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An Analysis and Commentary on Federal Health Care Issues
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Proposed FY 2021 Medicare IPPS and LTCH PPS Update Released

The Centers for Medicare and Medicaid Services (CMS) have released another extensively long proposed rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2021.

CMS is proposing numerous items including the following; (1) changes to the MS–DRG classifications and recalibrations of relative weights; (2) status of FY 2021 new technology applicants under the alternative pathways for certain medical devices and certain antimicrobial products; (3) changes to the hospital wage index; (4) changes to payment for allogeneic hematopoietic stem cell acquisition costs; (5) payment adjustment for chimeric antigen receptor (CAR) T-cell therapy clinical trial cases; (6) requirements for payment adjustments under the Hospital Readmissions Reduction Program; (7) newly established performance standards for the calculation of value-based incentive payments under the Hospital Value-Based Purchasing Program; (8) payment adjustments to hospitals under the Hospital Acquired Reduction (HAC) program; (9) policy changes related to medical residents affected by residency program or teaching hospital closure; and, (10) changes relating to quality data reporting.

The 1,602-page document is currently on public display at the *Federal Register* office and is scheduled for publication May 29. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10122.pdf. A comment period ending July 10 is provided.

The IPPS tables for the FY 2021 proposed rule are available through the Internet on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html . Click on the link on the left side of the screen titled, "FY 2021 IPPS Proposed Rule Home Page" or "Acute Inpatient—Files for Download."

The LTCH PPS tables for this FY 2021 proposed rule are available through the Internet on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1735-P.

Comment

Due, in-part, to Covid-19 issues CMS is waiving the requirement to issue this proposal as a final regulation 60-days prior to its effective date, and replacing it with a 30-day delay. This means CMS will have until September 1 to issue final FY 2021 IPPS and LTCH changes.

It is obvious that the Covid-19 pandemic is straining all. However, the Office of Management and Budget (OMB) says it received this proposed rule on January 30, 2020. Further, the Secretary of Health and Human Services signed the rule for clearance on April 9.

CMS projects this proposal would apply to approximately 3,300 acute care hospitals and to approximately 360 LTCH facilities for discharges occurring on and after October 1, 2020.

CMS projects total Medicare spending on inpatient hospital services, including capital, will increase by about $2.07 billion in FY 2021, primarily driven by a combined $1.98 billion increase in FY 2021 operating payments and uncompensated care payments, and a net increase of $89 million resulting from estimated changes in FY 2021 capital payments and new technology add-on payments.

CMS expects LTCH-PPS payments to decrease by approximately 0.9 percent or $36 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system.

As is common these days, the rule does contain a table of contents.

Note: For many payment issues, the rule's Addendum (beginning on page 1,332) contains much concise and extremely helpful payment information.

Finally, the first section of this analysis is based mainly on CMS' fact sheet of the rule. It provides a summary of items. The second section contains details from the rule, itself.

Fact Sheet Summary Information

Changes to Payment Rates under IPPS

The proposed increase in operating payment rates for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 3.1 percent. This reflects a projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage point productivity adjustment. This also reflects a proposed +0.5 percentage point adjustment required by legislation (for prior coding and documentation items).

CMS projects the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by 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. Therefore, CMS estimates a total increase in overall IPPS payments of approximately 2.1 percent.

Hospitals may be subject to other payment adjustments under the IPPS, including:

- Penalties for excess readmissions, which reflect an adjustment to a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid
- Penalty (1.0 percent) for worst-performing quartile under the Hospital-Acquired Condition Reduction Program
- Upward and downward adjustments under the Hospital Value-Based Purchasing Program.

Medicare Uncompensated Care Payments

CMS distributes a prospectively determined amount of uncompensated care payments to "Medicare disproportionate share hospitals" based on their relative share of uncompensated care nationally.

As required under law, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments, adjusted for the change in the rate of uninsured people. CMS proposes distributing roughly $7.8 billion in uncompensated care payments in FY 2021, a decrease of approximately $0.5 billion from FY 2020.

For FY 2021, CMS proposes to use a single year of data on uncompensated care costs from Worksheet S-10 of the FY 2017 cost report to distribute these funds.

In addition, CMS is proposing for all eligible hospitals to use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments for all subsequent fiscal years. CMS expects there to be an increasing number of hospitals audited for Worksheet S-10 with future cost reporting years. As a result, CMS says it has confidence that the best available data in future years will be the Worksheet S-10 data for cost reporting years for which audits have been conducted.

Innovation–Proposals for New Technology Add-On Payment Pathway for Certain Antimicrobial Products

In light of recent information that continues to highlight the significant concerns and impacts related to antimicrobial resistance and emphasizes the continued importance this issue represents both for Medicare beneficiaries and public health overall, CMS is proposing some changes regarding new technology add-on payments for certain antimicrobials for FY 2021.

CMS presents 24 new applications for new technology add-on payment for FY 2021. Of the 24 technologies, three technologies were submitted by applicants as a new medical device that is part of the FDA Breakthrough Devices Program and six technologies were submitted by applicants as a product that received FDA Qualified Infectious Disease Product (QIDP) designation. CMS is proposing to approve nine alternative pathway applicant technologies. The remaining 15 technologies were submitted by applicants under the traditional new technology add-on payment pathway criteria. Additionally, CMS proposes to continue the new technology add-on payments for 10 of the 18 technologies currently receiving the add-on payment (the remaining 8 technologies will no longer be within their newness period in FY 2021, which includes the Chimeric Antigen Receptor (CAR) T-cell therapies approved for the new technology add-on payment in FY 2019).

New MS-DRG for Chimeric Antigen Receptor (CAR) T-cell Therapy

Building on the actions CMS has taken to date for payments for new medical technologies, CMS is proposing to create a new MS-DRG specifically for cases involving CAR T-cell therapies. CMS says the new payment group would help to predictably compensate hospitals for their costs in delivering necessary care to Medicare beneficiaries and provide payment flexibility for the future as new CAR T-cell therapies become available.

Graduate Medical Education Policy

CMS is proposing policy changes related to closing teaching hospitals and closing residency programs to address the needs of residents attempting to find alternative hospitals in which to complete their training and to foster seamless Medicare indirect medical education and direct graduate medical education funding. This proposal would expand the existing definition of who is considered a displaced resident (beyond residents who are physically present at the hospital training on the day prior to or the

day of hospital or program closure). CMS notes that these proposed policies would provide greater flexibility for the residents to transfer while the hospital operations or residency programs were winding down, and would allow funding to be transferred for certain residents who are not physically at the closing hospital/closing program.

Hospital-Acquired Condition (HAC) Reduction Program

The HAC Reduction Program requires the Secretary to reduce payment by 1.0 percent for applicable hospitals, which are subsection (d) hospitals that rank in the worst-performing quartile on select measures of hospital-acquired conditions. CMS is proposing to:

- Automatically adopt applicable periods (i.e., performance periods for measures used in the Program) beginning with the FY 2023 program year and all subsequent program years and update the definition of *applicable period* at 42 CFR 412.170.
- Refine validation procedures used by the Program in order to align with the Hospital IQR Program's validation procedures.

Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmissions Reduction Program (HRRP) reduces payments to hospitals with excess readmissions. The program includes six claims-based outcomes measures. The ***21st Century Cures Act*** directs CMS to assess payment reductions based on a hospital's performance relative to other hospitals with a similar proportion of patients dually eligible for Medicare and full-benefit Medicaid. For the FY 2021 IPPS/LTCH PPS proposed rule, CMS is proposing to:

- Automatically adopt applicable periods (i.e., performance periods for measures used in the Program) beginning with the FY 2023 program year and all subsequent program years, and update the definition of *applicable period* at 42 CFR 412.152 to align with the automatic adoption proposal.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital IQR Program is a pay-for-reporting quality program that reduces payment to hospitals that fail to meet program requirements. CMS is proposing changes to reporting and public reporting of electronic clinical quality measures (eCQMs) and the current validation process. Specifically, this rule proposes to:

- Make changes to the hospital reporting of eCQMs including;
    - Progressively increasing the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three-year period, by requiring hospitals to report two quarters of data for the CY 2021 reporting period/FY 2023 payment determination, three quarters of data for the CY 2022 reporting period/FY 2024 payment determination, and four quarters of data beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years.
    - Beginning the public display of eCQM data on the *Hospital Compare* website (or its successor website) and/or data.medicare.gov, beginning with data reported by hospitals for the CY 2021 reporting period/FY 2023 payment determination and for subsequent years that would be included with the fall 2022 refresh of the website.
- Make changes to the Hospital IQR Program validation process including
    - For chart abstracted measure validation, requiring the use of electronic file submissions via a CMS-approved secure file transmission process and no longer allowing the submission of paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive.

