hfma
healthcare financial management association

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

The 2021 Inpatient Prospective Payment System (IPPS) Final Rule was made available on September 2, 2020. CMS estimates increases to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule, result in an estimated $3.5 billion increase in FY21 payments (+2.5%) 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. This summary has been updated to reflect the correct notice issued on December 1, 2020[1].

1) **Base Operating Rate**: The final 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 2.9%. This reflects the projected hospital market basket update of 2.4% reduced by a 0.0 percentage point productivity adjustment. This also reflects a final +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 Final 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	$4,071.57	$1,889.74	$3,696.01	$2,265.30
Did Not Submit Quality Data and Is a Meaningful User	$4,047.71	$1,878.67	$3,674.36	$2,252.02
Submitted Quality Data and Is Not a Meaningful User	$4,000.00	$1,856.52	$3,631.04	$2,225.48
Did Not Submit Quality Data and Is Not a Meaningful User	$3,976.14	$1,845.45	$3,609.39	$2,212.20
Puerto Rico	N/A	N/A	$3,696.01	$2,265.30

2) **National Capital Rate**: The final national capital rate for FY21 is $466.21.

[1] 2020-26698.pdf (federalregister.gov)
[2] Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013.

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 continues 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.

   Disproportionate Share Hospitals (DSH): In the final rule, CMS notes that due to the unprecedented nature of the COVID-19 pandemic, the Office of the Actuary updated its estimates of the uninsured (Factor 2). CMS now projects that the amount available to distribute as payments for uncompensated care (UC) for FY21 would decrease by approximately $60.5 million,[3] 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 was estimated for FY20 in last year's final rule.

   Projected 2021 DSH spending in the final rule ($15.171B) is approximately 8.5% lower than DSH spending ($16.583B) in the 2020 final rule. The final rule estimates that for FY20 and FY21, the uninsured rate will be 10.3% and 10.2%, respectively (increased from 9.5% in the proposed rule). Updating the uninsured rate in the final rule to account for the economic dislocation caused by the COVID-19 pandemic increased UC DSH payments available for allocation by $473 million, or approximately 6% compared with the proposed rule.

   Similar to the 2020 final rule, CMS again will use a single year of UC data from worksheet S-10 from the FY17 cost report for most hospitals to calculate Factor 3. This vintage of data was selected by CMS because 65% of the proposed UC payments have been subjected to audits. CMS will continue using single years of data moving forward and notes that it is in the process of auditing FY18 UC data.

   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 UC payments for Puerto Rico hospitals and Indian Health Service and Tribal hospitals for one more year (FY21), similar to the FY20 methodology.

[3] The proposed rule would have reduced UC DSH payments by $534 million relative to the FY20 final rule. The increase in UC DSH dollars is related to CMS recalculating the uninsured rate (Factor 2) for FY20 and FY21 in the final rule.

For FY21, hospitals have 15 business days from the date of public display of the FY21 IPPS final rule to review and submit comments on the accuracy of the UC DSH table and supplemental data file published in conjunction with the final rule.

5) **Outlier Threshold**: The final fixed loss outlier threshold increases to $29,064 ($30,006 proposed), compared with the FY20 final threshold of $26,552. This will decrease outlier payments relative to the prior year.

6) **Bad Debt**: The final rule clarifies/defines the following related to Medicare allowable bad debt:

Non-indigent beneficiary. 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, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for non-indigent beneficiaries, all of the following are applicable:

- A provider's collection effort, or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts must consist of all of the following:
    - Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients.
    - For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.
    - For cost reporting periods beginning on or after October 1, 2020, involve the issuance of a bill to the beneficiary (or the party responsible for the beneficiary's personal financial obligations) on or before 120 days after the latter of one of the following:
        - The date of the Medicare remittance advice that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts
        - The date of the remittance advice from the beneficiary's secondary payer, if any
        - The date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary
    - Include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages or personal contacts with this party
    - Last at least 120 days after paragraph from the initial bill before being written off as uncollectible
    - Start a new 120-day collection period each time a payment is received within a 120-day collection period
    - Maintaining and, upon request, furnishing verifiable documentation to its contractor that includes all of the following:
        - The beneficiary's file with copies of the bill(s) and follow-up notices

- The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients
- The 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.

