BKD Health Care

FFY 2021 IPPS and CY 2021 OPPS Rules & Other Healthcare Regulatory Updates

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Agenda

- FFY 2021 IPPS Final Rule
- CY 2021 OPPS/ ASC Proposed Rule
- CY 2021 Medicare Physician Fee Schedule
- Other Regulatory Updates

FFY 2021 IPPS Final Rule

IPPS Rate Update for FY 2021

FY 2021	W/Quality & Meaningful Use	W/Quality W/O Meaningful Use	W/O Quality W/ Meaningful Use	W/O Quality & Meaningful Use
Proposed Market Basket Rate Increase	2.4	2.4	2.4	2.4
Proposed Adjustment if No Quality Data Submitted	0	0	-0.6	-0.6
Proposed Adjustment if Not a Meaningful User	0	-1.8	0	-1.8
Proposed MFP Adjustment	0.0	0.0	0.0	0.0
Documentation & Coding Adjustment	0.5	0.5	0.5	0.5
Total Percentage Increase	2.9	1.1	2.3	0.5

MS-DRG Changes

- Documentation & coding adjustment: 0.5% increase, similar to 2020, & consistent with the previously scheduled rate increases through 2023
- Two new emergency ICD-10 codes have been approved since the October 2019 deadline
  - Vaping-related disorder
  - COVID-19
- New technology add-on payments for anti-microbial products
- Will use proposed threshold info going forward to evaluate if cost criteria are met for new MS-DRG

MS-DRG Changes

- Reassigning procedure codes from MS-DRG 16 (Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy) to create new MS-DRG 18 (Chimeric Antigen Receptor [CAR] T-Cell Immunotherapy) for cases reporting the administration of CAR T-Cell therapy
- Creating new MS-DRG 019 Simultaneous Pancreas & Kidney Transplant with Hemodialysis)
- Creating six new MS-DRGs 140-142 (Major Head & Neck Procedures with MCC, with CC, & without CC/MCC, respectively) & 143-145 (Other Ear, Nose, Mouth, & Throat O.R. Procedures with MCC, with CC, & without CC/MCC, respectively)

MS-DRG Changes

- Deleting MS-DRGs 129-130 (Major Head & Neck Procedures with CC/MCC or Major Device, & without CC/MCC, respectively, MS-DRGs 131-132 (Cranial & Facial Procedures with CC/MCC & without CC/MCC, respectively) & MS-DRGs 133-134 (Other Ear, Nose, Mouth, & Throat O.R. Procedures with CC/MCC & without CC/MCC, respectively)
- Reassigning procedure codes from MS-DRGs 469-470 (Major Hip & Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement, & without MCC, respectively)
  - Subject to post acute care transfer policy status

MS-DRG Changes

- Creating two new MS-DRGs, 521 & 522 (Hip Replacement with principal diagnosis of Hip Fracture with MCC & without MCC, respectively) for cases reporting a Hip Replacement Procedure with a principal diagnosis of a Hip Fracture
  - Subject to post acute care transfer policy status
- Reassigning procedure codes from MS-DRG 652 (Kidney Transplant) into two new MS-DRGs, 650 & 651 (Kidney Transplant with Hemodialysis with MCC & without MCC, respectively) for cases reporting Hemodialysis with a Kidney Transplant during the same admission

Charge Reporting

- Median payor-specific negotiated charge with Medicare Advantage (MA) plans
  - Definition of payor-specific negotiated charge aligns with Hospital Transparency final rule
  - Cost reporting periods (CRP) ending on or after 1/1/21
- Did not require reporting of all third-party payors
  - CMS acknowledged different in charge negotiation among third-party payors
  - CMS believes MA rates & Medicare rates are similar

Wage Index

- FFY 2021 wage index values based on cost reports beginning in FFY 2017 (9/30/17, 12/31/17, 6/30/18)
- Additional clarification due to number of appeals regarding Physician time salaries or contracted
  - Two-week, semiannual time study can be adequate
  - Reminder to submit physician allocation agreements with cost report filing
- Hospitals that convert to CAH on or after 1/24/19 through 1/24/20 excluded from wage index (eight total)
- National average hourly wage: **$45.23** – occupational mix adjusted (unadjusted is $45.27
  - **2.35%** increase over the prior year
  - Proposed was $45.07 occupational mix adjusted average

Wage Index

- Low Wage Index Hospital Policy – aka downward spiral or quartile adjustment – second year of four-year period of an increase to hospitals with a wage index below 25th percentile
  - 25th percentile is 0.8465 for FY 2021 rules (was 0.8457 for final FY 2020)
  - Increase for half the difference between wage index & 25th percentile
  - Similar budget neutrality adjustment will apply
- Labor share – 68.3% if above 1.00, 62% if below 1.00 (same as PY)

