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CMS RELEASES FINAL FY 2021 MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) REGULATIONS

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Contents

At A Glance

COVID-19 has challenged the financial outlook for many healthcare organizations. As leaders look ahead to FY 2021, they'll undoubtedly face challenges as they prepare to return to full patient capacity under new, more stringent protocols. In addition to navigating the difficulties of operating on relief funding to mitigate shrinking margins, in order to successfully steer their companies through the remainder of the pandemic, organizations will also need to turn their attention to changing Medicare policies and updated payment rates, given the effects they will have on margins.

Each year the Centers for Medicare & Medicaid Services (CMS) publishes the proposed and then final rules for the Inpatient Prospective Payment System (IPPS), updating Medicare payment regulations and rates. The final rule for FY 2021 was released on September 2, 2020. Highlights include:

- **Increase in IPPS payments** for FY 2021 is estimated to be $3.5 billion
- **Uncompensated care payments** are estimated to decrease by $60 million
- In an effort to bolster price transparency, changes have been made to **Medicare cost report data requirements**
- Changes to Medicare bad debt policy to codify long standing policies to attempt to decrease **Medicare bad debt appeals**
- Policy to **decrease disparities between low income wage index and high-income wage index hospitals** to be continued
- Change to the pay for reporting **Hospital Inpatient Quality Reporting program** to use electronic filing submission of this Data

Finalized Rates

Below is a table showing the rate increases for FY 2021 based on four scenarios on whether the provider submits quality data and is a meaningful user of Electronic Health Records (EHR).

TABLE 1

FY 2021	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	2.4	2.4	2.4	2.4
Adjustment for Failure to Submit Quality Data per ACA	–	–	(0.60)	(0.60)
Adjustment for Failure to be a Meaningful EHR user per ACA	–	(1.80)	–	(1.80)
MFP Adjustment under Section per ACA	–	–	–	–
Applicable Percentage Increase to Standardized Amount	2.4	0.6	1.80	0.00
Documentation and Coding Adjustment – American Tax Payer Relief Act of 2012 (Section 414 of the Medicare Access and Chip Reauthorization Act of 2015)	0.5	0.5	0.5	0.5
Increase in Operating Rates	2.9	1.1	2.30	0.5

