

FY 2019 Inpatient Prospective Payment System (IPPS) Final Rule Webinar



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August 28, 2018



Association of
American Medical Colleges

Information on Final Rule

The [FY 2019 IPPS Final Rule](#) was published in the *Federal Register* on August 17, 2018 (83 Fed. Reg. 41144).

AAMC IPPS Resources:
<https://www.aamc.org/initiatives/patientcare/277442/hospitalpaymentandquality.html>.

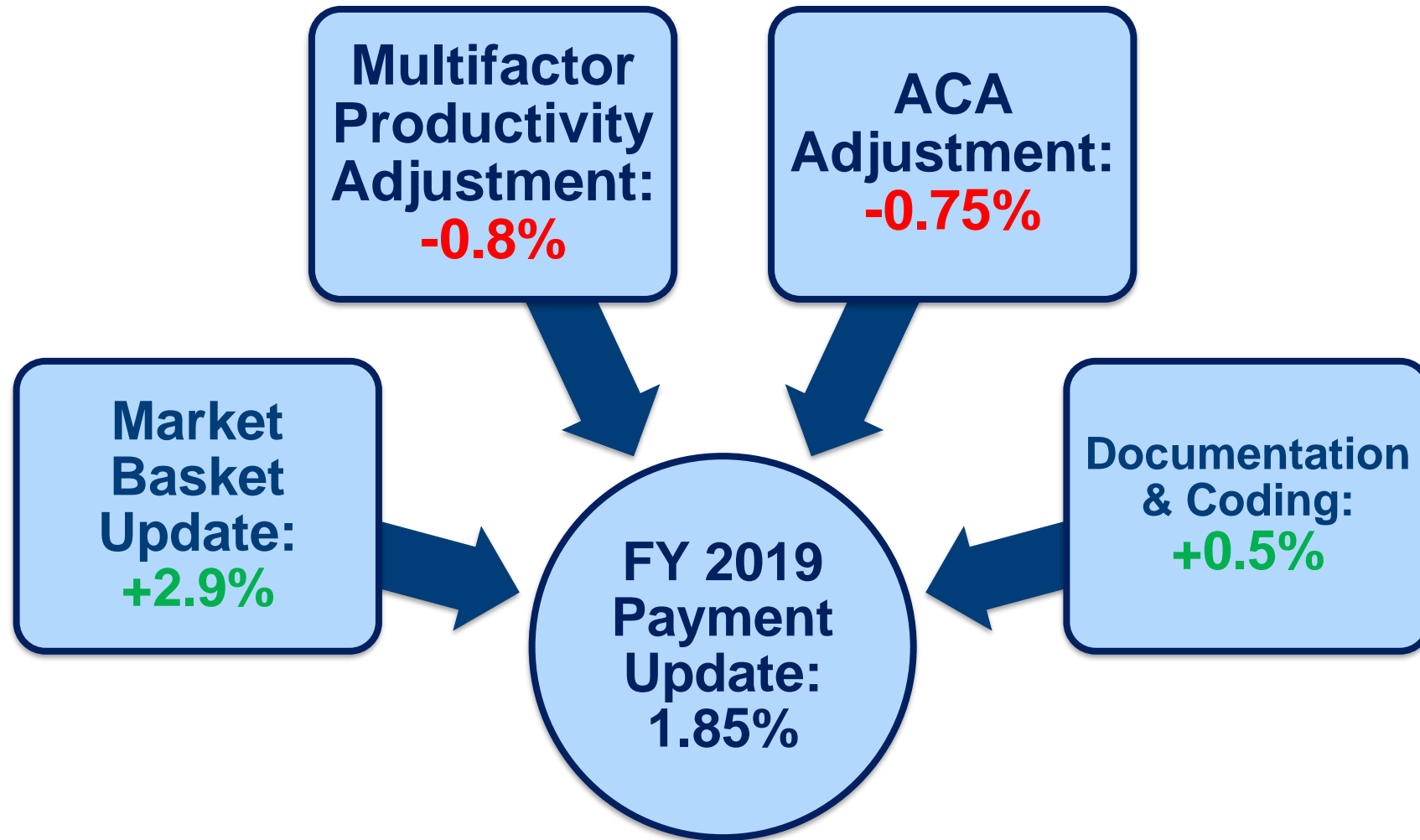
Final rule proposals take effect October 1, 2018 unless otherwise noted.

