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

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INTRODUCTORY SUMMARY AND BACKGROUND

On September 2, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a final 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 finalized changes would apply to approximately 3,300 acute care hospitals for discharges occurring on or after October 1, 2020.

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

IPPS FINAL RULE

The FY 2021 final rule is located in its entirety at the following link:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-19637.pdf

This document in PDF form is 2,160 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.

Changes to IPPS Payment Rates Overview

The final rule has established an 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 2.9 percent. This reflects the projected hospital market basket update of 3.0 percent reduced by a 0.4 percent multifactor productivity adjustment (MFP), as well as an implementation of a positive 0.5 percentage point adjustment required by legislation.

CMS estimates a total increase in overall IPPS payments of approximately 2.7 percent. This is based on a projected IPPS payment increase of nearly $3.5 billion, including operating payments, uncompensated care payments, capital payments and new technology add-on changes.

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.

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. After considering public comments, CMS is finalizing an adjustment of positive 0.5 percent to the standardized payment. This constitutes a permanent adjustment to payment rates.

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 proposed to move the deadline to request MS-DRG changes to October 20, 2020 for FY 2022. Given the unique circumstances for this final rule in which CMS waived the delayed effective date, the deadline of November 1, 2020 for FY 2022 MS-DRG requests will be maintained. CMS indicated the change in the deadline would be expected for FY 2023.

The FY 2021 ICD-10 MS-DRG GROUPER and Medicare Code Editor (MCE) Software Version 38, the ICD-10 MS-DRG Definition Manual files Version 38 and the Definitions of the Medicare Code Edits Manual Version 38 are available on the CMS website:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.

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, there are a total of 72,616 ICD-10-CM codes, including 490 additions, 47 revisions, and 58 deletions. There are a total of 78,115 ICD-10-PCS codes, including 544 new codes. There were no PCS code revisions or deletions. These codes can be found in tables 6A, 6B, 6C and 6E at:
https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page#Tables.

Code Severity (MCCs, CCs or non-CCs)

CMS has finalized severity levels under Version 38 of the ICD-10 MS-DRGs for FY 2021. These tables can be found on the CMS website:

Table 6I. — Complete MCC List--FY 2021
Table 6I.1—Additions to the MCC List--FY 2021
Table 6I.2—Deletions to the MCC List--FY 2021
Table 6J. — Complete CC List--FY 2021
Table 6J.1—Additions to the CC List--FY 2021
Table 6J.2—Deletions to the CC List--FY 2021

Certain diagnoses included on the CC list are not considered valid CCs in combination with a particular diagnosis for the following reasons: (1) to prevent coding of CCs for closely related conditions; (2) to prevent duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. The FY 2021 CC Exclusion List can be found in the ICD-10 MS-DRGs Version 38 as Appendix C of the Definitions Manual as parts 1 and 2; and in table 6K on the CMS website.

Replaced Devices Offered without Cost or with a Credit

In the FY 2008 final rule, 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 that will remain in FY 2021:

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 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 has finalized 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	0.421
Intensive Days	0.344
Drugs	0.187
Supplies & Equipment	0.297
Implantable Devices	0.293
Inhalation Therapy	0.147
Therapy Services	0.288
Anesthesia	0.071
Labor & Delivery	0.359
Operating Room	0.167
Cardiology	0.094
Cardiac Catheterization	0.100
Laboratory	0.107

Radiology	0.136
MRIs	0.070
CT Scans	0.034
Emergency Room	0.147
Blood and Blood Products	0.271
Other Services	0.343

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. After considering stakeholders' comments, CMS has finalized to use the same case threshold in recalibrating the proposed MS-DRG relative weights for FY 2021.

Hospital 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 continuing to use a labor-related share of 68.3 percent for discharges on or after October 1, 2020 for all hospitals (including Puerto Rico) whose wage indexes are greater than 1.000. Based on a multi-step methodology, the final FY 2021 unadjusted national hourly wage is $45.27.

Core-Based Statistical Area Changes

For FY 2021, CMS is finalizing its adoption of the core-based statistical areas (CBSAs) established by the Office of Management and Budget (OMB), specifically the September 14, 2018 OMB Bulletin No. 18-04 delineations. This means revised definitions for Metropolitan Statistical Areas (utilizing Metropolitan divisions as separate labor market areas when calculating wage index values); Micropolitan Statistical Areas (continuing to utilize these areas as "rural" when calculating each state's rural index); and Combined Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the Census. Under the final rule, the revisions also include:

- 34 counties reassigned from an urban to a rural CBSA;
- 47 counties reassigned from a rural to an urban CBSA; and
- 19 urban counties reassigned to a different urban CBSA.

CMS believes using the wage index values is 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. Because of this impact, CMS is finalizing a 5 percent transition cap on any decrease of a hospital's wage index so that it would not be less than 95 percent of the FY 2020 final wage index.

CMS is also finalizing the implementation of 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, 0.998015. This number is updated based on the final rule data.

Frontier Floor Policy

By law, hospitals in frontier states (Montana, Wyoming, North Dakota, South Dakota, and Nevada) cannot be assigned a wage index of less than 1.0000. This is referred to as the frontier floor policy, and it has been in place since FY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low

number of people per square mile when compared to other states. CMS finalized 44 hospitals within Montana, Wyoming, North Dakota, and South Dakota would receive the frontier floor value of 1.0000 for their FY 2021 wage index. CMS noted while Nevada met the definition of a frontier state, all hospitals within that state currently receive a wage index value greater than 1.000.

Continuation of the Low Wage Index Hospital Policy

In the FY 2020 IPPS final rule, CMS adopted a policy to help offset the wage index differences between high wage and low wage hospitals. This policy was thought to provide an opportunity for certain low wage index hospitals to increase employee compensation by increasing the wage index values for certain hospitals with low wage index values (known as the low wage index hospital policy). This policy was adopted in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. CMS indicated this policy would be effective for at least 4 years, beginning in FY 2020, in order to allow sufficient time for employee compensation increases implemented by these hospitals to be reflected in the wage index calculation. Therefore, for FY 2021, CMS is continuing the low wage index hospital policy, and also applying this policy in a budget neutral manner by applying a 5 percent adjustment to the standardized amounts.

Performance Standards for the Hospital Value-Based Purchasing (VBP) Program

Hospital VBP Program under which value-based incentive payments are made in a fiscal year to hospitals based on their performance on measures established for a performance period for such fiscal year. In this FY 2021 IPPS/LTCH PPS final rule, CMS is providing newly established performance standards for certain measures for the FY 2023 through FY 2026 program year. These standards include clinical outcomes; person and community engagement; safety; and efficiency and cost reduction.

By law, the amount available for value-based incentive payments under the VBP in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year. Therefore, the estimated amount available for value-based incentive payments for FY 2021 discharges is approximately $1.9 billion.

Hospitals Excluded from IPPS

Hospitals excluded from the prospective payment system receive payment for inpatient hospital services on the basis of reasonable costs, subject to a rate of increase ceiling. A discharge limit is set for each hospital based on its own cost experience in its base year and updated annually by a rate-of-increase percentage. CMS has finalized the rate-of-percentage of 2.4, which will be applied to the FY 2020 target amounts to calculate the FY 2021 target amounts.