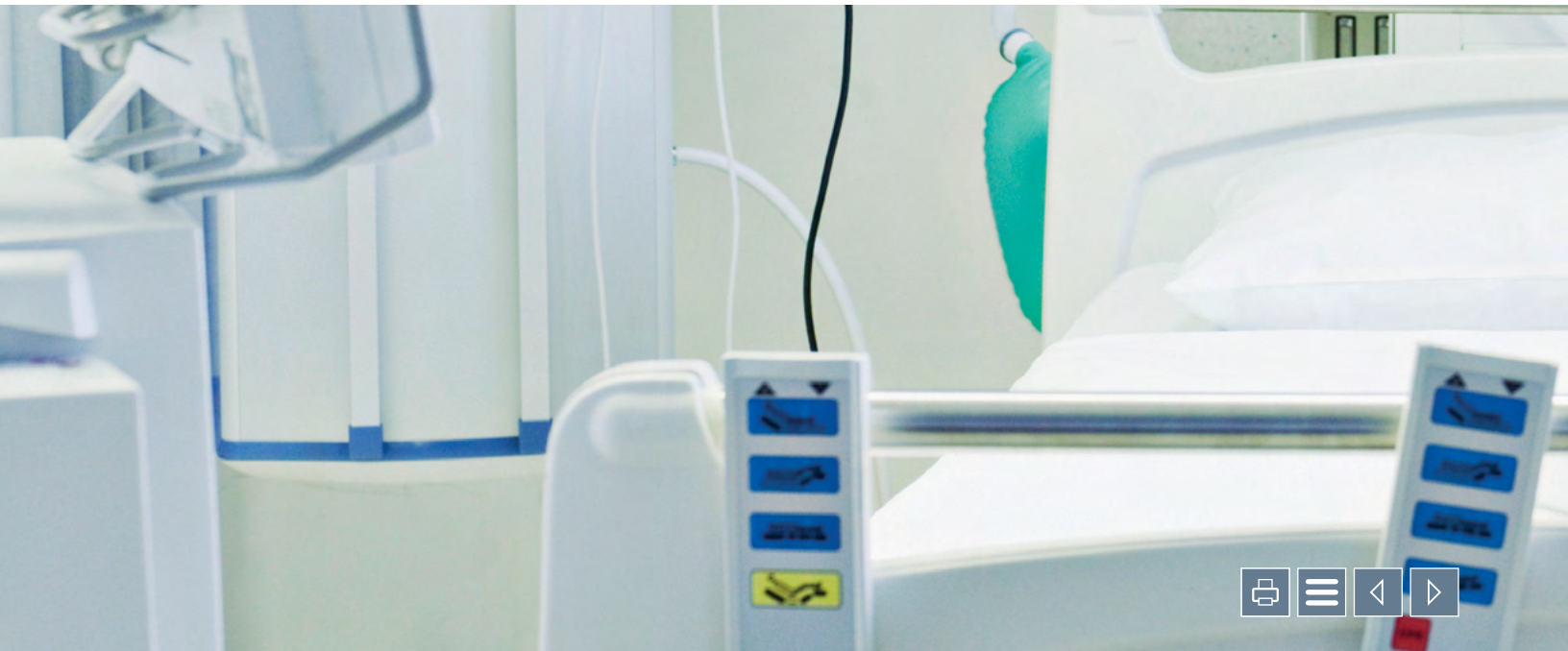

Table 1A shows the updated national Adjusted Operating Standardized amounts based on the rate updates per Table 1. For FY 2021, the full increase for a hospital that reports quality data and is a Meaningful EHR user will be 2.9%.

TABLE 1A. National Adjusted Operating Standardized Amounts; Labor/Nonlabor (68.3% Labor Share/31.7% Nonlabor Share If Wage Index Is Greater Than 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 %)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.60 %)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.80 %)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0.0 %)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,071.49	$1,889.70	$3,999.92	$1,856.01	$4,047.63	$1,878.63	$3,976.06	$1,845.41

TABLE 1B. National Adjusted Operating Standardized Amounts; Labor/Nonlabor (62% Labor Share/38% Nonlabor Share If Wage Index Is Less Than or Equal To 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 %)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.60 %)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.80 %)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0.0 %)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,695.94	$2,264.25	$3,630.97	$2,225.43	$3,674.28	$2,251.98	$3,609.31	$2,212.16

The rate increases, coupled with other changes to IPPS payment policies, will increase IPPS operating payments by approximately 2.7%. The overall increase in IPPS payments in FY 2021 will be approximately $3.5 billion in increase Medicare payments in FY 2021 as shown in Table II. This increase is significantly driven by the increase in IPPS rates as shown in the above Table 1.

CAPITAL PAYMENTS

Per Table 1C, the capital rate increased by 1.3% to $466.22 for FY 2021 which will increase capital payments by $27,000,000 per Table 2.

TABLE 1C. Capital Standard Federal Payment Rate

	FY 2021 Rate	FY 2020 Rate
National	$466.22	$462.33

TABLE 2

Operating Payments/Uncompensated Care Payments	$ 3,022,000,000
Capital Payments	$ 27,000,000
New Technology Add-On Payments	$ 479,000,000
Estimated Increase in Payments	**$ 3,528,000,000**

The combined IPPS operating payment and uncompensated care payments increased by $3,022,000,000—it is important to note that this includes a $60 million decrease in uncompensated care payments as outlined in the DSH and Uncompensated Care section of this summary.

The below summary of the FY 2021 IPPS Medicare rules will highlight the changes that will drive the increased rates and additional Medicare payments for FY 2021.

The impacts do not include the 2% Medicare sequestration reduction. This reduction began in FY 2013 and would have run through 2028 without legislation to discontinue this reduction or increase the length of time it is in effect. The Coronavirus Aid, Relief, and Economic Security (CARES) Act passed for COVID-19 relief for healthcare providers temporarily halted the sequestration reduction beginning May 1, 2020-Dec. 31, 2020, thus extending the sequestration period through 2030 absent any further regulations.

FY 2021 MS-DRG Relative Weights

FY 2007 ushered in a new era of relative DRG weights based on Medicare cost report data instead of charges. The data utilized in the cost-based weighting methodology for setting the MS-DRG weights are claims data from the FY 2019 MEDPAR file using diagnostic and procedure data for all Medicare inpatient bills and cost report data from the HCRIS data set that is three years prior to the IPPS fiscal year.