- Reducing the number of hospitals selected for validation from up to 800 to up to 400 hospitals.
- Combining the validation processes for chart-abstracted measures and eCQMs by aligning: (a) data submission quarters; (b) hospital selection; and (c) scoring processes by providing one combined validation score for the validation of chart-abstracted measures and eCQMs with the eCQM portion of the combined score weighted at zero.
- Formalizing the process for conducting educational reviews for eCQM validation in alignment with current processes for providing feedback for chart-abstracted validation results.

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program adjusts payments to hospitals under the IPPS for inpatient services based on their performance. CMS is providing estimated and newly established performance standards for certain measures for the FY 2023, FY 2024, FY 2025, and FY 2026 program years. CMS is not proposing to add new measures or remove measures from the Hospital VBP Program in this proposed rule.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The PCHQR Program collects and publishes data on an announced set of quality measures. CMS is proposing to:

- Refine two existing National Healthcare Safety Network (NHSN) measures, Catheter-Associated Urinary Tract Infection (CAUTI) and Central Line-Associated Bloodstream Infection (CLABSI), to incorporate an updated methodology developed by the Centers for Disease Control and Prevention that uses updated HAI baseline data that is risk-adjusted to stratify results by patient location.
- Begin to publicly report the updated versions of the CLABSI and CAUTI measures in fall CY 2022.

Hospital Star Ratings

CMS previously announced that it would include a proposed update to the Overall Hospital Quality Star Rating methodology in the FY 2021 IPPS proposed rule based on feedback received to date from stakeholders, including through a public comment period, listening sessions, a technical expert panel, and national quality conferences. However, in recognition of the significant impact of the COVID-19 public health emergency and the limited capacity of health care providers to review and provide comment on extensive proposals, CMS has limited annual rulemaking required by statute to essential policies as well as proposals that reduce provider burden and may help providers in the COVID-19 response.

Medicare and Medicaid Promoting Interoperability Programs

In 2011, the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT). Below are proposals for CY 2021 and later years, on which CMS is seeking public comment.

- CMS is proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program.

- CMS is proposing to continue the Query of Prescription Drug Monitoring Program (PDMP), measure as an optional measure worth five bonus points in CY 2021. This was originally proposed and finalized in the FY 2020 IPPS/LTCH PPS proposed and final rules.
- CMS is proposing to rename the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. The proposed name would read: Support Electronic Referral Loops by Receiving and Reconciling Health Information measure. This proposal more accurately reflects the actions required in the measure's numerator.

CMS also seeks public comment on the following proposals:

- The Medicare Promoting Interoperability Program is proposing to adopt the following in alignment with the Hospital IQR Program:
    - eCQM Reporting Periods
        - Progressively increase the number of quarters hospitals are required to report eCQM data
            - 2021 – 2 quarters of data
            - 2022 – 3 quarters of data
            - 2023 and each subsequent year – 4 quarters of data
    - Public Reporting of eCQM Data
        - Proposing to publicly report eCQM performance data for the first time, beginning with data reported for the CY 2021 reporting period, on *Hospital Compare* and/or data.medicare.gov, or any successor websites.

Changes to Payment Rates under LTCH PPS

Overall, for FY 2021, CMS expects LTCH-PPS payments to decrease by approximately 0.9 percent or $36 million, which reflects the continued statutory implementation of the revised LTCH PPS payment system. LTCH PPS payments for FY 2021 for discharges paid using the standard LTCH payment rate are expected to increase by 2.1 percent after accounting for the proposed annual standard Federal rate update for FY 2021 of 2.5 percent, and an estimated decrease in outlier payments and other factors.

LTCH PPS payments for cases that will complete the statutory transition to the lower payment rates under the dual rate system are expected to decrease by approximately 20 percent. This accounts for the LTCH site neutral payment rate cases that will no longer be paid a blended payment rate with the end of the statutory transition period, which represent approximately 25 percent of all LTCH cases and 10 percent of all LTCH PPS payments.

The material that follows is a section-by-section analysis of major components from the final rule. It does not follow the organization contained in the rulemaking. Not all items are presented.

To assist readers because CMS does not provide a table of contents nor page numbers, we have added select page numbers in red. These numbers are from the PDF version of the display copy file as posted on May 11. Items may be addressed in several different locations throughout the rule. Not all page sections are identified.

I. CHANGES TO PAYMENT RATES UNDER IPPS (Addendum Page 1,332)

Rate Update

The increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users would be 3.1 percent. This reflects a projected hospital market basket update of 3.0 percent reduced by a 0.4 percentage point multi-factor productivity (MFP) adjustment for a net increase of 2.6 percent.

Also included is a 0.5 percentage point adjustment required by Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MARCA) for prior documentation and coding payment reductions. The 2.6 and 0.5 amounts result in an increase of 3.1 percent.

CMS displays four applicable percentage increases to the standardized amounts for FY 2021, as specified in the following table. The market basket rate of increase below does NOT include the 0.5 percent documentation and coding adjustment. (Page 1,336)

Proposed FY 2021 Applicable Percentage Increases for the IPPS				
	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	3.0	3.0	3.0	3.0
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.75	-0.75
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.25	0	-2.25
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Applicable Percentage Increase Applied to Standardized Amount	2.6	0.35	1.85	-0.4

Standardized Payment Rates

The current FY 2020 standardized payment amounts, as corrected in the October 8, 2019 ***Federal Register***, are as follows:

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.6 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.35 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.85 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.4 Percent)	
Wage Index Greater Than 1.0000							
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,959.10	$1,837.53	$3,872.28	$1,797.23	$3,930.16	$1824.10	$3,843.34	$1,783.
Wage Index Equal to or Less Than 1.0000							
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,593.91	$2,202.72	$3,515.10	$2,154.41	$3,567.64	$2,186.62	$3,488.83	$2,138.31

The current (FY 2020) large urban labor rate is $3,959.10 and the non-labor rate is $1,837.53 for a total of $5,796.63. The other area labor rate is $3593.91 and the non-labor component is $2,202.72 for a total of $5,796.63.

CMS notes the proposed FY 2021 total labor/nonlabor amount for the full update in the table below, is $6,219.54 for both wage index areas – those greater than 1.0000 and those with values equal to or less than 1.0000.

The following table (Page 1,393) illustrates the changes from the FY 2020 national standardized amount to the proposed FY 2021 national standardized amount. The total FY 2020 rates for both the urban and other areas (large and other) is $5,796.63. These amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors, etc. as shown below. CMS says the result is a total labor/ non-labor amount of $6,219.54. The $6,219.54 amount is then adjusted for FY 2021 by the items beginning with the proposed FY 2021 update factors.

