Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

MAY 2020

FFY 2021 MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE – CMS-1735-P

On May 11, the Centers for Medicare & Medicaid Services (CMS) published its annual proposed rule updating the Inpatient Prospective Payment System (IPPS) effective Oct. 1, 2020 through Sept. 30, 2021 (this proposed rule will be published in the *Federal Register* on May 29). CMS estimates an overall increase is IPPS payments of 1.6%, or approximately $2.07 billion, in federal fiscal year (FFY) 2021 compared with FFY 2020. Comments are due July 10 by 4 p.m. CT. CMS waived the traditional 60-day timeframe between the publication of the final rule and the start of the federal fiscal year. Thus, the final rule may be published as late as Sept. 1. (Note: a summary of the FFY 2021 Long-Term Acute Care Hospital (LTCH) proposed rule can be found here.)

IPPS Proposed Market Basket Update (*pgs. 778-781*): CMS proposed a 3.0% market basket update, the 0.4 percentage point Affordable Care Act (ACA) productivity reduction, and a 0.5 percentage point increase to partially restore cuts made via the American Taxpayer Relief Act (ATRA) of 2021. Hospitals that fail to submit quality data would 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 provided 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
Proposed applicable percentage increase applied to standardized amount	2.6%	0.35%	1.85%	-0.4%

Proposed National Standardized Amounts (*Tables 1A-1E*): The table below summarizes the proposed standardized amounts. CMS proposed to continue using a labor-related share of 68.3% for the national standardized amounts for all IPPS hospitals that have a wage index value that is greater than 1.0000. CMS proposed a labor-related share of 62% for all IPPS hospitals whose wage index values are less than or equal to 1.0000.

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: $4,084.16 Non-Labor: $1,895.58	Labor: $3,994.60 Non-Labor: $1,854.01	Labor: $4,054.31 Non-Labor: $1,881.72	Labor: $3,964.74 Non-Labor: $1,840.15
<= 1.0000	Labor: $3,707.44 Non-Labor: $2,272.30	Labor: $3,626.14 Non-Labor: $2,222.47	Labor: $3,680.34 Non-Labor: $2,255.69	Labor: $3,599.03 Non-Labor: $2,205.86

Finally, CMS proposed a capital standard federal payment rate of $468.36.

Price Transparency and Proposed Changes to Medicare Severity-Diagnosis Related Group (MS-DRG) Data Collection and Weight Calculations (*pgs. 944-973*): CMS is implementing the Hospital Price Transparency Final Rule (IHA summary) through a proposed requirement that hospitals report median, payer-specific negotiated charges for inpatient services by MS-DRG. If finalized, CMS would require hospitals to report on the Medicare cost report the median negotiated rates for both Medicare Advantage organizations and third-party payers (which would include Medicare Advantage organizations). These data would be made public through the HCRIS dataset in a de-identified manner, making them usable for analysis by third parties. Additionally, CMS may use this information to revise its methodology for calculating inpatient PPS MS-DRG relative weights.

CMS proposed beginning this data collection for cost reporting periods ending on or after Jan. 1, 2021. CMS would begin using these data to estimate MS-DRG relative weights beginning in FFY 2024. Hospitals that do not negotiate payment rates and only receive non-negotiated payments for service would be exempt from this proposed data collection.

Finally, CMS indicated that they may consider ways to further reduce the role of the hospital chargemaster in Medicare IPPS payments through future rulemaking. Specifically, CMS is requesting comments on alternatives to the current use of hospital charges in determining other inpatient hospital payments, including outlier payments and new technology add-on payments.

Wage Index (*pgs.1335-1350, Table 3*): CMS proposed to 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 on this policy. CMS is implementing this policy in a budget neutral manner, resulting in a reduction to the FFY 2021 standardized amount for all hospitals.

CMS proposed to adopt the CBSA delineations published in the September 2018 Office of Management and Budget (OMB) Bulletin No. 18-04. This reassigns or alters some counties, which may impact the wage index for some providers. In an effort to alleviate significant losses in revenue, CMS proposed a two-year 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 full reduction would be implemented for FFY

2022. Also for FFY 2022, CMS intends to propose any updates from the more recent March 2020 OMB Bulletin No. 20-01, which was not issued in time for integration into these proposed rules.

