FY21 IPPS, LTCH Payment Rules Finalized

September 3, 2020

On September 2, 2020, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) final rule. The rule will increase inpatient hospital services payments by 2.7 percent while overall payments to LTCHs will decrease by 1.1 percent due to statutory implementation of the revised LTCH PPS payment system. The new rules take effect October 1, 2020.

Among various policies, CMS finalized a requirement that hospitals report the median rate they negotiate with Medicare Advantage organizations for inpatient services to help CMS calculate Medicare payment rates starting in FY2024. Additionally, CMS approved 13 technologies that applied for new technology add-on payments and adopted some changes regarding new technology add-on payments for certain antimicrobials for FY2021.

Click here for the CMS fact sheet and here for the final rule. The following provides some additional details of the final rule.

Payment Updates

In the final rule, CMS projects payments to acute care hospitals will increase by $3.5 billion in fiscal year 2021, or 2.7 percent. For hospitals that successfully participate in the Hospital Inpatient Quality Reporting program and are meaningful users of electronic health records, CMS will increase operating payments by 2.9 percent.

Payments to long-term care hospitals are expected to decrease 1.1 percent, or $40 million. This projected decrease is due to the continued statutory implementation of the revised LTCH PPS site neutral payment system under and the standard LTCH payment rates are expected to increase by 2.2 percent primarily with the annual standard Federal rate update for FY2021 of 2.3 percent.

Price Transparency Requirements

The rule allows for a waiver for CMS to implement it less than 60-days after its release due to the coronavirus pandemic, to begin collecting data in the upcoming fiscal year and tie the median charge for a service to pay rates by FY2024. This policy will require hospitals to report on their Medicare cost report the median payer-specific negotiated charge from all Medicare Advantage payers, by MS-DRG, for cost reporting periods ending on or after Jan. 1, 2021. CMS also finalized a market-based way to pay hospitals in FY2024 that will use the median payer-specific negotiated charge data negotiated between hospitals and MA organizations.

CMS did not however finalize the proposed requirement for hospitals to report the median payer-specific negotiated charge for all payers on the cost report stating that the difference between

how all payers handle inpatient hospital pay and how Medicare handles it could be bigger than if the agency only looked at MA plans' pay rates and would require a much longer time period to implement the changes by FY2024. CMS states that there will not be a transition between the pay methods.

New Technology Add-On Payments

The finalized rule creates 13 new add-on payments for new innovative technologies and one conditionally approved allowing for a total of 24 eligible technologies to receive add-on payments for FY2021 after eight technologies will lose their newness period for the next fiscal year. The 13 technologies include two technologies under the alternative pathway for new medical devices that are part of the FDA Breakthrough Devices Program and five technologies approved under the alternative pathway for products that received FDA Qualified Infectious Disease Product designation. CMS also expanded its alternative add-on payment program process for certain anti-microbial products finalized as part of FY2020 rule to include additional products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs considering recent information that continues to highlight the significant concerns and impacts related to antimicrobial resistance.

Medicare Uncompensated Care Payments

CMS estimates that uncompensated care payments will decrease by about $60 million from FY2020 for a projected total of roughly $8.3 billion in uncompensated care payments. CMS will continue to calculate uncompensated care payments based on a single year of data and will base its distribution of FY2021 uncompensated care on data from Worksheet S-10 of the FY 2017 Medicare cost report. This estimate of total uncompensated care payments reflects CMS Office of the Actuary's projections that incorporate the estimated impact of the COVID-19 pandemic.

Graduate Medical Education Policy

CMS will change its policy for closing teaching hospitals and closing residency programs to address the needs of residents and expand its definition of who is considered a displaced resident when teaching hospitals and residency programs close. The goal is to provide greater flexibility for the residents to transfer while the hospital operations or residency programs are winding down, and allow funding to be transferred for certain residents who are not physically at the closing hospital/closing program.