while the final rule also includes the *Long-Term Care Prospective Payment System* (LTC PPS), this article will focus on only the IPPS portion of the final rule.

2 “Hospital Acute Inpatient Services Payment System” Medicare Payment Advisory Commission, *Payment Basics*, October 2018, [http://medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_18\\_hospital\\_final\\_v2\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_hospital_final_v2_sec.pdf?sfvrsn=0) (Accessed 8/20/19).

3 “Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System (CMS-1716-F)” Centers for Medicare & Medicaid Services, *Fact Sheet*, August 2, 2019, <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0> (Accessed 8/19/19).

4 *Ibid.*

5 “Payment To Hospitals For Inpatient Hospital Services” 42 U.S.C. §1395ww(d)(2)(h) (2018).

6 CMS, *Fact Sheet*, August 2, 2019.

7 *Ibid.*

8 *Ibid.*

9 *Ibid.*

10 *Ibid.*

11 *Ibid.*

12 *Ibid.*

13 “CMS Releases Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) Final Rule” By Miranda A. Franco, Holland & Knight, August 7, 2019, <https://www.hklaw.com/en/insights/publications/2019/08/cms-releases-fiscal-year-fy-2020-ipps-final-rule> (Accessed 8/19/19).

14 *Ibid.*

15 “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care

Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals” Federal Register, Vol. 84, No. 159 (August 16, 2019), p. 42300-42339; Franco, August 7, 2019.

16 Federal Register, Vol. 84, No. 159 (August 16, 2019), p. 42180-42300; CMS, *Fact Sheet*, August 2, 2019.

17 Federal Register, Vol. 84, No. 159 (August 16, 2019), p. 42353-42380.

18 “CMS Announces Upcoming Enhancement of Overall Hospital Quality Star Ratings” Centers for Medicare & Medicaid Services, *Press Release*, August 19, 2019, <https://www.cms.gov/newsroom/press-releases/cms-announces-upcoming-enhancement-overall-hospital-quality-star-ratings> (Accessed 8/20/19).

19 Hospital Compare, <https://www.medicare.gov/hospitalcompare/search.html?> (Accessed 8/20/19).

20 “Hospital Compare overall hospital rating” Medicare.gov, <https://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html> (Accessed 8/20/19).

21 “CMS will change hospital star ratings methodology in 2021” By Maria Castellucci, *Modern Healthcare*, August 19, 2019, <https://www.modernhealthcare.com/safety-quality/cms-will-change-hospital-star-ratings-methodology-2021> (Accessed 8/20/19); CMS, *Press Release*, August 19, 2019.

22 Castellucci, August 19, 2019.

23 *Ibid.*

24 As of 2016. Medicare Payment Advisory Commission, October 2018.



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