# 2021 Medicare Updates Inpatient and Outpatient Prospective Payment Systems

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# Linda Corley – VP of Compliance

**Linda Corley, MBA, CRCR, CPC,** has worked collaboratively with hospitals and physician offices for the past twenty-five years. She has served as Controller of a University-owned, four hospital group; and provided insight to clinical and financial staff members on compliant reimbursement. Linda is a credentialed coder and a frequent HFMA presenter. She is a previous college professor who taught financial processes for healthcare, health information management skills, and billing and collections courses. Linda also has over fifteen years' experience on the national level of leading CDM Reviews, Coding and Billing Audits, and providing Consulting Services for revenue cycle improvement. She has served as Corporate Compliance Officer for Perot Systems and for Dell Revenue Cycle Services.

Linda currently is Vice President of Compliance and Quality Assurance for Xtend Healthcare

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# Agenda:

- **IPPS Final Rule was released as September 2, 2020; and will become effective October 1, 2020 (for the Fiscal 2021 Year).**

- **See https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page**

Agency's key priorities = Strengthening Medicare
Fostering Innovation

- **OPPS Proposed Rule – Discussed herein; but awaiting the Final Rule.**

- **Further advances CMS commitment to strengthen Medicare and to reduce provider burden for operation with increased flexibility.**

- **Also – CMS "Seeking to increase choice and encourage site neutrality"**

- **See https://www.federalregister.gov/public-inspection**

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# 2021 Inpatient Prospective Payment System Rule

## Payment Estimates

- CMS estimates a $3.5 billion increase in FY21 payments (+2.7%) compared to the FY20 final rule.
- The increases are primarily driven by a $3.0 billion increase in FY21 operating payments, and
- a net increase of $506 million resulting from estimated changes in FY21 capital payments and new technology add-on payments.
- National Capital Rate: The final national capital rate for FY21 is $466.22.

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# 2021 Inpatient Prospective Payment System Rule

## Proposed Changes to Payment Rates under IPPS

- Increase in operating payment rates = 2.9%

- Market basket update of 2.4%
  - Unaffected by 0.0% productivity adjustment!
  - Increased by 0.5% required legislative adjustment.

**Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013 – currently suspended under PHE.**

**HOWEVER:**

- **Must successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program, and**

- **Must qualify as a meaningful electronic health record (EHR) user**

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# 2021 Inpatient Prospective Payment System Rule

- **Outlier Threshold:**
  - CMS is adopting an outlier threshold for FY 2021 of $29,051. (compared to the FY 2020 final threshold of $26,552).
  - CMS projects that the outlier threshold for FY 2021 will result in outlier payments equal to 5.11% of operating DRG payments and 5.363% of capital payments.
- **Hospital Value-Based Purchasing (HVBP) Program:**
  - The HVBP program is budget neutral, but will redistribute about $1.9 billion (2% of base operating MSDRG payments) based on hospitals' performance scores.

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# 2021 Inpatient Prospective Payment System Rule

- **New Technology Add-on Payments**
  - Estimating $874 million in 2021; nearly a 120% increase over 2020

- **24 New applications for new technology add-on payments.**
  - 3 submitted by applicants as new medical devices – part of FDA Breakthrough Devices Program
  - 6 submitted by applicants as products that received FDA Qualified Infectious Disease Product (QIDP) designation.
    - **CMS approved all 9 applications**
  - 15 traditional new technology applications

- **CMS continuing add-on payments for 10 of the 18 technologies currently receiving add-on payment**
  - 8 will no longer be within their “newness” period
  - Including Chimeric Antigen Receptor (CAR) T-cell therapies approved in 2019

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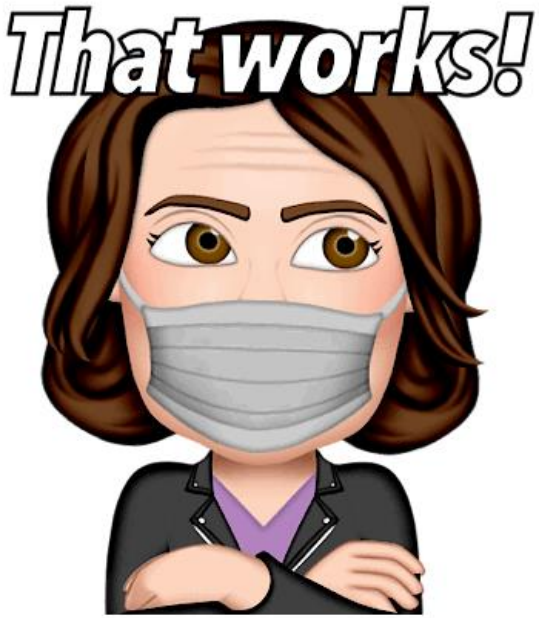
# 2021 Inpatient Prospective Payment System Rule

- Proposing to **expand payment for antimicrobial products (QIDPs)**
  - including products approved under FDA's Limited Pathway for Antibacterial and Antifungal Drugs (LPAD pathway).

- Also proposing to provide for conditional approval for antimicrobial products that meet the applicable criteria to receive the add-on payment, effective for discharges the quarter after the date of FDA marketing authorization instead of waiting until the next fiscal year.

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# 2021 Inpatient Prospective Payment System Rule

**New MS-DRG for Chimeric Antigen Receptor (CAR) T-cell Therapy (immunotherapy).**

- Creation of new MS-DRG specifically for these cases.
- The **ICD-10 procedure codes XW033C3 and XW043C3** are assigned to this new DRG, MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy).

- CMS conducted a review of data from existing instances of the utilization of CAR-T cell therapies to determine whether reimbursement under the currently used DRG was adequate and noting a "vast discrepancy" in resource consumption, **determined that a new MS-DRG code was warranted.**

- The standardized charge per case for this MS-DRG is $913,224.
- The payment for this DRG would be adjusted for each individual hospital based on a variety of factors (as all DRGs are).
- **Increased payment for 2021** as well as providing payment flexibility for the future as new CAR T-cell therapies become available.

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# 2021 Inpatient Prospective Payment System Rule

**Other Payment Adjustments under the IPPS Final Rule:**

**Up to 6% lost cash receipts due to Penalties!**

- **Penalties for excess readmissions**, which reflect an adjustment to a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid.
  - Six claims-based outcomes measure;
  - **penalty of up to 3%.**

- **Penalty** (1 percent) for worst-performing quartile under the **Hospital-Acquired Condition Reduction Program (HACs based on POAs).**

- Upward and downward adjustments under the **Hospital Value-Based Purchasing Program, penalty of up to 2%.**


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# 2021 Inpatient Prospective Payment System Rule

## Medicare Uncompensated Care Payments

- **Payments to Medicare disproportionate share hospitals based on their relative share of uncompensated care nationally.**

- **The Office of the Chief Actuary** has updated its projection of the rate of uninsurance for purposes of calculating the final Factor 2 for FY 2021 given the unprecedent impact of the COVID-19 PHE and more recent available data regarding levels of uninsurance.

- **Based on these data, CMS updates its rate of uninsurance to 10.3% for FY 2020 and 10.2% for FY 2021 (up from 9.5% used in the proposed rule for both years).**
  - This results in an uncompensated care amount for FY 2021 that is closer to FY 2020 levels than the proposed rule estimate.

- **CMS now projects that the amount available to distribute as payments for uncompensated care for FY 2021 would decrease by approximately $60.5 million, as compared with its estimate of the uncompensated care payments that will be distributed in FY 2020.**

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# 2021 Inpatient Prospective Payment System Rule

## Medicare Uncompensated Care Payments

- As required under law**, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured people.**

- CMS estimates distributing roughly $15.7 billion in uncompensated care payments in FY 2021, a decrease of approximately 8.5% from FY 2020.

- For FY 2021, we (CMS) **will use a single year of data on uncompensated care costs from Worksheet S-10 of the FY 2017 cost report** to distribute these funds, in part because we have conducted audits of this data.

- CMS finalized for all eligible hospitals to use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments for all subsequent fiscal years.

- We (CMS) expect there to be an increasing number of hospitals audited for Worksheet S-10 with future cost reporting years; and we (CMS) have confidence the best available data in future years will be the Worksheet S-10 data.

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# 2021 Inpatient Prospective Payment System Rule

## Graduate Medical Education Policy

- CMS is proposing policy changes related to closing teaching hospitals and closing residency programs to address the needs of residents attempting to find alternative hospitals in which to complete their training and to foster seamless Medicare indirect medical education and direct graduate medical education funding.

- This proposal would **expand the existing definition of who is considered a displaced resident** (beyond residents who are physically present at the hospital training on the day prior to or the day of hospital or program closure).

