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Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

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Note: We revised this article due to a revised CR 11879, which changed the 25th percentile wage index value from 0.8465 to 0.8649. We made this change in red print on page 4 of the article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by acute care and Long-Term Care Hospitals (LTCHs).

PROVIDER ACTION NEEDED

This article provides the Fiscal Year (FY) 2021 update to the Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Please make sure your billing staffs are aware of these updates.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a Prospective Payment System (PPS) for Medicare payment of inpatient hospital services. Also, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) updates these prospective payment systems annually. CR 11879 outlines those changes for FY 2021.

The following policy changes for FY 2021 went on display on September 2, 2020, and appeared in the Federal Register on September 18, 2020. All items covered in CR 11879 are effective for hospital discharges occurring on or after October 1, 2020, through September 30, 2021, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2020,

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that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2020, through September 30, 2021.

The FY 2021 Final Rule Data Files, FY 2021 Final Rule Tables, and FY 2021 MAC Implementation Files referenced in CR 11879 are available at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page. The files are also available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2021 IPPS Final Rule Home Page" or the link titled "Acute Inpatient--Files for Download" (and select "Files for FY 2021 Final Rule").

IPPS FY 2021 Update

A. FY 2021 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2021 IPPS/LTCH PPS Final Rule, available on the FY 2021 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, High Cost Outlier (HCO) threshold, and Cost-of-Living Adjustment (COLA) factors, refer to MAC Implementation File 1 available on the FY 2021 MAC Implementation Files webpage.

B. Medicare Severity-Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Classification of Diseases Tenth Revision (ICD-10) MS-DRG Grouper, Version 38.0, software package effective for discharges on or after October 1, 2020. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 38.0, which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2020.

For discharges occurring on or after October 1, 2020, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2020, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors received the MCE documentation in August 2020. Note that the MCE version continues to match the Grouper version.

CMS increased the number of MS-DRGs from 761 to 767 for FY 2021. CMS created 12 new MS-DRGs and deleted six MS-DRGs for FY 2021. For more information regarding the MS-DRG changes, specifically new MS-DRGs, deleted MS-DRGs and revised title descriptions, refer to MAC Implementation File 6 available on the FY 2021 MAC Implementation Files webpage.

See the ICD-10 MS-DRG V38.0 Definitions Manual Table of Contents and the Definitions of

Medicare Code Edits V38 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html) for the complete list of FY 2021 ICD-10 MS-DRGs and Medicare Code Edits.

C. Replaced Devices Offered without Cost or with a Credit

A hospital's IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2021 and a summary of the MS-DRG changes under this policy for FY 2021.

D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2021 have been evaluated against the general post-acute care transfer policy criteria using the FY 2019 MedPAR data according to the regulations under 42 CFR 412.4(c). As a result of this review, new MS-DRGs 521 and 522 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC and without MCC, respectively) will be added to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy.

See Table 5 of the FY 2021 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2021 Final Rule Tables webpage.

E. New Technology Add-On

For FY 2021, 10 technologies continue to be eligible for new technology add-on payment and 13 technologies are newly eligible for new technology add-on payments. (One technology was granted conditional approval pending Food and Drug Administration (FDA) marketing authorization. Additional instructions will be issued if FDA marketing authorization is granted in time for FY 2021 payments under the new conditional approval policy.) For more information on FY 2021 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or beginning to receive payments, refer to MAC Implementation File 8 available on the FY 2021 MAC Implementation Files webpage.

F. Cost of Living Adjustment (COLA) Update for IPPS PPS

There are no changes to the COLA factors for FY 2021. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2020, is in the FY 2021 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2021 MAC Implementation Files webpage.

G. Updating the Provider Specific File (PSF) for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

Your MAC will update their PSF by following the steps, in order, in the file on the FY 2021 MAC Implementation File webpage, to determine the proper wage index and other payments. For FY 2021, CMS implemented the revised OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, effective October 1, 2020, beginning with the FY 2021 IPPS wage index. Additional details are provided in the MAC implementation files to ensure MACs enter the correct Core-Based Statistical Areas (CBSAs) into the PSF as a result of this revision.

For FY 2021, the following policies will apply to the wage index:

- Increase the wage index values for hospitals with a wage index value below the 25th percentile wage index value of 0.8469 for FY 2021 across all hospitals
- Apply a 5 percent cap for FY 2021 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2020

H. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act and Certain Urban Hospitals Reclassified as Rural Hospitals Under 42 CFR 412.103

42 CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act (the Act), which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties.") Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated.

As noted above, for FY 2021 we implemented revised OMB delineations, which included changes to the counties that qualify as Lugar counties effective for FY 2021. For the list of Lugar counties for FY 2021, refer to Table 4B of the FY 2021 IPPS/LTCH PPS Final Rule, available on the FY 2021 Final Rule Tables webpage.

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The list of hospitals that have waived Lugar status for FY 2021 is on the FY 2021 MAC Implementation Files webpage.

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes.

Note, hospitals reclassified as rural under § 412.103 are not eligible for the capital Disproportionate Share Hospitals (DSH) adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1)).

I. Multicampus Hospitals

1. Wage Index

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also, note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF, (see the FY 2021 MAC Implementation Files webpage). Generally, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

2. Qualification for Certain Special Statuses

As explained in CR 10869 (Transmittal 4144; October 4, 2018), in the FY 2019 Final rule, CMS codified its current policies regarding how multicampus hospitals may qualify for special status as a Sole-Community Hospital (SCH), Rural Referral Center (RRC), Medicare-Dependent Hospital (MDH), and rural reclassification under 42 CFR 412.103. (A related MLN Matters article MM10869 is available for review at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10869.pdf.)

Specifically, the main campus of a hospital cannot obtain a SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s), and vice versa. Rather, the hospital (the main campus and its remote location(s)) are granted the special treatment or rural reclassification as one entity if the criteria are met. To meet the criteria, combined data from the main campus and its remote location(s) are used where the regulations at 42 CFR 412.92 for SCH, 42 CFR 412.96 for RRC, 42 CFR 412.103 for rural reclassification, and 42 CFR 412.108 for MDH require data, such as bed count, number of discharges, or case-mix index, for example.

Where the regulations require data that cannot be combined, specifically qualifying criteria related to location, mileage, travel time, and distance requirements, the hospital needs to demonstrate that the main campus and its remote location(s) each independently satisfy those requirements in order for the entire hospital, including its remote location(s), to be reclassified as rural or obtain a special status.

J. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospital (MDH) Program

1. Effective Date of SCH/MDH Status

As explained in CR 10869 (Transmittal 4144; October 4, 2018), for applications received on or after October 1, 2018, the effective date for MDH or SCH status is the date the MAC received the complete application (per revised § 412.108(b)(4) and § 412.92 (b)(2)(i)). An application is considered complete on the date the MAC received all supporting documentation needed to conduct the review.

2. Short Cost Reporting Periods and Sole Community Hospitals

For FY 2021, CMS amended the regulations that define the term "service area" at § 412.92(c)(3) to clarify CMS' policy when a provider has a short cost reporting period. Specifically, CMS amended § 412.92(c)(3) to reflect that where the hospital's cost reporting period ending before it applies for classification as a sole community hospital is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

K. Rural Referral Centers (RRCs)

For FY 2021, CMS amended the regulations at § 412.96 (c)(2)(iii) to address situations where a hospital's cost reporting period that began during the fiscal year used to compute the regional median discharge values for a given fiscal year is a short or a long cost reporting period (that is, less than or greater than 12 months). If the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges is for less than 12 months or longer than 12 months, the hospital's number of discharges for that cost reporting period will be annualized to estimate the total number of discharges for a 12-month cost reporting period.

In order to annualize the discharges, the discharges are divided by the number of days in the hospital's cost reporting period and then multiply by the length of a full year (365 or 366 calendar days, as applicable) to estimate the total number of discharges for a 12-month cost reporting period. For example, a short cost reporting period beginning on January 1 and ending on October 31 that is 10 months (or 304 days) with 4,200 discharges would be annualized in a non-leap year as follows: (4,200 ÷ 304) x 365 = 5,043 discharges annualized. Furthermore, if the hospital has multiple cost reports beginning in the same fiscal year and none of those cost reports are for 12 months, the hospital's number of discharges in the hospital's longest cost report beginning in that fiscal year would be annualized to estimate the total number of discharges for a 12-month cost reporting period.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2021

For FY 2021, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 15, 2020, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges beginning on or after

October 1, 2020 (through September 30, 2021). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2020 may continue to receive a low-volume hospital payment adjustment for FY 2021 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2021.

Accordingly, for FY 2021, such a hospital must send written verification that is received by its MAC no later than September 15, 2020, stating that it meets the mileage criterion applicable for FY 2021. If a hospital's request for low-volume hospital status for FY 2021 is received after September 15, 2020, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2021 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination. The regulations implementing the hospital payment adjustment policy are at § 412.101.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at https://www.qualitynet.org/inpatient/iqr/apu.