The updated 19 national average cost to charge ratios (CCRs) based on FY 2018 Medicare cost report data and the MEDPAR file that will be utilized for updating FY 2021 MS-DRGs are identified in Table 3. CCRS from FY 2019 and FY 2020 are presented for comparison purposes:

TABLE 3

	FY2019 Final 19 CCRs	FY2020 Final 19 CCRs	FY2021 Final 19 CCRs
Routine Days	0.451	0.432	0.421
Intensive Days	0.373	0.358	0.344
Drugs	0.196	0.189	0.187
Supplies & Equipment	0.299	0.299	0.297
Implantable Devices	0.321	0.299	0.293
Therapy Services	0.312	0.297	0.288
Laboratory	0.116	0.109	0.107
Operating Room	0.185	0.173	0.167
Cardiology	0.107	0.098	0.094
Cardiac Catheterization	0.115	0.106	0.100
Radiology	0.149	0.140	0.136
MRI	0.076	0.072	0.070
CT Scans	0.037	0.034	0.034
Emergency Room	0.165	0.152	0.147
Blood	0.306	0.283	0.271
Other Services	0.355	0.346	0.343
Labor & Delivery	0.363	0.373	0.359
Inhalation Therapy	0.163	0.150	0.147
Anesthesia	0.081	0.077	0.071

MS-DRG Documentation and Coding Adjustment

The methodology for MS-DRG adoption in FY 2008 created an $11 billion overpayment due to documentation and coding that did not reflect real changes in case mix. The American Taxpayer Relief Act of 2012 (ATRA) required an adjustment to FY 2014-2017 to recoup this amount. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) instituted a 0.5% positive adjustment to Medicare payments for FY 2018-2023 to standardize the payments. The 0.5% adjustment is reflected in the market basket update per Table 1.

Market-Based MS-DRG Relative Weight Data Collection

POTENTIAL CHANGE IN METHODOLOGY FOR CALCULATING MS-DRG RELATIVE WEIGHTS

To bolster transparency initiatives and reduce reliance on a hospital's chargemaster, CMS is finalizing development of the market-based approach for MS-DRG weight calculation. CMS will mandate that hospitals report market-based payment rates for all payers for cost reporting periods ending on or after Jan. 1, 2021. The information that is gathered will lead to a change in the method for calculating MS-DRG weights using market-based pricing. Due to this finalized change, hospitals are required to report the following information on their Medicare cost report:

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

CMS believes that because hospitals are required to report the payer-specific negotiated charges under the Hospital Price Transparency Final Rule, the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.

PROPOSED BUT NOT INCLUDED:

- The median payer-specific negotiated charge the hospital has negotiated with all its third-party payers, which would include MA organizations, by MS-DRG was proposed in the preliminary rule but was not included in the final rule

CMS will institute the methodology for calculating the IPPS MS-DRG relative weights to incorporate this market-based rate information beginning in FY 2024 without a transition period.

Outlier Payment

Additional payments are made in addition to DRG payments for high cost cases. To qualify for outlier payments, a case must have incurred costs that are more than the combined payment for the case including MS-DRG, IME, DSH uncompensated care and new technology payments plus the outlier threshold amount. The outlier amount will increase from $26,552 in FY 2020 to $29,051 for FY 2021 which will result in a decrease in outlier payments in FY 2021. The outlier threshold is estimated to result in outlier payments that are 5.11% of operating DRG payments and 5.34% of capital payments. In order to fund the operating and capital outlier payments, CMS will apply an adjustment of .0949 to the operating standardized amount and 0.9466 to the capital federal rate.

Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital (DSH) payment methodology beginning in FY 2014. Also, beginning in FY 2014, DSH hospitals began receiving 25% of the amount they previously would have been reimbursed under the traditional Medicare DSH formula. The remaining 75% adjusted for the percent of uninsured will be paid through the uncompensated care reimbursement methodology outlined below and updated for FY 2021.

FACTOR 1

Estimate of 75% (100% minus 25%) of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year. FY 2021 estimated DSH spending of $15,170,673,476 is 8.5% lower than the FY 2020 spending of $16,583,455,657.

