Medicare Inpatient Prospective Payment System
Proposed Rule Impact Analysis
Federal Fiscal Year 2021

-Version 1-

Analysis Description

The federal fiscal year (FFY) 2021 Medicare Inpatient Prospective Payment System (IPPS) Proposed Rule Analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments would change from FFY 2020 to FFY 2021 based on the policies set forth in the FFY 2021 IPPS proposed rule. The analysis compares the year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes, including:

- potential payment penalties under the Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive Programs;
- impact of CMS' adjustment to the wage index of hospitals in bottom quartile of wage index values nationally to reduce wage disparities;
- the proposed Core-Based Statistical Area changes updated by the Office of Management and Budget (OMB) Bulletin No. 18-04;
- quality-based payment adjustments; and
- Disproportionate Share Hospital (DSH) uncompensated care (UCC) payments.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2021 IPPS Proposed Rule Changes Modeled in this Analysis:

- Provider Type Changes: Changes to inpatient payments resulting from a change in provider type. This includes adjustments to both hospital specific rate (if received) and changes to the traditional, rate-based DSH payment calculation for hospitals that change special status.
- Marketbasket Update: 3.0% operating marketbasket increase and 1.5% capital marketbasket increase. Budget neutrality factors increase the operating update by 0.04% and reduce the capital update by 0.44%.
- ACA Mandated Marketbasket Reduction: 0.4 percentage point (PPT) productivity reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.
- MACRA-Mandated Coding Adjustment: 0.5% increase to the federal operating rate to prospectively increase the rate after the American Taxpayer Relief Act (ATRA) of 2012 retrospectively adjusted for what CMS claimed to be over-payments due to coding improvements.
- Wage Index/GAF: Updated wage index and capital GAF values; including any impact due to new wage data; reclassifications; and other adjustments to the wage indexes. A separate value is shown and is inclusive of all of CMS' proposed changes to the calculation of the wage index values of hospitals for FFY 2021 (including associated budget neutrality adjustments). These changes are broken out below the overall impact, and include those impacts due to: the expiration of the 5% stop loss adjustment to those hospitals whose FFY 2020 wage index that was less than 95% of what it was for FFY 2019; the proposed increase to the wage index values of those hospitals in the bottom quartile of wage index values nationally; and the proposed application of a 5% stop loss adjustment to those hospitals whose FFY 2021 wage index would be less than 95% of what it was for FFY 2020.
- Change in Urban/Rural Status: Changes to inpatient payments resulting from a change in geographic status between urban and rural. This includes adjustments to both the traditional, rate-based DSH payment calculation, as well as the traditional DSH transition proposed for FFY 2021 for hospitals that are converted from urban to rural as a result of the newly proposed CBSAs. Under the proposed DSH transition, hospitals would receive an add-on in FFY 2021 equal to 2/3rd of the difference between their rural-based DSH payments and what those payments would have been had the hospital remained urban. For FFY 2022, it is proposed that the add-on would be equivalent to 1/3rd of the difference, with no add-on provided for FFY 2023 and subsequent years.
- DSH–UCC Payment Changes: Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2021 proposed rule DSH Supplemental File. Changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2021 DSH supplemental file. The impacts also include year-to-year changes in hospital-specific UCC payment factors (Factor 3) for these hospitals, the impact of which is displayed separately.
- Change in Hospital Specific Rate: Reflects the impact to special status hospitals (Sole-Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs), or Essential Access Community Hospitals (EACHs)) where there is a change in payment status (hospital-specific vs federal) or where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments.
- MS-DRG Updates: Changes due to updates to the DRG groupings and weights. The impact shown is the case-mix change resulting from running the FFY 2018 Medicare claims data through the two DRG Grouper software programs (Grouper Version 37 for FFY 2020 and Grouper Version 38 for FFY 2021) and assigning the respective MS-DRG weights for each year.
- Quality-Based Payment Adjustments: Year-to-year change in hospital-specific quality performance and subsequent adjustments under the Value Based Purchasing (VBP), Readmissions Reduction, and Hospital Acquired Condition (HAC) Reduction programs.

- Low Volume Adjustment Changes: Reflects the change in overall payments made as a result of the Low Volume Hospital (LVH) Adjustment program. The LVH adjustment factors are from FFY 2020 IPPS final rule correction notice and the FFY 2021 IPPS proposed rule Impact Files. Distance eligibility for FFY 2020 was determined using the most recent 3 years of cost report data (2017, 2018 and 2019) as well as those that are shown to receive the adjustment in FFY 2021. If a hospital reported low volume payments in their most recent cost report, or had reported in its most recent year that the distance requirement had been met on Worksheet S-2, it is assumed that the hospital had met the distance requirement of the low volume adjustment.

Data Sources

Estimated FFYs 2020 and 2021 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2021 IPPS proposed rule Impact File and DSH Supplemental files. These files are available on CMS' website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-proposed-rule-home-page.

The inpatient federal operating and capital rates are from the FFY 2020 final rule correction notice and FFY 2021 proposed rule, as published in the *Federal Register*.

Medicare cases and case-mix indices are from the CMS FFY 2021 proposed rule Impact File and include cases, case-mix indices, and transfer-adjusted cases resulting from running the FFY 2018 Medicare claims data through the two DRG Grouper software programs (Grouper Version 37.0 for FFY 2020 and Grouper Version 38.0 for FFY 2021).

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFY 2020 final (corrected) and FFY 2021 proposed rule Impact Files and the wage index tables in the *Federal Register*.

The DSH impact estimates are based on the Impact and DSH Supplemental files published with the final FFY 2020 (corrected) and proposed FFY 2021 IPPS rules. The DSH Supplemental file includes: an indicator of DSH-eligible hospitals for FFY 2021, the national UCC pool dollars, and hospital-specific UCC factors/payment amounts.

The impact of the quality-based payment adjustments are based on the following: the FFY 2021 Readmissions adjustment factors are from the FFY 2021 IPPS proposed rule Impact File, and are proxies based on the FFY 2020 adjustment factors. The list of hospitals that could potentially be subject to the FFY 2021 HAC Reduction Program penalty is derived from hospital quality data available with the 1st quarter 2020 update of Hospital Compare (CMS did not provide this list with the rule). The FFY 2021 VBP adjustment factors are estimated based on hospital quality data available with the 1st quarter 2020 update of Hospital Compare (CMS' FFY 2021 VBP proxy adjustment factors are based on a prior program year). The FFY 2020 VBP and Readmissions adjustment factors are from the FFY 2020 IPPS final rule correction notice, and FFY 2020 HAC flags are from the 4th quarter 2019 update of Hospital Compare.

Note: This analysis was developed to measure the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, DSH eligibility, factors used to calculate the DSH and IME adjustments and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2021 proposed rule Impact File and DSH Supplemental File. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating FFY 2020 payments. Estimated FFY 2020 payments reflect the wage index, labor-share, DSH, IME and quality-adjusted federal payment amount (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated FFY 2020 payments, the proposed policy changes to the IPPS payment rates are applied. Then, the effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are calculated by substituting FFY 2020 values with FFY 2021 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the marketbasket update is applied to estimated FFY 2020 payments. Then, the change to the ACA-mandated marketbasket reduction is applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. marketbasket, ACA, etc.).

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding.

Hospitals with Special Status

MDH/SCH status and federal/hospital-specific payment determinations for MDH/SCHs are based on the status predicted by CMS in its corrected FFY 2020 final and FFY 2021 proposed rule impacts and DSH Supplemental files. If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, IME, and transfer adjustments), payments based on the hospital-specific rate are used in this analysis.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the hospital-specific rate is more beneficial, these hospitals are paid at 100% of the hospital-specific rate. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate.