CMS ISSUES IPPS/LTCH PROPOSED RULE FOR FY 2021

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On 11 May 2020, the Centers for Medicare & Medicaid Services (CMS) issued in pre-publication form the proposed rule for the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System for Fiscal Year (FY) 2021 (IPPS Proposed Rule).[1] Along with payment rates updates, the IPPS Proposed Rule contains a number of notable proposals, including in the following areas:

- Collection of Market-Based Medicare Severity Diagnosis Related Group (MS-DRG) Relative Weight Data on Medicare cost reports and Potential Change to the Methodology for Calculating MS-DRG Relative Weights
- New MS-DRG for Chimeric Antigen Receptor (CAR) T-Cell Therapies
- Disproportionate Share Hospital (DSH) Payment Adjustment and Uncompensated Care Payment
- Medicare Bad Debt Policy
- Hospital-Acquired Condition (HAC) Reduction Program
- Hospital Inpatient Quality Reporting (IQR) Program
- Reclassification of Hospitals from Urban to Rural
- Clarification of Applicable Rural Referral Center (RRC) Criteria for Purposes of Meeting Urban to Rural Reclassification at § 412.103(a)(3)

A high-level summary of these proposals is set forth below. While CMS indicated an intent to make the 2021 changes less substantial as providers are facing the day-to-day challenges of the COVID-19 crisis,[2] a number of changes, such as those set forth below, merit close attention by providers.

Comments are due by 10 July 2020. Because of the resources required for CMS to respond to the COVID-19 public health emergency, CMS has indicated it is waiving the 60-day delay in the effective date of the final rule and replacing it with a 30-day delay in the effective date of the final rule.[3] In this regard, providers will have a shorter window than normal to adjust to changes finalized in this year's IPPS final rule.

PROPOSAL TO COLLECT MARKET-BASED MS-DRG RELATIVE WEIGHT DATA AND POTENTIAL CHANGE TO THE METHODOLOGY FOR CALCULATING MS-DRG RELATIVE WEIGHTS

CMS proposes that hospitals report certain market-based rate information on cost reports for cost reporting periods ending on or after 1 January 2021.[4] CMS states that this proposal is intended to reduce the Medicare program's reliance on hospital chargemasters and advance the goals of President Trump's Executive Order (EO) 13813[5] (*Promoting Healthcare Choice and Competition Across the United States*) and EO 13890[6] (*Protecting and Improving Medicare for Our Nation's Seniors*) and the development of a market-based approach to payment that better reflects the market value for inpatient items and services.[7]

The IPPS Proposed Rule would require hospitals to report two median payer-specific negotiated charges by MS-DRG: (1) the median payer-specific negotiated charge with all Medicare Advantage (MA) payers, and (2) the median payer-specific negotiated charge with all third-party payers, including MA payers.[8] For third-party payers that do not use the same MS-DRG system as Medicare, the payer-specific negotiated charges are the charges that hospitals negotiate based on the system used by the third-party payer, such as per diem rates or All Patient Refined-DRGs.[9] CMS notes its expectation that this reporting should be less burdensome because hospitals would use the payer-specific negotiated charge data required to be made public under the Hospital Price Transparency final rule to calculate the information required to be reported on the cost report.[10]

CMS is also seeking comments on a potential change to methodology for calculating IPPS MS-DRG relative weights to incorporate this market-based information, beginning in FY 2024, as described by CMS in the IPPS Proposed Rule. CMS is considering adopting this methodology change in FY 2021 IPPS/LTCH PPS final rule.[11]

PROPOSAL FOR NEW MS-DRG FOR CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL THERAPIES

CMS proposes to create a new MS-DRG for CAR T-cell therapies beginning FY 2021.[12] CMS proposes to assign cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to this MS-DRG.[13] Prior to FY 2021, CAR T-cell therapy was reimbursed under the MS-DRG for bone marrow transplant with a new technology add-on payment. In conjunction with the creation of the new MS-DRG, CMS is proposing to discontinue the new technology add-on payment for KYMRIAH® and YESCARTA® in FY 2021.[14]

PROPOSED DSH PAYMENT ADJUSTMENT AND UNCOMPENSATED CARE PAYMENTS

The Affordable Care Act provided for a reduction to disproportionate share hospital (DSH) payments and for a new uncompensated care payment to eligible hospitals. For fiscal years on and after 2014, subsection (d) hospitals[15] that would otherwise receive a DSH payment pursuant to section 1886(d)(5)(F) of the Social Security Act (Act) instead receive two separate payments: (1) 25 percent of the amount they previously would have received for DSH (“the empirically justified amount”), and (2) an additional payment for the DSH hospital's proportion of uncompensated care. The additional payment for uncompensated care is based on three factors: (1) 75 percent of the payments that would otherwise be made under section 1886(d)(5)(F) of the Act, (2) 1 minus the percent change in the percent of individuals who are uninsured, and (3) a hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage.[16]