$15,170,673,476 *.75 = $11,378,005,107 = Uncompensated Care Pool

$15,170,673,476 *.25 = $ 3,792,668,369 = Empirical DSH payments

FACTOR 2

The Affordable Care Act established Factor 2 in the calculation of the uncompensated care payment. Specifically, the Act provides that for each FYs 2014, 2015, 2016 and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act, to that same percent for the year in question. In FY 2018 and forward, the act authorized the use of data sources other than CBO estimates to determine the uninsured percentage as determined by the Secretary based on data from the Census Bureau or other source determined appropriate by the Secretary and certified by the Chief Actuary of CMS. The Act also does not require that the percentage of individuals be limited to those under the age of 65 for FY 2018 and forward.

The criteria that was set for determining a data source are as follows:

- The source accounts for the full U.S. population
- Comprehensively accounts for both public and private health insurance coverage
- Utilized data from the Census Bureau
- Timeliness of the estimates
- Continuity of the estimates over time
- Accuracy of estimates
- Availability of projections

The source determined in FY 2018 that meets these criteria is data from CMS' Office of the Actuary (OACT), derived as part of the development of the National Health Expenditure Accounts (NHEA) which represents official estimates of the economic activity within healthcare according to CMS. This data estimated the uninsured rate for 2013 was 14% and for 2021 is 10.2%.

Based on this information the calculation of Factor 2 for FY 2021 is as follows:

1-((0. 102-0.14)/0.14) =1-.2714=0.7286

FACTOR 3 – FY 2021

Factor 3 is a hospital-specific value that identifies the share of the estimated uncompensated care amount for each hospital receiving Medicare DSH payments.

The hospital's Cost of Uncompensated care is from the Medicare cost report, WS S-10 Ln 30-comprised of the following elements:

- Cost of charity care (Line 23)
- Non-Medicare and non-reimbursable Medicare bad debt (Line 29)

Data from FY 2017 Medicare cost reports will be used as these audits began in June of 2019 and the results of those audits are available for FY 2021. The methodology of using one year of data will continue. FY 2018 uncompensated care data is in the process of being audited.

Below is a summary of the three factors used for the uncompensated care payments since FY 2014:

FYE	DSH Estimate	Factor 1 (75% of total DSH)	Percentage of Uninsured	Factor 2 Percentage	Factor 2 Dollar Amount
2014	12,772,000,000	9,579,000,000	17.00%	94.30%	9,032,997,000
2015	13,383,462,196	10,037,596,647	13.75%	76.19%	7,647,644,885
2016	13,411,096,528	10,058,322,396	11.50%	63.69%	6,406,145,534
2017	14,396,635,710	10,797,467,782	10.00%	55.36%	5,977,483,146
2018	15,552,939,524	11,664,704,643	8.15%	58.01%	6,766,695,164
2019	16,294,703,939	12,221,027,954	9.48%	67.51%	8,250,415,972
2020	16,583,455,657	12,437,591,743	9.40%	67.14%	8,350,599,096
2021	15,170,673,476	11,378,005,107	10.02%	72.86%	8,290,014,521

The projected decrease in payments for FY 2021 from FY 2020 is $60 million.

Medicare Bad Debts

Medicare beneficiaries are responsible for their share of related covered services in the form of deductibles and coinsurance. Medicare provides reimbursement for Medicare bad debt created when Medicare beneficiaries cannot pay the deductible and coinsurance amounts. An allowable Medicare bad debt must meet all the criteria set forth in Section 413.89(e) and the Provider Reimbursement Manual (PRM), Chapter 3, Section 308. Congress passed legislation implementing a moratorium stopping the HHS Secretary from making changes to Medicare bad debt reimbursement policies that were in effect on Aug. 1, 1987. This prohibition was known as the Bad Debt Moratorium. The moratorium was repealed by Congress in the Middle-Class Tax Relief and Job Creation Act of 2012, effective for cost reporting periods beginning on or after Oct. 1, 2012. With no prohibition in place, CMS is clarifying Medicare bad debt policies that have generated litigation and questions over the past years. The changes seek to clarify, update and put into code longstanding Medicare bad debt principles by revising Section 413.89, Bad Debts, Charity and Courtesy allowances. This rule will also recognize the new Accounting Standards Update-Topic 606 for revenue recognition and classification of Medicare bad debts. The effective date would be for cost reporting periods beginning before, on and after the effective date of this rule unless specified in the new regulation. The following is a summary of the amended Medicare bad debt policies:

REASONABLE COLLECTION EFFORTS

Regulation Section 413.89(e)(2) has a very limited statement concerning reasonable collection efforts. It currently says the provider must be able to establish reasonable collection efforts were made. Additional requirements were outlined in the PRM. CMS will add these longstanding policies to the regulation.

