Policy Brief

May 4, 2018

CMS Releases Annual Hospital Inpatient Payment Rule

CMS released its annual hospital Inpatient Prospective Payment System (IPPS) proposed rule, which increases inpatient payments by 3.4% ($4.1 billion) in Fiscal Year (FY) 2019. Hospitals will still be at risk for up to a 6% payment reduction based on their performance in CMS' pay-for-performance programs. The proposal also takes significant steps towards transparency in the Medicare program. Comments on the rule are due on June 25th. Below is an outline of the major policies proposed. If you have any comments or recommendations on these proposals, please contact us.

Transparency

- CMS seeks comments on how hospitals can better implement pricing transparency. CMS' specific questions on this issue can be found on page 1467 of the rule.
- Requires hospitals to make their current standard charges available online.
- Requires providers to inform patients about expected out-of-pocket costs for a service and what Medicare will pay before the service is rendered.
- Seeks comments on whether to define standard charges as:
    - The average or median rate for groups of services commonly billed together; or
    - The average discount off the chargemaster across all payers.

Hospital Value-Based Purchasing Program

- Removes 10 measures from the Hospital Value-Based Purchasing (VBP) Program, including six that are duplicative of Hospital-Acquired Condition (HAC) Reduction program measures.
- Proposes the following changes to the weight of Hospital VBP domains:
    - Safety Domain – Remove (currently at 25%)

    - Clinical Care Outcomes – increases from 25% to 50%
    - Person and Community Engagement – maintains 25%
    - Efficiency and Cost Reduction – maintains 25%
- Changes the Clinical Care domain name to the *Clinical Outcomes* domain beginning in FY 2020.

Inpatient Quality Reporting Program

- Removes 18 measures from the Hospital Inpatient Quality Reporting (IQR) program.
- Stratifies the Pneumonia Readmission measure (NQF #0506) data by highlighting both hospital-specific disparities and readmission rates for dual eligible beneficiaries.

Meaningful Use Program

- Renames the Meaningful Use Program to the Promoting Interoperability (PI) Program.
    - Reduces the number of required measures within the PI Program from 16 to 6.
- Requests comments on whether CMS should require that hospitals electronically:
    - Transfer medically necessary information to other facilities upon patient discharge.
    - Transfer patients' discharge information to community providers, if identified.
    - Present information, such as discharge instructions, to patients and third-party applications upon patient request.
- Seeks comments on how to better achieve interoperability or the sharing of health care data between providers.

Uncompensated Care Costs

- Increases the fixed-cost outlier threshold to $27,545, causing hospitals to absorb more costs before Medicare provides supplemental reimbursement.
- Uses Worksheet S-10 data from FY 2014 and FY 2015 cost reports in combination with insured low-income days data from FY 2013 cost reports to determine the distribution of uncompensated care payments.

Graduate Medical Education

- Beginning July 1, 2019, allows new urban teaching hospitals to loan slots to other *new* urban teaching hospitals.
- Announces the opportunity to apply for available slots due to the closing of two teaching hospitals. Interested parties must apply by July 23, 2018.

Long-Term Care Hospitals

- Eliminates the 25% referral rule for Long Term Care Hospitals (LTCHs), which allows for no more than 25% of an LTCH's patient base to be referred from a single hospital.

Hospital Inpatient Admission Orders

- Eliminates the requirement that a written physician order must be included in the medical record, in cases where the physicians' intent can be clearly derived.

Cost Reports Supporting Documentation

- Rejects cost reports that do not contain supporting documentation with a detailed bad debt list corresponding to the bad debt amounts in the cost report.
- To be eligible for Medicare DSH payment, cost report supporting documentation must include a detailed listing of Medicaid eligible days.
- Cost report supporting documentation must include a detailed listing of charity care and uninsured discounts.
- Requires that costs allocated from a home office or chain organization be documented with a Home Office Cost Statement.

Price Transparency: Hospitals in the Spotlight

Consumer demands and pressure to cut costs have fueled the fire on increased price transparency. Current proposals are targeting providers, payers and drug companies. But the media's persistent attention on hospital prices will continue to keep hospitals at the center of efforts. Below are the actions taking place to improve price transparency among hospitals, insurance and drug companies.