Changes from FY 2020 Standardized Amounts to the proposed FY 2021 Standardized Amounts

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2021 Base Rate after removing the following: 1. FY 2020 Geographic Reclassification Budget Neutrality (0.985447) 2. FY 2020 Operating Outlier Offset (0.949) 3. FY 2020 Rural Demonstration Budget Neutrality Factor (0.999771) 4. FY 2020 Lowest Quartile Budget Neutrality Factor (0.997894) This amount should be 0.997984 (as published last October 8 for the math to calculate. 5. FY 2020 Transition Budget Neutrality Factor (0.998835)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,247.95 Nonlabor (31.7%) $1,971.59 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,247.95 Nonlabor (31.7%) $1,971.59 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,247.95 Nonlabor (31.7%) $1,971.59 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,247.95 Nonlabor (31.7%) $1,971.59 *(Combined labor and nonlabor = $6,219.54)*
	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,856.11 Nonlabor (38%): $2,363.43 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,856.11 Nonlabor (38%): $2,363.43 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,856.11 Nonlabor (38%): $2,363.43 *(Combined labor and nonlabor = $6,219.54)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,856.11 Nonlabor (38%): $2,363.43 *(Combined labor and nonlabor = $6,219.54)*
FY 2021 Proposed Update Factor	1.026	1.0035	1.0185	0.996
FY 2021 Proposed MS-DRG Recalibration Budget Neutrality Factor	0.998761	0.998761	0.998761	0.998761
FY 2021 Proposed Wage Index Budget Neutrality Factor	0.999362	0.999362	0.999362	0.999362

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2021 Proposed Reclassification Budget Neutrality Factor	0.988003	0.988003	0.988003	0.988003
FY 2021 Proposed Lowest Quartile Budget Neutrality Factor	0.998241	0.998241	0.998241	0.998241
FY 2021 Proposed Transition Budget Neutrality Factor	0.998580	0.998580	0.998580	0.998580
FY 2021 Proposed Operating Outlier Factor	0.949	0.949	0.949	0.949
FY 2021 Proposed Rural Demonstration Budget Neutrality Factor	0.999642	0.999642	0.999642	0.999642
Proposed FY 2021 Stem Cell Acquisition Budget Neutrality Factor	0.999861	0.999861	0.999861	0.999861
Adjustment for FY 2021 Required under Section 414 of Pub. L. 114-10 (MACRA)	1.005	1.005	1.005	1.005
National Standardized Proposed Amounts for FY 2021 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7)	Labor: $4,084.16 Nonlabor: $1,895.58	Labor: $3,994.60 Nonlabor: $1,854.01	Labor: $4,054.31 Nonlabor: $1,881.72	Labor: $3,964.74 Nonlabor: $1,840.15
National Standardized Amount for FY 2020 if Wage Index is less Than or Equal to1.0000; Labor/Non-Labor Share Percentage (62.0/38.0)	Labor: $3,707.44 Nonlabor: $2,272.30	Labor: $3,626.14 Nonlabor: $2,222.47	Labor: $3,680.34 Nonlabor: $2,225.69	Labor: $3,599.03 Nonlabor: $2,205.86

The change between the final FY 2020 full market basket rate of increase amount of $5,796.63 and the FY 2021 proposed amount of $5,979.74 is $183.11, or a net increase of approximately 3.1 percent.

These amounts are before other adjustments such as the hospital value-based purchasing program, the readmission program, and the hospital acquired conditions program.

Labor-Share

The labor-related portion for areas with wage indexes greater than 1.0000 would continue at 68.3 percent. Areas with wage index values equal to or less than 1.000 would remain at 62.0. (Page 1,339)

Comment (Page 1,478)

CMS says that 54 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they are identified as *not meaningful* EHR users *but do submit* quality information.

CMS says that 67 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they failed the quality data submission process or did not choose to participate, but *are meaningful* EHR users.

CMS says 14 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2020 because they are identified as *not meaningfu*l EHR users that *do not submit* quality data under section.

Proposed Outlier Payments (Page 1,365)

To determine a projection of outlier payment reconciliations for the FY 2021 outlier threshold calculation, CMS is proposing to advance the methodology by 1 year and use FY 2015 cost reports (cost reports with a begin date on or after October 1, 2014, and on or before September 30, 2015).

CMS is proposing an outlier fixed-loss cost threshold for FY 2021 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$30,006**. The current dollar threshold is $26,552.

Comment (Page 1,390)

CMS says "our current estimate, using available FY 2019 claims data, is that actual outlier payments for FY 2019 were approximately 5.38 percent of actual total MS-DRG payments." Therefore, CMS is increasing the threshold to reduce the number of outlier payments.

As we have noted many times, CMS has rarely paid its 5.1 percent outlier pool. One must ask if the CMS policy about not making hospitals whole with regard to outliers is flawed and needs to be changed.

CMS says that making adjustments "would be neither necessary nor appropriate to make such an aggregate retroactive adjustment." This is an awful and wrong attitude response. The adjustments can be made prospectively.

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2021 (Page 1,414)

CMS is proposing a FY 2021 capital rate of **$468.36**. The current amount is $462.33 (as corrected October 8, 2019).

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2021 (Page 1,471)

The proposed FY 2021 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, 97 children's hospitals, the 6 short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, 16 religious nonmedical health care institutions, and 1 extended neoplastic disease care hospitals is the estimated percentage increase in the IPPS operating market basket for FY 2020 – is 3.0 percent.

II. CHANGES TO THE HOSPITAL AREA WAGE INDEX (Page 676)

CMS is proposing to implement revised OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, effective October 1, 2020 beginning with the FY 2021 IPPS wage index. CMS has already proposed this change for other PPS updates for FY 2021.

Urban Counties that Would Become Rural under the Revised OMB Delineations

CMS' analysis shows that a total of 34 counties (and county equivalents) and 10 hospitals that were once considered part of an urban Core-Based Statistical Area (CBSA) would be considered to be located in a rural area under the revised OMB delineations. The following chart lists the 34 urban counties that would be rural if CMS finalizes its proposal. (Page 681)

FIPS County Code	County/County Equivalent	State	Current CBSA	Labor Market Area
01127	Walker	AL	13820	Birmingham-Hoover, AL
12045	Gulf	FL	37460	Panama City, FL
13007	Baker	GA	10500	Albany, GA
13235	Pulaski	GA	47580	Warner Robins, GA
15005	Kalawao	HI	27980	Kahului-Wailuku-Lahaina, HI
17039	De Witt	IL	14010	Bloomington, IL
17053	Ford	IL	16580	Champaign--Urbana, IL
18143	Scott	IN	31140	Louisville/Jefferson County, KY-IN
18179	Wells	IN	23060	Fort Wayne, IN
19149	Plymouth	IA	43580	Sioux City, IA-NE-SD
20095	Kingman	KS	48620	Wichita, KS
21223	Trimble	KY	31140	Louisville/Jefferson County, KY-IN
22119	Webster	LA	43340	Shreveport-Bossier City, LA
26015	Barry	MI	24340	Grand Rapids-Wyoming, MI
26159	Van Buren	MI	28020	Kalamazoo-Portage, MI
27143	Sibley	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI
28009	Benton	MS	32820	Memphis, TN-MS-AR
29119	Mc Donald	MO	22220	Fayetteville-Springdale-Rogers, AR-MO
30037	Golden Valley	MT	13740	Billings, MT
31081	Hamilton	NE	24260	Grand Island, NE
38085	Sioux	ND	13900	Bismarck, ND
40079	Le Flore	OK	22900	Fort Smith, AR-OK
45087	Union	SC	43900	Spartanburg, SC
46033	Custer	SD	39660	Rapid City, SD
47081	Hickman	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN
48007	Aransas	TX	18580	Corpus Christi, TX
48221	Hood	TX	23104	Fort Worth-Arlington, TX
48351	Newton	TX	13140	Beaumont-Port Arthur, TX

FIPS County Code	County/County Equivalent	State	Current CBSA	Labor Market Area
48425	Somervell	TX	23104	Fort Worth-Arlington, TX
51029	Buckingham	VA	16820	Charlottesville, VA
51033	Caroline	VA	40060	Richmond, VA
51063	Floyd	VA	13980	Blacksburg-Christiansburg-Radford, VA
53013	Columbia	WA	47460	Walla Walla, WA
53051	Pend Oreille	WA	44060	Spokane-Spokane Valley, WA

With respect to determining Disproportionate Share Hospital (DSH) payments in the first year after a hospital loses urban status, the hospital will receive an adjustment to its DSH payment that equals two thirds of the difference between the urban DSH payments applicable to the hospital before its redesignation from urban to rural and the rural DSH payments applicable to the hospital subsequent to its redesignation from urban to rural. In the second year the hospital will receive an adjustment to its DSH payment that equals one third of the difference between the urban DSH payments applicable to the hospital before its redesignation and the rural DSH payments applicable to the hospital subsequent to its redesignation from urban to rural.

Rural Counties that Would Become Urban under the Revised OMB Delineations

CMS says that a total of 47 counties (and county equivalents) and 17 hospitals that were located in rural areas would now be located in urban areas under the revised OMB delineations. The following chart lists the 47 rural counties. (Page 684)

FIPS County Code	County/County Equivalent	State Name	New CBSA	Counties
01063	Greene	AL	46220	Tuscaloosa, AL
01129	Washington	AL	33660	Mobile, AL
05047	Franklin	AR	22900	Fort Smith, AR-OK
12075	Levy	FL	23540	Gainesville, FL
13259	Stewart	GA	17980	Columbus, GA-AL
13263	Talbot	GA	17980	Columbus, GA-AL
16077	Power	ID	38540	Pocatello, ID
17057	Fulton	IL	37900	Peoria, IL
17087	Johnson	IL	16060	Carbondale-Marion, IL
18047	Franklin	IN	17140	Cincinnati, OH-KY-IN
18121	Parke	IN	45460	Terre Haute, IN
18171	Warren	IN	29200	Lafayette-West Lafayette, IN
19015	Boone	IA	11180	Ames, IA
19099	Jasper	IA	19780	Des Moines-West Des Moines, IA
20061	Geary	KS	31740	Manhattan, KS
21043	Carter	KY	26580	Huntington-Ashland, WV-KY-OH
22007	Assumption	LA	12940	Baton Rouge, LA

FIPS County Code	County/County Equivalent	State Name	New CBSA	Counties
22067	Morehouse	LA	33740	Monroe, LA
25011	Franklin	MA	44140	Springfield, MA
26067	Ionia	MI	24340	Grand Rapids-Kentwood, MI
26155	Shiawassee	MI	29620	Lansing-East Lansing, MI
27075	Lake	MN	20260	Duluth, MN-WI
28031	Covington	MS	25620	Hattiesburg, MS
28051	Holmes	MS	27140	Jackson, MS
28131	Stone	MS	25060	Gulfport-Biloxi, MS
29053	Cooper	MO	17860	Columbia, MO
29089	Howard	MO	17860	Columbia, MO
30095	Stillwater	MT	13740	Billings, MT
37007	Anson	NC	16740	Charlotte--Concord-Gastonia, NC-SC
37029	Camden	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC
37077	Granville	NC	20500	Durham-Chapel Hill, NC
37085	Harnett	NC	22180	Fayetteville, NC
39123	Ottawa	OH	45780	Toledo, OH
45027	Clarendon	SC	44940	Sumter, SC
47053	Gibson	TN	27180	Jackson, TN
47161	Stewart	TN	17300	Clarksville, TN-KY
48203	Harrison	TX	30980	Longview, TX
48431	Sterling	TX	41660	San Angelo, TX
51097	King and Queen	VA	40060	Richmond, VA
51113	Madison	VA	47894	Washington-Arlington-Alexandra, DC-VA-MD-WV
51175	Southampton	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	Franklin City	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	Jackson	WV	16620	Charleston, WV
54065	Morgan	WV	25180	Hagerstown-Martinsburg, MD-WV
55069	Lincoln	WI	48140	Wausau-Weston, WI
72001	Adjuntas	PR	38660	Ponce, PR
72083	Las Marias	PR	32420	Mayagüez, PR

Urban Counties That Would Move to a Different Urban CBSA Under the Revised OMB Delineations

However, in other cases, if CMS adopts the revised OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. The following chart lists the urban counties that would move from one urban CBSA to a newly proposed or modified CBSA if the revised OMB delineations are adopted. (Page 689)

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	New CBSA Code	Proposed CBSA Name
17031	Cook	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17043	Du Page	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17063	Grundy	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17093	Kendall	IL	16974	Chicago-Naperville-Arlington Heights, IL	20994	Elgin, IL
17111	Mc Henry	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17197	Will	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
34023	Middlesex	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34025	Monmouth	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34029	Ocean	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34035	Somerset	NJ	35084	Newark, NJ-PA	35154	New Brunswick-Lakewood, NJ
36027	Dutchess	NY	20524	Dutchess County-Putnam County, NY	39100	Poughkeepsie-Newburgh -Middletown, NY
36071	Orange	NY	35614	New York-Jersey City-White Plains, NY-NJ	39100	Poughkeepsie-Newburgh -Middletown, NY
36079	Putnam	NY	20524	Dutchess County- Putnam County, NY	35614	New York-Jersey City-White Plains, NY-NJ
47057	Grainger	TN	28940	Knoxville, TN	34100	Morristown, TN
54043	Lincoln	WV	26580	Huntington-Ashland, WV-KY-OH	16620	Charleston, WV
72055	Guanica	PR	38660	Ponce, PR	49500	Yauco, PR
72059	Guayanilla	PR	38660	Ponce, PR	49500	Yauco, PR
72111	Penuelas	PR	38660	Ponce, PR	49500	Yauco, PR
72153	Yauco	PR	38660	Ponce, PR	49500	Yauco, PR

Proposed Transition for Hospitals Negatively Impacted *(Page 693)*

For FY 2021, CMS is proposing to provide for a transition of a 5.0 percent cap on any decrease in a hospital's wage index from the hospital's final wage index from the prior fiscal year (FY 2020). The proposed FY 2021 5.0 percent cap would be applied to all hospitals that have any decrease in their wage indexes, regardless of the circumstance causing the decline, so that a hospital's final wage index for FY 2021 will not be less than 95 percent of its final wage index for FY 2020.

Worksheet S-3 (Page 695)

The proposed FY 2021 wage index values are based on the data collected from Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2017

Occupational Mix Adjustment for FY 2021 (Page 714)

The FY 2021 occupational mix adjustment is based on the calendar year (CY) 2016 survey. The FY 2022 occupational mix adjustment will be based on a new calendar year (CY) 2019 survey.

CMS is reminding hospitals that they need to complete such by August 3, 2020.

The proposed FY 2021 Occupational Mix Adjusted National Average Hourly Wage is $45.07. (Page 717)

The proposed FY 2021 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows;

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$41.60
National LPN and Surgical Technician	$24.67
National Nurse Aide, Orderly, and Attendant	$16.93
National Medical Assistant	$18.20
National Nurse Category	$34.96

Proposed Rural Floor (Page 719)

By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS estimates that 255 hospitals would receive an increase in their FY 2021 wage index due to the application of the rural floor.

State Frontier Floor for FY 2021 (Page 720)

Forty-five (45) hospitals will receive the frontier floor value of 1.0000 for their FY 2021 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

The areas affected by the proposed rural and frontier floor policies are identified in Table 2 which is available on the CMS website.

Continuation of the Low Wage index Hospital Policy (Page 720)

For FY 2020, CMS finalized policies to reduce the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and doing so in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals, as well as by changing the calculation of the rural floor.

CMS notes that this policy will continue in FY 2021. Based on the data for this proposed rule, for FY 2021, the 25th percentile wage index value across all hospitals would be 0.8420. Hospitals with a wage index lower than 0.8420 will have their wage index increased by half the difference between their index and 0.8420.

MGCRB Reclassification and Redesignation Issues for FY 2021 (Page 723)

At the time this proposed rule was constructed, the Medicare Geographic Classification Review Board (MGCRB) had completed its review of FY 2021 reclassification requests. Based on such reviews, there are 435 hospitals approved for wage index reclassifications starting in FY 2021.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2021, hospitals reclassified beginning in FY 2019 or FY 2020 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 244 hospitals approved for wage index reclassifications in FY 2019 that will continue for FY 2021, and 279 hospitals approved for wage index reclassifications in FY 2020 that will continue for FY 2021.

Hospitals with One or Two Years of Wage Data Seeking MGCRB Reclassification (Page 727)

CMS is proposing to modify the regulation at § 412.230(d)(2)(ii)(A) to clarify that a hospital may qualify for an individual wage index reclassification by the MGCRB under § 412.230 to another labor market area if the hospital only has 1 or 2 years of wage data.

Assignment Policy for Hospitals Reclassified to CBSAs where One or More Counties move to a New or Different urban CBSA (Page 728)

CMS says that hospitals with current reclassifications are encouraged to verify area wage indexes on Table 2 in the appendix of this proposed rule, and confirm that the areas to which they have been reclassified for FY 2021 would continue to provide a higher wage index than their geographic area wage index.

Hospitals may withdraw or terminate their FY 2021 reclassifications by contacting the MGCRB within 45 days from the date this proposed rule is issued in the ***Federal Register*** (§ 412.273(c)).

CMS is proposing that current geographic reclassifications (applications approved effective for FY 2019, FY 2020, or FY 2021) that would be affected by CBSAs that are split apart or counties that shift to another CBSA under the revised OMB delineations, would ultimately be assigned to a CBSA under the revised OMB delineations that contains at least one county from the reclassified CBSA under the current FY 2020 definitions, and would be generally consistent with rules that govern geographic reclassification.

CMS is also proposing to allow such hospitals, or county groups of hospitals, to submit a request at wageindex@cms.hhs.gov mailbox for reassignment to another CBSA that would contain a county that is part of the current FY 2020 CBSA to which it is reclassified if the hospital or county group of hospitals can demonstrate compliance with applicable reclassification proximity rules.

The proposal contains tables (Page 732) which provides a list of current FY 2020 CBSAs where one or more counties would be relocated to a new or different urban CBSA. Hospitals with FY 2020 MGCRB reclassifications into the CBSAs would be subject to the proposed reclassification assignment policy. A third column of one table provides the "eligible" CBSAs of all proposed revised CBSAs that contain at least one county that is part of the current FY 2020 CBSA.

Lugar Status Determinations (Page 738)

CMS is proposing to update the CBSA labor market delineations to reflect the changes made in the September 14, 2018 OMB Bulletin 18-04. In that section, CMS proposed that 47 currently rural counties be added to new or existing urban CBSAs. Of those 47 counties, 23 are currently deemed urban under Section 1886(d)(8)(B) of the Act. Hospitals located in such a "Lugar" county, barring another form of wage index reclassification, are assigned the reclassified wage index of a designated urban CBSA and will no longer be designated as a Lugar county. A table with these counties in on page 741.

Due to the change in designation of some urban counties from "outlying" to "central" status by OMB, CMS is proposing to add two current rural counties in NY as "Lugar" counties. Specifically, hospitals located in Columbia county, NY (FIPSCD 36021) would be deemed "Lugar" hospitals and reclassified to urban CBSA 10580 (Albany-Schenectady-Troy, NY) and hospitals located in Sullivan county, NY (FIPCD 36105) would be deemed "Lugar" hospitals and reclassified to urban CBSA 39100 (Poughkeepsie-Newburgh-Middletown, NY).

A list of rural counties containing hospitals that would be redesignated as urban under section 1886(d)(8)(b) of the Act (based on proposed revised OMB delineations and 2010 census data) is on page 744.

Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 747)

Table 2, which is available on the CMS website, includes the proposed out-migration adjustments for the FY 2021 wage index. Table 4 consists of the following: A list of counties that would be eligible for the out-migration adjustment for FY 2021 identified by FIPS county code, the proposed FY 2021 out-migration adjustment, and the number of years the adjustment would be in effect. CMS notes that 203 hospitals would be eligible for out-migration

Clarification of Applicable Rural Referral Center (RRC) Criteria for Purposes of Meeting Urban to Rural Reclassification at § 412.103(a)(3) (Page 753)

CMS is clarifying that for purposes of meeting the urban to rural reclassification criterion at § 412.103(a)(3), the appropriate case-mix index (CMI) values and numbers of discharges to demonstrate RRC eligibility are those published in the IPPS/LTCH PPS final rule in effect as of the filing date (that is, the effective date) of the hospital's application for reclassification under § 412.103.

III. PROPOSED CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 43)

CMS is proposing numerous changes to a number of MS-DRGs for FY 2021.

CMS is proposing to do the following:

- Reassign procedure codes from MS-DRG 16 (Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy) to create new MS-DRG 18 (Chimeric Antigen Receptor [CAR] T-cell Immunotherapy) for cases reporting the administration of CAR T-cell therapy.

- Create new MS-DRG 019 (Simultaneous Pancreas and Kidney Transplant with Hemodialysis).

- Reassign procedures involving head, face, neck, ear, nose, mouth, or throat by creating six new MS-DRGs 140-142 (Major Head and Neck Procedures with MCC, with CC, and without CC/MCC, respectively) and 143-145 (Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) and deleting MS-DRGs 129-130 (Major Head and Neck Procedures with CC/MCC or Major Device, and without CC/MCC, respectively, MS-DRGs 131-132 (Cranial and Facial Procedures with CC/MCC and without CC/MCC, respectively) and MS-DRGs 133-134 (Other Ear, Nose, Mouth and Throat O.R. Procedures with CC/MCC and without CC/MCC, respectively).

- Reassign procedure codes from MS-DRGs 469-470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement, and without MCC, respectively) and create two new MS-DRGs, 521 and 522 (Hip Replacement with Principal diagnosis of Hip Fracture with MCC and without MCC, respectively) for cases reporting a hip replacement procedure with a principal diagnosis of a hip fracture.

- Reassign procedure codes from MS-DRG 652 (Kidney Transplant) into two new MS-DRGs, 650 and 651 (Kidney Transplant with Hemodialysis with MCC and without MCC, respectively) for cases reporting hemodialysis with a kidney transplant during the same admission.

Proposed Changes to MS-DRGs Subject to Post-acute Care Transfer Policy and MS-DRG Special Payments Policies (§ 412.4) (Page 770)

CMS is proposing to add MS-DRGs 521 and 522 to the list of MS-DRGs that are subject to the Post-acute care transfer policy. A list of proposed new or revised MS-DRGs subject to review of post-acute care transfer policy status for FY 2021 is as follows:

Proposed New or Revised MS-DRGs	MS-DRG Title	Total Cases	Post-acute Care Transfers (55th percentile: 1,378)	Short- Stay Post-acute Care Transfers	Percent of Short-Stay Post-acute Care Transfers to all Cases (55th percentile: 9.5089%)	Current Post-acute Care Transfer Policy Status	Proposed Post-acute Care Transfer Policy Status
016	Autologous Bone Marrow Transplant with CC/MCC	2,119	473*	141	6.6541*	No	No
018	Chimeric Antigen Receptor (CAR) T-cell immunotherapy	303	82*	16	5.2805*	New	No
019	Simultaneous Pancreas and Kidney Transplant with Hemodialysis	86	32*	14	16.2791	New	No
140	Major Head and Neck Procedures with MCC	649	378*	96	14.7920	New	No

Proposed New or Revised MS-DRGs	MS-DRG Title	Total Cases	Post-acute Care Transfers (55th percentile: 1,378)	Short- Stay Post-acute Care Transfers	Percent of Short-Stay Post-acute Care Transfers to all Cases (55th percentile: 9.5089%)	Current Post-acute Care Transfer Policy Status	Proposed Post-acute Care Transfer Policy Status
141	Major Head and Neck Procedures with CC	2,485	796*	82	3.2998*	New	No
142	Major Head and Neck Procedures without CC/MCC	1,371	219*	20	1.4588*	New	No
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC	755	356*	37	9.6689	New	No
144	Other Ear, Nose, Mouth and Throat O.R. Procedures with CC	1,591	457*	67	4.2112*	New	No
145	Other Ear, Nose, Mouth and Throat O.R. Procedures without CC/MCC	1,083	142*	0	0*	New	No
469	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	12,267	8,250	1484	12.0975	Yes	Yes
470	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC	358,203	223,426	0	0*	Yes	Yes**
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	14,946	13,425	5834	39.0339	New	Yes
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	50,215	45,844	15,908	31.6798	New	Yes
650	Kidney Transplant with Hemodialysis with MCC	2,252	745*	200	7.837*	New	No
651	Kidney Transplant with Hemodialysis without MCC	1,144	349*	74	6.4685*	New	No
652	Kidney Transplant	9,081	1,856	346	4.7267*	No	No

* Indicates a current post-acute care transfer policy criterion that the MS-DRG did not meet.
** As described in the policy at 42 CFR 412.4(d)(3)(ii)(D), MS-DRGs that share the same base MS-DRG will all qualify under the post-acute care transfer policy if any one of the MS-DRGs that share that same base MS-DRG qualifies

Changes to Specific MS-DRG Classifications

This is a relatively long and detailed section. The material below identifies some items being addressed only by name and corresponding page numbers. Items that CMS has discussed but is not proposing any changes are not listed.

- Bone Marrow Transplants (Page 54)
- Chimeric Antigen Receptor (CAR) T-Cell Therapies – (Page 58)
- Carotid Artery Stent Procedures – (Page 63)
- Temporomandibular Joint Replacements (Page 78)
- Insertion of Cardiac Contractility Modulation Device (Page 106)
- Acute Appendicitis (Page 111)
- Hip and Knee Joint Replacements (Page 121)
- Kidney Transplants (Page 135)
- Addition of Diagnoses to Other Kidney and Urinary Tract Procedures Logic (Page 151)
- Inferior Vena Cava Filter Procedures (Page 162)
- Horseshoe Abscess with Drainage (Page 169)
- Chest Wall Deformity with Supplementation (Page 171)
- Hepatic Malignancy with Hepatic Artery Embolization (Page 173)
- Hemoptysis with Percutaneous Artery Embolization (Page 176)
- Epistaxis with Percutaneous Artery Embolization (Page 183)
- Revision or Removal of Synthetic Substitute in Peritoneal Cavity (Page 186)
- Revision of Totally Implantable Vascular Access Devices (Page 188)
- Multiple Trauma with Internal Fixation of Joints (Page 191)
- Reassignment of Procedures among MS-DRGs 981 through 983 and 987 through 989 (Page 194)
- Operating Room (O.R.) and Non-O.R. Issues (Page 199)
- Endoscopic Revision of Feeding Devices (Page 204)
- Percutaneous/Endoscopic Biopsy of Mediastinum (Page 205)
- Percutaneous Endoscopic Chemical Pleurodesis (Page 208)
- Percutaneous Endoscopic Excision of Stomach (Page 209)
- Percutaneous Endoscopic Drainage (Page 213)
- Control of Bleeding (Page 217)
- Inspection of Penis (Page 218)

Additions and Deletions to the Diagnosis Code Severity Levels for FY *2021* (Page 223)

The following tables identify the additions and deletions to the diagnosis code MCC severity levels list and the additions and deletions to the diagnosis code CC severity levels list for FY 2021 and are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Table 6I.1--Proposed Additions to the MCC List--FY 2021;
Table 6I.2-- Proposed Deletions to the MCC List--FY 2021;
Table 6J.1-- Proposed Additions to the CC List--FY 2021; and
Table 6J.2-- Proposed Deletions to the CC List--FY 2021.

CC Exclusions List for FY 2021 (Page 224)

To identify new, revised and deleted diagnosis and procedure codes, for FY 2021, CMS has developed Table 6A.--New Diagnosis Codes, Table 6B.--New Procedure Codes, Table 6C.--Invalid Diagnosis Codes, and Table 6E.--Revised Diagnosis Code Titles for this proposed Rule.

Proposed Changes to the Medicare Code Editor (MCE) (Page 230)

Proposed Changes to Surgical Hierarchies (Page 338)

Replaced Devices Offered without Cost or with a Credit (Page 251)

IV. PROPOSED ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2021 (Page 269)

Beginning with discharges on or after October 1, 2019 (FY 2020), CMS finalized an increase in the new technology add-on payment percentage, as reflected at § 412.88(a)(2)(ii).

For a new technology other than a medical product designated by FDA as a Qualified Infectious Disease Products (QIDP), beginning with discharges on or after October 1, 2019, if the costs of a discharge involving a new technology (determined by applying CCRs as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 65 percent of the costs of the new medical service or technology; or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment.

For a new technology that is a medical product designated by FDA as a QIDPs, beginning with discharges on or after October 1, 2019, if the costs of a discharge involving a new technology (determined by applying CCRs as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 75 percent of the costs of the new medical service or technology; or (2) 75 percent of the amount by which the costs of the case exceed the standard DRG payment.

Proposed FY 2021 Status of Technologies Approved for FY 2020 New Technology Add-On Payments (Page 285)

For FY 2020, CMS provided new technology add-on payments for 18 items. For FY 2021, eight items would be discontinued and ten continued as shown in the table below. (Page 310)

Summary Table of Proposed FY 2021 Status of New Technologies Approved for FY 2020 New Technology Add-on Payments (NTAP)

Technology	Newness Start Date	Propose to Continue or Discontinue NTAP for FY 2021	Proposed Maximum NTAP Amount for FY 2021	Coding Used to Identify Cases Eligible for NTAP
KYMRIAH® and YESCARTA®	November 22, 2017	Discontinue	None	XW033C3 or XW043C3
VYXEOSTM	August 3, 2017	Discontinue	None	XW033B3 or XW043B3
VABOMERETM	August 29, 2017	Discontinue	None	XW033N5 or XW043N5 or National Drug Codes (NDC) 65293–0009–01 or 70842– 0120–01
remedē® System	October 6, 2017	Discontinue	None	0JH60DZ and 05H03MZ in combination with 05H33MZ or 05H43MZ
ZEMDRITM	June 25, 2018	Continue	$4,083.75	XW033G4 or XW043G4
GIAPREZATM	December 21, 2017	Discontinue	None	XW033H4 or XW043H4
Sentinel® Cerebral Protection System	June 1, 2017	Discontinue	None	X2A5312
AQUABEAM System	December 21, 2017	Discontinue	None	XV508A4
AndexXaTM	May 3, 2018	Continue	$18,281.25	XW03372 or XW04372
AZEDRA®	July 30, 2018	Continue	$98,150	XW033S5 and XW043S5
CABLIVI®	February 6, 2019	Continue	$33,215	XW013W5, XW033W5 and XW043W5
ELZONRISTM	December 21, 2018	Continue	$125,448.05	XW033Q5 and XW043Q5
BalversaTM	April 12, 2019	Continue	$3,563.23	XW0DXL5
ERLEADATM	February 14, 2018	Discontinue	None	XW0DXJ5
SPRAVATOTM	March 5, 2019	Continue	$1,014.79	XW097M5
XOSPATA®	November 28, 2018	Continue	$7,312.50	XW0DXV5
JAKAFITM	May 24, 2019	Continue	$3,977.06	XW0DXT5
T2Bacteria® Panel	May 24, 2018	Continue	$97.50	XXE5XM5

Proposed FY 2021 Applications for New Technology Add-On Payments

CMS has received the following items for new technology add-on payments. The final IPPS FY 2021 rule will announce those approved.

- Accelerate Pheno Test BC kit for use with Accelerate Pheno system (Page 311)
- BioFire® FilmArray® Pneumonia Panel (Page 347)
- ContaCT (Page 365)
- Supersaturated Oxygen (SSO2) Therapy (DownStream® System) (Page 392)
- EluviaTM Drug-Eluting Vascular Stent System (Eluvia) (Page 414)
- GammaTile (Page 440)
- Hemospray® Endoscopic Hemostat (Page 453)
- IMFINZI® (durvalumab) (Page 473)
- KTE-X19 (Page 489)
- Lisocabtagene Maraleucel (Liso-cel) (Page 519)
- Soliris (Page 536)
- SpineJack® System (Page 547)
- TECENTRIQ® (atezolizumab) (Page 573)
- WavelinQ™ (4F) EndoAVF System (Page 587)
- Zulresso™ (Page 603)

Proposed FY 2021 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 617)

CMS received 10 applications for new technology add-on payments for FY 2021 under the alternative new technology add-on payment pathway. One applicant withdrew its application prior to the issuance of this proposed rule. Of the remaining nine applications, three of the technologies received a Breakthrough Device designation from FDA and six have been designated as a Qualified Infectious Disease Product (QIDP) by the FDA.

Alternative Pathway for Breakthrough Devices

(1) BAROSTIM NEO® System (Page 619)
(2) NanoKnife® System (Page 622)
(3) Optimizer System (Page 628)

Alternative Pathways for Qualified Infectious Disease Products (QIDPs)

(1) Cefiderocol (Fetroja) (Page 632)
(2) Contepo (Page 636)
(3) NUZYRA® for Injection (Page 640)
(4) RECARBRIO™ (Page 646)
(5) XENLETA (Page 650)
(6) NUZYRA® for Injection (Page 656)

V. OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING SYSTEM

Rural Referral Centers (RRCs)—Proposed Annual Updates to Case-Mix Index and Discharge Criteria (§ 412.96) (Page 785)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Rural hospitals with fewer than 275 beds can qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2020, they must have a CMI value for FY 2019 that is at least--

- 1.70435; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed CMI values by region are set forth in the following table:

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.4463
2	Middle Atlantic (PA, NJ, NY)	1.5020
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5777
4	East North Central (IL, IN, MI, OH, WI)	1.6117
5	East South Central (AL, KY, MS, TN)	1.5412
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6540
7	West South Central (AR, LA, OK, TX)	1.7495
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7834
9	Pacific (AK, CA, HI, OR, WA)	1.6928

A hospital must also have the number of discharges for its cost reporting period that began during FY 2017 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 791)

Section 50204 of the ***Bipartisan Budget Act of 2018*** amended section 1886(d)(12) of the Act to provide for certain temporary changes to the low-volume hospital payment adjustment policy for FYs 2018 through 2022.