Webinar Agenda

- Payment Update
- Outlier Payments
- Disproportionate Share Hospital (DSH) and Uncompensated Care Payments
- Direct Graduate Medical Education (DGME) Affiliation Agreements and Open Slots
- Urban to Rural Reclassification
- Inpatient Admission Requirements
- Physician Certification of Claims
- Post-Acute Care Transfer Policy
- Cost Report Submission Requirements
- CAR-T Therapy
- Public Reporting of Hospital Standard Charges

Payment Updates

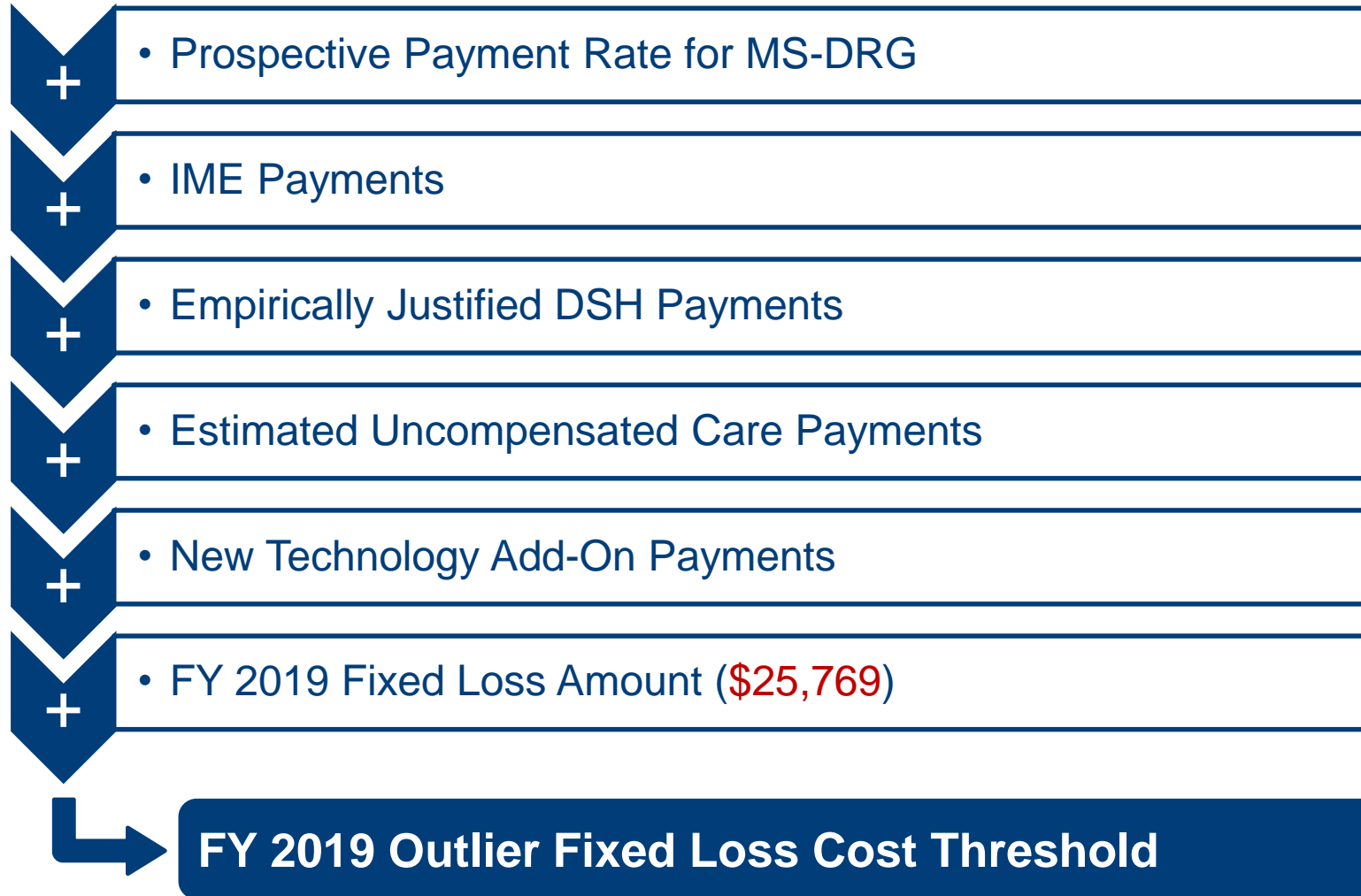
Final FY 2019 Market Basket Update



Overall Impact: All Hospitals: **2.4%**
Major Teaching Hospitals: **3.1%**

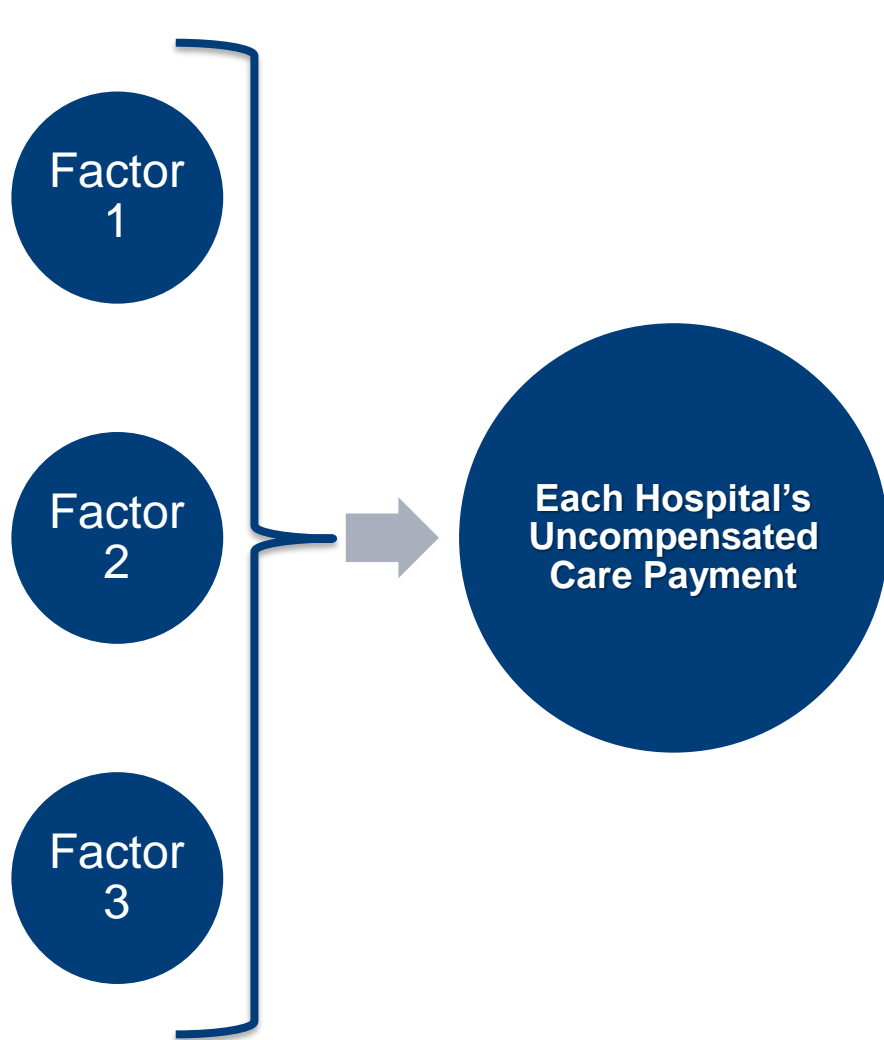
Outlier Payments

Final FY19 Outlier Fixed Loss Cost Threshold



Medicare DSH Payments

Final FY 2019 DSH Uncompensated Care Payment (UCP)



Factor 1: \$12.254 billion*

- Equals **75 percent of the aggregate DSH payments** that would have been made under the old statutory formula (without application of the ACA)

Factor 2: 67.51%

- Reduces the amount of Factor 1 by **insured pre-ACA to uninsured post-ACA**
- **FY 2019 Finalized UCP Amount: \$8.27 billion****

Factor 3: Determines Hospitals' % of UCP

- A hospital's UCP amount over set time period compared to UCP for **all qualifying hospitals** over the same time period.