1. Definition of non-indigent beneficiary

Collection efforts must be pursued for non-indigent beneficiaries. CMS will add a new paragraph at Section 413.89(e)(2)(i) to define, for Medicare bad debt purposes, a non-indigent beneficiary as a beneficiary 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. This would be effective for cost reports beginning before, on and after the effective date of this rule because this new policy codifies the meaning of the existing term.

2. Billing Timeliness

Amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A) to specify the reasonable collection effort requirement for a non-indigent beneficiary must be similar to the effort the provider, and/or the collection agency acting on the provider's behalf, puts forth to collect comparable amounts from non-Medicare patients.

- For cost reporting periods beginning before Oct. 1, 2020, a bill must be issued to the beneficiary on or shortly after discharge or death of the patient.
- Cost reporting periods beginning on or after Oct. 1, 2020, issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations must occur on or before 120 days after:
  - The date of the Medicare remittance advice; or
  - The date of the remittance advice from the beneficiary's secondary payer
  - The date of the notification that the beneficiary's secondary payer does not cover the services, if any; whichever is latest.
- A provider's reasonable collection effort must include other actions:
  - Actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than token, collection effort.
- Provider must maintain and furnish documentation to its contractor to support the Medicare bad debts
- Provider's bad debt collection policy describing the collection process for Medicare and non-Medicare patients
  - Beneficiary's account history documents
- The effective date of these revisions would be for cost report periods beginning before, on or after the effective date of this rule

3. 120 Day Collection Effort

Amend Section 413.89(e)(2) to specify the following:

- A bill cannot be considered uncollectible until at least 120 days since the first attempt to collect payment
- When a provider receives partial payment of deductible and coinsurance during the 120-day period, the event triggers a new 120-day period
- Effective date would be for cost reporting periods beginning before, on and after the effective date of this rule

4. Recoveries

CMS will amend Section 413.89(f) to add language, effective retroactively before, on or after the effective date of this rule, amounts collected from beneficiary:

- Amounts received after the write off date but before the end of the cost reporting date must reduce the bad debts claimed on the cost report
- Amounts received on an account that was claimed as a Medicare bad debt in a prior period must reduce the Medicare bad debts claimed in the period the amount is recovered

5. Collection Efforts

Amend Section 414.89(e)(2) to specify the following. Collection efforts for Medicare deductible and coinsurance must be similar to efforts for non-Medicare patients of like amounts. It is the provider's responsibility to confirm the collection agency expends the same efforts for collection of Medicare accounts as it does for non-Medicare accounts. The collection agency must use the same collection practices for comparable amounts of Medicare and non-Medicare accounts

- Collection accounts that remain at the collection agency cannot be claimed as a Medicare bad debt
- Collection fees charged by the collection agency are allowable as an administrative cost if the agency is performing a reasonable collection effort.
- The effective date of these revisions would be for cost report periods beginning before, on or after the effective date of this rule

6. Indigency Determination

For beneficiaries who are not Medicaid crossovers, the determination of indigency must take into account the total assets and resources of the patient. CMS will add detailed specifications for how a provider determines indigence for patients not eligible for Medicaid to this regulation. The effective date of this policy will be for cost reporting periods beginning on or after October 1, 2020.

- Hospital must determine the indigence of the Medicare beneficiary
- Total resources of the beneficiary must be considered:
  - Assets convertible to cash and not necessary for daily living
  - Income
- Provider should evaluate extenuating circumstances which would affect indigence such as liabilities and expenses if assets and income does not determine indigence
- Determination that no other source is responsible for the bill
- When indigence is determined, the debt is uncollectible without additional collection efforts

Due to the detailed language CMS is finalizing, healthcare organizations will need to ensure their charity care policies are very specific regarding the determination of eligibility.