In the IPPS Proposed Rule, CMS sets forth its proposed methodology and calculations for these three factors.[17] For FY 2021, to calculate Factor 3, CMS proposes to use a single year of Worksheet S-10 data for all eligible hospitals, with the exception of Indian Health Service (IHS) and tribal hospitals.[18] CMS also proposes in subsequent years to use the most-recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments for all eligible hospitals, with the exception of IHS and tribal hospitals.[19]

CMS indicates the expected result is a reduction in payments of approximately US$534 million for uncompensated care from FY2020 to FY2021,[20] driven by a proposed decrease in Factor 1, a proposed increase in Factor 2, and a decrease in the number of hospitals projected to be eligible to receive DSH in FY 2021.[21]

Hospitals should review their hospital-specific data in the IPPS Proposed Rule table and supplemental data file carefully and provide any comments to CMS in accordance with the timelines laid out in the IPPS Proposed Rule.[22]

PROPOSED REVISIONS TO MEDICARE BAD DEBT POLICY

CMS proposes to clarify, update, and codify what CMS indicates are "longstanding Medicare bad debt principles" by revising 42 C.F.R. § 413.89.[23] The commentary contains substantial discussion and proposed revisions to regulations, including related to reasonable collection efforts for various categories of beneficiaries.[24] CMS proposes that its clarification and codification of Medicare bad debt policies will be effective even for cost reporting periods beginning before the effective date of the IPPS Proposed Rule, which would otherwise generally be 1 October 2020, consistent with the language of the regulations.[25]

Additionally, CMS proposes to recognize the new Accounting Standards Update – Topic 606 for revenue recognition and classification of Medicare bad debts.[26]

GRADUATE MEDICAL EDUCATION

CMS proposes to add a definition of "displaced resident" to 42 C.F.R. § 413.79 for the purpose of temporary funding in the event of closing of a hospital or residency program, which would include those residents who leave a program after the hospital or program closure is publicly announced but before the actual hospital or program closure.[27]

HAC REDUCTION PROGRAM

CMS proposes an automatic adoption of the 24-month lookback period for data collection, where each year the lookback period would automatically be advanced one year from the previous program year.[28] CMS would accordingly amend the definition of "applicable period" at 42 C.F.R. § 412.170 to align with this proposal.[29]

CMS further proposes to align the HAC Reduction Program data validation process to align with the Hospital IQR Program validation process by shifting the quarterly submission deadlines so that both programs are aligned.[30]

The IPPS Proposed Rule would also reduce the number of hospital selected for validation under the HAC Reduction program by one third, randomly selecting 200 fewer hospitals for validation each year.[31]

CMS is also discontinuing allowing data submission through the use of CDs, DVDs, or flash drives beginning with Q1 2021 for FY 2024 program year validation.[32]

HOSPITAL IQR PROGRAM

CMS proposes to implement a process to incrementally combine the use of chart-abstracted measure data and electronic clinical quality measures (eCQM) data as part of the data verification process.[33] To accomplish this, CMS proposes a series of updates:

- Similar to the HAC Reduction Program changes, reduction in the validation pool for the IQR Program from 800 hospital to 400 hospitals[34] and discontinuation of allowing data submission through CDs, DVDs, or flash drives.[35]
- Progressively increase, over a three-year period, the number of quarters for which hospitals are required to submit eCQM data, with hospitals eventually being required to report four calendar quarters of data beginning with the CY 2023 reporting period/FY2015 payment determination period.[36]
- Eventual phase-in of the use of eCQMs for data validation, in addition to the current use of chart-abstracted measures. CMS proposes a weighted score proposal where a hospital's validation score would be a weighted combination of a hospital's validation performance for chart-abstracted measures and eCQMs.[37]
- Expansion of the criteria for targeting hospitals for validation to include hospital selection for eCQM[38] and update the education review process to address eCQM validation results.[39]

RECLASSIFICATION FROM URBAN TO RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT IMPLEMENTED AT 42 C.F.R. § 412.103

The IPPS Proposed Rule updates the classification of whether a location is urban or rural using delineations established in Office of Management and Budget Bulletin 18-04 to set IPPS base rates beginning in FY 2021. As a result of these changes, new Core-Based Statistical Areas (CBSAs) would be established, some urban counties would become rural, some rural counties would become urban, and some existing CBSAs would be split apart.[40]