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:

- The beneficiary's indigence must be determined by the provider; a beneficiary's signed declaration of indigence is not sufficient.
- The provider must take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income.
- The provider may consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined using an income and convertible asset test.
- The provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill.
- Once indigence is determined, the bad debt may be deemed uncollectible without applying the "reasonable collection effort" described above.

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.

When, through no fault of the provider, a provider does not receive a Medicaid remittance advice because the state does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the state does not generate a Medicaid remittance advice, the provider:

- Must submit to its contractor, all of the following auditable and verifiable documentation:
  - The state's Medicaid notification, stating that the state has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing
  - A calculation of the amount the state owes the provider for Medicare cost sharing
  - Verification of the beneficiary's eligibility for Medicaid for the date of service
- Must reduce allowable Medicare bad debt by any amount the state is obligated to pay, regardless of whether the state actually pays its obligated amount to the provider

- May include the Medicare deductible or coinsurance amount, or any portion thereof that the state is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

7) **MS-DRG Weight Setting/Negotiated Charge Reporting**: For cost reporting periods ending on or after January 1, 2021, CMS will require hospitals to report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations payers, by MS-DRG. The requirement applies to subsection (d) hospitals in the United States and Puerto Rico.

   The payer-specific negotiated charges used by hospitals to calculate these medians are 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 that can be crosswalked to an MS-DRG.

   Beginning in FY24, CMS will use the median payer-specific negotiated charge information for MA plans, collected on the cost report, to calculate MS-DRG relative weights. CMS is not finalizing a transition period in the rule for the new MS-DRG weights based on median MA rates but 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 payments.

   While CMS proposed a requirement that hospitals also report their median third-party payer rates in cost reports filed on or after January 1, 2021, it did not finalize this requirement.

8) **New MS-DRG for Chimeric Antigen Receptor (CAR) T-cell Therapy:** The final rule creates a new MS-DRG 018 specifically for cases involving CAR T-cell therapies. The new payment group helps to predictably compensate hospitals paid under the IPPS 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.

9) **Post-Acute Care Transfer Policy and Special Payment Policy:** Based on new MS-DRGs and changes to existing MS-DRGs, the final rule adds MS-DRGs to the list of those subject to the Post-Acute Care (PAC) Transfer and/or Special Payment Policy. Appendix 1 includes final additions to the special payment policy list. Appendix 2 includes the additions to the PAC transfer policy list.

10) **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.

11) **Policy Change Related to Medical Residents Affected by Residency Program or Teaching Hospital Closure:** The final rule defines *displaced resident* as a resident who:

a. Leaves a program after the hospital or program closure is publicly announced, but before the actual hospital or program closure
b. Is assigned to and training at planned rotations at another hospital who will be unable to return to his/her rotation at the closing hospital or program
c. Is accepted into a graduate medical education (GME) program at the closing hospital or program but has not yet started training at the closing hospital or program
d. Is physically training in the hospital on the day prior to or day of program or hospital closure or
e. Is on approved leave at the time of the announcement of closure or actual closure, and therefore, cannot return to his/her rotation at the closing hospital or program

To apply for the temporary increase in the IME and direct GME FTE resident caps, the receiving hospital would have to submit a letter to its Medicare Administrative Contractor no later than 60 days after beginning to train the displaced residents, and must include in the letter either-- (1) the last 4 digits of the Social Security number of the displaced resident; or (2) the National Provider Identifier of the displaced resident.

The maximum number of FTE resident cap slots that could be transferred to all receiving hospitals is the number of IME and direct GME 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.

12) **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, elective knee/hip replacement and coronary artery bypass grafting will be subject to a maximum 3% penalty. CMS estimates the Hospital Readmissions Reduction Program will save approximately $553 million in FY21.

