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FY 2021 Medicare Hospital IPPS and LTCH Final Rule

Changes effective October 1, 2020

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On September 2, 2020, the Centers for Medicare and Medicaid Services (CMS) issued the final rule relating to reimbursement policies for fiscal year 2021, which begins October 1, 2020. Key provisions of the rule are summarized herein. The rule was published in the Federal Register on September 18 (which can be found here).

Executive Summary

Generally, acute care hospitals and long-term acute care hospitals (LTCH) are reimbursed by Medicare under a prospective payment system. In this structure, each case is assigned a payment rates based on the patient's diagnosis and the severity of the patient's condition. For this purpose, patients in an acute care hospital are assigned a Medicare Severity Diagnosis-Related Group (MS-DRG), while LTHC patients are assigned a Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG). Therefore, the hospital receives a pre-established payment for each case, regardless of the patient's actual length of stay or cost of care, subject to certain outlier provisions.

Accordingly, CMS is required to update payment rates on an annual basis, accounting for changes in the cost of providing care in the applicable setting. The Inpatient Prospective Payment System (IPPS) utilizes a national base rate, adjusted for certain factors such as the patient's condition and labor costs in the geographic area where a hospital is located. LTCH rates are also updated annually, considering the cost of goods and service unique to that type of facility.

The updated payment rates reflected in the Final Rule are applicable to patient discharges occurring on or after October 1, 2020. The five most significant changes contained in the final rule are as follows:

1. **IPPS Payment Rates** – For general acute care hospitals, the IPPS payment rate will increase by 2.9% if the hospital participates in the Hospital Inpatient Quality Reporting Program and is a meaningful user of electronic health records.

2. **LTCH Payment Rates** –The LTCH PPS standard payment rate will increase by 2.3%, but will be reduced by 2% (i.e., net increase of only 0.3%) for LTCHs that fail to submit required quality data. However, total payments to LTCHs are expected to decline by approximately 1.1% in total as a result of the end of a statutory transition period for site-neutral payment rate cases.

3. **Uncompensated Care Payments –** For FY 2021, approximately $8.3 billion in uncompensated care payments will be distributed, reflecting a reduction of $60 million from FY 2020.

4. **Value-Based Purchasing** – The FY 2021 Final Rule provides new performance standards for certain measures in the FY 2023 to FY 2026 program years.

5. **Use of Price Transparency Information for DRG Weight setting** - According to the Final Rule, hospitals will report median payer-specific negotiated charges (i.e., negotiated rates) for Medicare Advantage organizations on the Medicare cost report for reporting periods ending on or after January 1, 2021. This data will be used in a new methodology for calculating MS-DRG relative weights for inpatient hospital stays beginning in FY 2024. The Price Transparency final rule requires all hospitals to publish their payer specific negotiated rates for all services and service packages beginning January 1, 2021.

IPPS Payment Rates

For general acute care hospitals, the IPPS payment rate will increase by 2.9% so long as the hospital participates in the Hospital Inpatient Quality Reporting (IQR) Program and is a meaningful user of electronic health records (EHR). This increase reflects a projected hospital market basket update of 2.4%, plus a 0.5% adjustment related to changes in MS-DRG documentation and coding that do not reflect real changes in case mix, as required by The American Taxpayer Relieve Act of 2012. No productivity adjustment was applied.

Hospitals may be subject to the following payment adjustments:

- Penalties for excess readmissions (maximum penalty of 3%) associated with specific conditions, including:
    - Acute myocardial infarction;
    - Heart failure;
    - Pneumonia;
    - Chronic obstructive pulmonary disease;
    - Elective hip or knee replacement; and
    - Coronary artery bypass grafting;
- Penalties for Hospital-Acquired Conditions (1% penalty for the worst-performing quartile of applicable hospitals, as compared to the national average); and
- Adjustments under Value-Based Purchasing (VBP) program (all hospitals subject to 2% reduction in base DRG payments).

LTCH Payment Rates

A LTCH is a hospital with an average inpatient length of stay greater than 25 days. The LTCH

PPS standard payment rate will increase by 2.3%, but will be reduced by 2% (i.e., net increase of only 0.3%) for LTCHs that fail to submit required quality data. However, total payments to LTCHs are expected to decline by approximately 1.1% in total as a result of the end of a statutory transition period for site-neutral payment rate cases. This stems from the FY 2016 IPPS/LTCH PPS final rule, which adopted the application of "site neutral" payment rates for discharges not meeting a statutory exclusion. The FY 2019 extended the transitional blended payment rate cases for an additional two years. FY 2021, therefore, is the first year that the blended payment rate will be completely phased out.

Technology Add-On Payments

CMS has approved thirteen technologies for add-on payments in FY 2021, including the following:

- Two related to new medical devices in connection with the FDA Breakthrough Device Program;
- Five related to alternative medical pathways for products that received FDA Qualified Infectious Disease Product (QIDP) designation;
- Six that were submitted under the traditional new technology add-on payment pathway criteria.

Additionally, one technology that has been designated as a QIDP but still awaits FDA approval has been conditionally approved by CMS. The technology add-on payments currently in place for ten of the eighteen technologies currently receiving it will continue, while eight will not due to the expiration of the newness period. Accordingly, a total of 24 technologies are eligible to receive add-on payments in FY 2021, which is expected to result in a 120% increase in technology add-on payments from FY 2020 levels.