N. Hospital Acquired Condition Reduction Program (HAC)

The Hospital-Acquired Condition (HAC) Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals with respect to HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment adjustment applies to all Medicare fee-for-service discharges for that fiscal year.

CMS did not make the list of providers subject to the HAC Reduction Program for FY 2021 public in the final rule, because hospitals have until August 2020 to notify CMS of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Corrections period. Updated hospital-level data for the HAC Reduction Program will be made publicly available on the Hospital Compare or successor website in January 2021.

O. Hospital Value Based Purchasing (VBP)

For FY 2021, CMS will implement the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2021. CMS expects to post the final value-based incentive payment adjustment factors for FY 2021 in the near future in Table 16B of the FY 2021 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2021 IPPS/LTCH PPS Final Rule Tables webpage).

P. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2021 in the near future in Table 15 of the FY 2021 IPPS/LTCH PPS final rule (which are available via the Internet on the

FY 2021 IPPS/LTCH PPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the HRRP in FY 2021 (such as Maryland hospitals), have an HRRP payment adjustment factor of 1.0000. For FY 2021, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

In the FY 2021 IPPS/LTCH PPS Final Rule, CMS finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2021. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2021, which is available via the Internet on the FY 2021 Final Rule Data Files webpage.

The interim estimated uncompensated care payments that are paid on a per claim basis will be reconciled at cost report settlement with the total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File.

For FY 2021, new hospitals for uncompensated care payment purposes, that is, hospitals with CCNs established after October 1, 2017, that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2021 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation can be found in the FY 2021 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by the total uncompensated care payment amount finalized in the FY 2021 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement. For FY 2021, Puerto Rico hospitals that do not have a FY 2013 report are considered new hospitals and would be subject to this new hospital policy, as well.

For FY 2021, newly merged hospitals, for example, hospitals that have a merger during FY 2021 or mergers not known at the time of development of the final rule, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

Consistent with the policy adopted in FY 2014 and applied in each subsequent fiscal year, CMS used a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount, is divided by the hospital's historical 3-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that is used to make interim uncompensated care payments to each

projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

- Under the policy adopted in the FY 2021 final rule, if a hospital submits a request to its MAC, for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year, then the MAC shall review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. Examples include, but are not limited to, the following:
- a request showing a large projected increase in discharges during the fiscal year to support reduction of its per discharge uncompensated care payment amount.
- a request that its per discharge uncompensated care payment amount be reduced to zero midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital.

The MAC shall evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the beginning of the Federal fiscal year and/or with midyear request when the 3-year average of discharges is lower than hospital's projected FY 2021 discharges. If following review of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount determined by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request does not change how the total uncompensated care payment amount shall be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the fiscal year are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

R. Outlier Payments

IPPS Statewide Average Cost-to-Charge Ratios (CCRs)
Tables 8A and 8b contain the FY 2021 Statewide average operating and capital CCRs for urban and rural hospitals. Tables 8A and 8B are available on the FY 2021 Final Rule Tables webpage. Per the regulations in 42 CFR Sections 412.84(i)(3)(iv)(C), for FY 2021, Statewide average CCRs are used in the following instances:

- New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR Section 489.18).
- Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with 42 CFR 412.8(b). For FY 2021, hospitals with an operating CCR in excess of 1.142 or a capital CCR in excess of 0.135 are assigned the appropriate statewide average CCR.
- Hospitals for whom the MAC obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in Section 20.1.2.1 of Chapter 3 of the Medicare Claims Processing Manual available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.

Additionally, for all hospitals, use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

S. Payment Adjustment for CAR T-cell Clinical Trial and Expanded Access Use Immunotherapy Cases

For FY 2021, a new MS DRG was created for cases that include procedures describing CAR T-cell therapies (MS-DRG 018 Chimeric Antigen Receptor (CAR) T-Cell Immunotherapy). In addition, an adjustment to the payment amount for clinical trial and expanded access use immunotherapy cases that group to new MS-DRG 018 was adopted. For FY 2021, under this payment adjustment at new § 412.85, payment for such discharges is adjusted by adjusting the DRG weighting factor by a factor of 0.17.

Under this policy, a payment adjustment will be applied to claims that group to new MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there is expanded access use of immunotherapy. However, when the CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment will not be applied in calculating the payment for the case.

To notify the MAC of a case where there was expanded access use immunotherapy of CAR T-cell therapy products, the provider may enter a Billing Note NTE02 "Expand Acc Use" on the electronic claim 837I or a remark "Expand Acc Use" on a paper claim, and MACs shall add payer-only condition code "ZB" so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), the provider may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim, and MACs shall add payer-only condition code "ZC" so that the Pricer will not apply the payment adjustment in calculating the payment for the case.

T. Payment Adjustment for Hospitals with High Percentage of End Stage Renal Disease (ESRD) Discharges

Under § 412.104(a), an additional payment is provided to a hospital for inpatient services provided to End Stage Renal Disease (ESRD) beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into certain MS-DRGs, where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges.

In the FY 2021 IPPS/LTCH PPS final rule, the list of MS-DRGs to be excluded in determining a hospital's eligibility for the additional payment for hospitals with high percentages of ESRD discharges was updated. Beginning in FY 2021, discharges classified to the following MS-DRGs are excluded in determining a hospital's eligibility for the additional payment for hospitals with high percentages of ESRD discharges: MS-DRG 019 (Simultaneous Pancreas/Kidney Transplant with Hemodialysis); MS-DRGs 650 and 651 (Kidney Transplant with Hemodialysis with MCC, without MCC, respectively); and MS-DRGs 682, 683, and 684 (Renal Failure with MCC, with CC, without CC/MCC, respectively).

LTCH PPS FY 2021 Update

A. FY 2021 LTCH PPS Rates and Factors

The FY 2021 LTCH PPS Standard Federal Rates are in Table 1E available on the FY 2021 Final Rule Tables webpage. Other FY 2021 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2021 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 38 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2020, and on or before September 30, 2021.

B. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon settlement of the cost report. MACs may use the form letter available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and Section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital

were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by Section 1886(m)(6)(C)(iii) of the Act. We note BRs 11616.11, 11616.11.1. BRs 11616.11.2 and 11616.11.3 continue to apply, subject to the provisions of Section 3711(b)(1) of the CARES Act for the duration of the COVID-19 public health emergency period. (Refer to CR 11742 for additional implementation on information on Section 3711(b)(1) of the CARES Act. A related MLN Matters article is available at https://www.cms.gov/files/document/mm11742.pdf.)

C. LTCH Quality Reporting (LTCHQR) Program

Under the LTCHQR Program, for FY 2021, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality-reporting data in accordance with the LTCHQR Program for that year. MACs will receive more information under separate cover.

D. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF are in Medicare Claims Processing Manual, Chapter 3, 42 CFR 20.2.3.1 and Addendum A.

1. LTCH Statewide Average CCRs

Table 8C contains the FY 2021 Statewide average LTCH total CCRs for urban and rural LTCHs. Table 8C is available on the FY 2021 Final Rule Tables webpage. Per the regulations in 42 CFR Sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2021, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR Section 489.18).

2. LTCHs with a total CCR in excess of 1.253 (referred to as the total CCR ceiling).

3. Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in Section 150.24 of Chapter 3 of the Medicare Claims Processing Manual. Additionally, for all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

2. LTCH Labor Market Areas and Wage Indexes

For FY 2021, CMS updated the CBSA-based labor market area (geographic classification) delineations under the LTCH PPS based on the revised OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, effective October 1, 2020.

For FY 2021, a 5 percent cap will be applied to any decrease in a hospital's LTCH PPS wage index from its FY 2020 LTCH PPS wage index. A list of LTCHs whose FY 2021 LTCH PPS wage index decreased by more than 5-percent along with their FY 2020 LTCH PPS wage index value is on the FY 2021 MAC Implementation Files webpage.

F. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2021. The COLAs effective for discharges occurring on or after October 1, 2020, are in the FY 2021 IPPS/LTCH PPS final rule and are also in MAC Implementation File 2 available on the FY 2021 MAC Implementation Files webpage.

Note: the same COLA factors are used under the IPPS and the LTCH PPS for FY 2021.

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2021 IPPS/LTCH PPS final rule, CMS established an update to an extended neoplastic disease care hospital's target amount for FY 2021 of 2.4 percent.

ADDITIONAL INFORMATION

The official instruction, CR 11879, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10571cp.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
March 9, 2021	We revised this article due to a revised CR 11879, which changed the 25th percentile wage index value from 0.8465 to 0.8649. We made this change in red print on page 4 of the article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.
September 22, 2020	Initial article released.