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Executive Summary: Key Financial and Operational Impacts from the Proposed FY21 Inpatient Prospective Payment System Rule

The 2021 IPPS (Inpatient Prospective Payment System) Proposed Rule was made available on May 11, 2021. CMS estimates that the total impact of all policy changes will increase overall payments to IPPS hospitals by approximately 1.6%,[1] or $2.7 billion, in FY21. This summary provides an overview of major provisions. A detailed summary of the rule will be available on the HFMA Regulatory Summary Page shortly.

1) **Base Operating Rate**: The proposed increase in operating payment rates for hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 3.1%. This reflects the projected hospital market basket update of 3.0% reduced by a 0.4 percentage point productivity adjustment. This also reflects a proposed +0.5 percentage point adjustment required by legislation. The table below provides standardized operating amounts based on the various wage index and program participation scenarios.

FY21 Proposed Rule Tables 1a-1c[2]

	Standardized Operating Amounts Wage Index > 1		**Standardized Operating Amounts Wage Index < 1**	
	Labor	Nonlabor	Labor	Nonlabor
Submitted Quality Data and Is a Meaningful User	$4,084.16	$1,895.58	$3,707.44	$2,272.30
Did Not Submit Quality Data and Is a Meaningful User	$4,054.31	$1,881.72	$3,626.14	$2,222.47
Submitted Quality Data and Is Not a Meaningful User	$3,994.60	$1,854.01	$3,626.14	$2,222.47
Did Not Submit Quality Data and Is Not a Meaningful User	$3,964.74	$1,840.15	$3,599.03	$2,205.86
Puerto Rico	N/A	N/A	$3,707.44	$2,272.30

[1] 3.1% operating payment update for hospitals that report IQR data and "meaningful users." This includes a market basket update of 3.0% reduced by a 0.4 percentage point productivity adjustment. This also reflects a proposed +0.5 percentage point documentation and coding adjustment required by legislation. Changes to payment policy including changes to uncompensated care disproportionate share hospitals, bad debt, new technology add on, and capital payments will result in an overall IPPS increase of approximately 1.6%, on average.

[2] Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013.

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2) **National Capital Rate**: The proposed national capital rate for FY21 is $468.36.

3) **Documentation and Coding**: CMS continues a six-year add-back related to prior year documentation and coding reductions by increasing operating payments by .5% for FY21. Absent changes in legislation, this increase will continue annually through FY23.

4) **Wage Index:** For FY21, CMS proposes to continue the low wage index hospital policy finalized in FY20. This policy will continue to be applied in a budget-neutral manner by proposing an adjustment to the standardized amounts. CMS states this is the second year (of at least four years) that this policy will be in effect to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. For details on the FY20 Final Rule wage index policy, please see HFMA's detailed summary available here.

5) **Disproportionate Share Hospitals (DSH)**: CMS projects that the amount available to distribute as payments for uncompensated care for FY21 would decrease by approximately $534 million, as compared with its estimate of the uncompensated care payments that will be distributed in FY20. This is driven by a significantly lower estimate of DSH expenditures to calculate Factor 1 than has been projected in prior years.

   The proposed projected 2021 DSH spending ($15.359B) is approximately 7% lower than 2020 DSH spending ($16.583) in the prior year's final rule. Additionally, CMS's estimates of Factor 2 used to calculate the pool of dollars to be distributed to eligible hospitals appears to have been calculated prior to the COVID-19 pandemic and resulting economic downturn. The proposed rule estimates that for FY20 and FY21, the uninsured rate will be 9.5%.

   Similar to the 2020 final rule, CMS again proposes to use a single year of uncompensated care data from worksheet S-10 off the FY17 cost report for most hospitals. This vintage of data was selected by CMS because it has been subject to audits. CMS proposes to continue to use data regarding low-income insured days (Medicaid days for FY13 and FY18 Supplemental Security Income days) to determine the amount of uncompensated care payments for Puerto Rico hospitals and Indian Health Service and Tribal hospitals for one more year (FY21), similar to the FY20 methodology.

   For FY21, CMS is proposing that after the publication of the FY21 IPPS/Long-Term Care Hospitals (LTCH) PPS final rule, hospitals would have 15 business days from the date of public display of the FY21 IPPS/LTCH PPS final rule to review and submit comments on the accuracy of the uncompensated care (UC) DSH table and supplemental data file published in conjunction with the final rule.

6) **Outlier Threshold**: The proposed fixed loss outlier threshold increases to $30,006 (compared to the FY20 final threshold of $26,473), which will decrease outlier payments.

7) **Bad Debt**: CMS attempts to clarify existing bad debt policies. Among other issues the rule proposes to define the following:

- **Non-Indigent Beneficiary**: A non-indigent beneficiary is one who has not been determined to be categorically or medically needy by a state Medicaid Agency to receive medical assistance from Medicaid, and has not been determined to be indigent by the provider for Medicare bad debt purposes. CMS reaffirms that the provider's required collection efforts set forth in Provider Reimbursement Manual section 310 apply only to non-indigent beneficiaries.