- These proposed policies would provide greater flexibility for the residents to transfer while the hospital operations or residency programs were winding down, and would allow funding to be transferred for certain residents who are not physically at the closing hospital/closing program.

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# 2021 Inpatient Prospective Payment System Rule

## Price Transparency

- CMS proposes that hospitals would report certain market-based payment rate information on their Medicare cost report for periods ending on or after Jan. 1, 2021.

- This information would be used in the new methodology for calculating MS-DRG relative weights.

- **CMS proposes that hospitals would report on the Medicare cost report the following data elements:**
  - the median payer-specific negotiated charge by MS-DRG that the hospital has negotiated with all of its MA payers
  - the median payer-specific negotiated charge by MS-DRG that the hospital has negotiated with all of its third-party payers, which would include MA organizations

- The data would become publicly accessible in the Healthcare Cost Report Information System (HCRIS) dataset in a de-identified manner.

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# 2021 Inpatient Prospective Payment System Rule

## Price Transparency

- Beginning in FY 2024, CMS will use the median payer-specific negotiated charge information for MA plans, collected on the cost report, **to calculate MSDRG relative weights.**

- CMS not finalizing a transition period in the rule for the new MS-DRG weights based on median MA rates.

    - May reconsider the need for a transition period in a future rule.

- CMS will continue to produce a charge-based weight schedule for “several years” after it moves to market-based weights for MS-DRG payment

- Requirement that hospitals also report their median third-party payer rates in cost reports filed on or after January 1, 2021,  not finalized.

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# 2021 Inpatient Prospective Payment System Rule

**Hospital-Acquired Condition (HAC) Reduction Program**

- **By law, the penalty applies to 25% of all hospitals or 777 of 3,111 non-Maryland hospitals with a HAC score. The reductions in payment is not budget neutral!**

- **The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to reduce payment by one percent for applicable hospitals, which are**
  - hospitals that rank in the worst-performing quartile on select measures of hospital-acquired conditions.

- **In the FY 2021 IPPS/LTCH PPS Final Rule, CMS approved the following:**
  - Automatically adopt applicable periods (i.e., performance periods for measures used in the Program) beginning with the FY 2023 program year and all subsequent program years, and
  - update the definition of *applicable period* at 42 CFR 412.170.
  - Refine validation procedures used by the Program in order to align with the Hospital IQR Program's validation procedures, which happen concurrently.

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# 2021 Inpatient Prospective Payment System Rule

## Hospital Readmissions Reduction Program (HRRP)

- **The HRRP reduces payments to hospitals with excess readmissions, and includes six claims-based outcomes measures.**
- **The HRRP will reduce FY 2021 payments to an estimated 2,545 hospitals or 85% of all hospitals. CMS estimates the program will save approximately $553 million in FY21.**
- **The 21st Century Cures Act directs CMS to assess payment reductions based on a hospital's performance relative to other hospitals with a similar proportion of patients dually eligible for Medicare and full-benefit Medicaid.**
- **No changes are made to the HRRP measures for 2021, the methodology for calculating the payment adjustment, or other program features.**

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# 2021 Inpatient Prospective Payment System Rule

## Hospital Inpatient Quality Reporting (IQR) Program

- **The Program is a "pay-for-reporting" quality program that reduces payment to hospitals that fail to meet program requirements.**

- **For FY 2021, CMS is proposing changes to reporting and public reporting of electronic clinical quality measures (eCQMs) and the current validation process.**

- **Specifically, the rule proposes to make changes to the hospital reporting of eCQMs including**
  - Progressively increasing the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three-year period,
    - by requiring hospitals to report two quarters of data for the CY 2021 reporting period/FY 2023 payment determination,
    - three quarters of data for the CY 2022 reporting period/FY 2024 payment determination, and
    - four quarters of data beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years.

