



IPPS FY2021 Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) have released the annual Hospital Inpatient Prospective Payment System (IPPS) [proposed rule](#), which does not include any changes to the overall Hospital Star Rating Program as previously announced by CMS. CMS expects a payment increase of 1.6 percent for hospitals and an overall decrease of 0.9 percent for long-term care hospitals. The rule predicts a market basket increase of 3.0 percent. **Comments on the rule are due July 10, 2020.**

Key Provisions:

Price Transparency

- Require hospitals to report certain market-based payment rate information on Medicare cost reports for reporting periods ending on or after January 1, 2021. This would be used to change the methodology for calculating MS-DRG relative weights. The data reported would include:
 - Median payer-specific negotiated charges for all Medicare Advantage (MA) payers by MS-DRG.
 - Median payer-specific negotiated charges for all other third-party payers by MS-DRG.

New Methodology for Inpatient Payments

- CMS seeks comments on using the median negotiated charges (either from all payers or only MA) to adjust Medicare payment rates beginning in FY 2024.
 - MS-DRG relative weights would use hospital-reported median charges as a proxy for hospital resources used to provide inpatient services.
 - The charge data would be a subset of payer-specific negotiated charges that, starting January 1, 2021, hospitals would be required to make public under 45 CFR Part 180.
- CMS seeks comments on:
 - The best way to calculate a single standardized median payer-specific negotiated charge across hospitals.
 - Alternatives that would capture market-based information for the potential use in Medicare Fee-for-Service (FFS) payments.
 - The relative burden of calculating and submitting a median negotiated reimbursement amount.



IPPS FY2021 Proposed Rule

MS-DRGs

- Adopt a +0.5 adjustment to the standardized amount of Medicare payments for acute care hospitals.
- Create a new MS-DRG for CAR T-cell immunotherapy. These therapies would no longer be eligible for the new technology add-on payment.
- Create two new MS-DRGs, 521 (hip replacement with principal diagnosis of hip fracture with MCC) and 522 (hip replacement with principal diagnosis of hip fracture without MCC). Currently, these procedures would be assigned to MS-DRGs 469 or 470, which trigger episodes of care under the Comprehensive Care for Joint Replacement (CJR) model. CMS seeks comments on how these new MS-DRGs may impact the CJR model and whether they should be incorporated into the CJR model's proposed extension to December 31, 2023.

ICD-10-CM Code Updates

- Add 490 new, 47 revised, and 58 invalidated ICD-10-CM codes. Newly proposed ICD-10-CM codes include options for sickle cell anemia and arthritis. The list of proposed changes to the ICD-10-CM/PCS codes is available in [tables 6A–6K and 6P.1a–6P.4a of the proposed rule](#).

New Technology Add-On Payments

- Include Qualified Infectious Disease Products (QIDPs) approved through the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) pathway in the new technology add-on payment pathway.

Low Wage Index Hospital Policy

- Continue the low wage hospital policy implemented in the FY2020 IPPS/LTCH PPS final rule.

DSH and Uncompensated Care Payments

- Use uninsured estimates from the Office of the Actuary in the calculation of *Factor 2*.
- Use a single year of uncompensated care data from Worksheet S-10 of the FY2017 cost reports to calculate *Factor 3* in the FY2021 methodology for all hospitals (except for Indian Health Service, Tribal and Puerto Rican hospitals).
- Calculate *Factor 3* for all subsequent fiscal years using the most recent available single year of audited Worksheet S-10 data.



IPPS FY2021 Proposed Rule

Hospital Inpatient Quality Reporting Program

- Change the reporting, submission and public display requirements for eCQMs by:
 - Progressively increasing the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three-year period. Hospitals will be required to report:
 - Two quarters of data for the CY2021 reporting period (FY2023 payment determination);
 - Three quarters of data for the CY2022 reporting period (FY2024 payment determination);
 - Four quarters of data for the CY2023 reporting period (FY2025 payment determination), as well as for subsequent years.
 - Hospitals will still be allowed to report three self-selected eCQMs as well as the Safe Use of Opioids eCQM.
 - Publicly display eCQM data beginning with data reported by hospitals for the CY2021 reporting period.
 - Expanding the requirement to use EHR technology to all hybrid measures in the IQR program.
 - Require that all participants submit chart abstracted measures electronically.

Promoting Interoperability Program

- Establish a reporting period of a minimum of any continuous 90-day period in in CY 2022 for new and returning participants.
- Maintain the Electronic Prescribing Objective's *Query of PDMP* measure as optional and worth five bonus points in CY 2021.
- Modify the name of the *Support Electronic Referral Loops by Receiving and Incorporating Health Information* measure.
- Progressively increase the number of quarters for which hospitals are required to report eCQM data, from the current requirement of one self-selected calendar quarter of data, to four calendar quarters of data over a three-year period.
- Publicly report eCQM performance data on the *Hospital Compare* and/or data.medicare.gov websites.



IPPS FY2021 Proposed Rule

Graduate Medical Education

- Expand the definition of a “displaced resident” to allow residents to transfer more easily between hospitals, along with their funding.

PPS-exempt Cancer Hospital Quality Reporting Program

- Calculate rates using updated hospital-acquired infection baseline data stratified by patient location for the following program measures:
 - Catheter-associated Urinary Tract Infection (CAUTI) (NQF #0138)
 - Central Line-associated Bloodstream Infection (CLABSI) (NQF #0139)
- Publicly display the refined versions of the measures beginning in the fall of CY 2022.

Patient Records

- Require providers and practitioners to submit patient records to Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) in an electronic format.
- Establish reimbursement rates of \$3.00 per patient record that is submitted to the QIO in electronic format and \$0.15 per page for requested patient records submitted by facsimile or by photocopying and mailing (plus the cost of first class postage for mailed photocopies), after a waiver is approved by the QIO.