Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

SEPTEMBER 2020

FFY 2021 MEDICARE IPPS FINAL RULE – CMS-1735-F

On Sept. 3, the Centers for Medicare & Medicaid Services (CMS) published its annual final rule updating the Inpatient Prospective Payment System (IPPS) effective Oct. 1, 2020 through Sept. 30, 2021 (this final rule will be published in the *Federal Register* on Sept. 18). CMS estimates an overall increase is IPPS payments of 2.7%, or approximately $3.5 billion, in federal fiscal year (FFY) 2021 compared with FFY 2020. A summary of the FFY 2021 Long-Term Acute Care Hospital (LTCH) proposed rule is here. IHA's comments on the FFY 2021 IPPS proposed rule are here. All page numbers in this summary refer to the desk copy of the final rule.

IPPS Market Basket Update (*pp. 27 and 1082-1089)*: CMS finalized a 2.4% market basket update (proposed a 3.0%), a 0.0 percentage point productivity reduction (proposed at 0.4 percentage point reduction), and a 0.5 percentage point increase to partially restore cuts made via the American Taxpayer Relief Act (ATRA) of 2012. Hospitals that fail to submit quality data will experience an additional one-quarter reduction to the initial market basket, and hospitals that do not meet meaningful use requirements are subject to a three-quarter reduction to the initial market basket. A summary is in the table below.

FFY 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
Percentage increase applied to standardized amount	2.9%	1.1%	2.3%	0.5%

National Standardized Amounts (*pp. 1942-1944, 2019-2020*): The table below summarizes the final standardized amounts. CMS finalized a labor-related share of 62% for IPPS hospitals with wage index values less than or equal to 1.0000, and a labor-related share of 68.3% for IPPS hospitals with wage index values greater than 1.0000. (pp. 1942-1944)

Wage Index	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
<= 1.0000	Labor: $3,696.01 Non-Labor: $2,265.30	Labor: $3,631.04 Non-Labor: $2,225.48	Labor: $3,674.36 Non-Labor: $2,252.02	Labor: $3,609.39 Non-Labor: $2,212.20
> 1.0000	Labor: $4,071.57 Non-Labor: $1,889.74	Labor: $4,000.00 Non-Labor: $1,856.52	Labor: $4,047.71 Non-Labor: $1,878.67	Labor: $3,976.14 Non-Labor: $1,845.45

CMS finalized a capital standard federal payment rate of $466.21 (proposed at $468.36).

Price Transparency and Changes to Medicare Severity-Diagnosis Related Group (MS-DRG) Data Collection and Weight Calculations (*pp. 1341-1409*): CMS is implementing the Hospital Price Transparency Final Rule (IHA summary) through a requirement that hospitals report median, payer-specific negotiated charges for inpatient services by MS-DRG. Beginning with Medicare cost reporting periods ending on or after Jan. 1, 2021, hospitals must report on the Medicare cost report the median negotiated rates for Medicare Advantage organizations. CMS noted that hospitals must make this information public in accordance with the Hospital Price Transparency final rule. Beginning in FFY 2024, CMS will use these data to calculate inpatient PPS MS-DRG relative weights.

In the final rule, CMS reiterates that Sections 1815(a) and 1833(e) of the Social Security Act state that CMS may withhold Medicare payments from providers that fail to furnish all information requested by the Secretary of Health and Human Services to determine payment amounts under the Medicare program.

Disproportionate Share Hospital (DSH) Payment Changes (*pp. 1159-1224 and 2063-2070*): Under the Medicare DSH program, hospitals receive 25% of the empirically justified DSH payments, with the remaining 75% flowing into a separate funding pool for DSH hospitals. After adjusting for the percentage of uninsured individuals, CMS estimates the FFY 2021 uncompensated care amount at approximately $8.29 billion, a decrease of roughly $60.6 million compared to FFY 2020. CMS also finalized the use of the FFY 2017 Medicare Cost Report Worksheet S-10 data to determine the distribution of FFY 2021 DSH uncompensated care payments. Beginning in FFY 2022, CMS will use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments.

Overall Hospital Quality Star Ratings (*pp. 1269-1270*): CMS did not propose changes to its star rating methodology in the FFY 2021 IPPS proposed rule. However, CMS refers readers to the CY 2021 OPPS/ASC proposed rule for proposed methodological changes to calculating Overall Star Ratings. The methodology utilizes publicly reported data collected on hospital inpatient and outpatient measures. IHA will review and comment on the proposed methodology by Oct. 5.

CAR T-Cell Therapy (*pp. 74-83*): Beginning FFY 2021, CMS discontinued new technology add-on payments (NTAPs) for two current CAR T products: KYMRIAH® and YESCARTA®.

CMS created a new MS-DRG for CAR T-Cell Therapy: MS-DRG 018 "Chimeric Antigen Receptor (CAR) T-cell Immunotherapy." CMS proposed a relative weight of 37.329 to MS-DRG 018. Previously, CAR T cases were included in MS-DRG 016; given the new MS-DRG, CMS will re-title MS-DRG 016 to "Autologous Bone Marrow Transplant with CC/MCC"

Medicare Bad Debt (*pp. 1737-1801*): CMS finalized several regulatory revisions specific to Medicare bad debt. These include the following:

- For the purposes of Medicare bad debt, a non-indigent beneficiary is 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 (retroactive effective date).