7. Dual Eligible Account

Medicare beneficiaries enrolled in Medicare and who also have full Medicaid coverage are dual eligible patients. Some patients in this category have full coverage while others have partial Medicaid coverage, meaning Medicaid will pay all or a partial amount of the Medicare cost sharing. To be considered a reasonable collection effort:

- Must bill state Medicaid program to determine no other source but the patient would be responsible for the medical bill; this has long been referred to as the "must bill" policy
- The provider must provide the Medicaid remittance advice (RA) from the state Medicaid program referred to as the "RA requirement"
- The amount the state is obligated to pay will not be included as allowable Medicare bad debt. This is true regardless of whether payment was made, or an RA is provided indicating Medicaid has no obligation to pay
- If no Medicaid remittance advice is available due to state's processes not generating a Medicaid remittance advice, submit the following:
  - State's Medicaid notification it has no obligation to pay
  - Evidence of the amount the state should be responsible to pay
  - Beneficiary's Medicaid eligibility

This revision will be effective for cost reporting periods beginning before, on and after the effective date of this rule

8. Accounting Standard-Topic 606

Under this topic, bad debts would not be reported separately as an operating expense but rather be an implicit price concession and included as a reduction in patient revenue and are no longer considered uncollectible accounts receivable and notes receivable. What is important to understand is that Topic 606 terminology does not change the requirements that must be met for claiming Medicare bad debts.

The final rule would recognize bad debts as implicit price concessions for cost reporting periods beginning on or after Oct. 1, 2020.

The April 4, 2019 MLN SE article gave providers flexibility to report Medicare bad debts that were written off to contractual Allowances for cost reports beginning before October 1, 2019. For cost report periods beginning after October 1, 2019 Medicare bad debts must be written off to an expense account.

CMS is finalizing that cost report periods beginning before October 1, 2020, Medicare bad debts must be written off to an expense account for uncollectible accounts. Effective for cost reporting periods beginning on or after Oct. 1, 2020, bad debts must be charged to an uncollectible receivables account that results in a reduction in revenue. These changes are not retroactive. The effective date of these changes is the effective date of these rules.

FY 2021 Wage Index

The IPPS labor portion of the payments are adjusted for differences in hospital's cost of labor which is known as the wage index adjustment. In updating prospective payments to hospitals, the standardized amounts need to be adjusted for differences in wage levels in a geographic area when compared to the national average hospital wage level. The wage index information utilized for FY 2021 is from cost report periods beginning in FY 2017. The occupational mix information will be from the 2016 Occupational Mix Survey.

CORE BASED STATISTICAL AREAS (CBSA)

CMS utilizes CBSA's delineations as labor markets from the Office of Management and Budget (OMB) from 2015. This information is based on 2010 census data. Based on updates to this information there are several new market delineations that have significant impacts on wage index.

Thirty-four counties and 10 hospitals will change from urban to rural in FY 2021. The wage index data from these organizations go into calculating the rural wage index. CMS has instituted a transition for hospital's DSH payments to be based on two-thirds of the urban formula and one-third of rural formula in FY 2021, one-third of the urban formula and two-thirds of the rural formula in FY 2022 and 100 % of the rural formula in FY 2023.

Forty-seven counties and 17 hospitals and critical access hospitals (CAHS) will have their designations change from rural to urban. These hospitals' wage data will go into calculating the urban wage index of the CBSA where they are located. A CAH must be designated as a rural hospital to be eligible for CAH status. CMS has granted a two-year period for those CAHs moving from rural to urban to apply for reclassification from urban to rural to maintain their CAH status.

CONTINUATION OF THE LOW WAGE INDEX HOSPITAL POLICY

In FY 2020, CMS adopted a policy to provide an opportunity to low wage index hospitals to increase compensation by increasing their wage index values. The goal is to decrease disparities between high wage and low wage hospitals. The policy was to be budget-neutral based on an adjustment to the standardized amounts for all hospitals. The phase-in period for this was four years to allow these increases to be reflected in the wage index calculation. This policy is to continue in FY 2021. Hospitals with a wage index value below the 25-percentile would be increased by half the difference between the final wage index value for the hospital and the 25-percentile wage index value for all hospitals. The FY 2021 25-percentile wage index value for all hospitals is .8465. The process will again be budget-neutral by applying a factor to the standardized amount. Similar to FY 2020, a 5% cap is placed on any decrease in a hospital's wage index due to any reason causing the decline so the hospital's final wage index for FY 2021 will not be less than 95% of its FY 2020 wage index value.

Medical Education

Approved teaching hospitals are paid for their medical education training programs for direct costs and indirect costs as outlined below.

GRADUATE MEDICAL EDUCATION (GME)

Hospitals with an approved teaching program are paid for direct costs of GME based on the weighted number of residents and Medicare patient load (percentage of the hospital's Medicare inpatient days) in the Medicare cost reporting period and the hospital's per resident amount.