*Office of the Actuary (OACT) uses June 2018 Medicare DSH estimates to determine Factor 1.

**CMS uses National Health Expenditure Accounts (NHEA) estimates to determine Factor 2

Final FY 2019 Factor 3 Methodology

Time Period and Data Source

- Worksheet S-10 Data for FY 2014, FY 2015.
- Low-income insured days for FY 2013.

Uncompensated Care Definition

- Same as last year.
- Line 30 of S-10, which is cost of charity care (Line 23) combined with non-Medicare and non-reimbursable Medicare bad debt (Line 29).

Aberrant Data

- Finalizes alternate methodology for hospitals where ratio of UCP to total operating costs is unusually high.

Direct Graduate Medical Education (DGME)

GME Affiliated Groups for New Urban Teaching Hospitals

Background

- Restrictions on new urban teaching hospitals participating in affiliated groups – could only get increase in cap, not decrease.
- Concern that **existing** residency programs would circumvent FTE caps.

Finalized Changes

- Finalizes proposal that allows “**new urban teaching hospitals**” that started teaching programs after 1996 to form affiliated groups with each other.
- Beginning with affiliation agreements entered into July 1, 2019 to June 30, 2020 residency training year.
- Applies to GME affiliation agreements **and** emergency affiliation agreements.

Available Resident Slots: Teaching Hospital Closure

Round 13: Memorial Hospital of Rhode Island – Pawtucket, RI

CCN	Provider name	City and state	CBSA code	Terminating date	IME FTE resident cap (including +/- MMA Sec. 422 ¹ and ACA Sec. 5503 ² adjustments)	Direct GME FTE resident cap (including +/- MMA Sec. 422 ¹ and ACA Sec. 5503 ² adjustments)
410001	Memorial Hospital of Rhode Island.	Pawtucket, RI	39300	January 31, 2018.	67.75 + 5.91 sec. 422 increase = 73.66 ³ .	75.56 – 0.47 sec. 422 reduction – 2.47 sec. 5503 reduction = 72.62. ⁴

Applications must be ***RECEIVED (NOT POSTMARKED)*** by CMS **by October 31, 2018.**

Applying for Available Slots

- **Application Information**

- Access the Application at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Section-5506-Application-Form.pdf>

- Submit hard copy applications to CMS Central Office.
- Applications must be ***RECEIVED (NOT POSTMARKED)*** by CMS **by October 31, 2018.**

Email Follow-up After Application Submission

- CMS is encouraging hospitals to notify the CMS Central Office of the mailed application by sending an email to:
ACA5506application@cms.hhs.gov
- In the email, the hospital should state:
 - On behalf of [insert hospital name and Medicare CCN#], I, [insert your name], am sending this email to notify CMS that I have mailed to CMS a hard copy of a section 5506 application under Round 13 due to the closure of Memorial Hospital of Rhode Island. If you have any questions, please contact me at [insert phone number] or [insert your email address].”

Application Criteria

Demonstrated Likelihood Criteria

- Hospital does not have room under its cap but will establish new residency program
- Hospital does not have room under its cap but will take over all or part of existing residency program; expanding existing residency program
- Hospital is part of a GME affiliated group agreement with the closed hospital

Level Priority

- Same or contiguous core-based statistical area (CBSA)
- Same state
- Same region
- Section 5503 (“Distribution of Additional Residency Positions”)

Ranking Criteria

- Eight criteria
- Addresses why the hospital is requesting the increase in FTE cap(s) (assuming the closed hospital, affiliated hospital, took in residents, etc.)