13) **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 final rule.

14) **Hospital-Acquired Conditions (HAC) Reduction Program**: The 1% payment reduction applies to hospitals that rank in the worst-performing quartile (25%) of all applicable hospitals, relative to the national average, of conditions acquired during the applicable period and on all of the hospital's discharges for the specified fiscal year. In this FY21 IPPS final rule, CMS is finalizing the following policies to:

- Automatically adopt applicable periods beginning with the FY23 program year and all subsequent program years, unless otherwise specified by the Secretary
- Refine the process for validation of HAC Reduction Program measure data in alignment with the Hospital Inpatient Quality Reporting (IQR) Program measure validation policies finalized in this rule
- Update the definition of *applicable period* to align with the policy to automatically adopt applicable periods

The final rule does not provide an estimate of the savings related to the HAC program for FY21.

15) **IQR Program:** The rule finalizes 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.

    CMS also finalizes proposals to streamline the validation processes under the Hospital IQR Program. These include:

    - Updating the quarters of data required for validation for both chart-abstracted measures and eCQMs
    - Expanding targeting criteria to include hospital selection for eCQM
    - Changing the validation pool from 800 hospitals to 400 hospitals
    - Removing the current exclusions for eCQM validation selection
    - Requiring electronic file submissions for chart-abstracted measure data
    - Aligning the eCQM and chart-abstracted measure scoring processes
    - Updating the educational review process to address eCQM validation results

16) **Promoting Interoperability**: CMS finalizes an 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.

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

    The final rule also progressively increases the number of quarters for which hospitals are required to report eCQM data, from the current requirement of one self-selected calendar quarter of data, to four calendar quarters of data, over a three year period. It requires:

- Two self-selected calendar quarters of data for the CY21 reporting period
- Three self-selected calendar quarters of data for the CY22 reporting period
- Four calendar quarters of data beginning with the CY23 reporting period

The submission period for the Medicare Promoting Interoperability Program will be the two months following the close of the respective calendar year.

Finally, the rule requires publicly reporting eCQM performance data beginning with the eCQM data reported by eligible hospitals and critical access hospitals for the reporting period in CY21 on the Hospital Compare and/or data.medicare.gov websites or successor websites.

17) **Long-Term Care Hospital (LTCH) PPS Standard Federal Rate:** The final rule increases the standard federal rate by 2.3% to $43,755.34 for LTCHs that submit quality data. The reduced rate, for those that don't submit quality data is $42,899.90 (i.e., a .3% increase).

CMS expects LTCH PPS payments to decrease by approximately $40 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system.

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Appendix 1: List of Final New or Revised MS-DRGs Subject to Review of Post-Acute Care Transfer Policy Status for 2021

New or Revised MS-DRGs	MS-DRG Title	Current Postacute Care Transfer Policy Status	Proposed Postacute Care Transfer Policy Status
16	Autologous Bone Marrow Transplant with CC/MCC	No	No
18	Chimeric Antigen Receptor (CAR) T-Cell Immunotherapy	New	No
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis	New	No
140	Major Head and NeckProcedures with MCC	New	No
141	MajorHead and Neck Procedures with CC	New	No
142	Major Head and Neck Procedures without CC/MC	New	No
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC	New	No
144	Other Ear, Nose, Mouth and Throat O.R. Procedures with CC	New	No
145	Other Ear, Nose, Mouth and Throat O.R. Procedures without CC/MCC	New	No
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total	Yes	Yes
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	Yes	Yes
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	New	Yes
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	New	Yes
650	Kidney Transplant with Hemodialysis with MCC	New	No
651	Kidney Transplant with Hemodialysis without MCC	New	No
652	Kidney Transplant	No	No

Appendix 2: List of Final New or Revised MS-DRGs Subject to Review of Special Payment Policy Status for FY21

Revised MS-DRG	MS-DRG Title	Current Special Payment Policy Status	Special Payment Policy Status
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total	Yes	Yes
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	Yes	Yes
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	New	Yes
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	New	Yes