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# 2021 Inpatient Prospective Payment System Rule

## Hospital Inpatient Quality Reporting (IQR) Program

- **Beginning the public display of eCQM data on the *Hospital Compare* website and/or data.medicare.gov, beginning with data reported by hospitals for the CY 2021 reporting period/FY 2023 payment determination and for subsequent years that would be included with the fall 2022 refresh of the website.**

- **Make changes to the Hospital IQR Program validation process including:**

    - **For chart abstracted measure validation, requiring the use of electronic file submissions via a CMS-approved secure file transmission process and no longer allowing the submission of paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive.**

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# 2021 Inpatient Prospective Payment System Rule

## Hospital Inpatient Quality Reporting (IQR) Program

- **Make changes to the Hospital IQR Program validation process including:**
  - **Reducing the number of hospitals selected for validation from up to 800 to up to 400 hospitals.**
  - **Combining the validation processes for chart-abstracted measures and eCQMs by aligning:**
    (a) data submission quarters;
    (b) hospital selection; and
    (c) scoring processes by providing one combined validation score for the validation of chart-abstracted measures and eCQMs with the eCQM portion of the combined score weighted at zero.
  - **Formalizing the process for conducting educational reviews for eCQM validation in alignment with current processes for providing feedback for chart-abstracted validation results.**

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# 2021 Inpatient Prospective Payment System Rule

## Hospital Inpatient Quality Reporting (IQR) Program

**• The rule finalizes changes to the hospital reporting of eCQMs, including progressively increasing the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three-year period:**

- For FY23 payment (CY21 reporting) hospitals must report data for 2 self-selected calendar quarters;
- For FY24 payment (CY22 reporting) hospitals must report data for 3 self-selected calendar quarters;
- For FY 2025 payment (CY23 reporting) and subsequent years, hospitals must report data for all 4 calendar quarters.

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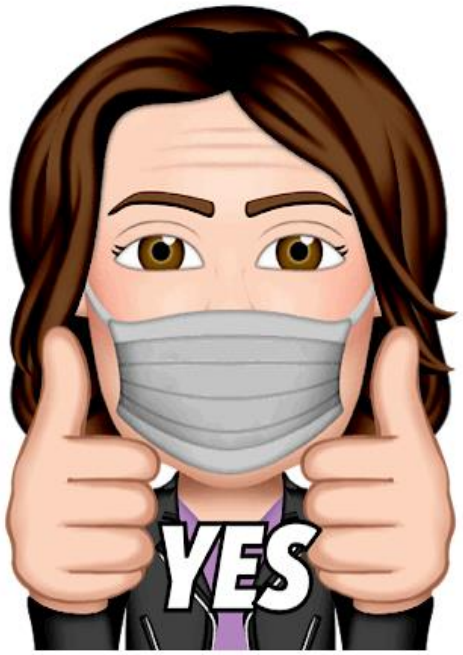
# 2021 Inpatient Prospective Payment System Rule

## Hospital Value-Based Purchasing (VBP) Program

- **The Hospital VBP Program adjusts payments to hospitals under the IPPS for inpatient services based on their performance.**
- **CMS is providing estimated and newly established performance standards for certain measures for the FY 2023, FY 2024, FY 2025, and FY 2026 program years.**
- **CMS did not propose to add new measures or remove measures from the Hospital VBP Program in this 2021 Final Rule.**

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# 2021 Inpatient Prospective Payment System Rule

## PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

- **The PCHQR Program collects and publishes data on an announced set of quality measures.**

- **CMS is proposing to:**
  - Refine two existing National Healthcare Safety Network (NHSN) measures:
    - Catheter-Associated Urinary Tract Infection (CAUTI) and
    - Central Line-Associated Bloodstream Infection (CLABSI),
    - to incorporate an updated methodology developed by the Centers for Disease Control and Prevention that uses updated HAI baseline data that is risk-adjusted to stratify results by patient location.
  - Begin to publicly report the updated versions of the CLABSI and CAUTI measures in fall CY 2022.

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# 2021 Inpatient Prospective Payment System Rule

## Medicare and Medicaid Promoting Interoperability Programs

- **In 2011, the EHR Incentive Programs were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT).**

- **Below are our proposals for CY 2021 and later years, on which we are seeking public comment.**

  - We (CMS) are proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and CAHs).

  - We (CMS) are proposing to continue the Query of PDMP measure as an optional measure worth five bonus points in CY 2021.

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# Changing to 2021 Updates for

**The Outpatient Prospective Payment System**

**Paid under Ambulatory Payment Classifications**


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# 2021 Outpatient Prospective Payment System Rule

## Proposed Elimination of the Inpatient Only List

- **We (CMS) proposes to eliminate the Inpatient Only (IPO) list over a three-year transitional period with the list completely phased out by CY 2024.**

- **We propose to begin with the removal of nearly 300 musculoskeletal-related services,**

  - which would make these procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate;

  - in addition to the existing ability for payment in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician.