In Illinois, counties that would experience changes under OMB Bulletin No. 18-04 include:

County	Current CBSA	Proposed CBSA
DeWitt	14010, Bloomington, IL	Rural
Ford	16580, Champaign-Urbana, IL	Rural
Fulton	Rural	37900, Peoria, IL
Johnson	Rural	16060, Carbondale, IL
Cook	16974, Chicago-Naperville-Arlington Heights, IL	16984, Chicago-Naperville-Evanston, IL
DuPage	16974, Chicago-Naperville-Arlington Heights, IL	16984, Chicago-Naperville-Evanston, IL
Grundy	16974, Chicago-Naperville-Arlington Heights, IL	16984, Chicago-Naperville-Evanston, IL
Kendall	16974, Chicago-Naperville-Arlington Heights, IL	20994, Elgin, IL
McHenry	16974, Chicago-Naperville-Arlington Heights, IL	16984, Chicago-Naperville-Evanston, IL
Will	16974, Chicago-Naperville-Arlington Heights, IL	16984, Chicago-Naperville-Evanston, IL

The proposed FFY 2021 IPPS hospital wage index values for Illinois are as follows:

CBSA	Final FFY 2020	Proposed FFY 2021*
Bloomington	0.9160	0.9046
Cape Girardeau	0.8270	0.8326
Carbondale	0.8270	0.8326
Champaign-Urbana	0.8848	0.8807
Chicago-Naperville-Evanston	1.0337	1.0246
Danville	0.9291	0.9267
Decatur	0.8566	0.8513
Elgin	1.0465	1.0524
Kankakee	0.9025	0.9057
Lake County	1.0395	1.0215
Peoria	0.8623	0.8659
Rock Island	0.9047	0.8597
Rockford	0.9751	0.9704
St. Louis	0.9260	0.9192
Springfield	0.9350	0.9151
Rural	0.8259	0.8326

*The actual wage index for an individual provider may be higher for FFY 2021, as determined by the proposed 5% limit on decreases for any provider from the FY 2020 wage index value.

Disproportionate Share Hospital (DSH) Payment Changes (*pgs. 798-863*): 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 that FFY 2021 uncompensated care amount will be approximately $7.82 billion, which is a decrease of roughly $530 million compared to FFY 2020. CMS also proposed the use of FFY 2017 Medicare Cost Report Worksheet S-10 data to determine the distribution of FFY 2021 DSH uncompensated care payments. FFY 2017

Worksheet S-10 data have been audited, and moving forward CMS proposed to use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments.

Inpatient Quality Reporting (IQR) Program (*pgs. 1090-1139*): CMS proposed two changes to the IQR electronic clinical quality measure (eCQM) reporting requirements. First, CMS proposed to progressively increase, over three years, 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 data (reported for calendar year (CY) 2023). The intent is to provide more comprehensive and reliable data for both patients and providers. Second, CMS proposed the public reporting of eCQM measure results, starting with data from CY 2021.

CMS also proposed gradual changes to the IQR measure validation process beginning in FFY 2021. Specifically, CMS proposed updating the quarters of data required for validation for both chart-abstracted measures and eCQMs, expanding targeting criteria to include hospital selection for eCQMs, 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 measures data, aligning the eCQM and chart-abstracted measure scoring process, and updating the education review process to address eCQM validation results.

CMS did not propose the adoption of any new measures. Tables summarizing the measures for FFY 2022-2024 payment determinations can be found on pgs. 1093-1096. Hospitals that do not submit required quality data will experience a 2 percentage point reduction to their annual market basket update.

Hospital-Acquired Condition (HAC) Reduction Program (*pgs. 911-922*): CMS proposed changes to the validation process to align the HAC program with proposed changes to the IQR program, aligning the hospital selection and data submission quarters beginning with FFY 2024 so there would be only one pool of hospitals submitting data for validation. CMS proposed using measure data from the third and fourth quarters of 2020 for the FFY 2023 program year for both random and targeted validation pools. For FFY 2024 and subsequent program years, CMS proposed using measure data from all of CY 2021 for both the HAC and IQR programs, with data submission deadlines for chart-abstracted measures falling in the middle of the fifth month following the end of the reporting year.

Additionally, beginning FFY 2024, CMS proposed reducing the total validation pool from 600 hospitals to 400 hospitals, and requiring hospitals to submit digital files when submitting medical records for validation of HAC measures. Under this proposal, CD, DVD, or flash drive files would no longer be accepted; only PDF copies of medical records submitted via direct electronic file submission through a CMS-approved secure file transmission process would be allowed.

Finally, CMS proposed amending the definition of *applicable period* at 42 CFR 412.170 beginning FFY 2023. Specifically, the applicable period will automatically advance by one year from the prior fiscal year's applicable period.

Hospital Readmissions Reduction Program (RRP) (*pgs. 877-887*): Similar to HAC, CMS proposed the automatic adoption of applicable periods for RRP program years beginning in FFY 2023. Under this proposal, the applicable period for RRP measures and determining dual eligibility

would be the three-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 is not proposing the removal or adoption of additional measures at this time.

Hospital Value-Based Purchasing (VBP) Program (*pgs. 888-910*): CMS provided newly established performance standards for the FFY 2026 program year as follows:

Measure	Achievement Threshold	Benchmark
Clinical Outcomes Domain		
MORT-30-AMI	0.874426	0.890687
MORT-30-HF	0.885949	0.912874
MORT-30-PN	0.843369	0.877097
MORT-30-COPD	0.914691	0.932157
MORT-30-CABG	0.970568	0.980473
COMP-HIP-KNEE*	0.024019	0.016873
Efficiency and Cost Reduction Domain		
Medicare Spending per Beneficiary (MSPB)*	Median MSPB ratio across all hospitals during the performance period.	Mean of the lowest decile MSPB ratios across all hospitals during the performance period.

*Lower values represent better performance.

Proposed FFY 2021 proxy hospital VBP program adjustment factors can be found in Table 16. CMS did not propose adding new measures or removing measures from the Hospital VBP program.

Hospital Overall Star Ratings (*CMS Fact Sheet*): Due to the ongoing COVID-19 public health emergency, CMS did not propose planned changes to its star rating methodology.

CAR T-Cell Therapy (*pgs. 62-63*): CMS proposed the creation of a new MS-DRG for CAR T-Cell therapy: MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy). The proposed relative weight is 37.1412, which better reflects the high cost of CAR T-cell therapy than its current MS-DRG. Additionally, CMS Proposed to revise the title of MS-DRG 016 as CAR T-cell therapy will no longer be included to: Autologous Bone Marrow Transplant with CC/MCC. CMS proposed to discontinue new technology add-on payments for the two CAR T products currently available.

Complications or Comorbidities (CC) and Major Complications or Comorbidities (MCC) (*pgs. 220-223*): CMS continues to analyze CCs and MCCs, and introduced a set of guiding principles that would be used to determine whether the presence of a specified secondary diagnosis would typically lead to increased hospital resource use. CMS seeks public comment on these guiding principles (below), as well as other possible ways the agency can incorporate meaningful indicators of expected resource use and clinical severity by a secondary diagnosis.

Proposed guiding principles as meaningful indicators of expected resource use by a secondary diagnosis:

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 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.

New Technology Add-on Payments (NTAPs) (*pgs. 269-675*): CMS presented 24 new applications for NTAPs in this proposed rule, and proposed the continuation of NTAPs for 10 current NTAP technologies in FFY 2021 (*pg. 310*).

Additionally, under the FFY 2020 IPPS final rule, technologies in the U.S. Food and Drug Administration (FDA) Breakthrough Devices Program and technologies with FDA Qualified Infectious Disease Product (QIDP) designation were considered new and not substantially similar to existing technologies. CMS proposed extending this decision to products approved through FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) starting in FFY 2022. Further, CMS proposed conditional NTAP approval for QIDPs and LPADs that do not receive FDA marketing authorization or LPAD pathway approval by July 1, but otherwise meet the applicable NTAP criteria.

Contact IHA

Sources:
Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals. May 29, 2020. Available from: https://www.federalregister.gov/documents/2020/05/29/2020-10122/medicare-programs-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Accessed May 1, 2020.

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