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Proposed FY 2020 IPPS and LTCH PPS Address Rural Health & Medical Innovation

On April 23, the Trump Administration proposed changes that build on the progress made over the last two years and further the agency's priority to transform the health care delivery system through competition and innovation while providing patients with better value and results. The proposed rule would update Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities, "Rethinking Rural Health" and "Unleashing Innovation," by proposing historic changes to the way Medicare pays hospitals.

"One in five Americans are living in rural areas and the hospitals that serve them are the backbone of our nation's health care system," said CMS Administrator Seema Verma. "Rural Americans face many obstacles as the result of our fragmented health care system, including living in communities with disproportionately higher poverty rates, more chronic conditions, and more uninsured or underinsured individuals. The Trump administration is committed to addressing inequities in health care, which is why we are proposing historic Medicare payment changes that will help bring stability to rural hospitals and improve patients' access to quality health care."

In last year's proposed rule, CMS invited comments on changes to the Medicare inpatient hospital wage index. Many responses reflected a common concern that the current wage index system makes the disparities between high and low wage index hospitals worse. To address these disparities, we are proposing to increase the wage index of low wage index hospitals. This change would ensure that people living in rural areas have access to high quality, affordable health care. We are considering several ways to implement this change, and the agency looks forward to comments on the different approaches.

We are also announcing proposals that would ensure Medicare beneficiaries have access to a world-class health care system by unleashing innovation in medical technology and removing potential barriers to innovation and competition in order to expedite access to novel medical technology.

"Transformative technologies are coming to the private market, but Medicare's antiquated payment systems have not contemplated these technologies," said CMS Administrator Seema Verma. "I am particularly concerned about cases that have been reported to the agency in which Medicare's inadequate payment has

led hospitals to curtail access to needed therapies. We must continually update our policies in response to the rapid pace of advancement in medical science.”

To ensure that Medicare payment supports broad access to transformative technologies, we are proposing several payment policy changes. These include proposing to increase the new technology add-on payment, which provides hospitals with additional payments for cases with high costs involving new technologies, including potentially new antimicrobial therapies. The increase would apply to all technologies receiving add-on payments starting on October 1, so that when a physician determines that a patient needs a qualifying new therapy, the hospital at which the therapy is administered would be able to more completely cover its costs. This change would promote patient access and reduce the uncertainty that innovators face regarding payment for new medical technologies for Medicare beneficiaries.

We are also proposing to modernize payment policies for medical devices that meet the Food and Drug Administration’s (FDA’s) Breakthrough Devices designation. For devices granted this expedited FDA approval, real-world data regarding outcomes for the devices in different patient populations is often limited. At the time of approval, it can be challenging for innovators to meet the requirement for evidence demonstrating “substantial clinical improvement” in order to qualify for new technology add-on payments.

Therefore, we are proposing to waive for two years the requirement for evidence that these devices represent a “substantial clinical improvement.” Waiving this requirement would provide additional Medicare payment for the technologies for a period of time while real-world evidence is emerging, so Medicare beneficiaries do not have to wait for access to the latest innovations. In the proposed rule, we highlight the unique challenges associated with paying for CAR-T technology in particular, the first-ever gene therapy to treat certain forms of cancer for which no other treatment options exist.

For More Information:

- [Proposed Rule](#)
- [Fact Sheet](#), includes proposed changes to payment rates and quality programs

See the full text of this excerpted [CMS Press Release](#) (issued April 23).

IRF: FY 2020 Proposed Payment and Policy Changes

On April 17, CMS proposed a rule that would update Medicare payment policies for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the Inpatient Rehabilitation Quality Reporting Program for FY 2020. We are proposing to update IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket estimate of 3.0 percent increase factor, reduced by a 0.5 percentage point multifactor productivity adjustment). We are proposing that if more recent data becomes available, we would use the more recent estimates to determine the FY 2020 market basket update and multi-factor productivity adjustment in the final rule. Accounting for an additional update to the outlier threshold so that estimated outlier payments remain at 3.0 percent of total payments, we project that IRF payments will increase by 2.3 percent (or \$195 million) for FY 2020, relative to payments in FY 2019.

The proposed rule also includes:

- Proposed case-mix group revisions (using FY 2017 and FY 2018 data)
- Proposal to rebase and revise the IRF market basket
- Ensuring quality and safety/interoperability

CMS will accept comments on the [proposed rule](#) until June 17. See the full text of this excerpted [CMS Fact Sheet](#) (issued April 18).

IPF: FY 2020 Proposed Payment and Quality Reporting Updates

On April 18, CMS proposed a rule that would update Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System and the IPF Quality Reporting Program for FY 2020.

We estimate total IPF payments to increase by 1.7 percent or \$75 million in FY 2020. The IPF market basket update, which is used to update IPF payment rates, is 3.1 percent. After adjusting that 3.1 percent by two reductions required by law (the productivity adjustment of 0.5 percentage point and a 0.75 percentage point reduction), the net market basket update to IPF payment rates is 1.85 percent. Additionally, estimated payments to IPFs are reduced by 0.15 percentage point due to updating the threshold amount used in calculating outlier payments. For FY 2020, we are proposing to rebase and revise the IPF market basket to reflect a 2016 base year from a 2012 base year.

CMS will accept comments on the [proposed rule](#) until June 17. See the full text of this excerpted [CMS Fact Sheet](#) (issued April 18).

SNF: FY 2020 Proposed Payment and Policy Changes

On April 19, CMS issued a proposed rule for FY 2020 that updates the Medicare payment rates and the quality programs for Skilled Nursing Facilities (SNFs). Effective October 1, we will begin using a new case-mix model, the Patient Driven Payment Model (PDPM). The PDPM focuses on the patient's condition and resulting care needs, rather than on the amount of care provided, in order to determine Medicare payment.

We project that aggregate payments to SNFs will increase by \$887 million, or 2.5 percent, for FY 2020 compared to FY 2019. We attribute this estimated increase to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment.

The proposed rule also includes:

- Sub-regulatory process for ICD-10 code revisions for PDPM
- Aligning SNF PPS group therapy definitions with other post-acute care settings

CMS will accept comments on the [proposed rule](#) until June 18. See the full text of this excerpted [CMS Fact Sheet](#) (issued April 19).

Hospice: FY 2020 Proposed Payment Rate Update

On April 19, CMS issued a proposed rule that would update the hospice payment rates, wage index, and cap amount for FY 2020. This rule also:

- Proposes to rebase the continuous home care, general inpatient care, and inpatient respite care per diem payment rates in a budget-neutral manner
- Proposes to modify the election statement requirements to require the hospice to include additional information aimed at increasing coverage transparency for patients that elect hospice
- Solicits comments on the interaction of the hospice benefit and various alternative care delivery models

As proposed, hospice payment rates are updated by 2.7 percent (\$540 million increase in their payments) for FY 2020. This is based on the proposed FY 2020 hospital market basket increase of 3.2 percent reduced by the multifactor productivity adjustment of 0.5 percentage point, resulting in a proposed 2.7 percent increase in hospice payment rates for FY 2020. Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket update for the year.

The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments per patient made to a hospice annually. The proposed hospice cap amount for the FY 2020 cap year will be \$29,993.99, which is equal to the FY 2019 cap amount (\$29,205.44) updated by the proposed FY 2020 hospice payment update percentage of 2.7 percent.

CMS will accept comments on the [proposed rule](#) until June 18. See the full text of this excerpted [CMS Fact Sheet](#) (issued April 19).

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