- The reasonable collection effort requirement for a non-indigent beneficiary must be similar to efforts made to collect comparable amounts from non-Medicare patients.
    - For cost reporting periods beginning before Oct. 1, 2020, collection efforts must involve the issuance of a bill on or shortly after discharge or death.
    - For cost reporting periods beginning on or after Oct. 1, 2020, collection efforts must involve the issuance of a bill on or before 120 days after the latter of one of the following:
        - The date of the Medicare remittance advice that is produced from processing the claim for services furnished to the beneficiary that generates the beneficiary's cost sharing amounts;
        - The date of the remittance advice from the beneficiary's secondary payer, if any; or
        - The date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary.
    - A provider's reasonable collection effort must also include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party (retroactive effective date).
- Should a provider receive a partial payment within the minimum 120-day required collection effort period, the provider must continue the collection effort for an additional 120 days. Collection efforts may end when no payments have been received during a consecutive 120-day effort period (retroactive effective date).
- 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 (retrospective effective date).
- Providers must maintain and furnish (upon request) verifiable documentation all of the following:
    - The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients;
    - Patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.; and
    - The beneficiary's file with copies of the bill(s) and follow-up notices.
- An indigent non-dual eligible beneficiary is a Medicare beneficiary who is determined to be indigent by the provider and not eligible for Medicaid as categorically or medically needy. Once indigence is determined, the bad debt may be deemed uncollectible without applying a collection effort. Unpaid deductible and coinsurance amounts without the provider's documentation of an indigence determination will not be considered as allowable bad debts. This policy is effective for cots reporting periods beginning on or after Oct. 1, 2020.
- Codification that the provider must bill the State for the Qualified Medicare Beneficiaries (QMB) Medicare cost sharing and submit the resulting Medicaid RA to Medicare so that any State Medicare cost sharing liability can be deducted from the Medicare bad debt reimbursement. CMS will also codify an alternate Medicaid RA documentation policy so

that, in limited circumstances, providers can comply with the must bill policy and still evidence a State's cost sharing liability (or absence thereof) for dual eligible beneficiaries when a State does not process a Medicare crossover claim and issue a Medicaid RA to providers.
    - Under the alternate Medicaid RA documentation policy, providers must submit all of the following:
        - The State Medicaid notification indicating that the State has no obligation to pay the beneficiary's Medicare cost sharing, or notification proving the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim;
        - Documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing; and
        - Documentation verifying the beneficiary's eligibility for Medicaid on the date of service.
- Accounting Standard Update Topic 606: Bad debts (also known as "implicit price concessions"), charity, and courtesy allowances represent reductions in revenue (retroactive effective date).
- Providers cannot write off Medicare bad debts to a contractual allowance account. For cost reporting periods beginning before Oct. 1, 2020, providers must charge Medicare bad debts to an expense account for uncollectible accounts. For cost reporting periods beginning on or after Oct. 1, 2020, providers must charge Medicare bad debts to an uncollectible receivables account that results in a reduction in revenue.

Complications or Comorbidities (CC) and Major Complications or Comorbidities (MCC) (*pp. 318-331*): CMS updated nine proposed guiding principles meant to help determine whether the presence of a specified secondary diagnosis would typically lead to increased hospital resource use. The revised guiding principles are as follows:

1. Represents end of life/near death or has reached an advanced stage associated with systemic physiologic decompensation and debility;
2. Denotes organ system instability or failure;
3. Involves a chronic illness with susceptibility to exacerbations or abrupt decline;
4. Serves as a marker for advanced disease states across multiple different comorbid conditions;
5. Reflects systemic impact;
6. Post-operative/post-procedure condition/complication impacting recovery;
7. Typically requires higher level of care (that is, intensive monitoring, greater number of caregivers, additional testing, intensive care unit care, extended length of stay);
8. Impedes patient cooperation and/or management of care; and
9. Recent (last 10 years) change in best practice, or in practice guidelines and review of the extent to which these changes have led to concomitant changes in expected resource use.

CMS will continue soliciting feedback regarding these guiding principles and other possible ways the agency can incorporate meaningful indicators of clinical severity by a secondary diagnosis.

NTAPs (*pp. 445-933*): There are 24 technologies eligible for NTAPs beginning FFY 2021, and 10 current NTAP technologies that will continue receiving NTAPs in FFY 2021 (*p. 507*).

Additionally, beginning FFY 2022 CMS will extend its FFY 2020 final rule policy to consider technologies in the Food and Drug Administration (FDA) Breakthrough Devices program and with the FDA Qualified Infections Disease Product (QIDP) designation as new and not substantially similar to existing technologies to products approved through FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD). Further, CMS will grant conditional NTAP approval for QIDPs and LPAD products that do not receive FDA marketing authorization or LPAD pathway approval by July 1, but otherwise meet applicable NTAP criteria.