Urban to Rural Reclassification

Changes to Urban to Rural Reclassification Rule: IME

Hospitals



- Main Campus
- 1 or More Remote Locations
- Provide Services and Bill Under IPPS
- Both Facilities Meet Provider-Based Criteria (42 CFR 413.65)

Clarifies that the **IME Cap Adjustment** will only be applicable to these teaching hospitals if both the main campus and remote location(s) are **BOTH** rural or reclassified as rural.

Inpatient Admission Requirements

Finalized Changes to Rule on Inpatient Admission Orders

Previously

- Inpatient admission orders required to be present in medical record for Part A payments.
- Technical discrepancies (*i.e.*, missing signature, signature timing) prevent payments despite medical necessity and reasonableness.

Finalized

- Revises 42 CFR 412.3(a) to remove language requiring physician order in the medical record as a condition of Medicare payment.
- Medical reviews to focus primarily on medical necessity and reasonableness.
- CMS claims intent was never to have payments denied for services that were, otherwise, medically necessary.
- A patient remains an inpatient after being formally admitted pursuant to an inpatient admission order but evidence of the order is not needed for Medicare payment for an inpatient stay.

Physician Certification of Claims

Finalized Revisions to Physician Certification for Claims

Current Language*

- Lists requirements for physician statements certifying and recertifying medical necessity.
- Specifies that when supporting info is available elsewhere, no need to repeat so long as *it indicates where it can be found.*
- Claims denied when location not specified, even when apparent to reviewer.



Finalized Change*

- Eliminates the language requiring the physician to state the precise location of the supporting information.
- Searchable EHR making current requirement obsolete.

***42 CFR 424.11**

Post-Acute Care Transfer

Final Post-Acute Care Transfer Policy: Hospice

Background

- Discharge from hospital to rehab hospital/unit, psych hospital/unit, SNF, or HHA.
- Prior to geometric mean length of stay.
- Payment based on one of two methodologies.
- BBA 2018 requires CMS to expand to early discharges to hospice.