INDIRECT MEDICAL EDUCATION (IME) PAYMENT ADJUSTMENT FACTOR

Teaching hospitals receive an add on payment to their DRG payment to reimburse hospitals for the increased cost of treatment compared to non-teaching hospitals. The IME formula has a multiplier factor used to calculate the IME payment. The factor is set each year by statute. The factor has been 1.35 for discharges occurring since FY 2008. The factor for FY 2021 will continue to be 1.35. CMS estimates that by utilizing this factor for FY 2021, IPPS IME payments will increase by 5.5% for every 10% increase in a hospital's resident to bed ratio.

TREATMENT OF RESIDENTS AFFECTED BY CLOSURE OF A RESIDENCY PROGRAM OR TEACHING HOSPITAL

To more appropriately address residents attempting to find a new hospital residency program after closure of their existing teaching hospital or residency program, CMS is amending its policy to allow residents to transfer hospitals while the program is transitioning to the closure date. It would also present a more seamless transfer of GME and IME funding for residents not physically at the closing of the hospital or program. A displaced resident is defined as the following per the FY IPPS 2021 rule:

- Leaves a program after the hospital or program closure is publicly announced, but before the actual hospital or program closure
- Is assigned to and training at planned rotations at another hospital and who will be unable to return to his or her rotation at the closing hospital or program
- Is accepted into a GME program at the closing hospital or program but has not yet started training at the closing hospital or program

- Is physically training at the hospital on the day prior to or on the day of program or hospital closure
- Is on approved leave at the time of the announcement of closure or actual closure and cannot return to their rotation at the closing hospital or program

In order for a hospital to have a temporary increase in the IME and GME FTE caps, the receiving hospitals must submit documentation to the Medicare Administrative Contractor within 60 days after the resident begins training at their hospital. The information submitted must include:

- The last four digits of the Social Security number of the displaced resident or
- The national provider Identifier of the displaced resident

The maximum FTE resident slots that can be transferred is the number of IME and GME cap slots belonging to the closed hospital. If the hospital requesting the increase is already over their cap, there is no guarantee of a cap increase that would come with the displaced resident.

Low Volume Hospitals

Hospitals meeting certain criteria for low volume status would receive an additional payment under IPPS starting in FY 2005. When this payment was first established, a hospital had to have less than 200 total discharges and be located more than 25 road miles from the nearest hospital. The regulations were amended for FYs 2019-2022. For these FYs the hospital must have less than 3,800 total discharges and be more than 15 miles from the nearest hospital. The hospitals will receive an additional 25% payment adjustment based on the total per discharge payments including capital, DSH, IME and outlier payments for hospitals with 500 or fewer discharges and reduced based on a linear sliding scale for hospitals with more discharges with a complete elimination of this payment for hospitals with more than 3,800 discharges in a fiscal year. In FY 2023, the low-volume criteria and payment will revert to the requirements in effect prior to FY 2011. The requirement is fewer than 200 discharges and be located more than 25 miles from the nearest hospital.

Quality Star Rating Program

Under the Hospital Star rating structure, CMS reports on measures comparing hospitals and publishes this information on the Hospital Compare website. This reporting has caused issues with hospitals regarding how the data is developed. Hospitals have expressed these concerns and CMS had committed to modifications. The revisions are not incorporated into these rules as the emphasis for CMS this year is on crucial polices due to efforts and attention on COVID-19.

Hospital Readmissions Reduction Program (HRRP)

This program reduces a hospital's Operating DRG payment for excess readmissions for certain conditions exceeding expected levels. FY 2021's reduction and those of fiscal years going forward will be based on a hospital's risk adjusted readmission rates over a three-year period for the following unplanned readmissions:

- Acute myocardial infarction (AMI)
- Heart failure (HF)
- Pneumonia
- Chronic obstructive pulmonary disease (COPD)
- Elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA)
- Coronary artery bypass graft (CABG) surgery

The annual reduction is capped at 3% for a payment adjustment factor of .97. CMS estimated 2,545 hospitals will have their base operating DRG payments reduced by their FY 2021 hospital-specific payment adjustment factors. The estimated saving of this program in FY 2021 will be approximately $553 million in FY 2021.