Wage Index

- **OMB delineations – county changes based on previous OMB Bulletin from 9/14/18**
- Micropolitan areas (10K to 50K) rural hospitals continue to be considered in states rural wage index
- Rural becoming urban
  - 47 counties – 17 hospitals
  - Impact on CAHs in these new urban counties

Wage Index

- Urban becoming rural
  - 34 counties – 10 hospitals
- Urban counties moving to a different urban CBSA – (CBSA name/# change only)
- Urban counties changing to another urban CBSA – potential wage index impacts
- 5% cap on any hospitals which see a decrease as a result of the OMB county changes with a budget neutrality adjustment

Low Volume Adjustment (LVA)

- **FY 2019–2022**
  - LVA criteria: hospitals must have fewer than **3,800** total discharges and must be located more than **15** road miles from the nearest subsection(d) hospital
- **FY2023–**
  - LVA criteria: hospitals must have fewer than **200** total discharges and must be located more than **25** road miles from the nearest subsection(d) hospital

Low Volume Adjustment (LVA)

- Low Volume Payment Adjustment

  =0.25-[0.25/3300] x(number of total discharges-500)=(95/330)-(number of total discharges/13200)

- Written requests to MAC by 9/1/20 for discharges beginning 10/1/20
  - Subsequent requests effective prospectively within 30 days of the date the MACs LVA determination

DSH – Uncompensated Care Payments

- Uncompensated care pool $8.3 billion
  - $500 million or 6% more than proposed
  - $60 million less than FFY 2020
  - To account for COVID
    - Decreased Factor 1 $11.378 billion (proposed $141 million higher) due to estimated decrease in discharges
- Using FY2017 Worksheet S-10 for FFY 2021
  - June 30 HCRIS, proposed March 30
- Plan to continue to use single year
  - FY 2018 audits in process for next year

DSH – Uncompensated Care Payments

- Key takeaways
  - Maintain auditable documentation for charity care & bad debt amounts
  - Cost-to-charge ratio replacement for all-inclusive rate providers with CCR greater than 50% (big deal!)
  - CCR will not be trimmed for hospitals that have had S-10 audits

Payment for Allogeneic Hematopoietic Stem Cell Acquisition Costs

- Reimbursement changing from PPS to reasonable cost (similar to solid organ transplants)
  - Worksheet A, line 77
  - New “D-4 like” worksheet to calculate cost
  - Budget neutral

IME/GME

- No change in IME factor
- Displaced Residents
  - Definition: Residents who are physically training at the time of a program or hospital closure
  - Amending three policies
    1. Displacement date would be determined by date of public announcement (press release or formal announcement)
    2. Allow funding to be transferred for residents that were not physically training, but intended to train
    3. Receiving hospital will need to apply for a temporary cap increase by submitting a letter to their MAC including resident name, last four digits of SSN, prior hospital & program name, & amount of cap increase needed
       - If the closing program/hospital was already at its cap, there is no guarantee that a cap slot would be transferred

Provider Reimbursement Review Board (PRRB) Appeals

- Mandatory electronic filing requirement
  - PRRB will provide 120 days' notice before mandatory requirement starts
  - PRRB portal only allow notices/communications with one email address
    - Provider responsible to submit changes

Medicare Bad Debt Policy Revisions

- Definition of non-indigent beneficiary
  - Not “categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid” &
  - “Not determined to be indigent by the provider for bad debt purposes”
  - Retroactive definition to add clarity
- Retroactive issue
  - Longstanding policies
  - Promote fairness & save time in reopening/revision requests

Medicare Bad Debt Policy Revisions

- Proposing to codify long-standing Medicare Bad Debt regulations “before FYB 10/1/2020”
  - Definition of non-indigent, non-Medicaid or hospital determined indigent beneficiary
  - Issue a bill shortly after discharge or death of benefit
  - 120 days of collection effort from later of first patient bill or most recent patient payment
  - Recoveries must reduce allowable bad debt in current year
  - Collection effort same for Medicare & non-Medicare of “like amount”
  - Claim after returned from agency
  - Documentation available for auditors
  - Crossover must bill remains but for states that do not crossover, alternatives acceptable