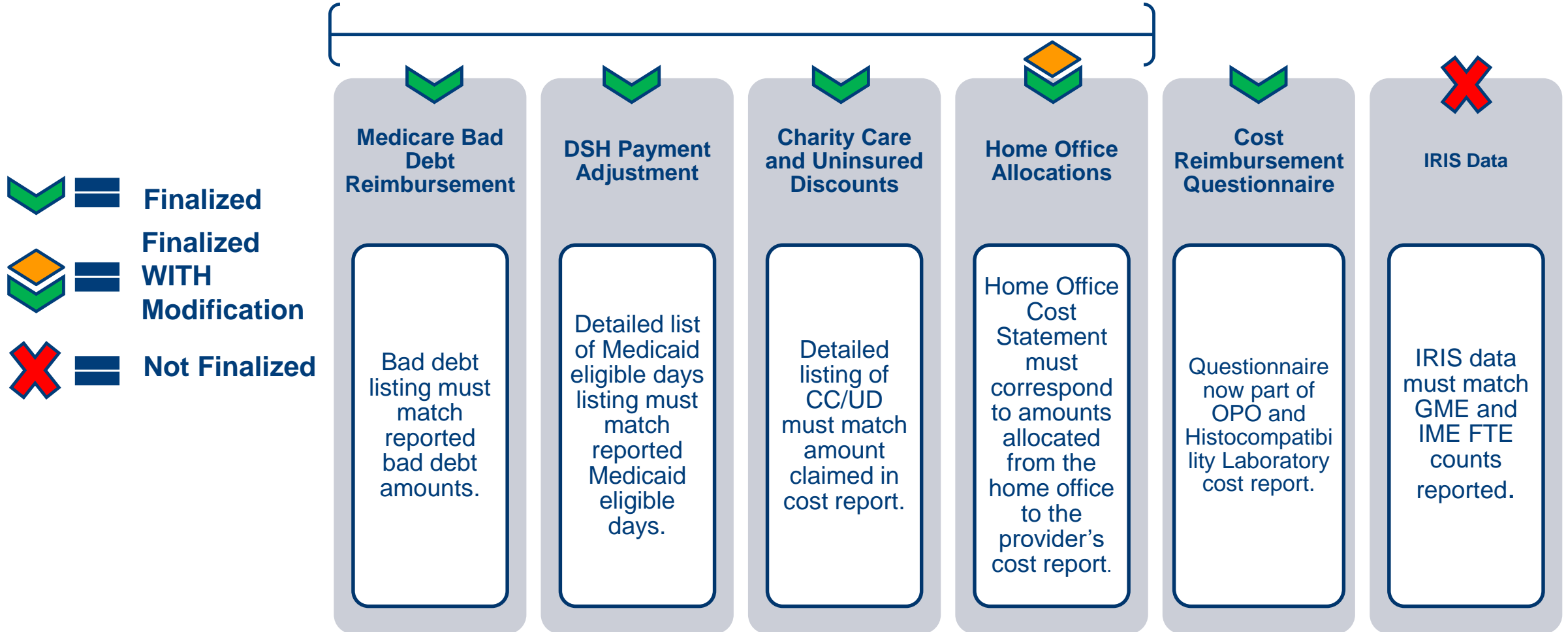
Expansion to Hospice

- Clarifies language from proposed rule.
- Patient Discharge Status codes 50 and 51 subject to the policy.
- Inpatient claims without discharge status codes 50 and 51 billed on the same day as the hospice **will be returned**. May be rebilled with corrected codes.
- Effective for discharges on or after October 1, 2018.

Cost Report Submissions

Finalized Revisions to Requirements for Cost Report Submission

Effective cost reporting periods beginning on/after October 1, 2018*



*Cost reports submitted without new documentation/submission requirements **will be rejected**

Chimeric Antigen Receptor T-Cell (CAR-T) Therapy

Chimeric Antigen Receptor (CAR) T-Cell Therapy

CD-19 directed T-cell immunotherapies – KYMRIATM and YESCARTATM

Assigned CAR T-cell therapy cases to MS-DRG 016

- ICD-10-PCS codes – *XW033C3 and XW043C3*

Finalized revision to MS-DRG 016

- Autologous Bone Marrow Transplant with CC/MCC ***or T-cell Immunotherapy***

Approved for new technology add-on payment

- Maximum NTAP for a case for FY 2019 = \$186,500

EXAMPLE: CAR T-Cell Therapy Payment

Standard IPPS payment (not wage index adjusted, no DSH, no uncompensated care, no IME) = \$36,944.41

- Standardized Amount = \$5,649.51
- MS-DRG 016 Relative Weight = 6.5394

New Technology Add-on Payment (NTAP) = Lesser of

- 50% of unreimbursed costs
- Maximum = \$186,500

Additional Outlier Payment = 80% of:

- Hospital Cost for the Case =
 - *(Hospital Charges for the Case x Cost-to-Charge Ratio) minus (IPPS standard payment + IME Payment + DSH Payment + Uncompensated Care Payment + NTAP) minus Outlier Threshold (\$25,769)*

Public Listing of Hospital Standard Charges

Finalized Hospital Price Transparency Requirements

- Requires hospitals to publicly list standard charges via the internet in machine readable format
- Information must be updated at least annually, more often as appropriate
- Effective January 1, 2019

Questions?

FY 2019 IPPS Final Rule References

- Payment Update (p. 41394 - 41396)
- Outlier Payments (p. 41717 - 41723)
- Disproportionate Share Hospital (DSH) Payments (p. 41401 - 41428)
- Direct Graduate Medical Education (DGME) Affiliation Agreements (p. 41492 – 41498) and Open Slots (p. 41498 - 41499)
- Urban to Rural Reclassification (p. 41369 - 41374)
- Inpatient Admission Requirements (p. 41506 - 41510)
- Physician Certification of Claims (p. 41688)
- Post-Acute Care Transfer Policy (p. 41390 - 41394)
- Cost Report Submission Requirements (p. 41677 - 41686)
- CAR-T Therapy: MS-DRG (p. 41172- 41174), New Technology (p. 41283 - 41299), Outlier (p. 41723)
- Public Reporting of Hospital Standard Charges (p. 41686 - 41688)

AAMC Contacts

Hospital Payment Policy

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