Inpatient Quality Reporting (IQR) Program (*pp. 1524-1631*): CMS finalized two changes to the IQR electronic clinical quality measure (eCQM) reporting requirements. First, CMS will progressively increase the number of quarters for which hospitals are required to report eCQM data from one self-selected quarter of data (current) to four quarters of reported data for calendar year (CY) 2023. Second, CMS will publicly report eCQM measure results starting with CY 2021 data on *Hospital Compare* and/or data.medicare.gov. CMS also finalized the addition of EHR Submitter ID as the fifth key element for file identification beginning with the CY 2021 reporting period/FFY 2023 payment determination.

CMS also finalized changes to the IQR measure validation process. CMS will implement these changes gradually, starting in FFY 2021.

CMS did not adopt any new measures.

Medicare and Medicaid Promoting Interoperability Programs (*pp. 1652-1692*): CMS finalized changes to the Medicare and Medicaid Electronic Health Records (HER) reporting period, establishing a minimum of any continuous 90-day period in CY 2022 for new and returning participants attesting to CMS for the Medicare Promoting Interoperability Program. CMS also finalized to continue the Query of Prescription Drug Monitoring Program (PDMP) measure as optional and worth five bonus points in CY 2021. Finally, in an effort to align with the Hospital IQR Program, CMS will progressively increase the number of quarters hospitals are required to report eCQM data, and publicly report eCQM performance data beginning with data reporting by eligible hospitals and CAHs for the CY 2021 reporting period on Hospital Compare and/or data.medicare.gov.

Wage Index (*pp. 934-1073 and Table 3*): CMS will continue the FFY 2020 IPPS final rule policy of increasing the wage index value for hospitals below the 25th percentile. See IHA's FFY 2020 IPPS summary for more information. CMS will decrease the FFY 2021 standardized amount for all hospitals to make this policy budget neutral.

CMS finalized the adoption of the CBSA delineations published in the September 2018 Office of Management and Budget (OMB) Bulletin No. 18-04. In an effort to alleviate significant losses in revenue, CMS finalized a transition period, adopting these new CBSA assignments effective Oct. 1, 2020 along with a 5% cap on the reduction of a provider's wage index for FFY 2021 compared

to its wage index for FFY 2020. The Illinois counties impacted by this Bulletin are in IHA's FFY 2021 IPPS proposed rule summary. The final FFY 2021 pre-floor, pre-reclassified IPPS wage indices for Illinois CBSAs are as follows:

CBSA	Wage Index	Geographic Adjustment Factor	Reclassified Wage Index	Reclassified Geographic Adjustment Factor	State Rural Floor	FFY 2021 Average Hourly Wage
Bloomington	0.9008	0.9310	0.8861	0.9205		41.0126
Cape Girardeau	0.8289	0.8794				35.6856
Carbondale	0.8289	0.8794				37.2421
Champaign-Urbana	0.8825	0.9180	0.8825	0.9180		39.9297
Chicago-Naperville-Evanston	1.0350	1.0238	1.0192	1.0131		47.1234
Danville	0.9227	0.9464	0.9227	0.9464		41.4949
Decatur	0.8478	0.8931				38.5964
Elgin	1.0479	1.0326	1.0209	1.0143		47.7122
Kankakee	0.9019	0.9317	0.8737	0.9117		41.0611
Lake County	1.0174	1.0119				46.3154
Peoria	0.8621	0.9034				39.2517
Rock Island	0.8525	0.8965	0.8525	0.8965		38.5997
Rockford	0.9662	0.9767	0.9557	0.9694		43.9883
St. Louis	0.9153	0.9412	0.9153	0.9412		41.6710
Springfield	0.9111	0.9382	0.8915	0.9244		41.4807
Rural	0.8358	0.8844	0.8358	0.8844	0.8289	37.7397

Hospital-Acquired Condition (HAC) Reduction Program (*pp. 1296-1310*): CMS finalized validation process changes to align the HAC program with changes to the IQR program. Specifically, beginning in FFY 2024 quarterly submission requirements will align with the Hospital IQR Program's submission quarters. Additionally, the number of hospitals selected for validation will reduce from "up to 600" to "up to 400," and hospitals will be required to submit electronic copies of records to the Clinical Data Abstraction Center beginning with Q1 2021 data for the FFY 2024 program year.

CMS also finalized the automatic adoption of applicable periods for HAC beginning in FFY 2023 so that the applicable period automatically advances by one year from the prior fiscal year's applicable period.

Hospital Readmissions Reduction Program (RRP) (*pp. 1258-1269*): CMS finalized the automatic adoption of applicable periods for RRP program years beginning in FFY 2023. The applicable period for RRP measures and determining dual eligibility for the FFY 2023 program year is the 3-year period from July 1, 2018 through June 30, 2021. For each subsequent program year, the applicable period would automatically advance one year from the prior fiscal year's applicable period.

CMS did not propose to remove or adopt any additional measures for the RRP.

Hospital Value-Based Purchasing (VBP) Program (*pp. 1271-1295*): CMS provided newly established performance standards for FFY 2023-2026 program years. See pp. 1287 through 1291 for more information.

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Sources:
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