Medicare Bad Debt Policy Revisions

- Proposing to codify long-standing Medicare Bad Debt regulations “on or after FYB 10/1/2020”
  - Issue a bill on or before 120 days after later of Medicare RA, RA from secondary payor & date of notification of no secondary coverage
  - Indigent MUST include assets, & income & determine no one else legally responsible. May include liabilities & expenses
  - Indigent may be deemed uncollectible without applying a collection effort once the provider has determined indigency

Medicare Bad Debt Policy Revisions

- ASU 606 Revenue Recognition
  - “Cost reporting periods beginning before October 1, 2020”
    - Bad debts, charity, & courtesy allowances represent reductions in revenue
    - Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (crossovers)
  - “Cost reporting periods beginning on or after October 1, 2020”
    - Charity & courtesy allowances represent reductions in revenue
    - Medicare bad debts must not be written off to a contractual allowance account but must be charged to uncollectible receivables account that results in a reduction of revenue (crossovers)

CY 2021 OPPS/ ASC Proposed Rule

Payment Update

Market Basket Increase	3.0%
Less: Multifactor Productivity Adjustment	0.4%
Actual Rate Update	2.6%

340B Program Changes

- 340B Average Sales Price (ASP) less 28.7%
  - ASP less 34.7% plus 6% add on
  - Rural SCHs, PPS-exempt cancer hospitals & children's hospitals exempt

Physician-Owned Hospitals

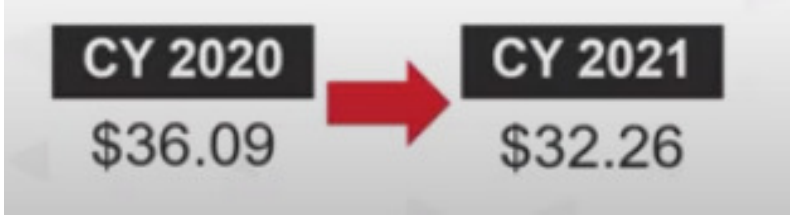
- Remove unnecessary regulatory restrictions on physician owned hospitals if high Medicaid
- Include beds in a physician-owned hospital's baseline consistent with state law

Changes to Inpatient Only List

- Eliminate Inpatient-Only Procedure List over three years
  - First up – removing 300 musculoskeletal-related services

CY 2021 Medicare Physician Fee Schedule

- Expansion of telehealth services, including home health visits & care planning
- CMS reduced various RVUs across the PFS but those changes alone are not adequate enough to offset the expected increase in Medicare spending
- Medicare reduced conversion factor to cover the remaining increase



Other Regulatory Updates

GME & Allied Health

Change Request 11642 dated 8/21/2020

BBRA of 1999, Section 541 added some cost report reimbursement for Medicare Advantage plans with limit on allied health payment pool $60 million

BIPA of 2020, Section 512 changed formula for allied health to account for hospital utilization

CR applies percentage reduction from hospital utilization to consider payment pool for allied health

CR revises percentage reduction for GME

Result: increase GME, decrease allied health

Applicable to open cost reports & within three years of NPR

DHHS Rural Action Plan

September 2020

Goals

- *"1. **Build a Sustainable Health and Human Services Model for Rural Communities** by empowering rural providers to transform service delivery on a broad scale*
- *2. **Leverage Technology and Innovation** to deliver quality care and services to rural communities more efficiently and cost-effectively*
- *3. **Focus on Preventing Disease and Mortality** by developing rural-specific efforts to improve health outcomes*
- *4. **Increase Rural Access to Care** by eliminating regulatory burdens that limit the availability of needed clinical professionals"*

Community Health Access & Rural Transformation (CHART)

Goals of CHART

- Improve rural hospital financial stability
- Reduce administrative burden so can increase flexibility
- Keep access to care in rural communities

Community Transformation Tract

- Paid for quality & outcomes, not volume
- CMS to select up to 15 lead organizations (spring 2021)

ACO Transformation Tract

- CMS select up to 20 rural-focused ACOs for shared saving program (fall 2021)

Provider Relief Fund – Phase 3 Distribution

- Until November 6, 2020 to apply
- Phase 3 General Distribution - $20B
  - Considers changes in operating revenues and operating expenses from patient care due to coronavirus
  - Ensures providers receive 2% of annual patient care revenues, with potential for an add-on payment for eligible providers

Provider Relief Fund – Phase 3 Distribution

- Who is Eligible?
  - New: Providers that began practicing during the period of Jan. 1, 2020 – March 31, 2020
  - New: Behavioral Health providers who accept commercial insurance or bill patients directly for care
  - Previously Eligible: Providers who previously received, rejected or accepted a General/Targeted Distribution Provider Relief Fund payment.

Questions & Contact Information

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Thank You!

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