CMS proposes implementing transition policies to help mitigate impacts on hospitals by placing a 5 percent cap on the decrease in any hospital's wage index from the hospital's final wage index for FY 2020, such that a hospital's final wage index for FY 2021 would not be less than 95 percent of its final wage index for FY 2020.[41] In order to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile wage index value, CMS is proposing to apply a budget neutrality adjustment in the same manner as CMS applied it in FY 2020, i.e., as a uniform budget neutrality factor.[42]

As in FY 2020, CMS proposes to remove urban to rural reclassifications from the calculation of the rural floor to prevent inappropriate payment increases under the rural floor.[43]

The changes in urban/rural status would also impact DSH payments. To ease this impact, the first year after a hospital loses urban status, CMS proposes that the hospital will receive an adjustment to its DSH payment that equals two-thirds of the difference between the urban DSH payments applicable to the hospital before its

redesignation from urban to rural and the rural DSH payments applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an adjustment to its DSH payment that equals two-thirds of the difference.[44]

CLARIFICATION OF APPLICABLE RURAL REFERRAL CENTER (RRC) CRITERIA FOR PURPOSES OF MEETING URBAN TO RURAL RECLASSIFICATION AT 42 C.F.R. § 412.103(A)(3)

RRCs receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification. 42 C.F.R. § 412.103(a)(3) sets out the general rules under which a hospital can qualify for reclassification from urban to rural; however, 42 C.F.R. § 412.96(c) provides alternative criteria that the hospital could use to qualify a rural hospital as an RRC. The criteria under § 412.96 includes criteria (among other factors) related to the hospital's Case Mix Index (CMI) and its number of discharges.

In the IPPS Proposed Rule, CMS acknowledges that there is confusion about which fiscal year's published CMI and number of discharges should be used for the purpose of meeting the alternative standard under § 412.96. CMS is therefore clarifying that the appropriate CMI and discharges are those published in the IPPS/LTCH PPS final rule in effect when the RRC classification will be effective, which is at the start of the hospital's next cost reporting period.[45]

KEY TAKEAWAYS

Notwithstanding CMS's stated intent to focus primarily on essential policies and proposals to reduce provider burden, the IPPS Proposed Rule still contains material changes that, if finalized, could have long-term impacts on hospital providers. As such, providers should carefully review the rule as it relates to the items outlined above and the many topics not covered herein to assess the particular impact that the IPPS Proposed Rule may have on their facility. The K&L Gates' Health Care practice regularly advises clients in the area of Medicare reimbursement and stands ready to assist health systems and hospitals in assessing the impact of these proposed rule changes on their current and future operations.

FOOTNOTES

[1] 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. The IPPS Proposed Rule will be published in the *Federal Register* on 29 May 2020.

[2] *See* Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P).

[3] IPPS Proposed Rule, at 11.

[4] *Id*. at 944–46.

[5] *See* Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 12, 2017) (promotion of association health plans, short-term, limited duration insurance, and health reimbursement arrangements to operate across state lines and create competition in the health care market).

[6] *See* Exec. Order No. 13,890, 84 Fed. Reg. 53,573 (Oct. 3, 2019) (promotion of protecting and improving existing Medicare program in opposition to "Medicare for All").

[7] IPPS Proposed Rule, at 944–48.

[8] *Id*. at 949–51.

[9] *Id*.

[10] *Id*.

[11] *Id*. at 951–52.

[12] MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy).

[13] IPPS Proposed Rule, at 62.

[14] *Id*. at 290.

[15] A subsection (d) hospital is a hospital as defined in section 1886(d)(1)(B) of the Act—largely hospitals paid under the IPPS.

[16] IPPS Proposed Rule, at 10.

[17] *Id*. at 808–60.

[18] *Id*. at 840.

[19] *Id*.

[20] *Id*. at 23.

[21] *Id*. at 1510.

[22] *Id*. at 861–62.

[23] *Id*. at 1210.

[24] The categories of beneficiaries include: non-indigent beneficiaries, *id*. at 1212, beneficiaries determined indigent by providers using required criteria, *id*. at 1227, and dual-eligible beneficiaries and the Medicaid remittance advice, id. at 1230.

[25] *Id*. at 1210–11.

[26] *Id*. at 1240, 1250.

[27] *Id*. at 926 –30.

[28] *Id*. at 915.

[29] *Id*. at 921.

[30] *Id*. at 917.

[31] *Id*. at 919.

[32] *Id*. at 920.

[33] *Id*. at 1111.

[34] *Id*. at 1122.

[35] *Id*. at 1123.

[36] *Id*. at 1100.

[37] *Id*. at 1128.

[38] *Id*. at 1117.

[39] *Id*. at 1131.

[40] *Id*. at 680.

[41] *Id*. at 692.

[42] *Id*. at 721.

[43] *Id*. at 722.

[44] *Id*. at 683–84.

[45] *Id*. at 753–55.

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