In addition to the new technologies noted above, CMS has also adopted some changes regarding add-on payments for certain antimicrobial products in FY 2021, in response to concerns surrounding antimicrobial resistance and the resultant impact on public health. These changes include the expansion of add-on payments for QIDPs to include products approved under the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD). To qualify, antimicrobial drugs must not be "substantially similar" to an existing technology and must meet certain "substantial clinical improvement" criterion. There are also provisions to allow eligible products to begin to receive the technology add-on payment sooner if they meet the pathway criteria but still await FDA approval.

Uncompensated Care

The Affordable Care Act changed the payment methodology for Medicare disproportionate share hospitals (DSH) beginning in FY 2014, with DSHs receiving 25% of the amount they previously would have received under the statutory formula for DSH payments and the remaining 75% paid after reductions for changes in the percentage of uninsured individuals. Payments are determined based on a DSH's relative share of uncompensated care nationally. For FY 2021, approximately $8.3 billion in uncompensated care payments will be distributed, reflecting a reduction of $60 million from FY 2020. The amounts will be allocated based on information contained in hospitals' FY 2017 cost reports since these reports have already been subject to audit. For subsequent years, CMS will adopt a policy in which the most recent available single year of audited cost report data (Worksheet S-10) will be used to determine uncompensated care payments.

Value-Based Purchasing Program

The FY 2021 Final Rule did not change any changes to measures adopted in the FY 2020 IPPS/LTCH PPS Final Rule for the FY 2023 and FY 2024 program years. However, the rule does provide new performance standards for certain measures in the FY 2023 to FY 2026 program years. Changes for FY 2023 include updates to the following measures in the Safety Domain, calculated using four quarters of CY 2019 data:

- CAUTI;
- CLABSI;
- CDI;
- MRSA Bacteremia; and
- Colon & Abdominal Hysterectomy SSI.

Additionally, new performance standards for the FY 2023 Program Year were established for a new Person and Community Engagement Domain, which includes the following Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:

- Communication with nurses;
- Communication with doctors;
- Responsiveness of hospital staff;
- Communication about medicines;
- Hospital cleanliness and quietness;
- Discharge information;
- Care transition; and
- Overall rating of hospital.

Additional updates were made for FY 2024, FY 2025, and FY 2026 Program Years.

Inpatient Quality Reporting Program

The Inpatient Quality Reporting (IQR) Program subjects hospitals to penalties (by way of payment reductions) for failure to meet program requirements. Several policies related to reporting, submission, and public display requirements were adopted in the FY 2021 Final Rule, including the following:

- Increasing over a three-year period the number of quarters for which electronic clinical quality measures (eCQMs) is reported:
    - Two quarters in the CY 2021 reporting period for FY 2021 payment determination;
    - Three quarters in the CY 2022 reporting period for FY 2024 payment determination; and
    - Four quarters beginning with the CY 2023 reporting period for FY 2025 and subsequent years.
- Requiring public display of eCQMs, beginning with data reported in the CY 2021 reporting period.

PPS-Exempt Cancer Hospital Quality Reporting Program

Two program measures within the PPS-Exempt Cancer Hospital Quality Reporting Program have been refined to adopt an updated methodology developed by the Center for Disease Control and Prevention (CDC):

- Catheter-associated urinary tract infection (CAUTI); and
- Central line-associated bloodstream infection (CLABSI).

The updated CAUTI and CLABSI measures will be reported publicly beginning in fall 2022.

Medicare & Medicaid Promoting Interoperability Programs

The Final Rule adopts several changes intended to increase stability of the Medicare and Medicaid programs, reduce the burden on hospitals, and clarify existing policies. Updates include the following:

- Establishes an EHS reporting period of a minimum of any continuous 90-day period in CY 2022 for new and returning participants;
- Maintains Electronic Prescribing Objective's Query of PDMP measures as optional, worth 5 bonus points in FY 2021;
- Changes the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to Support Electronic Referral

Loops by Receiving and Reconciling Health Information measure;

- Increases the number of quarters for which hospitals must report eCQM data, as described in the IQR section above;
- Adopts public reporting (on the Hospital Compare and/or data.medicare.gov websites or their successors) of eCQM performance data beginning with data reported in the CY 2021 reporting period; and
- Corrects errors and amend regulation text relating to incentive payments for Puerto Rico hospitals and regulatory citations for the Office of the National Coordinator for Health Information and Technology certification criteria.

Market-Based MS-DRG Relative Weights

According to the Final Rule, hospitals will report median payer-specific negotiated charges (i.e., payer specific negotiated rates) for Medicare Advantage organizations on the Medicare cost report for reporting periods ending on or after January 1, 2021. The payer-specific negotiated charges used by hospitals to calculate these amounts would be the same payer-specific negotiated charges for service packages hospitals are required by make public under the Hospital Price Transparency Final Rule, cross-walked to MS-DRGs. This data will be used in a new methodology for calculating MS-DRG relative weights for inpatient hospital stays beginning in FY 2024.