In accordance with CMS' previously established process, a hospital must make a written request for low-volume hospital status that is received by its MAC by September 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for low-volume hospital status in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges for the fiscal year beginning on or after October 1 immediately following the request.

A hospital receiving the low-volume hospital payment adjustment for FY 2020 may continue to receive a low-volume hospital payment adjustment for FY 2021 without reapplying if it continues to meet the applicable mileage and discharge criteria.

Qualifying hospitals with 500 or fewer total discharges will receive a low-volume hospital payment adjustment of 25 percent. For qualifying hospitals with fewer than 3,800 discharges but more than 500 discharges, the low-volume payment adjustment is calculated by subtracting from 25 percent the proportion of payments associated with the discharges in excess of 500. As such, for qualifying hospitals

with fewer than 3,800 total discharges but more than 500 total discharges, the low-volume hospital payment adjustment for FYs 2019 through 2022 is calculated using the following formula:

Low-Volume Hospital Payment Adjustment = 0.25 – [0.25/3300] x (number of total discharges - 500) = (95/330) - (number of total discharges/13,200).

For this purpose, CMS specified that the "number of total discharges" is determined as total discharges, which includes Medicare and non-Medicare discharges during the fiscal year, based on the hospital's most recently submitted cost report.

Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105) (Page 798)

No change here; the IME formula multiplier remains at 1.35.

VI. PROPOSED PAYMENT ADJUSTMENTS FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHS) FOR FY 2021 (§ 412.106) (Page 808)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, is reduced to reflect changes in the percentage of individuals who are uninsured.

For FY 2014 and each subsequent fiscal year, a subsection (d) hospital that would otherwise receive DSH payments made under section 1886(d)(5)(F) of the Act receives two separately calculated payments.

- Sole community hospitals (SCHs) that are paid under their hospital-specific rate are not eligible for Medicare DSH payments.
- Maryland hospitals are not eligible for Medicare DSH payments and uncompensated care payments because they are not paid under the IPPS.
- Medicare-dependent, small rural hospitals (MDHs) that are paid based on the IPPS are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- IPPS hospitals that elect to participate in the Bundled Payments for Care Improvement Advanced Initiative (BPCI Advanced) model starting October 1, 2018, will continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- IPPS hospitals that are participating in the Comprehensive Care for Joint Replacement Model continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.
- Hospitals participating in the Rural Community Hospital Demonstration Program are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

There are 3 factors in determining the amount of such payments.

Calculation of Factor 1 for FY 2020 (Page 808)

For purposes of calculating Factor 1 and modeling the impact of this FY 2021 IPPS/LTCH PPS proposed rule, CMS used the Office of the Actuary's December 2019 Medicare DSH estimates, which were based on data from the September 2019 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2020 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2020 IPPS/LTCH PPS final rule.

The Office of the Actuary's December 2019 estimate for Medicare DSH payments for this proposed FY 2021 rule is $11,518,901,035.84, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2021 ($15,358,534,714.46 minus $3,839,633,678.61).

Calculation of Proposed Factor 2 for FY 2021 (Page 816)

The statute states that, for FY 2018 and subsequent fiscal years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the Secretary, based on data from

the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified).

The Actuary's projections for CY 2020 and CY 2021 are as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2020: 9.5 percent.
- Percent of individuals without insurance for CY 2021: 9.5 percent.
- Percent of individuals without insurance for FY 2021 (0.25 times 0.095) +(0.75 times 0.095): = 9.5 percent
- 1-|((0.095 - 0.14)/0.14)| = 1 - 0.3214 = 0.6786 (67.86 percent).

For FY 2020 and subsequent fiscal years, section 1886(r)(2)(B)(ii) of the Act no longer includes any reduction to the previous calculation. Therefore, CMS is proposing that Factor 2 for FY 2021 would be 67.86 percent.

The proposed FY 2021 uncompensated care amount is $15,358,534,714.46x 0.6786 = $7,816,726,242.92. Therefore, the final Factor 2 for FY 2021 is 67.14 percent.

The following shows the 75 percent amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" was $8.273 billion
- The FY 2020 "pool" is $8.351 billion
- The FY 2021 "pool" will be $7.817 billion

Calculation of Factor 3 for FY 2021 (Refer page 824)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2014 and subsequent fiscal years.

CMS is proposing to use a single year of Worksheet S–10 data from FY 2017 cost reports to calculate Factor 3 in the FY 2021 methodology for all eligible hospitals with the exception of Indian Health Service (IHS) and Tribal hospitals and Puerto Rico hospitals.

VII HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP) (Page 877)

The Hospital Readmissions Reduction Program currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery. CMS is not proposing to remove or adopt any additional measures at this time.

Beginning in FY 2021, a "dual-eligible" is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in data sourced from the State MMA files for the month the beneficiary was discharged from the hospital, except for those patient beneficiaries who die in the month of discharge, who will be identified using the previous month's data sourced from the State MMA files.

For FY 2021, a hospital subject to the Hospital Readmissions Reduction Program would have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

CMS estimates the 2,583 hospitals will be subject to a payment reduction of up to 3.0 percent.

VIII. HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: POLICY CHANGES (Page 888)

The Hospital VBP Program adjusts payments to IPPS hospitals for inpatient services based on their performance on an announced set of measures. Section 1886(o)(7)(B) of the Act instructs the Secretary to reduce the base operating DRG payment amount for a hospital for each discharge in a fiscal year by an applicable percent. The FY 2021 program year will be 2.00 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2021 will be approximately $1.9 billion.

CMS says that it is not proposing to add new measures or remove current measures from the Hospital VBP Program in this proposed rule.

IX. HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM (Page 911)

The HAC Reduction Program establishes an incentive for hospitals to reduce hospital-acquired conditions by requiring the Secretary to reduce applicable IPPS payment by 1.0 percent to all subsection (d) hospitals that rank in the worst-performing 25 percent of all eligible hospitals.

HAC Reduction Program Measures for FY 2021		
Short Name	Measure Name	NQF #
CMS PSI 90	CMS Patient Safety and Adverse Events Composite (PSI)	0531
CAUTI	CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CLABSI	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus*(MRSA) Bacteremia Outcome Measure	1716

CMS is not proposing to adopt or remove any measures. CMS says that it expects 780 hospitals will be in the Worst-Performing Quartile.

X. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS
(Page 1,090)

CMS is not proposing to adopt any new measures in this proposed rule. The measures set forth in the final FY 2020 rules are not changing for FY 2021

The following table summarizes the previously finalized Hospital IQR Program measure set for the FY 2022 payment determination:

Measures for the FY 2022 Payment Determination		
Short Name	Measure Name	NQF #
National Healthcare Safety Network Measures		
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
Claims-Based Patient Safety Measures		
COMP-HIP-KNEE *++	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
CMS PSI 04	CMS Death Rate among Surgical Inpatients with Serious Treatable Complications	+
Claims-Based Mortality Measures		
MORT-30-STK	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	N/A
Claims-Based Coordination of Care Measures		
READM-30-HW R	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	2882
Claims-Based Payment Measures		
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia	2579
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	N/A
Chart-Abstracted Clinical Process of Care Measures		
PC-01	Elective Delivery	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
EHR-based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures (eCQMs))		
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
PC-05	Exclusive Breast Milk Feeding	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438

Measures for the FY 2022 Payment Determination		
Short Name	Measure Name	NQF #
STK-06	Discharged on Statin Medication	0439
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Patient Experience of Care Survey Measures		
HCAHPS**	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition Measure)	0166 (0228)

* Finalized for removal from the Hospital IQR Program beginning with the FY 2023 payment determination, as discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41558 through 41559).