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# 2021 Outpatient Prospective Payment System Rule

## Proposed Elimination of the Inpatient Only List

- **We also solicit comment on several related issues including**
  - whether three years is an appropriate time frame for transitioning to eliminate the IPO list,
  - whether there are other services that are candidates for removal from the IPO list for CY 2021, and
  - how we should sequence the removal of additional clinical families and/or specific services from the IPO list in future rulemaking.

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# 2021 Outpatient Prospective Payment System Rule

## Proposed Elimination of the Inpatient Only List

- **Additionally, procedures removed from the IPO list will eventually become subject to the 2-midnight rule.**
- **In the CY 2020 OPPS/ASC final rule, CMS finalized a two-year exemption from certain medical review activities related to the 2-midnight rule for procedures newly removed from the IPO list.**
- **In this rule, we propose to continue the two-year exemption from certain medical review activities relating to patient status for procedures removed from the IPO list beginning in CY 2020 and subsequent years.**
- **We solicit comment on whether the 2-year period is appropriate, or whether a longer or shorter exemption period would be more appropriate.**

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# 2021 Outpatient Prospective Payment System Rule

## Payment Methodology for 340B Purchased Drugs

- **Section 340B of the Public Health Service Act (340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices.**

- **In the CY 2018 OPPS/ASC final rule, CMS reexamined the appropriateness of the prior Average Sale Price (ASP) plus 6 percent payment methodology for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts.**

- **Beginning January 1, 2018, Medicare adopted a policy to pay an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals acquired through the 340B Program that had been subject to ongoing litigation and was upheld by the D.C Circuit Court on July 31, 2020.**

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# 2021 Outpatient Prospective Payment System Rule

## Payment Methodology for 340B Purchased Drugs

- **In this rule, we are proposing to adopt a rate of ASP-34.7 percent with a 6 percent add-on amount for overhead and handling costs for a net proposed rate of ASP-28.7 percent for separately payable drugs or biologicals that are acquired through the 340B Program.**

- **We also solicit comment on an alternative proposal of continuing the current Medicare payment policy of paying ASP-22.5 percent for 340B-acquired drugs for CY 2021 and subsequent years.**

- **This proposed rate is based on the results of a 340B hospital survey of drug acquisition cost administered earlier this year.**

- **Additionally, we are proposing that rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals be excepted from either of the proposed 340B payment policies and that these hospitals would continue to report informational modifier "TB" for 340B-acquired drugs, and continue to be paid ASP+6 percent.**

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# 2021 Outpatient Prospective Payment System Rule

## Updates to OPPS Payment Rates

- **In accordance with Medicare law, CMS proposes to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent.**

- **This proposed update is based on**

  - the projected hospital market basket increase of 3 percent

  - minus a 0.4 percentage point adjustment for multi-factor productivity (MFP).

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# 2021 Outpatient Prospective Payment System Rule

## Partial Hospitalization Program (PHP) Rate Setting

- **The CY 2021 OPPS/ASC proposed rule would update Medicare payment rates for Partial Hospitalization Program (PHP) services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs).**
- **The PHP is a structured intensive outpatient program consisting of a group of mental health services paid on a per diem basis under the OPPS, based on PHP per diem costs.**
- **CMS is proposing to maintain the unified rate structure established in CY 2017, with a single PHP Ambulatory Payment Classification (APC) for each provider type for days with three or more services per day.**
- **Accordingly, CMS is proposing to calculate the CY 2021 PHP APC per diem rate for HB PHPs based on updated cost data and to calculate the rate for CMHCs based on the proposed cost floor.**

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# 2021 Outpatient Prospective Payment System Rule

## Lab Testing – Cancer related protein-based MAAAs

- **The CY 2021 OPPS proposed rule would exclude cancer-related protein-based MAAAs, which are not generally performed in the hospital outpatient department setting, from the OPPS packaging policy.**

- **CMS will revise the Laboratory DOS policy to add these tests to the Laboratory DOS provisions at § 414.510(b)(5).**

- **These proposals, if finalized, would require laboratories performing cancer-related protein-based MAAAs that meet the DOS requirements at § 414.510(b)(5), to bill Medicare directly for those tests instead of seeking payment from the hospital.**

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# 2021 Outpatient Prospective Payment System Rule

## Physician E&M Visit Codes – Definition Changes

- **Elimination of history and physical as elements for code selection**
  - While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level.

- **Allows providers to choose whether documentation is based on Medical Decision Making (MDM) or Total Time.**
  - The definition of time is minimum time, not typical time
  - Represents total physician/qualified health care professional (QHP) time spent on date of service
  - The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination
  - Does not need to be counseling time
  - Apply when code selection is primarily based on time and not MDM

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# Time: Office and Other Outpatient E/M Services

## New Patient (Total Time on the Date of the Encounter)

| New Patient E/M Code | Typical Time (2020) | Total Time (2021) |
|---|---|---|
| 99201 | 10 minutes | Code deleted |
| 99202 | 20 minutes | 15-29 minutes |
| 99203 | 30 minutes | 30-44 minutes |
| 99204 | 45 minutes | 45-59 minutes |
| 99205 | 60 minutes | 60-74 minutes |

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# Time: Office and other Outpatient E/M Services

## Established Patient (Total Time on the Date of the Encounter)

| Established Patient E/M Code | Typical Time (2020) | Total Time (2021) |
|---|---|---|
| 99211 | 5 minutes | Time component removed |
| 99212 | 10 minutes | 10-19 minutes |
| 99213 | 15 minutes | 20-29 minutes |
| 99214 | 25 minutes | 30-39 minutes |
| 99215 | 40 minutes | 40-54 minutes |

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# 2021 Outpatient Prospective Payment System Rule

## Physician E&M Visit Codes – Definition Changes

- **Modifications to the criteria for Medical Decision Making (MDM)**
  - Revised Table of Risk
- **Providers may choose to document and choose the level of service for office or outpatient E/M codes based on MDM.**
- **Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.**
- **Defined by three elements:**
  - Number and complexity of problems addressed during the encounter
  - Amount and/or complexity of data reviewed and analyzed
  - Risk of complications, morbidity, and/or mortality of decisions made at the visit, associated with the patient's problems, the diagnostic procedures, treatments
- **Four types: straightforward, low, moderate, and high**

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# Comparison of CY 2020 Work RVU to CY 2021

| HCPCS Code | Current Total Time (mins) | Current Work RVU | CY 2021 Total Time (mins) | CY 2021 Work RVU |
|---|---|---|---|---|
| 99201 | 17 | 0.48 | N/A | N/A |
| 99202 | 22 | 0.93 | 22 | 0.93 |
| 99203 | 29 | 1.42 | **40** | 1.6 |
| 99204 | 45 | 2.43 | **60** | 2.6 |
| 99205 | 67 | 3.17 | **85** | 3.5 |
| 99211 | 7 | 0.18 | 7 | 0.18 |
| 99212 | 16 | 0.48 | 18 | 0.7 |
| 99213 | 23 | 0.97 | 30 | 1.3 |
| 99214 | 40 | 1.5 | 49 | 1.92 |
| 99215 | 55 | 2.11 | **70** | 2.8 |
| 99417 | N/A | N/A | 15 | 0.61 |

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# 2021 Medicare Updates – IPPS and OPPS


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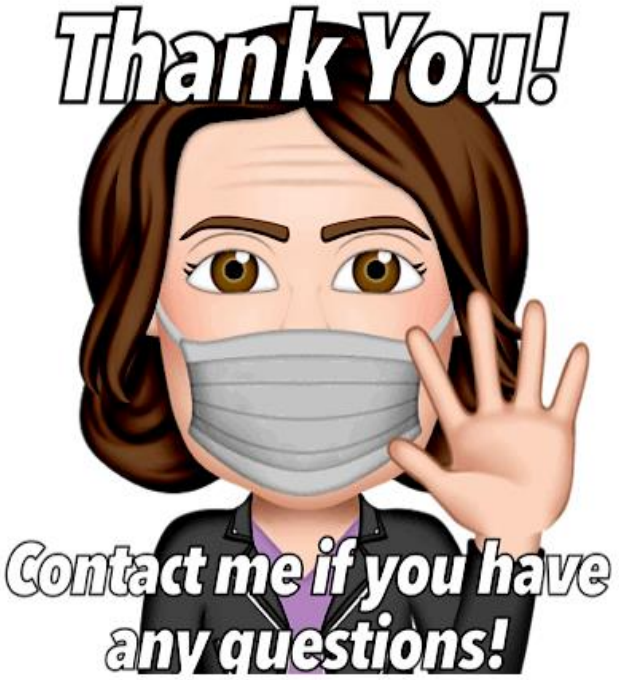


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