Insurance

- A California bill would allow the state to set prices for commercial insurance. Maryland already sets the prices paid by all payers.

Hospitals

- In its annual payment rule, CMS proposes requiring hospitals to post their charges online.

- California Attorney General is suing Sutter Health for price gouging.
- The Texas Supreme Court recently ordered a hospital to disclose its reimbursement rates.
- Numerous states have made efforts to make the costs of hospital procedures available. These include:
    - California, which requires hospitals to share prices for 25 common outpatient procedures.
    - New Jersey, which requires hospitals to post average charges and length of stay for major diagnoses.
    - New Hampshire, which lists expected out-of-pocket costs and total price of emergency visits.
    - Florida, which has a database that lists price comparisons of services in hospitals and ambulatory surgery centers.

Drug Companies

- Oregon requires drug manufacturers to justify when a drug price exceeds $100 a month or if there is a net increase of 10% or more. Massachusetts and Nebraska currently have similar legislation pending.
- The CREATES Act, a bipartisan house bill, would stop pharmaceutical companies from blocking the entrance of less expensive prescription drug alternatives in the marketplace. The goal is to help families and patients afford critical medications.

Gun Violence: A Public Health Epidemic

In response to rising gun-related injuries and deaths, public health professionals in many states are leaping into action. Just this March, the Centers for Disease Control and Prevention (CDC) was permitted to address gun violence as an epidemic when the Trump Administration lifted a decades-long ban. The CDC was previously prohibited from conducting gun violence research, despite such violence outpacing all other causes of premature death in the U.S. Below are some of the recent public health responses to gun violence.

The American Hospital Association has launched an anti-violence campaign. Hospitals Against Violence is an advocacy initiative aimed at combating all forms of violence that provides resources for the national, state and local levels.

Several states have taken legislative action to address gun violence. As the gun violence conversation has intensified, Florida, Colorado and Illinois (as well as others) have taken legislative action looking to protect public health and safety.

Researchers and governors have joined forces to launch a multistate gun violence consortium. Seven governors have teamed up to study gun violence as a public health issue. To date, nearly 40 public health researchers have agreed to join the consortium to fill the gap created by the CDC research limitation.

Kansas City health workers are using "battlefield medicine" to save gun violence victims. Truman Medical Center in Kansas City, Missouri, has been training school administrators and police officers on using tourniquets to stanch gunshot bleeding.

A Texan disability-rights group has begun data collection on gun violence maiming. ADAPT of Texas has launched multiple new studies to determine the number of people who became permanently disabled because of gun violence.

340B Program Update

Last week, a bill to reform the 340B program was introduced by U.S. Representatives Buddy Carter (R-GA) and Chris Collins (R-NY). This proposal would require 340B hospitals to submit outpatient revenue and charity care data for all hospitals and registered child sites. This would not include uncompensated care data.

Scheduled for today, the American Association of Medical Colleges, America Essential Hospitals, AHA and three hospitals will also present oral arguments against the 28.5% payment cut to 340B facilities that took place the beginning of this year.

A Look at The Federal Register

CMS issued proposed policy and payment rules for Post-Acute Care (PAC) sites in FY 2019. The effected payment systems include: Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs) and Hospice. The comment deadline for each of the rules is June 26th. Below is an outline of the proposed changes.

SNF Payments

CMS proposes to increase SNF payments by 2.4% (an $850 million increase). CMS also proposes an overhaul of the SNF payment system that would replace the current Resource Utilization Group (RUG) unit of payment with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM).

IRF Payments

CMS proposes to increase IRF payments by 0.9% (a $75 million increase). CMS is also seeking comments on the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (nurse practitioners and physician assistants).

IPF Payments

CMS proposes to increase IPF payments by 0.98% (a $50 million increase). CMS also proposes to remove eight measures from the IPF Quality Reporting Program.

Hospice

CMS proposes to increase both hospice payments and the statutory annual cap by 1.8% (a $340 million increase).

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