- **Issuance of a Bill:** Bills must be issued to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after: (1) the date of the Medicare remittance advice; or (2) the date of the remittance advice from the beneficiary's secondary payer, if any; whichever is latest.

- **120-Day Collection Effort:** When the provider receives a partial payment within the minimum 120-day required collection period, the provider must continue the collection effort and the day the partial payment is received is day one of the new collection period. For each subsequent partial payment received during a 120-day collection effort period, the provider must continue the collection effort and the day the subsequent partial payment is received is day one of the new collection period.

- **Similar Collection Effort:** A provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. A provider's dissimilar debt collection practices for Medicare and non-Medicare patient accounts do not constitute a reasonable collection effort to claim reimbursement from Medicare for a bad debt. This standard applies regardless of whether the effort is made by the provider "in-house" or by a collection agency on behalf of the provider.

- **Reasonable Collection Effort, Beneficiaries Determined Indigent by Provider Using Required Criteria:** A provider must apply its customary methods for determining whether the beneficiary is indigent under the following requirements:
  1) The beneficiary's indigence must be determined by the provider; a beneficiary's signed declaration of indigence is not sufficient.
  2) The provider must take into account a beneficiary's total resources which includes, but is not limited to, an analysis of assets (only those convertible to cash and unnecessary for the beneficiary's daily living), liabilities, and income and expenses.
  3) The provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill.

- **Reasonable Collection Effort, Dual Eligible Beneficiaries and the Medicaid Remittance Advice:** The provider must submit a bill to the state Medicaid program to determine the state's cost-sharing obligation to pay all, or a portion of, the applicable Medicare deductible and coinsurance. The provider must then submit to its contractor a Medicaid remit reflecting the state's payment decision. Any amount that the state is obligated to pay, either by statute or

under the terms of its approved Medicaid state plan, will not be included as an allowable Medicare bad debt, regardless of whether the state actually pays its obligated amount to the provider.

8) **MS-DRG Weight Setting/Negotiated Charge Reporting:** CMS proposes that hospitals report certain market-based payment rate information on their Medicare cost report for cost reporting periods ending on or after January 1, 2021. As part of the proposed rule, CMS included a request for comment on a potential change to the methodology for calculating the IPPS MS-DRG relative weights that would use the information collected to reflect relative market-based pricing. If CMS ultimately proposes and finalizes this policy in a future rule, the change would be effective in 2024.

   The rule specifically proposes the following be reported on hospital Medicare cost reports:

   (1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations payers, by MS-DRG.

   (2) The median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS-DRG.

   The payer-specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be cross-walked to an MS-DRG.

   In the rule, CMS seeks comment on a potential change to the methodology for calculating the IPPS MS-DRG relative weights to incorporate this market-based rate information. Beginning in FY24, CMS is considering a methodology that utilizes the proposed median payer-specific negotiated charge information for Medicare Advantage Plans, collected on the cost report, to calculate MS-DRG relative weights.

9) **New MS-DRG for Chimeric Antigen Receptor (CAR) T-cell Therapy:** CMS is proposing to create a new MS-DRG specifically for cases involving CAR T-cell therapies. The new payment group would help to predictably compensate hospitals for their costs in delivering necessary care to Medicare beneficiaries and provide payment flexibility for the future as new CAR T-cell therapies become available.

10) **Post-Acute Care Transfer Policy and Special Payment Policy:** Based on new MS-DRGs and changes to existing MS-DRGs, the proposed rule adds MS-DRGs to the list of those subject to the Post-Acute Care (PAC) Transfer and/or Special Payment Policy. Appendix I includes proposed additions to the special payment policy list. Appendix II includes proposed additions to the PAC transfer policy list.

The proposed PAC transfer and special payment policy status of these MS-DRGs is reflected in Table 5 associated with this proposed rule, which is listed in section VI of the Addendum to the proposed rule and available on the CMS website.

11) **Indirect Medical Education (IME) Adjustment Factor:** For discharges occurring during FY21, the formula multiplier is 1.35. This is the same as prior years going back to FY08.

12) **Policy Change Related to Medical Residents Affected by Residency Program or Teaching Hospital Closure:** The rule proposes to change two aspects of the current Medicare policy. First, rather than link the Medicare temporary funding for the affected residents to the day prior to, or the day of, program or hospital closure, CMS proposes that the key day would be the day the closure was publicly announced. Second, by removing the link between Medicare temporary funding for the residents, and the day prior to, or the day of, program or hospital closure, CMS proposes to also allow funding to be transferred temporarily for residents who are not physically at the closing hospital/ closing program, but had intended to train at (or return to training at, in the case of residents on rotation) the closing hospital/closing program.