Value-Based Incentive Payments Under the Hospital VBP Program

The VBP Program provides hospitals with value-based incentives based on performance measures in a respective year. The payments are funded for FY 2021 based on a reduction of 2% to the base operating DRG payment for discharges occurring for that year. The pool of money will fund incentive payments based on a hospital's Total Performance Score (TPS). The payments are budget-neutral which means the total amount available for these payments must equal the reduced payments in that year. FY 2021 available pool for VBP incentives will be approximately $1.9 billion.

Hospital Acquired Conditions (HAC) Reduction Program

The HAC program provides hospitals an incentive to reduce hospital acquired conditions. The 1% reduction applies to hospitals that rank in the worst performing quartile (25%) of all hospitals.

Hospital Inpatient Quality Reporting Program (IQR)

The IQR is a pay-for-reporting quality program. Hospitals that fail to comply with these requirements receive reduced payments. FY 2021 changes include reporting changes and public reporting of electronic clinical quality measures (eCQMs) as follows:

- Require use of electronic file submission instead of paper copies
- Increase reporting from one quarter to four quarters over a three-year period
- Report information publicly on the Hospital Compare website or data.medicare.gov

Provider Review Reimbursement Board (PRRB)

The PRRB is where disputes are handled for Medicare final determinations. In August 2018, the Office of Hearings (OH) released a web-based portal for electronic submission of provider appeals and PRRB correspondence. The PRRB will be allowed to mandate electronic submission in FY 2021. The PRRB must give 120 days notice prior to mandatory electronic submission requirements taking effect. OH is providing guidance for organizations that may be filing appeals, and have not already registered for the portal, to begin using the system now and to become acquainted with the system to avoid problems when the system is mandated.

LTCH PPS Payment Rates

LTCHs have been reimbursed under a structure that pays an LTCH PPS standard federal payment when the site-neutral payment criteria are met for exclusion.. If the criteria for exclusion from site-neutral payments are not met, they will be paid on a site-neutral payment rate. These exclusions include:

- Cases do not have primary diagnosis related to psychiatric or rehab (the DRG criterion)
- Case must be preceded by a discharge from an acute care hospital which included at least a three-day stay in an intensive care unit (the ICU criterion)
- Case must be preceded by discharge from an acute care hospital and the LTCH discharge must be based on at least 96 hours of ventilator services in the LTCH (the ventilator criterion)

An LTCH will be paid the PPS standard federal rate if the DRG criterion is met and either the ICU or the ventilator criterion is met.

The changes by CMS will decrease by approximately $40 million. This amount is made up of the following changes:

- LTCH standard federal payment rate increased by 2.3% – Increase payments by an estimated $74 million
- LTCH site-neutral payment rate will decrease payments by 20% – Decrease payments by $114 million

LTCH Site-Neutral Payments	($114 million)
LTCH PPS Payments	$ 74 million
Overall LTCH Payment Decrease	**($ 40 million)**

Critical Access Hospitals (CAHS)

The Frontier Community Health Integration Project (FCHIP) demonstration allows entities to develop and test new models of care to improve access to better delivery of acute care, extended care and other healthcare services to Medicare beneficiaries without an increase in costs. This was to be budget-neutral. The baseline period for the budget neutrality measurement was from Aug. 1, 2016 through July 31, 2019. The program allows models of care under telehealth, skilled nursing services and ambulance services. CAHs were selected for participation with the goal of budget neutrality that will produce savings through reduced transfers and admissions to other healthcare providers. If the baseline period analysis of claims and other documents such as Medicare cost reports shows increased payments over the three-year period, CMS would recoup these expenditures by reducing payments to all CAHs. Current available data budget neutrality results are not sufficient to warrant any reductions at this time. CMS will delay any budget neutrality adjustments and will revisit in FY 2022.

BDO Takeaways

- The collective pressures of COVID-19 and the evolving reimbursement methodologies for FY 2021 will cause healthcare leaders concerned about government reimbursement to look at innovative ideas to reduce expenses, enhance reimbursement and improve overall margins.
- As organizations emerge from COVID-19 into uncertain financial paths forward, they will need to account for all financial aspects affecting how an organization operates and consider the updated payment policies and rates as they project future margins.
- Already facing negative margin pressures, CFOs and their teams will need to look at new avenues to increase their reimbursement by means of the various payment incentives built into Medicare reimbursement through quality indicators by transforming the overall consumer experience and investing in innovative funding sources.

For additional questions, reach out:

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