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MEMORANDUM

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**To:** AAHKS **From:** Epstein Becker & Green, P.C.  
**Date:** May 27, 2020  
**Re:** **2021 Medicare Inpatient Prospective Payment System Proposed Rule**

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On May 11, 2020, the Centers for Medicare & Medicaid Services (“CMS”) published a proposed rule that updates payment policies, payment rates, and quality provisions for service furnished under the Medicare Inpatient Prospective Payment System (“IPPS”) for acute and long-term care hospitals in fiscal year 2021.

This summary covers proposals that may be relevant to AAHKS members’ surgical practice, as well as other initiatives that are significant to hospitals and the health industry more broadly. CMS will accept comments on this proposed rule through July 10, 2020.

**I. New Hip Fracture DRGs**

CMS received a request from an external commenter in 2019 to restructure the DRGs for TJAs that utilize an oxidized zirconium bearing surface implants. Instead, CMS decided to propose new DRGs for THAs with a primary diagnosis of hip fracture.

a. Requestor Proposed Options

According to the requestor, several international joint replacement registries, retrospective claims review, and published clinical studies show compelling short-term, mid-term and long-term clinical outcomes for patients receiving oxidized zirconium bearing surface implants. The requestor stated that without specific DRGs, beneficiary access to these implants is restricted and the benefit to patients and cost savings cannot be recognized. The requestor is anonymous under CMS procedures. The requestor presented 3 restructuring options as follows.

*i. New DRG for all TJAs using the Specific Implant*

The requestor proposed to reassign all TJAs with an oxidized zirconium bearing surface implant from DRG 470 to the suggested new DRG. The requestor reported that its own analysis indicated there were approximately 18,000 TJA cases and the average length of stay with an oxidized zirconium bearing surface implant was shorter than the cases without such an implant.

*ii. New DRG for all THAs Using the Specific Implant as well as all THA Fracture Cases Without the Specific Implant*

The requestor proposed reassigning to a new DRG all cases (1) in DRG-470 reporting THA with hip fracture and (excluding those with an oxidized zirconium bearing surface implant); and (2) all THAs with an oxidized zirconium bearing surface implant, with or without a principal diagnosis of hip fracture.

*iii. Reassign All THA Fracture Cases Using the Specific Implant from DRG 470 to DRG 469*

The requestor stated this option would maintain the two existing DRGs for TJA and would only involve moving a small subset of cases (approximately 300) from DRG 470 to DRG 469. The requestor characterized this as the least disruptive option since the two MS-DRGs and estimated relative weights would remain essentially the same.

**b. Requester Rational for Restructuring**

According to the CMS, the requestor offered the following reasons for the restructuring to recognize oxidized zirconium bearing surface implants:

- patients receiving an oxidized zirconium bearing surface implant may be walking earlier after surgery and the risk of infection may be reduced as a result of the shorter hospitalization;
- distinguishing these implants is clinically justified because the implants are designed for increased longevity;
- other countries have established higher government reimbursement for these implants to reflect the increased value of the technology;
- multiple joint replacement registries have reported “excellent hip replacement results”, including a 33% reduced risk of revision;
- U.S. data sources, including Medicare claims, show strong short-term outcomes, reduced 30-day readmissions, fewer discharges to SNF, shorter LOS, and more frequent discharges to home, resulting in less costly post-acute care; and
- the requestor’s own analysis of Medicare claims data found statistically reduced SNF costs, hospital length of stay, 90-day episode costs, and 55% decreased mortality at 180 days for the oxidized zirconium bearing surface implant cases.

**c. CMS Analysis of Requestor’s DRG Proposals**

CMS performed its own analysis of TJA claims data and reported the following based on the requestors proposed alignments:

| <b>DRGs for THA and TKA Procedures with and without an Oxidized Zirconium Bearing Surface Implant with and without a Principal Diagnosis of Hip Fracture</b>                         |                        |                               |                      |
|--|------------------------|-------------------------------|----------------------|
| <b>MS-DRG</b>  | <b>Number of Cases</b> | <b>Average Length of Stay</b> | <b>Average Costs</b> |
| <b>DRG 469-All cases</b>   | 25,701                 | 5.9                           | \$22,126             |
| <b>DRG 470-All cases</b>   | 386,221                | 2.3                           | \$14,326             |
| <b>DRG 470-Cases reporting a total hip replacement or total knee replacement procedure with an oxidized zirconium bearing surface implant (Option 1)</b>                             | 18,898                 | 2.1                           | \$14,808             |
| <b>DRG 470-Cases reporting a total hip replacement procedure without an oxidized zirconium bearing surface implant with a principal diagnosis of hip fracture (Option 2)</b>         | 47,316                 | 4.5                           | \$16,077             |
| <b>DRG 470-Cases reporting a total hip replacement procedure with an oxidized zirconium bearing surface implant with or without a principal diagnosis of hip fracture (Option 2)</b> | 7,241                  | 1.9                           | \$13,875             |
| <b>DRG 470-Cases combined for Option 2</b>   | 54,557                 | 4.2                           | \$15,785             |
| <b>DRG 470-Cases reporting a total hip replacement procedure with an oxidized zirconium bearing surface implant with a principal diagnosis of hip fracture (Option 3)</b>            | 316                    | 4                             | \$18,304             |

Based on the claims analysis, CMS' clinical advisors<sup>1</sup> stated that the data does not support adopting any of the requestor's 3 proposals to restructure DRGs for these specific implants. For the first option, the clinical advisors also believe that the characteristics of the patients and resources used for a case that involves a THA or TKA with an oxidized zirconium bearing surface implant are not clinically distinct from the characteristics of the patients and resources used for the cases reporting a THA or TKA without an oxidized zirconium bearing surface implant.

For the second option, the clinical advisors noted that the variation in the volume (47,316 cases and 7,241 cases), average length of stay (4.5 days and 1.9 days), and the average costs

<sup>1</sup> Various CMS staff who also possess medical degrees and who may actively practice medicine.

(\$16,077 and \$13,875) for each subset of option 2 and that the total average cost for the combined cases identified for the second option (\$15,785) is very similar to the costs of all the cases in DRG 470 (\$14,326).

For the third option, CMS clinical advisors noted that while the data shows a longer length of stay and higher average costs for these cases, the analysis of the cases reporting a THA without an oxidized zirconium bearing surface implant with a principal diagnosis of hip fracture under option 2 also demonstrated a longer length of stay and higher average costs. They therefore recommended CMS conduct further review specifically of those cases reporting THA with a principal diagnosis of hip fracture, with or without an oxidized zirconium bearing surface implant.

d. CMS Analysis in Support of New DRGs for Fracture Cases

Based on the advice of their clinical advisors and in connection with the request to examine the claims data and consider alternative configurations, CMS performed additional analysis of those cases reporting THA with a principal diagnosis of hip fracture for both DRGs 469 and 470. Generally, when reviews shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS often reassigns them to a different DRG with comparable resource use or creates a new DRG.

| <b>MS-DRGs for Total Hip and Knee Replacement Procedures with a Principal Diagnosis of Hip Fracture</b>   |                        |                               |                      |
|---|------------------------|-------------------------------|----------------------|
| <b>MS-DRG</b>   | <b>Number of Cases</b> | <b>Average Length of Stay</b> | <b>Average Costs</b> |
| MS-DRG 469-All cases  | 25,701                 | 5.9                           | \$22,126             |
| MS-DRG 469 – Cases reporting a total hip replacement procedure with a principal diagnosis of hip fracture | 14,163                 | 7.2                           | \$21,951             |
| MS-DRG 470-All cases  | 386,221                | 2.3                           | \$14,326             |
| MS-DRG 470- Cases reporting a total hip replacement procedure with a principal diagnosis of hip fracture  | 47,632                 | 4.5                           | \$16,092             |

In light of these findings, CMS' clinical advisors supported differentiating the cases reporting a THA with a principal diagnosis of hip fracture from those cases without a hip fracture by assigning them to a new DRG. They noted that clinically, individuals who undergo THA following hip fracture tend to require greater resources for effective treatment than those without hip fracture. They further noted that the increased complexity associated with hip fracture patients can be attributed to the post traumatic state and the stress of pain, possible peri-articular bleeding, and the fact that this subset of patients, most of whom have fallen as the

cause for their fracture, may be on average more frail than those who require THA because of degenerative joint disease. *Therefore, for FY 2021, CMS proposes to create*

- MS-DRG 521 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC);
- MS-DRG 522 (Hip Replacement with Principal Diagnosis of Hip Fracture without MCC)

If THAs with fractures are moved into new DRGs it would mean that such cases would no longer be included in CMS models and quality programs based on DRGs 469 and 470, such as CJR, Readmissions Reduction Program, Value-Based Purchasing, Hospital Compare, and any other program that does not distinguish between elective and non-elective TJA. CMS has invited providers to provide feedback on the CJR impacts as a part of comment letters on the CJR extension proposed rule due June 23.

## II. Proposed Average Reimbursement Levels

The following illustrates CMS' proposed weights and associated reimbursement rates for applicable DRGs. Note that this chart represents the **National Payment Amount**, which is projected by CMS as the baseline amount that will be paid nationally for the DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases.

| DRG        | 2019   |             | 2020   |             | 2021   |             |
|------------|--------|-------------|--------|-------------|--------|-------------|
|            | Weight | Rate        | Weight | Rate        | Weight | Rate        |
| <b>469</b> | 3.1742 | \$17,921.78 | 3.1399 | \$18,200.84 | 3.0989 | \$18,530.61 |
| <b>470</b> | 1.9898 | \$11,234.56 | 1.9684 | \$11,410.09 | 1.9104 | \$11,423.69 |
| <b>521</b> | --     | --          | --     | --          | 3.0652 | \$18,329.99 |
| <b>522</b> | --     | --          | --     | --          | 2.1943 | \$13,121.34 |

## III. Reduction of Hospital Payments for Excess Readmissions

The statutory Hospital Readmissions Reduction Program requires a reduction to a hospital's base operating DRG payment to account for excess readmissions following select admissions. Since FY 2017, the reduction is based on a hospital's risk-adjusted readmission rate during a 3-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), elective THA or TKA, and coronary artery bypass graft (CABG) surgery.

CMS estimates that 2,583 hospitals will have their base operating DRG payments reduced in 2020 due to excessive readmissions under this program, resulting in approximately \$563 million in savings to Medicare in 2020.

CMS is proposing to extend the use of a 3-year look-back data collection period for the calculation of readmission performance. That is, for FY 2023, the applicable period for the Hospital Readmissions Reduction Program measures and for determining dual eligibility will be the 3-year period from July 1, 2018 through June 30, 2021. Under this proposed policy, for all subsequent years, CMS would advance this 3-year period by 1 year unless otherwise specified through notice and comment rulemaking.

#### **IV. New MS-DRG Weights Based on Transparency in Hospital Charges and Privately Negotiated Rates**

CMS is proposing that hospitals report the following on their Medicare cost reports:

- the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (“MA”) payers, by MS-DRG; and
- the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG.

CMS further proposes that this collected data would be used in a potential change to the methodology for calculating the IPPS DRG relative weights to reflect relative market-based pricing. CMS is proposing this to reduce reliance on the hospital chargemaster, which CMS views as unreliable. Today, DRG weights reflect the average level of resources for an average Medicare patient in the DRG, as represented by average hospital charges, relative to the average level of hospital charges for all Medicare patients.

Beginning in 2024, CMS would implement a methodology for estimating the DRG relative weights using the median payer-specific negotiated charge for each MS-DRG for payers that are MA plans. CMS is requesting comments on this proposed new methodology. CMS is also considering alternatives to this approach, such as the use of the median payer-specific negotiated charge for all third-party payers, or other alternative collections of payer-specific negotiated charges or other market-based information such as a median negotiated reimbursement amount that a hospital negotiates with its MA plans or third party payers

CMS estimates a low administrative burden on hospitals to report this data because hospitals are already to publically report payer-specific negotiated charges under regulations imposed in the 2020 Hospital OPPI Final Rule. Recall, this requirement is currently being litigated as the American Hospital Association, the Federation of American Hospitals, the American Association of Medical Colleges, and 37 state hospital associations have sued to block CMS’ implementation of the disclosure requirement.

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