CALIFORNIA HOSPITAL ASSOCIATION

Federal Regulatory Summary

as prepared by Health Policy Alternatives, Inc.

SUMMARY OF FINAL RULE — SEPTEMBER 2020

FFY 2021 Long-Term Care Hospital Prospective Payment System

Overview

On September 3, the Centers for Medicare & Medicaid Services published its final rule addressing rate updates and policy changes to the Medicare long-term care hospital (LTCH) prospective payment system (PPS) for federal fiscal year (FFY) 2021. The following summary, prepared by Health Policy Alternatives, Inc., provides detailed information on LTCH PPS payment policies as well as quality updates. **The policies in the final rule are generally effective October 1, 2020, unless otherwise specified.**

For Additional Information

CHA will distribute DataSuite reports providing hospital-specific analyses intended to show providers how Medicare fee-for-service payments will change from FFY 2020 to FFY 2021 based on the policies set forth in the final rule.

For questions or for additional information related to the final rule summary, please contact Megan Howard, vice president, federal policy, at (202) 488-3742 or mhoward@calhospital.org. For questions related to the FFY 2021 LTCH PPS DataSuite reports, please contact Alenie Reth at areth@calhospital.org or (916) 552-7682.

Table of Contents

Long-Term Care Hospital Prospective Payment System (LTCH PPS)

Background

Since FY 2016, LTCHs have been paid under a dual-rate payment structure. An LTCH case is either paid at the "LTCH PPS standard federal payment" when the criteria for site neutral payment rate exclusion are met or a "site neutral payment rate" when the criteria are not met. Site neutral cases will be paid an IPPS comparable amount. The criteria for exclusion from the site neutral payment remain the same for FY 2021:

- Case cannot have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation (the DRG criterion).
- Case must be immediately preceded by discharge from an acute care hospital that included at least 3 days in an intensive care unit (the ICU criterion).
- Case must be immediately preceded by discharge from an acute care hospital and the LTCH discharge must be assigned to an MS-LTC-DRG based on the beneficiary's receipt of at least 96 hours of ventilator services in the LTCH (the ventilator criterion).

To be paid the LTCH PPS standard federal payment, the case must meet the DRG criterion and either the ICU or ventilator criterion.

CMS updates payments for LTCHs using a process that is generally consistent with prior regulatory policy and that cross-links to relevant IPPS provisions. For FY 2016 and FY 2017, the site neutral payment rate was a blend of the LTCH PPS standard federal rate and the IPPS comparable amount. Section 51005 of the BBA 2018 extended the transitional blended payment rate (50 percent LTCH standard federal payment and 50 percent IPPS comparable amount) for site neutral payment cases for an additional 2 years. The FY 2019 IPPS final rule made conforming changes to the regulations to implement the extended transitional blended payment.

Summary of Changes to LTCH PPS Rates for FY 2021*	
Standard Federal Rate, FY 2020	$42,677.64
Final Rule Update factors	
Update as required by Section 1886(m)(3)(C) of the Act (including MFP reduction)	+2.3%
Penalty for hospitals not reporting quality data (including MFP reduction)	-2.0%
Net update, LTCHs reporting quality data	+2.3% (1.023)
Net update LTCHs not reporting quality data	0.3% (1.003)
Final Rule Adjustments	
Average wage index budget neutrality adjustment	1.0016837

Permanent budget neutrality adjustment factor of 0.991249 for the cost of the elimination of the 25-percent threshold policy for FY 2021 (and subsequent years); removal of FY 2020 adjustment factor of 0.990737	1.000517
Standard Federal Rate, FY 2021	
LTCHs reporting quality data ($42,677.64*1.023*1.0016837*1.000517)	$43,755.34
LTCHs not reporting quality data ($42,677.64*1.003*1.0016837*1.000517)	$42,899.90
Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$27,195
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$29,051
Impact of Policy Changes on LTCH Payments in 2021	
Total estimated impact	-1.1% (-$40 million)
LTCH standard federal payment rate cases (75% of LTCH cases)	+2.2% (+$74 million)
Site neutral payment rate cases (25% of LTCH cases)**	-24% (-$114 million)
*More detail is available in Table IV: "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2021". Table IV does not include the impact of site neutral payment rate cases. ** LTCH site neutral payment rate cases are paid a rate that is based on the lower of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.	

LTCH PPS MS-DRGs and Relative Weights

1. Background

Similar to FY 2020, the annual recalibration of the MS-LTC-DRG relative weights for FY 2021 is determined using data only from claims qualifying for LTCH PPS standard federal rate payment and claims that would have qualified if that rate had been in effect. The MS-LTC-DRG relative weights are not used to determine the site neutral payment rate and site neutral payment case data are not used to develop the relative weights.

2. Patient Classification into MS-LTC-DRGs

CMS continues to apply the same MS-DRG classification system used for the IPPS payments to the LTCH PPS in the form of MS-LTC-DRGs. Other MS-DRG system updates are also incorporated into the MS-LTC-DRG system for FY 2021 since the two systems share an identical base. MS-DRG changes are described elsewhere in this summary and details can be found in section II.D. of the preamble of the final rule.

3. Development of the MS-LTC-DRG Relative Weights

In developing the FY 2021 relative weights, CMS uses its current methodology and established policies related to the hospital-specific relative-value methodology, volume-related and

monotonicity adjustments, and the steps for calculating the relative weights with a budget neutrality factor (described in more detail below).

4. Relative Weights Source Data

The FY 2021 relative weights are derived from the March 2020 update of the FY 2019 MedPAR file. These data are filtered to identify LTCH cases meeting the established site neutral payment exclusion criteria. The filtered data are trimmed to exclude all-inclusive rate providers, Medicare Advantage claims, and demonstration project participants, yielding the "applicable LTCH data." (CMS notes there were no data from any LTCHs paid under a demonstration project in the march 2020 update.) The applicable LTCH data are used with Version 38 of the GROUPER to calculate the FY 2021 MS-LTC-DRG relative weights.

5. Hospital-Specific Relative-Value Methodology (HSRV)

CMS continues to use its HSRV methodology in FY 2021, unchanged from FY 2020, to mitigate relative weight distortions due to nonrandom case distribution across MS-LTC-DRGs and charge variation across providers. The HSRV methodology scales each LTCH's average relative charge value by its case mix.

6. Volume-related adjustments

CMS continues to account for low-volume MS-LTC-DRG cases as follows:

- If an MS-LTC-DRG has at least 25 cases, it is assigned its own relative weight.
- If an MS-LTC-DRG has 1-24 cases, it is assigned to one of five quintiles based on average charges; CMS finds that there are 251 such MS-LTC-DRGs. CMS then determines a relative weight and average length of stay for each quintile; each quintile's weight and length of stay are then assigned to each MS-LTC-DRG within that quintile. (CMS directs readers to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html for these low-volume MS-LTC-DRGs.)
- If an MS-LTC-DRG has zero cases after data trims are applied (CMS identifies 347 of these MS-LTC-DRGs), it is cross-walked to another MS-LTC-DRG based on clinical similarities in resource use intensity and relative costliness in order to assign an appropriate proposed relative weight. If the MS-LTC-DRG that is similar is a low-volume DRG that has been assigned to one of the five quintiles noted above, then the zero volume MS-LTC- DRG would be assigned to that same quintile. This total excludes the 11 transplant, 2 "error" and 15 psychiatric or rehabilitation MS-LTC-DRGs. (CMS directs readers to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html for these zero-volume MS-LTC-DRGs.)

CMS will assign a 0.0 relative weight for the 11 transplant MS-LTC-DRGs since no LTCH has been certified by Medicare for transplantation coverage. CMS also will assign a 0.0 relative weight for the 2 "error" MS-LTC-DRGs (998 and 999) which cannot be properly assigned to an MS-LTC-DRG group. CMS will not calculate a weight for the 15 psychiatric and rehabilitation proposed MS-LTC-DRGs because these MS-LTC-DRGs would never include any LTCH cases meeting the site neutral payment rate exclusion criteria.

7. Treatment of Severity Levels, Monotonicity Adjustments

Each MS-LTC-DRG contains one, two or three severity levels; resource utilization and relative weights typically increase with higher severity. When relative weights decrease as severity increases in a DRG ("nonmonotonic"), CMS combines severity levels within the nonmonotonic MS-LTC-DRG for purposes of computing a relative weight to assure that monotonicity is maintained. Adjustments for nonmonotonicity in determining the FY 2021 MS-LTC-DRG final relative weights are shown in Table 11 in section VI. of the Addendum to the final rule.

8. Selected Steps for Determining the MS-LTC-DRG Relative Weights

CMS continues its methodology of calculating the relative weights by first removing cases with a length of stay of 7 days or less (Step 1) and then removing statistical outliers (Step 2). The effect of short stay outlier (SSO) cases (those with a length of stay of five-sixths or less of the average for that MS-LTC-DRG) is adjusted for by counting an SSO as a fraction of a discharge based on the ratio of the length of stay of the SSO case to the average length of stay for the MS-LTC-DRG for non-SSO cases (Step 3).

CMS applies its existing two-step methodology to achieve budget neutrality for the FY 2021 MS-LTC-DRG and relative weights update (Step 7). First, a normalization adjustment is applied to the recalculated relative weights to ensure that the recalibration does not change the average case mix index (1.25878 proposed for FY 2021). Second, a budget neutrality factor is applied to each normalized relative weight (0.9993445 proposed for FY 2021).

Extensive discussion of the entire 7-step process to determine MS-LTC-DRG relative weights is provided in the final rule (pages 1,453 to 1,468 of the display copy).

Changes to the LTCH PPS Payment Rates and Other Changes

1. Overview LTCH PPS Payment Rate Adjustments

Only LTCH discharges meeting the site neutral payment rate exclusion criteria are paid based upon the LTCH PPS standard federal payment rate. The LTCH PPS uses a single payment rate to cover both

operating and capital-related costs, so that the LTCH market basket includes both operating and capital cost categories.

2. Annual Update for LTCHs

Based on IGI's second-quarter 2020 forecast, the annual update to the LTCH PPS standard federal payment rate is equal to 2.3 percent. CMS notes that the proposed update of 2.9 percent was developed before the economic impacts of the COVID-19 pandemic. As discussed in section VII.D of the final rule (summarized below), CMS rebases and revises the 2013-based LTCH market basket to reflect a 2017 base year.

In determining the multifactor productivity adjustment for FY 2021, because of the economic uncertainty caused by the COVID-19 pandemic, CMS believes it is more appropriate to use IGI's June 2020 macroeconomic forecast (-0.1) instead of the second quarter IGI forecast (0.7) that the agency would normally use. CMS notes that subtracting a negative (-0.1) would have resulted in a 0.1 percentage point increase to the update, and the statute does not permit a productivity increase to the update. Thus, CMS applies an MFP adjustment of 0.0 percentage points to the market basket update.

Thus, the update is equal to the 2017-based LTCH market basket of 2.3 percent less 0.0 percentage points (PP) for multifactor productivity. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update is further reduced by 2.0 percentage points. CMS notes that the "other adjustment" under section 1886(m)(4)(F) of the Act does not apply for FY 2021. The LTCH update for FY 2021 is as follows:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	2.3%	2.3%
Multifactor Productivity	0.0 PP	0.0 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.3%	0.3%

3. Area Wage Levels and Wage-Index

CMS finalizes its proposal to adopt the revised labor market area delineations announced in OMB Bulletin No. 18-04 effective for FY 2021 under the LTCH PPS. This is consistent with the changes finalized for the IPPS for FY 2021 as described in section III.A. of this summary. Accordingly:

- 34 counties (and county equivalents) formerly considered part of an urban CBSA are considered to be located in a rural area;
- 47 counties (and county equivalents) located in rural areas are considered to be located in urban areas; and

- Some urban counties shift from one urban CBSA to another urban CBSA or shift between existing and new CBSAs.

Because some LTCHs will experience decreases in their wage index values, CMS implements a budget neutral transition policy to help mitigate significant negative impacts that LTCHs may experience due to the adoption of the revised OMB delineations. CMS will apply a 5-percent cap on any decrease in an LTCH's wage index from the LTCH's final wage index from the prior fiscal year; thus, an LTCH's final wage index for FY 2021 will not be less than 95 percent of its final wage index for FY 2020.

As noted above, CMS rebases and revises the 2013-based LTCH market basket to reflect a 2017 base year. CMS finalizes an FY 2021 labor-related share of 68.1 percent based on IGI's second quarter 2020 forecast of the 2017-based LTCH market basket. This is based on the sum of the labor- related portion of operating costs (63.7%) and capital costs (4.4%). Operating costs include the following cost categories: wages and salaries; employee benefits; professional fees; labor-related; administrative and facilities support services; installation, maintenance, and repair services; and all other labor-related services. CMS notes that the difference from the FY 2020 labor-related share is attributable to the revision to the base year cost weights, the revision to the starting point of the calculation of base year from 2013 to 2017, and the use of an updated IHS Global Inc. forecast and reflecting an additional year of inflation.

CMS computes the wage index in a manner that is consistent with prior years, taking into account the revised labor market area delineations announced in OMB Bulletin No. 18-04. It calculates an area wage level budget neutrality adjustment of 1.0016837.

4. Elimination of the 25 percent Rule

In the FY 2019 IPPS rule, CMS adopted a policy to eliminate the 25 percent rule. This rule would have paid LTCHs at an IPPS comparable amount for all discharges not meeting the criteria to be paid the LTCH standard rate above 25 percent of the LTCH's total discharges. CMS adopted a policy to make elimination of this policy budget neutral through two temporary one-time adjustments to the LTCH standardized amount (0.990878 for FY 2019 and 0.990737 for FY 2020) and one permanent one-time adjustment to the LTCH standardized amount of 0.991249 for FY 2021 and subsequent years. A one-time temporary adjustment means the adjustment is removed for the following year while a one-time permanent adjustment stays on the rate and is not removed.

For FY 2021, CMS removes the 0.990737 adjustment (calculated by applying a factor of 1/0.990737) and applies the permanent one-time adjustment of 0.991249. CMS calculates an adjustment factor of 1.000517 for FY 2021 and subsequent years for the elimination of the 25 percent rule.

5. LTCH Standard Federal Payment Rate Calculation

CMS calculates the following LTCH PPS standard federal payment rates for FY 2021:

- $43,755.34 for LTCHs reporting quality data, calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.023 (statutory update factor) * 1.0016837 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $43,755.34

- $42,899.90 for LTCHs not reporting data to the LTCH QRP, calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.003 (statutory update factor less quality adjustment) * 1.0016837 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $42,899.90

6. Cost-of-Living (COLA) Adjustment

CMS continues updating the COLA factors for Alaska and Hawaii as it has done since FY 2014. To account for higher living costs in Alaska and Hawaii, a COLA is provided to LTCHs in those states. The COLA is determined by comparing Consumer Price Index growth in Anchorage, Alaska and Honolulu, Hawaii to that of the average U.S. city. The COLA is capped at 25 percent and updated every 4 years. Shown below are the FY 2021 COLAs.

Cost-of-Living Adjustment Factors for Alaska and Hawaii Under the LTCH PPS for FY 2021	
Alaska	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
All other areas of Alaska	1.25
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

7. High-Cost Outlier (HCO) Case Payments

Section 1886(m)(7)(A) of the Act requires CMS to reduce the LTCH standard federal payment rate by 8 percent for HCOs. Section 1886(m)(7)(B) requires CMS to set the outlier threshold such that estimated outlier payments equal 99.6875 percent of the 8 percent estimated aggregate payments for standard federal payment rate cases (that is, 7.975 percent). Based on LTCH claims from the March 2020 update of the FY 2019 MedPAR file and CCRs from the March 2020 update of the PSF, CMS calculates an HCO threshold of $27,195 for FY 2021 which CMS estimates will result in 7.975 of LTCH standard federal payment rate cases being paid as HCOs. The HCO payment continues to equal 80 percent of the estimated care cost and the outlier threshold (adjusted standard rate payment plus fixed-loss amount). If an HCO case is also an SSO case, the HCO payment will equal 80 percent of the estimated case cost and the outlier threshold (SSO payment plus fixed-loss amount).

CMS continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount. For FY 2021, CMS finalizes a fixed-loss amount for site neutral payment rate cases of $29,051. CMS also applies a budget neutrality factor of 0.949 for site neutral payment rate cases for FY 2021. Consistent with the policy adopted in FY 2019, CMS the HCO budget neutrality adjustment will not be applied to the HCO portion of the site neutral payment rate amount. CMS estimates that HCO payments for site neutral payment rate cases would be 5.1 percent of the site neutral payment rate payments.

8. IPPS DSH and Uncompensated Care Payment Adjustment Methodology

CMS continues its policy of including an applicable operating Medicare DSH and uncompensated care payment amount in the calculations of the "IPPS comparable amount" (42 CFR §412.529) and the "IPPS equivalent amount" (§412.534 and §412.536). For FY 2021, the DSH/uncompensated care amount equals 75.90 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA.

Rebasing of the LTCH Market Basket

1. Background

CMS proposed to rebase and revise the LTCH market basket based on data from cost reports beginning in FY 2017. The current LTCH market basket is from a 2013 base year. CMS did not receive any comments on its proposed policies, and it finalizes the proposal without modification.

2. 2017-Based LTCH Market Basket Cost Categories and Weights

To determine the index, CMS uses only those LTCHs that have a Medicare average length of stay that is within 25 percent of the LTCH's average length of stay for all patients. CMS believes this selection criterion will result in a more accurate reflection of the structure of costs for Medicare covered days. This selection criterion is the same as was used for the FY 2013- based LTCH market basket.

The selection criterion results in exclusion of 9 percent of LTCH providers. Included LTCH providers had an average Medicare length of stay of 25 days; an all patient average length of stay of 27 days, and aggregate Medicare utilization (based on days) of 58 percent. Excluded LTCH providers had an average Medicare length of stay of 27 days, average facility length of stay of 70 days, and aggregate Medicare utilization of 15 percent.

The LTCH market basket includes seven categories of costs plus a residual "all other" category. CMS derives the cost weights the same way for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket with the exception of home office/related organization contract labor:

(1) Wages and Salaries. Costs reported on Worksheet A, column 1, lines 30 through 35, 50 through 76 (excluding 52, 61, and 75), 90 through 91, and 93 and the proportion of overhead salaries that are attributed to Medicare allowable costs centers.

(2) Employee Benefits. Costs reported on Worksheet S-3, part II, column 4, lines 17, 18, 20, and
22. Worksheet S-3 is voluntary for LTCHs. Only 20 percent of LTCHs reported these data. However, CMS believes it has a large enough sample to produce a reasonable employee benefits cost weight because it did not change materially after weighting to reflect the characteristics of the universe of LTCHs (type of control (nonprofit, for-profit, and government) and by region).

(3) Contract Labor. Costs reported on Worksheet S–3, part II. Only 44 percent of LTCHs voluntarily reported costs on Worksheet S-3 part II. CMS's analysis indicates there is a large enough sample to produce a reasonable contract labor cost weight.

(4) Pharmaceuticals. Costs reported on Worksheet B, part I, column 0, lines 15 and 73 and then removing a portion of these costs attributable to salaries (adjusted by the ratio of Worksheet A, column 1, lines 15 and 73 divided by the sum of Worksheet A, columns 1 and 2, lines 15 and 73).

(5) Professional Liability Insurance. Premiums, paid losses and self-insurance costs reported on Worksheet S-2, part I, columns 1 through 3, line 118.

(6) Home Office/Related Organization Contract Labor. Costs reported on Worksheet S–3, part II, column 4, lines 14, 1401, 1402, 2550, and 2551 for those LTCH providers reporting total salaries on Worksheet S-3, part II, line 1. For the 2013-based LTCH market basket, CMS used the 2007 Benchmark Input-Output expense data published by the Bureau of Economic Analysis.

CMS believes the proposed methodology for the 2017-based LTCH market basket is a technical improvement over the prior methodology because it represents more recent data that is representative compositionally and geographically of LTCHs.

(7) Capital. Worksheet B, part II, column 26, lines 30 through 35, 50 through 76 (excluding 52, 61, and 75), 90 through 91 and 93.

(8) All Other. Reflects all remaining costs that are not captured in the seven cost categories listed.

CMS excludes those LTCHs with cost weights that are less than or equal to zero for a category as well as those cost weights that are in the top and bottom 5 percent for all cost categories except home office/related organization contract labor. For this cost category, CMS finalizes its proposal to remove the top 1 percent only as not all LTCHs have a home office and the cost weight for this category may appropriately be zero.

Major Cost Categories	**2013 Weight**	**2017 Weight**
Wages and Salaries	41.5	42.6
Employee Benefits	6.5	6.2
Contract Labor	5.9	4.4
Professional Liability	0.9	0.5
Pharmaceuticals	7.6	6.2
Home Office/Related Organization Contract Labor	N/A	1.9
Capital	9.7	9.9
All Other	27.8	28.3

CMS provides further detail on the data sources used to derive weights within the capital and all other category. The final detailed cost weights including the subcomponents of capital and all other are found in table E4 (beginning on page 1,496 of the display copy).

3. Selection of Proposed Price Proxies

CMS uses the same price proxies for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket with one highly technical change to how CMS proposes to determine the weight for chemicals—a subcomponent of the all other category.

4. FY 2021 Market Basket Update for LTCHs

CMS finalizes an FY 2017-based LTCH market basket update of 2.3 percent for FY 2021. If continued, the FY 2013-based LTCH market basket update would have been 2.4 percent. The FY 2013-based LTCH market basket and the FY 2017-based LTCH market basket differed by 0.2 percentage points or less for each year between FYs 2016-2019 and forecast for FY 2020 through FY 2023. The FY 2017-based LTCH market basket averaged 0.1 percentage point lower in this time period than the FY 2013 LTCH market basket.

5. FY 2021 Labor-Related Share

The labor-related share of the LTCH standard federal rate is adjusted for area differences in costs. The remaining portion of the LTCH standard federal rate is a uniform national amount. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market.

CMS uses the same labor-related categories of costs for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket: wages and salaries; employee benefits; professional fees: labor-related services; administrative and facilities support services; installation, maintenance, and repair services; all other: labor-related services; and a portion of the capital-related costs from the 2017-based LTCH market basket. Professional fees: labor-related services include a proportion of the home office/related organization contract labor costs.

The final labor-related share for FY 2021 is 68.1 percent compared to 66.3 percent based on the 2013-based LTCH market basket. The different contribution of each cost weight category to the overall difference is shown in the table below:

Major Cost Categories	2013-Based LTCH MB	2017-Based LTCH MB
Wages and Salaries	46.6	47.1
Employee Benefits	7.2	6.8
Professional Fee: Labor-Related	3.4	4.4
Administrative and Facilities Support Services	0.9	1.0

Installation, Maintenance, and Repair Services	2.1	2.1
All Other: Labor-Related Services	2.0	2.3
Subtotal	62.2	63.7
Labor-Related Portion of Capital (46%)	4.1	4.4
Total Labor-Related Share	66.3	68.1

Impact of Payment Rate and Policy Changes to LTCH PPS Payments

CMS Impact Analysis for LTCHs

CMS projects that the overall impact of the payment rate and policy changes, for all LTCHs from FY 2020 to FY 2021, will result in a decrease of 1.1 percent or $40 million in aggregate payments from $3.774 billion to $3.733 billion for the 363 LTCHs included in this impact analysis. CMS attributes this decrease primarily to the rolling end to the statutory transitional blended payment rate for site neutral payment cases. This impact results from a decrease in payment for site neutral cases of $114 million and an increase in payment of LTCH standard federal payment rate cases of $74 million.

CMS indicates that there will no longer be any transitional payment for site-neutral cases in FY 2021 like there was in FY 2020 based on the start date of the LTCH's cost reporting period. The lack of a transitional payment will result in a reduction in payment estimated at 24 percent or approximately $114 million for the 25 percent of cases that are estimated to be paid at a site neutral rate.

For the approximately 75 percent of cases estimated to be paid at the standard federal rate, payment is estimated to increase 2.2 percent or approximately $74 million. This increase is primarily due to the proposed 2.3 percent annual update to LTCH standard federal rate for FY 2021 and a 0.5 percent decrease in the proportion of FY 2021 LTCH payments attributed to high cost outliers.

CMS estimates that high cost outliers in FY 2020 will be about 8.005 percent of estimated total LTCH PPS standard federal payment rate payments. As it does annually, CMS proposes to set the high cost outlier threshold for LTCH standard federal payment rate cases so that 7.975 percent of total payment are made as high cost outliers. The difference between the 8.005 percent figure for FY 2020 and the estimate of 7.975 percent for FY 2021 accounts for the 0.03 percent reduction in payment for high cost outliers.

CMS was unable to model the impact of LTCH PPS payment changes for site neutral payment rate cases as it did for standard federal payment rate cases. Thus, Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2021" in the final rule shows the detailed impact by location, participation date, ownership type, region, and bed size for only LTCH PPS standard federal payment rate cases and does not include the detailed impact in payments for site neutral payment rate cases. CMS reports that regional differences in impacts are largely due to updates to the wage index.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

The LTCH QRP was first implemented in FY 2014, as required under section 1886(m) of the Act. Further developed in rulemaking, the LTCH QRP follows many of the policies established for the IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. An LTCH must meet LTCH QRP patient assessment and quality data reporting requirements or be subject to a 2.0 percentage point update factor reduction. LTCHs submit data on the LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS) patient assessment instrument to CMS using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system.

No changes are made to the LTCH QRP in this rule. The table below displays the measures previously adopted for the LTCH QRP for FYs 2020 through 2022.

LTCH QRP Measures, by Year				
Measure Title	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X	X
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)	X	Replaced		
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		X	X	X
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X	Removed	
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	X	X	X	X
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	X	X	Removed	
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	X	X
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)	Removed			
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	X	X	X	X
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	X	X	X	X

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)	X	X	X	X
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X	X	X	X
LTCH QRP Measures, by Year				
Measure Title	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
NHSN Ventilator Associated Event Outcome Measure	X	X	Removed	
Medicare spending per beneficiary MSPB-PAC LTCH	X	X	X	X
Discharge to Community PAC LTCH*	X	X	X	X
Potentially Preventable Readmissions 30 Days Post LTCH Discharge	X	X	X	X
Drug Regimen Review Conducted with Follow-up		X	X	X
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay		X	X	X
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate		X	X	X
Transfer of Health Information to the Provider – PAC Measure				X
Transfer of Health Information to the Patient – PAC Measure				X
* Measure updated to remove baseline nursing facility patients beginning in FY 2020.				

Changes for Hospitals and Other Providers

Submission of Electronic Patient Records to Quality Improvement Organizations

1. Background

A Quality Improvement Organization (QIO) is an organization comprised of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare. Current law authorizes QIOs to have access to the records of providers, suppliers, and practitioners under Medicare in order to perform their functions. Providers and practitioners are required to provide patient care data and other pertinent data to the QIO when the QIO is collecting review information. CMS proposed to make electronic submission the default method of submission, mandating all providers and practitioners who provide patient records to the QIO to submit them in electronic format unless they have an approved waiver.

2. Proposed Changes CMS

proposed:

- To define “patient record” as all patient care data and other pertinent data or information (whether or not part of the medical record) relating to care or services provided to an individual patient, in the possession of the provider or practitioner, as requested by a QIO for the purpose of performing one or more QIO functions.
- Patient records must be delivered in electronic format, unless a QIO approves a waiver. Initial waiver requests by those providers that are required to execute a written agreement with the QIO would be expected to be made at the time of the written agreement although the waiver could be requested later if necessary. Other providers and practitioners who are not required to execute a written agreement with a QIO would request a waiver by giving the QIO notice of their lack of capability to submit patient records in 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. Only one reimbursement would be provided by the QIO for each patient record submitted, per request, even if a particular patient record is submitted to the QIO using multiple different formats, in fragments, or more than once in response to a particular request.

These proposed changes would be applicable to all providers and practitioners providing patient records to QIOs for purpose of QIO reviews. CMS proposed a number of regulatory changes to ensure that reimbursement is permitted for all healthcare providers and practitioners, on the same basis and at the same rates. It is further streamlining all of the regulations related to submission and payment for providing medical records to be in the same section of the regulations.

CMS proposed to remove a step-by-step analysis of how the cost of photocopying was calculated from the regulations. That same step-by-step analysis for the updated rate is included in the preamble to the regulations and is also furnished for the $3.00 electronic record fee and $0.15 facsimile fee.

These fees were determined by using the annual salary and fringe benefits cost of a GS-5, step 5 medical records clerk ($53,918 per year or $26 per hour) in combination with assumptions about productivity and workload for electronic patient records plus the additional costs of a photocopier and supplies for photocopied records and a telephone for facsimile records.

CMS estimates these policies will save $71.8 million over 5 years; $37.6 million from reimbursement for sending patient records via facsimile, photocopying and mailing and $34.2 million from payment to QIOs to cover the cost of scanning and uploading paper-based patient records.

Comments/Responses: One commenter indicated that CMS should eliminate reimbursement for patient records submitted by photocopying, mailing and facsimile and only pay for electronic submission of patient records to encourage modernization. CMS disagreed saying that up to 20 percent of providers may lack the capacity to submit patient records in electronic format. There were no other comments. CMS is finalizing all of the above proposals without modification.

Mandatory Provider Review Reimbursement Board (PRRB) Electronic Filing

3. Background

The PRRB is an independent board for resolving payment disputes typically arising from certain Medicare Part A final determinations (usually cost report audit appeals). Staff support is provided to the PRRB by CMS' Office of Hearings (OH). On August 16, 2018, the OH and the Board released the OH Case and Document Management System (OH CDMS)—a web-based portal where providers can file appeals and the PRRB can release outgoing electronic correspondence and Board decisions with immediate system notification of an action. This system is already in use by all MACs and many others that have appeals before the PRRB.

4. Technical Changes to Support Electronic Filing

The OH proposed technical changes to the regulations consistent with use of the OH CDMS electronic system:

- Update the definitions of "date of receipt" and "reviewing entity" to indicate that submissions to an electronic filing system are considered received on the date of electronic delivery.
- "In writing or written" means hard copy or electronic submission. (Date of receipt by a party or affected nonparty continues to be presumed to be 5 days after the date of issuance).
- Technical changes are made throughout to apply terms to both hard copy and electronic submissions.
- Update provisions related to subpoenas, so that it generally conforms to other technical changes being proposed except for adding "If the subpoena request is being sent to a nonparty subject to the subpoena, then the subpoena must be sent by certified mail" in accordance with section 205(d) of the Act.

5. Intention to Revise Board Instructions to Require Mandatory Electronic Submissions

No earlier than FY 2021, the PRRB may require that all new submissions be filed electronically using OH CDMS. Stakeholders can access the Electronic Filing webpage located at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing. The OH recommends that parties to PRRB appeals, who have not already done so, sign up for and begin using OH CDMS as soon as possible to allow time to become familiar with the

system and avoid any issues that may arise if signing up for the system is delayed until after use of the system becomes mandatory.

Comments/Responses: Public comments were largely positive to these proposals although there were a number of comments addressing specific issues:

Schedule of Providers (SOP). A few commenters stated that SOPs for group appeals should be accepted in PDF format like every other document filed in PDF format via OH CDMS. CMS will consider this comment for future OH CDMS instructions.

System Downtime. A few commenters stated that there should be an exception to mandatory electronic filing if a user is unable to access OH CDMS for a filing deadline due to system downtime. CMS responded that this issue is not significantly different from those associated with hard copy filings where the regulations already provide allowances if a reviewing entity is unable to conduct business in the usual manner.

Single System Representative. One commenter expressed concern about what happens if its single system representative is no longer employed. CMS responded that it is the responsibility of the provider and/or representative to notify the PRRB to maintain updated information for a system representative.

Batch Uploads. Appeals that involve a large number of providers must be entered individually rather than as a group. The commenter requested the ability to do batch uploads to make electronic filing more appealing than paper filing. OH CDMS does not have this functionality yet but CMS will consider it as it upgrades the system.

Mandating Electronic Filing: Some commenters asked that mandatory electronic filing not be required and, if it will be required, hospitals be given more than 60 days advanced notice. CMS believes it is reasonable to require electronic appeals further noting the system has been available for close to two years. Nevertheless, CMS will provide at least 120 days notice prior to requiring electronic reporting.

Duplicate Appeals. One commenter stated that OH CDMS requires users to conclusively state that the appeal issues are not pending in any other appeal, but a user can never know with absolute certainty whether another party has mistakenly filed an appeal on a duplicate issue. CMS responded that it is reasonable to expect a provider or its representative to know of any appeals that have been filed.

Security Concerns: One commenter expressed concern about requiring applicants to provide their Social Security number for a limited credit check. CMS outlined how OH CDMS is part of a larger enterprise identity management system ("EIDM") that authenticates individual users of many CMS data systems. There is a system-wide EIDM security.

Presume Date of Receipt: Several commenters suggested that CMS revise the regulatory definition of "date of receipt" so that the 5-day presumption of receipt does not apply to PRRB decisions or other documents issued electronically to providers. All parties to an appeal are notified of the decision instantaneously. CMS responded that it did not propose any changes to "date of receipt." It further indicated that the present regulatory text continues to serve its original purposes of avoiding any problem of verifying when a document or other material is actually received to begin a review period.

Medicare Bad Debt Policy

6. Background

Under the Medicare program, beneficiaries may be responsible for payment of premiums, copayments, deductibles, and coinsurance amounts that are related to covered services. In accordance with section 1861(v)(1) of the Act and regulations at §413.89, Medicare pays some of the uncollectible deductible and coinsurance amounts to certain providers, suppliers and other entities eligible to receive reimbursement for bad debt of Medicare beneficiaries. To be an allowable Medicare bad debt, the debt must meet all of the following criteria (see §413.89(e) and Provider Reimbursement Manual (PRM), Chapter 3, Section 308):

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

Statute prohibited the Secretary from making changes to Medicare bad debt policies on August 1, 1987 for hospitals in effect. This moratorium ended for cost reporting periods beginning on or after October 1, 2012. CMS is using the FY 2021 IPPS rule to clarify certain Medicare bad debt policies that have been the subject of litigation, and generated interest and questions from stakeholders over the past several years. Additionally, CMS will recognize the new Accounting Standards Update (ASU) – Topic 606 for revenue recognition and classification of Medicare bad debts and make technical corrections to the regulations.

CMS proposed to make many of these changes effective retroactively under the authority of section 1871(e)(1)(A)(ii) of the Act that allows retroactive rulemaking when the alternative is contrary to the public interest. The proposed rule explained why it would be in the public interest for these policies to apply retroactively. In other circumstances, CMS proposed prospective changes to the regulations effective for cost reporting periods beginning on or after October 1, 2020.

7. Proposed Revisions to Regulations

a. Reasonable Collection Efforts. CMS proposed significant revisions to §413.89(e)(2). Currently, this section of the regulation only states that "the provider must be able to establish that reasonable collection efforts were made." More detailed requirements were in the PRM. Below is a list of items CMS proposed be added to this section of the regulation:

Non-Indigent Beneficiaries. Reasonable collection efforts are only required from non-indigent beneficiaries. CMS proposed to add §413.89(e)(2)(i) that states: "A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes." The preamble indicates this policy is not new and has existed since the promulgation of Medicare bad debt policy.

Comment/Response: Some commenters were supportive of the proposal to codify the definition of a non-indigent beneficiary because it would provide clarity to Medicare bad debt policies. Other commenters suggested the definition should not be applied retroactively. CMS indicated that retroactive codification of the definition of a non-indigent beneficiary serves to promote a public interest of providing clarity because the definition has existed inherently in the longstanding bad debt collection effort policies that applied, and continue to apply, to a non-indigent beneficiary. Prospective application would create more confusion in that it would suggest a change in CMS policy and the potential for providers to resubmit past cost reports. CMS is finalizing this policy as proposed.

Issuance of a Bill. CMS proposed to codify requirements currently in the PRM into §413.89(e)(2) including the following:

- The collection effort must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.
- For cost reporting periods beginning before October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.
- For cost reporting periods beginning on or after October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following: ○ The date of the Medicare remittance advice.
    - ○ The date of the remittance advice from the beneficiary's secondary payer, if any.
- The collection effort must also include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

CMS proposed to make all of the above requirements effective retroactively except for the provisions that have an effective date of cost reporting periods beginning on or after October 1,

2020. For the regulations that have retroactive effect, the rule indicates the policies are long-standing from the PRM that are being codified in regulation.

The provisions effective on or after October 1, 2020 are intended to give more precise meaning to the term "shortly after." For cost reporting periods beginning prior to October 1, 2020, providers are only required to issue a bill "shortly after discharge or the death of the beneficiary." For cost reporting periods beginning on or after October 1, 2020, the requirement is to issue a bill on or before 120 days after the latter of the date of the Medicare remittance advice or the date of remittance advice from the beneficiary's secondary payer, if any.

Comments/Responses: Commenters were supportive of CMS' proposal and also requested that the proposed timeframe within which to issue a bill to the beneficiary also include a third circumstance of the date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary. CMS agreed and is modifying its final rule policy to consistent with this comment.

A few commenters requested that CMS further define "personal contacts" with beneficiaries to collect the unpaid deductibles and coinsurance amounts, and whether personal contacts can include communication methods such as email and text message. CMS responded that the definition of a "personal contact" means an encounter where two or more people are in visual or physical proximity to each other or a face-to-face encounter. It did not address whether "personal contacts" can include email and text messages.

Final Decision: CMS is finalizing the above policy as proposed with a modification to indicate that for cost reporting periods beginning on or after October 1, 2020, reasonable collection effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following: 1) the date of the Medicare remittance advice; 2) the date of the remittance advice from the beneficiary's secondary payer, if any; or 3) the date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary

120-day Collection Effort and Reporting Period for Writing Off Bad Debts. CMS is making two changes in this section of the rule. First, CMS is adding a requirement to §413.89(e)(2) that a bill cannot be considered uncollectible until at least 120 days have passed since the provider first attempted to receive payment. If the provider receives partial payment, the 120-day period restarts. This policy will be effective retroactively as CMS states that it merely codifies in regulation what was an established policy in the PRM. CMS indicates that the requirement to restart the 120 days upon receiving a partial payment is a clarification of a policy CMS established in response to inquiries.

Second, CMS is revising an existing provision of the regulations (§413.89(f)) to clarify that any payment on the account made by the beneficiary, or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report. If the collection is made in a cost reporting period after the

debt has been written off as uncollectible, the recovered amount must be used to reduce the provider's reimbursable costs in the period in which the amount is recovered. However, the amount of such reduction in the period of recovery must not exceed the actual amount reimbursed by the program for the related bad debt in the applicable prior cost reporting period. CMS proposes to make this policy effective retroactively.

Comments/Responses: While some commenters were supportive of the proposal, other commenters objected to the policy as unnecessarily requiring hospitals to keep their accounts receivable open for longer periods of time. Commenters were not supportive of a retroactive effective date for the codification of this provision as they believed providers would be confused by the applicability of the policy for various cost reporting periods.

CMS responded that its longstanding position, asserted in court cases and legal documents over the years, is that if the provider continues to receive money, then the account is not a worthless account without value. This longstanding bad debt policy has existed in Medicare guidance, including the PRM, for decades. Giving the regulatory provision retroactive effect does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers or beneficiaries. CMS is finalizing its policy as proposed.

Similar Collection Effort and Collection Agency Fees. As indicated above, CMS proposed to modify §413.89(e)(2) to add the following provision: The collection effort must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.

This proposed provision of the regulation codifies an existing provision of the PRM. CMS clarifies confusion over how this policy has been understood. Similar collection efforts mean that the provider must take the same actions to collect Medicare and non-Medicare debts alike. For example, if a provider elects to refer its non-Medicare accounts to a collection agency, the provider must similarly refer Medicare accounts of "like amount" without regard to class of patient.

The collection agency's effort to collect the debt must also be similar between Medicare and non-Medicare patients. This means that for comparable amounts, the collection agency must use similar collection practices for both accounts. The effort must constitute a genuine, rather than a token, collection effort. Collection accounts that remain at a collection agency cannot be claimed by the provider as a Medicare bad debt. Further, a fee charged by a collection agency can be considered an allowable administrative expense but cannot be written off to bad debt. CMS proposed to make this policy effective retroactively.

Comments/Responses Some commenters suggested that accounts at a collection agency have little to no value and providers simply place them with collection agencies for the small possibility of a collection. Other commenters suggested that if a payment were to be made on an account while at a collection agency, providers could reconcile the amount paid and record it as a recovery on the provider's subsequently submitted cost report.

CMS responded that it has been its longstanding policy that an account that remains at a collection agency remains in a collection effort status, and thus cannot be claimed as a Medicare bad debt.

Some commenters suggested that further definitions be set forth for what constitutes a genuine, and not a token collection effort. CMS responded that a genuine, rather than a token, collection effort has been addressed in PRM §310 as "also including… subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort." As CMS has asserted in the past in policy statements and proceedings, a genuine collection effort requires the provider to engage in prompt and continuous collection efforts, over at least 120 days, advising the beneficiary of the amounts to be collected, engaging in subsequent follow up and billing, and may include the provider engaging a collection agency.

CMS is finalizing this policy as proposed.

Documentation of Reasonable Collection Efforts. CMS proposed to add §413.89(e)(2)(A)(i)(6) to codify long-standing provisions of the PRM related to documentation of reasonable collection efforts.

The provider must maintain and, upon request, furnish to the Medicare contractor documentation of the provider's collection effort, whether the provider performs the collection effort in house or whether the provider uses a collection agency to perform the required collection effort on the provider's behalf. The documentation of the collection effort must include: the provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients; the patient account history documents which show the dates of various collection actions such as the issuance of bills, follow-up collection letters, reports of telephone calls and personal contact, etc. CMS proposed to make this policy effective retroactively.

Comments/Responses: Commenters disagreed with setting forth documentation requirements in regulation suggesting the need for flexibility makes these issues more appropriate for sub-regulatory guidance. CMS cited other provisions of regulations that provide documentation requirements but indicated the provisions are sufficiently general to allow for needed flexibility. CMS is finalizing this policy as proposed.

b. Determining Indigency. For beneficiaries that are not Medicaid eligible, CMS indicates that the PRM requires that the beneficiary's total resources be considered when a provider evaluates a beneficiary's indigence. CMS propose new paragraph (e)(2)(ii)(A) that provides for determining indigence for beneficiaries that are not Medicaid eligible as follows:

1. The beneficiary's indigence must be determined by the provider, not the beneficiary;
2. The provider must take into account a beneficiary's total resources which include, but are not limited to, an analysis of assets (only convertible to cash and unnecessary for the beneficiary's

daily living), liabilities, and income and expenses. The provider may consider any extenuating circumstances that would affect the determination of the beneficiary's indigence; and

3. The provider must determine that no source other than the beneficiary (for example, a legal guardian) would be legally responsible for the beneficiary's medical bill.

CMS proposed to make this policy effective retroactively.

Comments/Responses: Like for other issues, there were objections to retroactive application of these policies with commenters indicating that the PRM guidance was suggestive and not mandatory. CMS responded that its longstanding policy has been that PRM guidelines require a provider to take into account the beneficiary's total resources to include the consideration of a beneficiary's assets, income, liabilities and expenses and CMS is merely codifying longstanding policy. Comments were in the following areas:

Evaluation of Liabilities and Expenses: Many commenters suggested that only a patient's income be considered when determining whether a patient is indigent and also suggested that an evaluation of a patient's assets, liability and expenses requires additional resources and burden to the provider. CMS agrees that liabilities and expenses do not need to be reviewed once a patient is qualified as indigent based upon income and assets. However, CMS believes that assets must continue to be considered when they are convertible to cash, unnecessary for the beneficiary's daily living and can be used for the beneficiary's medical cost sharing expenses. If a beneficiary does not qualify for indigence based in income and assets, a further review of liabilities and expenses continues to be necessary to qualify a beneficiary's indigence.

Presumptive Eligibility Tools. Some commenters suggested that providers be permitted to use presumptive eligibility tools—such as those used to qualify patients for federal, state and local uncompensated care or charity care programs—to qualify Medicare beneficiaries for indigence determinations for Medicare bad debt purposes. CMS disagreed saying that many presumptive eligibility tools cursorily review a patient's financial status, based either on the patient's declaration or demographic presumptions, or income and presume one to be indigent.

Conflict with Other Indigence Programs. Commenters asserted that the proposal to codify the Medicare bad debt indigence evaluation criteria contradicts terms of indigence policies from other programs. These programs do not permit providers to inquire about a patient's assets, liabilities, or expenses, and therefore a provider's compliance with Medicare bad debt indigence policy would adversely cause providers to be non-compliant with other indigent policies. CMS distinguished other programs from Medicare's bad debt policy as other programs may pay beneficiaries directly while the bad debt program compensates providers for bad debts of its patients. Medicare's rules are relevant to this particular purpose while a determination of indigence for another program may have different purposes and program criteria.

Improvements in Beneficiary's Financial Position. Some commenters objected to having to conclude "that there has been no improvement in the beneficiary's financial status" once indigence is determined as a vague and burdensome requirement. CMS agreed with these

comments and indicated that flexibility should be afforded to providers to not being continually required to review a beneficiary's financial condition once indigence is determined. If a provider discovers that the beneficiary's financial condition has improved following the provider's determination of indigence, CMS expects the provider will no longer classify the beneficiary as indigent and implement reasonable collection efforts for the nonindigent beneficiary.

Final Action: CMS is finalizing its proposal with two modifications:

1. If indigence can be determined based solely on income and assets, no review of expenses and liabilities will be necessary although extenuating circumstances and expenses and liabilities may be reviewed if indigence is not established based on a review of income and assets; and
2. Monitoring for a change in a patient's financial status once indigence is determined will not be required although if the provider becomes aware of a change in financial circumstances, it must take that into account when determining indigence.

CMS is also requiring that the provider must maintain and, upon request, furnish its Medicare contractor with the provider's indigence determination policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider's determination of each beneficiary's indigence or medical indigence.

CMS will evaluate burden estimates for the recordkeeping requirements if they are not already accounted for the existing Paperwork Reduction Act approvals. As CMS changed its final rule policies based on public comment, it is finalizing these policies with an effective date for cost reporting periods beginning on or after October 1, 2020.

c. Dual Eligible Beneficiaries. Dual eligible beneficiaries are Medicare beneficiaries who are enrolled in Medicare (either Part A, Part B, or both), and are also enrolled in "full Medicaid" coverage and/or the Medicare Savings Program. Some of these dual eligible beneficiaries have full Medicaid coverage while others have partial Medicaid coverage where Medicaid may pay some or all of the beneficiary's Medicare cost sharing. The proposed rule provided a detailed discussion of these partial Medicaid programs as well as complex issues where Medicaid may not provide information on whether it has an obligation to pay for a Medicare beneficiary's liability because a provider is not enrolled in Medicaid or for other reasons.

To satisfy the reasonable collection effort, a provider that has furnished services to a dual eligible beneficiary must determine whether Medicaid (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible and/or coinsurance amounts. A provider satisfies this requirement by:

1. Billing the state Medicaid program to determine that no source other than the patient would be legally responsible for the patient's medical bill; for example, Title XIX, local welfare agency and guardian (the "must bill requirement"); and

2. Obtaining and submitting to the MAC, a Medicaid remittance advice (RA) from the state Medicaid program (the "RA requirement"). If a provider does not bill the state and submit the Medicaid RA to Medicare with its claim for bad debt reimbursement for dual eligible beneficiaries, the result is that unpaid deductible and coinsurance amounts cannot be included as an allowable Medicare bad debt.

CMS proposed to codify this policy in §413.89(e)(2). Any amount that the state is obligated to pay, either by statute or under the terms of its approved Medicaid state plan, will not be included as an allowable Medicare bad debt, regardless of whether the state actually pays its obligated amount to the provider or provides the Medicaid RA indicating that it has no obligation to pay. However, the Medicare deductible and/or coinsurance amount, or any portion thereof that the state is not obligated to pay, can be included as an allowable Medicare bad debt. Unpaid deductible and coinsurance without collection effort documentation will not be considered as allowable bad debts. CMS proposed to make this policy effective retroactively.

CMS acknowledges that challenges exist for providers when states do not comply with the federal statutory requirements and suggests potential alternatives to the "must bill" policy and Medicaid RA that it could adopt in the final rule. CMS welcomed suggestions from stakeholders regarding the best alternative documentation to the Medicaid RA and whether it should or could adopt such a policy effective for past cost reporting periods. Doing so would serve an important public interest by allowing providers with cases currently pending before the PRRB an avenue for timely and cost-effective resolution.

Comments/Responses: Like for other issues, there were objections to retroactive application of these policies with commenters indicating in this case that CMS' retroactive application lacks statutory authority and violates the bad debt moratorium. CMS disagreed and its response indicated that these or similar policies relevant to the time period under consideration were in place prior to the bad debt moratorium. Further, CMS provided citations to a number of court precedents that it believes directly upheld these policies (and one that prohibited CMS from liberalizing the policy during the moratorium) or supports retroactive application. As with other bad debt policies being codified, CMS indicates that these policies will reduce confusion rather than increase it by making past and current policy clearer. Other comments were on:

Must Bill Policy. Some commenters asserted that the must bill policy does not serve an important interest because states pay little, if anything, toward a dual eligible beneficiary's Medicare cost sharing. Some commenters noted that the crossover billing process sometimes fails for other various reasons. CMS disagreed reiterating that it believes the best documentation to evidence states' cost sharing liability for a dual eligible beneficiary is the Medicaid RA. If the Medicare crossover billing fails or is not completed in certain instances, the provider has the opportunity to work with its contractor to identify and resolve the issue.

Alternate Documentation to the RA not Furnished by the State. Commenters were disappointed CMS did not propose specific alternate documentation to the Medicaid RA. Commenters suggested some specific alternatives CMS could use as documentation of Medicaid's lack of payment obligation for Medicare coinsurance and deductibles.

CMS responded that alternate documentation must contain all of the following:

1. The state Medicaid notification that the state has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim;
2. Documentation setting forth the state's liability, or lack thereof, for the Medicare cost sharing; and
3. Documentation verifying the beneficiary's eligibility for Medicaid for the date of service.

For #1 above, the inability to enroll must be through no fault or deficiency of the provider. Sufficient evidence of this requirement would be documentation showing that the state Medicaid agency does not recognize the provider as a Medicaid provider type for purposes of processing a Medicare crossover cost sharing claim. In some states it may be difficult to supply evidence that the state will not enroll a specific provider type. In these circumstances, Medicare contractors will afford providers flexibility in producing acceptable evidence. CMS encourages states to consider separate enrollment pathways for Medicare providers that seek to enroll in Medicaid solely for the purposes of processing Medicare crossover claims for dually eligible beneficiaries.

For #2 above, documentation setting forth the state's lack of liability for the Medicare cost sharing can be produced by the provider, in part, from the state plan documents and may also include other documents such as state and state contractor fee schedules or payment rates, or other documents the provider produces that can be verified by the contractor. Medicare contractors will afford providers flexibility in producing documentation acceptable to evidence the state's Medicare cost sharing in the absence of a Medicaid RA.

For #3 above, documentation verifying the beneficiary's eligibility for Medicaid for the date of service could take the form of an eligibility report from a state's eligibility verification system. Medicare contractors will afford providers flexibility in producing acceptable evidence of the beneficiary's eligibility for Medicaid for the date of service.

CMS will work with the providers, states, and Medicare contractors on guidelines for acceptable alternative documentation to the Medicaid RA.

Final Action. CMS is finalizing its "must bill" policy and use of the Medicaid RA as documentation of the state's lack of obligation to pay Medicare beneficiary cost sharing. If this information is not available from the state, CMS is codifying the use of alternate documentation as outlined above. CMS is making all of these policies retroactive and will continue to evaluate alternative Medicaid RA documentation policy so that any policy refinements can be addressed in future rulemaking, if needed. Medicare contractors are being instructed to work with providers to resolve cases pending before the PRRB so that providers may experience relief and burden reduction through the application of this rule to their existing cases.

d. Accounting Standard Update Topic 606 and Accounting for Medicare Bad Debt

(1) Accounting Standard Update (ASU) Topic 606.

The Financial Accounting Standards Board's (FASB) ASU 2014-09, Revenue from Contracts with Customers (Topic 606), was published in May 2014 with the first implementation period in 2018. Under the ASU Topic 606, an amount representing a bad debt would generally no longer be reported separately as an operating expense in the provider's financial statements, but will be treated as an "implicit price concession," and included as a reduction in patient revenue. Topic 606 makes other related changes.

To implement Topic 606, CMS proposed to modify the regulations to add that, effective for cost reporting periods beginning on or after October 1, 2020 that "bad debts, also known as 'implicit price concessions' are amounts considered to be uncollectible from accounts that were created or acquired in providing services" and "bad debts, also known as 'implicit price concessions,' charity, and courtesy allowances represent reductions in revenue."

Comments/Responses: Commenters agreed with CMS' policy but requested that it be adopted retroactive to the effective date of Topic 606. CMS is not adopting the policy retroactively as CMS' prior policy was not the policy described by Topic 606. Retroactive implementation in this case could require provider to change past reporting practices unnecessarily.

(2) Medicare Bad Debt and Contractual Allowances

CMS indicates that many providers are incorrectly writing off Medicare-Medicaid crossover bad debts to a contractual allowance account because they are unable to bill the beneficiary for the difference between the billed amount and the Medicaid claim payment amount. Other providers are writing these amounts off to a contractual allowance account because the Medicaid remittance advice referenced the unpaid amount as a "Medicaid contractual allowance."

These Medicare-Medicaid crossover claims amounts do not meet the classification requirements for a Medicare bad debt because the amounts were written off to a contractual adjustment or allowance account instead of a bad debt expense account. CMS proposed to add paragraph (c)(3) to §413.89(c) to clarify that, effective for cost reporting periods beginning on or after October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debt or implicit price concession).

Comments/Responses: Commenters did not support the precise regulatory language and suggested an alternative. Other commenters objected to the proposal as increasing burden because it will require a change in accounting practices that are permissive under Generally Accepted Accounting Principles. One commenter suggested that providers classify their Medicare-Medicaid crossover bad debt as contractual allowances and contractors reimburse them for a portion of these contractual allowance amounts. There were various opinions on whether this change should be applied retroactively to the effective date of ASU Topic 606, CMS sub-regulatory guidance on this issue or prospectively.

CMS responded that it is never appropriate for a provider to write off Medicare-Medicaid crossover bad debt amounts to a contractual allowance account simply because they are unable to bill the beneficiary for the difference between the billed amount and the Medicaid claim payment amount. It is likewise inappropriate to present these amounts to Medicare for reimbursement as Medicare bad debts. CMS agreed with comments on the regulatory language and will substitute "must not be written off to a contractual allowance account but must be charged to an uncollectible receivables account that results in a reduction in revenue" instead of an "expense account" as to where a bad debt can be written off. CMS is not codifying this policy retroactively as it is a change from prior policy.

Medicare Payment Advisory Commission (MedPAC) Recommendations

In its March 2020 Report to Congress, MedPAC recommended an update to the hospital inpatient rates by 2 percent with the difference between this and the update amount specified in current law to be used to increase payments in a new suggested Medicare quality program, the "Hospital Value Incentive Program (HVIP)." HVIP would replace the current hospital quality programs. CMS responded that consistent with the statute, it is establishing an applicable percentage increase for FY 2020 of 2.4 percent, provided the hospital submits quality data and is a meaningful EHR user consistent with statutory requirements. CMS does not have the authority to eliminate the current quality programs or establish HVIP.