Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule (CMS-1735-P)

W.L. GORE and Associates

INTRODUCTORY SUMMARY AND BACKGROUND

On May 11, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2021.

With a few exceptions, CMS reimburses acute care hospitals under IPPS. Under this payment system, CMS sets base payment rates for inpatient admissions on the diagnoses and procedures performed. The facility receives a single payment for each case based on the reimbursement classification determined at discharge. IPPS cases are paid by Medicare Severity Diagnosis-Related Groups (MS-DRGs).

Certain hospitals and hospital units are excluded from IPPS:

- Inpatient rehabilitation facility (IRF) hospitals and units
- Long-term care hospitals (LTCHs)
- Psychiatric hospitals and units
- Children's hospitals
- Cancer hospitals
- Extended neoplastic disease care hospitals
- Hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa)
- Religious nonmedical health care institutions (RNHCIs)
- Critical Access Hospitals (CAH)

The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the MS-DRG to which the case is assigned. Each MS-DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

Section 1886(d)(4)(C) of the Act requires the Secretary adjust the MS-DRG classifications and relative weights at least annually to account for changes in use of resources. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. This is known as the "market basket" for the hospital.

The proposed changes would apply to approximately 3,200 acute care hospitals for discharges occurring on or after October 1, 2020.

Due to the use of resources during the COVID-19 response, CMS is waiving the 60-day delay in the effective date of the final rule and replacing it with a 30-day delay in the effective date of the final rule.

IPPS PROPOSED RULE

The FY 2021 proposed rule is located in its entirety at the following link:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10122.pdf

This document in PDF form is 1,602 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

Proposed Changes to IPPS Payment Rates

The proposed increase in payment rates for acute care hospitals under IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and demonstrate meaningful use of Electronic Health Record (EHR) program by approximately 3.1 percent. This reflects the projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage productivity adjustment, as well as a proposed +0.5 percentage point adjustment required by legislation.

CMS projects the operating payment rate increase with the other proposed changes to IPPS payment polices will be approximately 2.5 percent. Proposed changes in uncompensated care payments, new technology add-on payments, and capital payments will decrease IPPS payments by approximately 0.4 percent.

Individual hospitals may be subject to other payment adjustments including:

- Penalties for excess admissions under the Hospital Readmissions Reduction Program (HRRP)
- Penalties for worst performing under the Hospital Acquired Condition (HAC) Reduction Program
- Adjustments under the Hospital Value-Based Purchasing (VBP) Program.

CMS estimates a total increase in overall IPPS payments of approximately 1.6 percent. This is based on a projected IPPS payment increase of nearly $2.07 billion, including operating, capital and new technology changes.

Proposed MS-DRG Documentation and Coding Adjustment

Section 631 of the American Taxpayer Relief Act of 2012 (ATRA) requires a recoupment adjustment to the standardized amount of Medicare payments to acute care hospitals to account for changes in MS-DRG documentation and coding that do not reflect real changes in case-mix. For a 4-year period of FYs 2014-2017, this totaled $11 billion. For FY 2021, CMs is proposing to make an adjustment of +0.5 percent to the standardized payment amount.

Proposed Changes to Specific MS-DRG Classifications

In 2018, CMS changed the deadline to request MS-DRG classifications changes to November 1 of each year. This change was made in order to have more time to evaluate MS-DRG change requests and propose updates; and thus added 5 additional weeks for the data analysis and review process. The deadline for FY 2021 requests was November 1, 2019.

Since this change, CMS recognized the increased number and complexity of the requested changes to the MS-DRG classifications. Because of this, even more time is needed to evaluate requests, analyze data and consider any proposed rules. Therefore, CMS is moving the deadline to request MS-DRG changes to October 20, 2020 for FY 2022.

CMS is providing a test version of the ICD-10 MS-DRG Grouper Software Version 38, which includes new diagnosis and procedure codes; the draft version of the ICD-10 MS-DRG Definitions Manual Version 38; and the supplement diagnosis code mapping file from version 37 to version 38. These can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

The 2021 IPPS proposed rule includes nearly 600 ICD-10-CM coding changes, specifically 490 new codes, 47 revised codes, and 58 deleted codes. This is almost double the 324 proposed changes in the FY 2020 IPPS proposed rule.

O.R. vs Non-O.R. Procedures

Currently, each ICD-10-PCS procedure code has designations that determine whether and in what way the presence of that procedure on a claim impacts the MS-DRG assignment:

- Each ICD-10-PCS procedure code is either designated as an O.R. procedure for purposes of MS DRG assignment ("O.R. procedures") or is not designated as an O.R. procedure for purposes of MS-DRG assignment ("Non-O.R. procedures").
- For each procedure that is designated as an O.R. procedure, that O.R. procedure is further classified as either extensive or non-extensive.
- For each procedure that is designated as a non-O.R. procedure, that non-O.R. procedure is further classified as either affecting the MS-DRG assignment or not affecting the MS-DRG assignment.
- For new procedure codes that have been finalized and are proposed to be classified as O.R. procedures or non-O.R. procedures affecting the MS-DRG, MS-DRG assignment is then selected and subject to public comment.

In this proposed rule, CMS is addressing requests that were received regarding changing the designation of specific ICD-10–PCS procedure codes from non-O.R. to O.R. procedures or changing the designation from O.R. procedure to non-O.R. procedure. Parameters include whether the procedure would typically require the resources of an operating room; whether it is an extensive or a nonextensive procedure; and to which MS-DRGs the procedure should be assigned.

Proposed Changes to the ICD-10-CM and ICD-10-PCS Coding Systems

CMS has identified new, revised, and deleted diagnosis and procedure codes for FY 2021. These code titles are adopted as a part of the ICD-10 Coordination and Maintenance Committee meeting process. Therefore, they are not subject to comment in the proposed or final rules. For FY 2021, the proposed codes include a total of 72,616 ICD-10-CM codes and 77,781 ICD-10-PCS codes. These codes can be found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-proposed-rule-home-page#Tables

Proposed Changes to Code Severity (MCCs, CCs or non-CCs)

In the FY 2020 IPPS final rule, CMS postponed any changes to the severity level designations for 1,492 ICD-10-CM diagnosis codes. CMS decided this postponement after receiving recommendations that they conduct further analysis before finalizing any proposals. The proposed additions and deletion to the diagnosis code MCC and CC severity levels for FY 2021 can be found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-proposed-rule-home-page#Proposed

Replaced Devices Offered without Cost or with a Credit

In the FY 2008, CMS implemented a policy to reduce a hospital's IPPS payment for certain MS-DRGs in which the implantation of a device that failed or was recalled determined the base MS-DRG assignment. This is based on a credit for a replaced device equal to 50 percent or more of the cost of the device. The following table includes relevant MS-DRGs currently under the policy:

MDC	MS-DRG	MS-DRG Title
05	216	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
05	217	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
05	218	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
05	219	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
05	220	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
05	221	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC
05	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
05	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC
05	270	Other Major Cardiovascular Procedures with MCC
05	271	Other Major Cardiovascular Procedures with CC
05	272	Other Major Cardiovascular Procedures without CC/MCC

The final list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit will be included in the FY 2021 IPPS final rule and also will be issued to providers in the form of a Change Request (CR).

MS-DRG Relative Weights

CMS calculates MS-DRG relative weights based on 19 national cost to charge ratios (CCRs), claims data from the MedPAR (Medicare Provider Analysis and Review) file and Medicare cost reports. After adjustments are made to determine Medicare-specific charges, the total specific Medicare costs (for all hospitals) are divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs. CMS calculated the proposed FY 2021 relative weights based on 19 CCRs just like FY 2020. The methodology CMS is proposing to use to calculate the FY 2021 MS-DRG cost-based relative weights is based on claims data in the FY 2019 MedPAR file and data from the FY 2018 Medicare cost reports. The proposed 19 national average CCRs for FY 2021 are listed in the following table:

Group	CCR
Routine Days	0.422
Intensive Days	0.347
Drugs	0.190
Supplies & Equipment	0.304
Implantable Devices	0.300
Inhalation Therapy	0.148
Therapy Services	0.291
Anesthesia	0.074
Labor & Delivery	0.369
Operating Room	0.169
Cardiology	0.095
Cardiac Catheterization	0.102
Laboratory	0.108
Radiology	0.138
MRIs	0.070
CT Scans	0.034
Emergency Room	0.149
Blood and Blood Products	0.272
Other Services	0.350
Routine Days	0.422
Intensive Days	0.347

When the MS-DRG weights were recalibrated for previous years, CMS sets a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. CMS is proposing to use the same case threshold in recalibrating the proposed MS-DRG relative weights for FY 2021. Stakeholders are invited to comment on the proposed changes in relative weights from FY 2020.

Proposed Wage Index

The Medicare wage index is one of the factors that determines a hospital's overall payment from CMS. Its sole purpose is to maintain a consistent payment structure across IPPS hospitals and recognize the difference in labor market costs across the country. CMS is proposing to continue to use a labor-related share of 68.3 percent for discharges on or after October 1, 2020.

For FY 2021, CMS is proposing to revise the core-based statistical areas (CBSAs) established by the Office of Management and Budget (OMB). This means revised definitions for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the Census. Some urban counties would become rural under the revisions; some rural counties would become urban counties; and some urban counties would move to a different urban CBSA. If finalized, CMS believes the wage index values being more representative of actual labor costs in a given area. However, they also recognize some hospitals would see decreases in wage index values, while others would see higher wage index values. For FY 2021, CMS is also proposing a 5 percent cap on any decrease of a hospital's wage index so that it would not be less than 95 percent of the final wage index for FY 2020.

CMS is also proposing to apply a budget neutrality adjustment to ensure estimated total payments under the proposed transition for hospitals that have a decrease in their wage indexes for FY 2021. This would equal what estimated total payments would have been without the proposed transition, 0.998580. This number will be updated based on the final rule data.