**In the CY 2019 OPPS/ASC PPS final rule with comment period (83 FR 59140 through 59149), CMS finalized removal of the Communication About Pain questions from the HCAHPS Survey effective with October 2019 discharges, for the FY 2021 payment determination and subsequent years.

+ Measure is no longer endorsed by the NQF, but was endorsed at time of adoption.

Section 1886(b)(3)(B)(viii)(IX)(bb) of the Act authorizes the Secretary to specify a measure that is not endorsed by the NQF as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the inpatient setting.

++ CMS has updated the short name for the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550) measure from Hip/Knee Complications to COMP-HIP-KNEE in order to maintain consistency with the updated Measure ID and hospital reports for the *Hospital Compare* website.

Comment

The quality material is extensive. The simple part is CMS is not changing the measures, but much centers on Form, Manner, Timing of Quality Data Submission, Validations and periods of time. The material extends some 50 pages.

XI. PROPOSED CHANGES TO THE PAYMENT RATES FOR THE LTCH PPS FOR FY 2021 (Page 1,420)

Updates to the Payment Rates for the LTCH PPS for FY 2021

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of 2.5 percent for FY 2021. CMS is proposing to apply a permanent budget neutrality adjustment factor (applied to LTCH PPS standard Federal payment rate cases only) for the cost of the elimination of the 25-percent threshold policy for FY 2021. Thus, CMS is proposing to apply a factor of 1.025 to the FY 2020 LTCH PPS standard Federal payment rate of $42,677.64 to determine the proposed FY 2021 LTCH PPS

CMS is proposing to establish an annual update to the LTCH PPS standard Federal payment rate of 0.5 percent (that is, an update factor of 1.005) for FY 2021 for LTCHs that fail to submit the required quality reporting data for FY 2021 as required under the LTCH QRP.

CMS is applying a permanent budget neutrality adjustment factor of 0.991249 to the LTCH PPS standard Federal payment rate for the cost of the elimination of the 25-percent threshold policy for FY 2021 and subsequent years after removing the temporary budget neutrality adjustment factor of 0.990737 that was applied to the LTCH PPS standard Federal payment rate for the cost of the elimination of the 25-percent threshold policy for FY 2020.

CMS is proposing to apply an area wage level budget neutrality factor to the FY 2021 LTCH PPS standard Federal payment rate of 1.0018755.

Accordingly, CMS is proposing to establish an LTCH PPS standard Federal payment rate of **$43,849.28** (calculated as $42,677.64 x 1.000517 x 1.025 x 1.0018755) for FY 2021.

CMS is proposing a total labor related share for FY 2021 of 68.0 percent (the sum of 63.6 percent for the operating cost and 4.4 percent for the labor-related share of capital-related costs).

There is a COLA for Alaska and Hawaii. Those values are the same as for the IPPS.

CMS is proposing to compute the FY 2021 LTCH PPS standard Federal payment rate area wage index values consistent with the "urban" and "rural" geographic classifications proposed for the IPPS.

Proposed Adjustment for High-Cost Outlier (HCO) Cases

Under the regulations at § 412.525(a)(2)(ii) and as required by section 1886(m)(7) of the Act, the fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875 percent of 8 percent (that is, 7.975 percent) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

CMS is proposing a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2021 of $30,515. CMS is proposing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, a fixed-loss amount for site neutral payment rate cases of $30,006.

FINAL COMMENTS

Even with history and redundancy, the rule is fairly well written. Nonetheless, its sheer size and the continuing increase in the size of recent CMS PPS updates make it difficult to summarize and analyze. There are too many items that cannot be covered in this analysis.

CMS appears to be placing a hold Quality Reporting.

This analysis has not discussed issues, in-depth, relating to eCQMs, timing reporting, validations, PPS Cancer Hospitals, LTCH hospitals quality, and other related quality items.

It's surprising that the Medicare payment pool is decreasing in the DSH area considering the increasing numbers of people without insurance.

CMS did not update its previous analysis of statewide changes to the area wage index and, therefore, we are unable to show such as provided in previous years.

TABLES

The following IPPS tables for this proposed rule are generally available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html Click on the link on the left side of the screen titled, "FY 2021 IPPS Proposed Rule Home Page" or "Acute Inpatient-Files- for Download."

Table 2.	Proposed Case-Mix Index and Wage Index Table by CCN—FY 2021
Table 3.	Proposed Wage Index Table by CBSA—FY 2021
Table 4A.	Proposed List of Counties Eligible for the Out-Migration Adjustment under Section 886(d)(13) of the Act—FY 2021
Table 4B.	Proposed Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR COUNTIES)—FY 2021
Table 5.	Proposed List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay—FY 2021
Table 6A.	New Diagnosis Codes--FY 2021
Table 6B.	New Procedure Codes--FY 2021
Table 6C.	Invalid Diagnosis Codes--FY 2021
Table 6E.	Revised Diagnosis Code Titles--FY 2021
Table 6G.1.	Proposed Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2021
Table 6G.2.	Proposed Principal Diagnosis Order Additions to the CC Exclusions List--FY 2021
Table 6H.1.	Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2021
Table 6H.2.	Proposed Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2021
Table 6I.1.	Proposed Additions to the MCC List--FY 2021
Table 6I.2.	Proposed Deletions to the MCC List--FY 2021
Table 6J.1.	Proposed Additions to the CC List--FY 2021
Table 6J.2.	Proposed Deletions to the CC List--FY 2021
Table 6P.	ICD-10-CM and ICD-10-PCS Codes for Proposed MS-DRG Changes—FY 2021 (Table 6P contains multiple tables, 6P.1a. through 6P.4a., that include the ICD-10-CM and ICD-10-PCS code lists relating to proposed specific MS-DRG changes. These tables are referred to throughout section II.D. of the preamble of this proposed rule.)
Table 7A.	Proposed Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2019 MedPAR Update—December 2019 GROUPER Version 37 MS-DRGs
Table 7B.	Proposed Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2019 MedPAR Update—December 2019 GROUPER Version 38 MS-DRGs
Table 8A.	Proposed FY 2021 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
Table 8B.	Proposed FY 2021 Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals

Table 16. Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2021
Table 18. Proposed FY 2021 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this FY 2021 proposed rule are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1735-P:

Table 8C. Proposed FY 2021 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
Table 11. Proposed MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2020 through September 30, 2021
Table 12A. Proposed LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2020 through September 30, 2021
Table 12B. Proposed LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2020 through September 30, 2021

DRG WEIGHTS

The following table identifies those MS-DRGs with 100,000 or more discharges from the proposed rule's tables 5 and table 7B.

	LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS)				
	RELATIVE WEIGHTING FACTORS				
MS-DRG	MS-DRG Title	Discharges	Proposed FY 2021 Weights	Final FY 2020 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	107,748	1.0158	1.0277	-1.16%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	145,197	1.2219	1.2157	0.51%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	128,896	1.1213	1.144	-1.98%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	149,883	1.3082	1.3335	-1.90%
194	SIMPLE PNEUMONIA & PLEURISY W CC	102,235	0.8605	0.8886	-3.16%
291	HEART FAILURE & SHOCK W MCC	393,303	1.3388	1.3458	-0.52%
378	G.I. HEMORRHAGE W CC	126,849	0.9908	0.9881	0.27%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	136,555	0.7621	0.7615	0.08%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	358,203	1.9104	1.9684	-2.95%
682	Renal FAILURE W MCC	103,143	1.4683	1.478	-0.66%
683	RENAL FAILURE W CC	126,537	0.876	0.8973	-2.37%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	128,166	0.7895	0.7908	-0.16%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	607,421	1.8652	1.8564	0.47%

This year, 1 DRGs that previously had more than 100,000 had fewer discharges and is removed from the table above – DRG 603 (Cellulitis w/o MCC).

Most Proposed FY 2021 weights for these DRGs would be less than those in FY 2020.

These 13 MS-DRGs contain 2.6 million discharges or approximately 29 percent of the 9.1 million MS-DRG discharges. Note, this year's discharges are less than in FY 2020.