    To apply for the temporary increase in the Medicare resident cap, the receiving hospital would have to submit a letter to its Medicare Administrative Contractor within 60 days of beginning the training of the displaced residents. The maximum number of FTE resident cap slots that could be transferred to all receiving hospitals is the number of IME and direct graduate medical education FTE resident cap slots belonging to the hospital that has the closed program, or that is closing. Therefore, if the originating hospital is training residents in excess of its caps, there is no guarantee that a cap slot will be transferred along with a displaced resident.

13) **Hospital Readmissions Reduction Penalty (HRRP)**: Hospitals with higher-than-expected risk adjusted readmissions rates over a three-year period for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective knee/hip replacement and coronary artery bypass grafting will be subject to a maximum 3% penalty. CMS does not provide an estimate of hospital payment reductions in FY21 as a result of the HRRP in the proposed rule.

14) **Value Based Purchasing (VBP) Program**: The estimated amount of base operating MS-DRG payment amount reductions for the FY21 program year and, therefore, the estimated amount available for value-based incentive payments for FY21 discharges is approximately $1.9 billion. All hospitals will be subject to a 2% reduction in base operating DRG payments.

    CMS is providing estimated and newly established performance standards for certain measures for the FY23, FY24, FY25 and FY26 program years. CMS is not proposing to add new measures or remove measures from the Hospital VBP Program in the proposed rule.

15) **Inpatient Quality Reporting (IQR) Program:** The rule proposes to make changes to the hospital reporting of electronic clinical quality measures (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 CY21

reporting period/FY23 payment determination, three quarters of data for the CY22 reporting period/FY24 payment determination, and four quarters of data beginning with the CY23 reporting period/FY25 payment determination and for subsequent years.

Beginning the public display of eCQM data on the *Hospital Compare* website (or its successor website) and/or data.medicare.gov, beginning with data reported by hospitals for the CY21 reporting period/FY23 payment determination and for subsequent years that would be included with the fall 2022 refresh of the website.

The rule also makes changes to the validation process. Among other changes, the rule proposes to reduce the number of hospitals selected for validation from a maximum of 800 to a maximum of 400 hospitals.

16) **Promoting Interoperability**: For 2021 and beyond, CMS proposes an electronic health record (EHR) reporting period of a minimum of any continuous 90-day period in CY22 for new and returning participants (eligible hospitals and critical access hospitals) in the Medicare Promoting Interoperability Program attesting to CMS.

    To better align the Promoting Interoperability Program with the Hospital IQR Program, the rule proposes to align eCQM reporting periods and publicly report eCQM data on the *Hospital Compare* website, as described above.

    The rule would continue the "Query of Prescription Drug Monitoring Program" measure as an optional measure worth 5 bonus points in CY21. And CMS is proposing to rename the "Support Electronic Referral Loops by Receiving and Incorporating Health Information" measure. The proposed name would read: "Support Electronic Referral Loops by Receiving and Reconciling Health Information" measure.

17) **Long-Term Care Hospital (LTCH) PPS Standard Federal Rate:** The proposed rule increases the standard federal rate by 2.5% to $43,849.28 for LTCHs that submit quality data. The reduced rate, for those that don't submit quality data is $42,993.68 (.5% increase).

    LTCH PPS payments for cases that will complete the statutory transition to the lower payment rates under the dual rate system are expected to decrease by approximately 20%. This accounts for the LTCH site-neutral payment rate cases that will no longer be paid a blended payment rate with the end of the statutory transition period, which represent approximately 25% of all LTCH cases and 10% of all LTCH PPS payments.

    CMS expects LTCH PPS payments to decrease by approximately 0.9%, or $36 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system.

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Appendix I: List of Proposed New or Revised MS-DRGs Subject to Review of Post-Acute Care Transfer Policy Status for 2021

Proposed New or Revised MS-DRGs	MS-DRG Title
16	Autologous Bone Marrow Transplant with CC/MCC
18	Chimeric Antigen Receptor (CAR) T-cell Immunotherapy
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis
140	Major Head and NeckProcedures with MCC
141	MajorHead and Neck Procedures with CC
142	Major Head and Neck Procedures without CC/MCC
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC
144	Other Ear, Nose, Mouth and Throat O.R. Procedures with CC
145	Other Ear, Nose, Mouth and Throat O.R. Procedures without CC/MCC
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC
650	Kidney Transplant with Hemodialysis with MCC
651	Kidney Transplant with Hemodialysis without MCC
652	Kidney Transplant

Appendix II: List of Proposed New or Revised MS-DRGs Subject to Review of Special Payment Policy Status for FY21

Proposed New or Revised MS-DRGs	MS-DRG Title
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC