2021 IPPS Final Rule
Key Points

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The 2021 Hospital Inpatient Prospective Payment System (IPPS) Final Rule has been issued and changes are on the way that can affect your organization's Medicare reimbursement.

As part of our commitment to help protect and enhance your Medicare revenue, we've developed this expert analysis of the FY 2021 IPPS Final Rule to quickly give you insight into the most important changes.

BESLER remains your trusted advisor and we look forward to helping you identify areas of revenue opportunity for your facility.

Jonathan H. Besler

The Medicare Hospital Inpatient Prospective Payment System (IPPS) rates are required by law to be updated annually.

The original goal of IPPS was to incentivize hospitals to operate efficiently, while compensating hospitals for the cost of providing high quality health care to Medicare beneficiaries.

This report contains key changes to the FY 2021 IPPS Final Rule.

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Market Basket Rate

- The Market Basket Rate increase for the upcoming federal fiscal year is **2.4%**
- That is the maximum a hospital provider can receive
- It is adjusted downward based on whether or not the hospital submitted Quality Data and whether or not the hospital is a meaningful user

Market Basket Rate

The following table illustrates the various scenarios

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 under Section 1886)b)(3)(B)(viiii) of the Act	0	0	(0.6)	-0.6
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	(1.8)	0	(1.8)
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	0	0	0	0
Applicable Percentage Increase Applied to Standardized Amount	2.4	0.6	1.8	0

National Adjusted Operating Standardized Amounts

TABLE 1A. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (68.3 PERCENT LABOR SHARE/31.7 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.6 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.8 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0 Percent)	
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	$1,856.48	$4,047.63	$1,878.63	$3,976.06	$1,845.41

National Adjusted Operating Standardized Amounts

TABLE 1B. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.6 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.8 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,695.94	$2,265.25	$3,630.97	$2,225.43	$3,674.28	$2,251.98	$3,609.31	$2,212.16

National Adjusted Operating Standardized Amounts

TABLE 1C. FINAL RULE ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National[1]	Not Applicable	Not Applicable	$3,695.94	$2,265.25

[1]For FY 2021, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

National Adjusted Operating Standardized Amounts

TABLE 1E- LTCH PPS STANDARD FEDERAL PAYMENT RATE		
	Full Update (2.3 Percent)	Reduced Update* (0.3 Percent)
Standard Federal Rate*	$43,755.34	$42,899.90

* For LTCHs that fail to submit quality reporting data for FY 2021 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the annual update is reduced by 2.0 percentage points as required by section 1886(m)(5) of the Act.

Capital Standard Federal Payment Rate

The Capital Standard Federal Payment Rate will be $466.22

Up from $462.33 from FY 2020

Medicare DSH and Uncompensated Care Payments

Medicare DSH and Uncompensated Care Payments

The estimated Medicare DSH amount for FY 2021 is $15,170,673,476

(25% of which pertains to Empirical DSH)

Uncompensated Care

Uncompensated Care is comprised of three factors:

1. Estimated Medicare DSH
2. CMS' uninsured estimate
3. UC payment calculation

Factor #1: Estimated Medicare DSH

Factor 1 is the estimated Medicare DSH amount for FY 2021 of $15.170 Billion less the 25% for Empirical DSH

The result is $11,378,005,107 for Factor 1

Factor #2: CMS' uninsured estimate

Factor 2 is the uninsured estimate produced by CMS' Office of the Actuary.

The estimate in the proposed rule was 67.86% however, the Final Rule used a revised estimate of 72.86% accounting for the effects of COVID-19.

Its application results in a total Uncompensated Care budget of $8,290,014,520 ($11,378,005,107 x 72.86), which is down slightly from $8.4 billion in FY 2020

Factor #3: UC payment calculation

Factor 3 determines the portion a hospital receives in UC payments. For FFY 2021, Factor 3 will be calculated using Line 30 of Worksheet S-10 from 2017 cost report data. This is the most recent and available single year audited S-10 data.

For future years, CMS will use the most recent and available single year audited S-10 data.

Wage Index

Wage Index

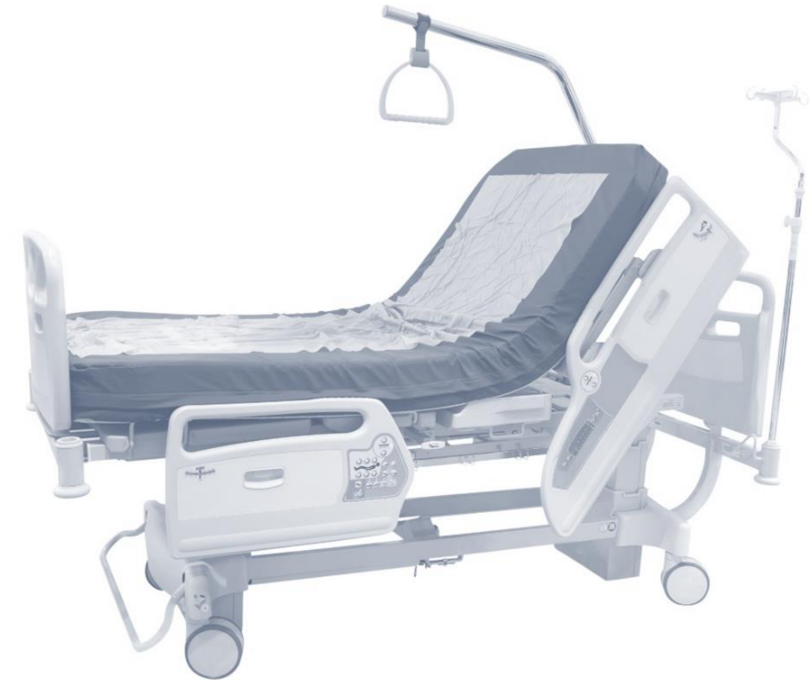
- Based on revised OMB delineations, 34 counties designated as Urban would become Rural beginning with the FY 2021 wage index
- 47 counties that were previously Rural will now be considered Urban
- 19 counties would move to another CBSA or to a new or modified CBSA
- There is a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2020

Wage Index

- The FY 2021 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2017 (beginning on or after 10/1/16 and before 10/1/17)
- The 2016 Medicare Wage Index Occupational Mix Survey is applicable for the FY 2021 wage index

Low Wage Index Hospitals

- Hospitals with a wage index value below the 25th percentile will continue to have their wage index value increased by half the difference between the final wage index for that hospital and the 25th percentile across all hospitals
- The 25th percentile for FY 2021 is estimated to be 0.8420



Rural Floor

- The area wage index applicable to any hospital located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state, which is estimated to benefit 285 hospitals In FY 2021
- The rural floor for this FY 2021 final rule is calculated without the wage data of hospitals that have reclassified as rural under § 412.103

New MS-DRGs

There are 12 new MS-DRGs for FFY 2021:

MS-DRG	MS-DRG Title	Weights
018	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL IMMUNOTHERAPY	37.3290
019	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS	6.6619
140	MAJOR HEAD AND NECK PROCEDURES WITH MCC	3.9806
141	MAJOR HEAD AND NECK PROCEDURES WITH CC	2.2075
142	MAJOR HEAD AND NECK PROCEDURES WITHOUT CC/MCC	1.6088
143	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH MCC	2.9638
144	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH CC	1.7505
145	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITHOUT CC/MCC	1.2135
521	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITH MCC	3.0634
522	HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	2.1891
650	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITH MCC	4.5131
651	KIDNEY TRANSPLANT WITH HEMODIALYSIS WITHOUT MCC	3.6936

MS-DRG 018 is of particular interest due to its very high DRG Weight. In addition, MS-DRGs 129 and 130 will be deleted

MS DRGs Subject to Post-Acute Transfer Policy

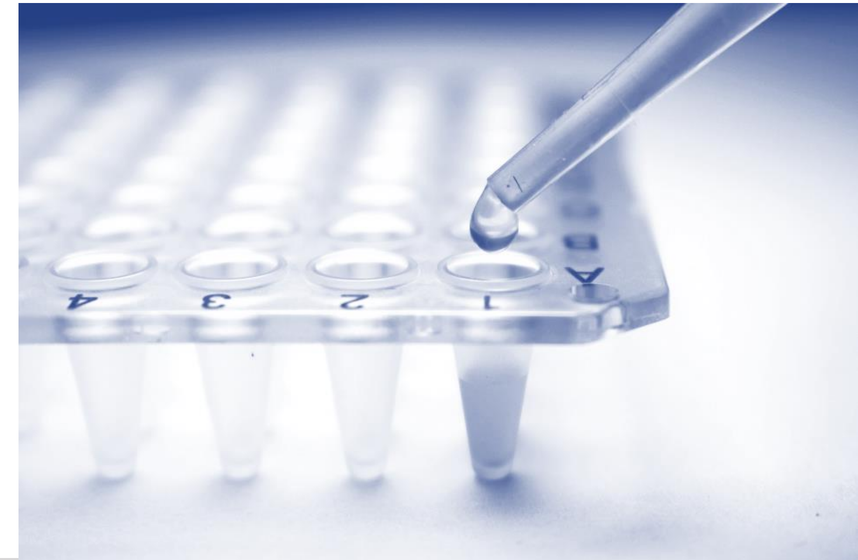
The following DRGs will be added to the list of MS-DRGs that are subject to the post-acute transfer policy:

- 521 – Hip replacement with principal diagnosis of hip fracture with MCC
- 522 – Hip replacement with principal diagnosis of hip fracture without MCC

Acquisition costs and add-on payments

Stem Cell Acquisition Costs

- Effective for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant will be reimbursed on a reasonable cost basis
- A hospital that furnishes an allogeneic hematopoietic stem cell transplant is not required to be a Medicare certified transplant center as is required for solid organs; therefore, a hospital that bills using revenue code 0815 for inpatient allogeneic hematopoietic stem cells is sufficient verification



New Technology Add-On Payments

- CMS will establish a process in which certain antimicrobial products approved as QIDPs (Qualified Infectious Disease Products), approved under an alternative inpatient new technology add-on payment pathway, would receive conditional approval for a payment even if the product has not been granted FDA marketing authorization by July 1, but otherwise meets the applicable add-on payment criteria.

This appears directly correlated with the COVID-19 pandemic

Price Transparency

Price Transparency

- Hospitals will report on their Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organization payers, by MS-DRG, for cost reporting periods ending on or after January 1, 2021
- In addition, CMS is finalizing the adoption of a market-based MS-DRG relative weight methodology for calculating the MS-DRG relative weights, beginning in FY 2024
- The market-based MS-DRG relative weight methodology would utilize the median payer-specific negotiated charge data negotiated between hospitals and MA organizations

Medicare Performance Programs

Hospital Acquired Conditions Reduction Program

- The Hospital Acquired Conditions Reduction Program (HAC) currently evaluates participating hospitals through six measurements:
  - One is a CMS patient safety and adverse events measure
  - Five are CDC health care-associated infections measures.

Hospital Acquired Conditions Reduction Program

Since 2019, CMS has used a 24-month period to collect sets of measurements

This 24-month period methodology will become permanent and will advance by one year automatically thereafter every year

Hospital Readmissions Reduction Program

- The Hospital Readmission Reduction Program reduces payments to hospitals based on readmission rates
- Traditionally, CMS has used three years of data for measuring readmissions, and the applicable period is announced with each rulemaking
- CMS is making permanent the three-year reporting period of readmission data for the Hospital Readmissions Reduction Program
- The measures created in FY 2019 will remain unchanged
- This program is expected to save CMS over $500 million and impact over 2,000 hospitals

Hospital Value Based Purchasing Program

- CMS is providing newly established performance standards for certain measures for:
  - FY 2023 program year
  - FY 2024 program year
  - FY 2025 program year
  - FY 2026 program year

The estimated amount available for value-based incentive payments for FY 2021 discharges is approximately $1.9 billion

Hospital Inpatient Quality Reporting

- Hospitals are required to report data on measures selected by the Secretary for a fiscal year in order to receive the full annual percentage increase that would otherwise apply to the standardized amount applicable to discharges occurring in that fiscal year
- CMS has finalized proposals to the reporting, submission, and public display requirements of the data (eCQM) to include the increase of the number of quarters of data being reported

Medicare Bad Debt

Medicare Bad Debt

- The requirements for a Medicare Bad Debt are in 42 CFR 413.89 and in the PRM Chapter 3
- The PRM Chapter 3 is more specific concerning the requirements and has been applied by most MACs
- It appears the main objective by CMS is to codify these longstanding applications
- Documentation required includes Bad Debt Collection Policy, Patient Account history that documents collection efforts, and indigence determination policy

Medicare Bad Debt **Key Requirements**

- **Efforts to collect** the Medicare deductible and coinsurance must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients

- **Reasonable collection efforts** for non-indigent beneficiaries must last at least 120 days; and must start anew each time a payment is received

Medicare Bad Debt **Key Requirements**

- **A bill must be issued on or before 120 days** after the latter of one of the following:
  1. 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
  2. The date of the remittance advice from the beneficiary's secondary payer, if any
  3. The date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary

Medicare Bad Debt **Key Requirements**

- In order to **conclude that a non-dual eligible beneficiary is indigent**, the provider:

  1. Must not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence
  2. 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

Medicare Bad Debt **Key Requirements**

- In order to conclude that a non-dual eligible beneficiary is indigent, the provider:

3. 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
4. Must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid program

Medicare Bad Debt **Key Requirements**

- **Dual eligible accounts** - The provider must bill the state and submit the resulting Medicaid RA to Medicare and deduct the appropriate state cost sharing liability from the Medicare bad debt reimbursement
- **Financial reporting**
  - For cost reporting periods **before October 1, 2020**, Medicare bad debts must not be written off to a contractual allowance account but must be **charged to an expense account for uncollectible accounts**
  - **For cost reporting periods on or after October 1, 2020**, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an **uncollectible receivables account** that results in a reduction in revenue

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We serve as advocates for hospitals, so that they, in turn, can better advance the health and well-being of their patients.

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