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FY 2022 IPPS and LTCH Final Rule

OVERVIEW

On August 2nd, the Centers for Medicare and Medicaid Services (CMS) issued a final rule updating Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2022.

Under this rule, standardized Medicare IPPS payments will increase by 2.5 percentage points, or $3.4 billion, for acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. Combined with increases in capital payments, new technology payments, and other changes, hospital inpatient payments (before taking into account Medicare disproportionate share hospital (DSH) and uncompensated care payments) will increase by $3.7 billion. However, DSH and uncompensated care payments will decrease by $1.4 billion compared to FY 2021, for an overall FY 2022 increase of $2.3 billion.

LTCH aggregate payments for FY 2022 will increase by approximately 1.1%, or $42 million. CMS estimates that approximately 25% of LTCH cases will be paid at the site neutral payment rate, which is estimated to increase by 3% in aggregate, or approximately $11 million. The remaining 75% of LTCH are estimated to meet the patient-level criteria for exclusion from the site neutral payment rate and will be paid under the standard payment rate for the full year, which will increase by approximately 0.9%, or approximately $31 million. This is the result of an increase of 1.9% in LTCH PPS payments under the standard payment rate and a decrease of 0.8% in high-cost outlier payments.

CMS notes that it is using data from FY 2019 for this rate-setting process. Ordinarily, FY 2022 rate-setting would be expected to use FY 2020 data, but utilization and spending patterns in FY 2020 were markedly different due to the COVID-19 Public Health Emergency (PHE).

Notably, the final rule does not address proposals included in the proposed rule related to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME), and to organ acquisition payment policy for transplant hospitals, donor community hospitals, and organ procurement organizations. CMS notes that due to the "number and nature" of comments on these proposals, they will be addressed in future rulemaking.

The final rule is available here. A fact sheet is available here.

NEW COVID-19 TREATMENTS ADD-ON PAYMENT (NCTAP)

CMS finalized its proposal to extend the New COVID-19 Treatments Add-On Payment (NCTAP), which offered a 20% bonus, through the end of the fiscal year in which the PHE ends for all eligible products. For products that are separately approved for new technology add-on payments for FY 2022, the NCTAP will be reduced by the amount of that add-on. The NCTAP applies to COVID-19 inpatient discharges occurring on or after November 2, 2020 that meet certain criteria.

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REPEAL OF MARKET-BASED DATA COLLECTION AND MARKET-BASED MS-DRG RELATIVE WEIGHT METHODOLOGY

CMS finalized its proposal to repeal the requirement, established by the previous administration, that a hospital must include on the Medicare cost report the median payer-specific charge it has negotiated with all of its Medicare Advantage payers for cost reporting periods ending on or after January 1, 2021.

CMS also finalized its proposal to repeal the market-based MS-DRG relative weight methodology adopted for FY 2024. Instead, CMS will continue using the existing cost-based methodology for FY 2024 and subsequent years.

WAGE INDEX DISPARITIES

CMS finalized the continuation of a policy adopted in FY 2020 to mitigate wage index disparities by increasing the wage index for hospitals with a wage index below the 25th percentile by half the difference between the otherwise applicable wage index value for those hospitals and the 25th percentile wage index value across all hospitals. CMS notes this policy will be in effect for at least four years beginning in FY 2020. In order to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile, CMS is applying a uniform budget neutrality factor to the standardized amount applied to all hospitals.

CMS also finalized the statutory provision in the American Rescue Plan that applies a minimum imputed area wage index for hospitals in all-urban states (Delaware, New Jersey, and Rhode Island).

UNCOMPENSATED CARE PAYMENTS

CMS finalized updates to estimates of the three factors used to determine uncompensated care payments for FY 2022 and projects that the total amount available for uncompensated care for FY 2022 will decrease by approximately $1.4 billion, as compared to estimated uncompensated care payments for FY 2021.

NEW TECHNOLOGY ADD-ON PAYMENTS

CMS finalized a one-year extension of New Technology Add-On Payments (NTAPs) for 13 technologies for which the NTAP would otherwise have been discontinued beginning FY 2022 and approved 42 technologies that are eligible to receive add-on payments for FY 2022. CMS estimates that FY 2022 Medicare spending on NTAPs will be $1.5 billion, a 77 percent increase over the FY 2021 spending level.

MEDICAID ENROLLMENT OF MEDICARE PROVIDERS

CMS finalized the requirement that, for purposes of determining Medicare cost-sharing obligations for dually-eligible enrollees, state Medicaid programs must allow all Medicare-enrolled providers and suppliers to enroll in Medicaid, regardless of whether they are eligible to enroll in the program, so long as they meet all other federal Medicaid enrollment requirements.

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ADVERSE EVENT REDUCTION PROGRAMS

Hospital Readmissions Reduction Program

CMS finalized several policy changes to the Hospital Readmissions Reduction Program (HRRP) for FY 2022, including:

- Adopting a cross-program measure suppression policy for the duration of the COVID-19 PHE.
- Suppressing the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506) for the FY 2023 program year.
- Modifying the remaining five condition-specific readmission measures to exclude COVID-19-diagnosed patients from the measure denominator, beginning with the FY 2023 program year.
- Using the Medicare Provider Analysis and Review (MedPAR) data that aligns with the applicable period for FY 2022.
- Automatically adopting the use of MedPAR data corresponding to the applicable period beginning with the FY 2023 program year and all subsequent program years.
- Updating the regulatory text to reflect that Hospital Compare has been renamed Care Compare.
- Clarifying the Extraordinary Circumstances Exceptions (ECE) policy.

Hospital-Acquired Condition (HAC) Reduction Program

CMS also finalized several policy changes to the HAC Reduction Program for FY 2022, including:

- Adopting a cross-program measure suppression policy for the duration of the COVID-19 PHE.
- Applying the measure suppression policy to suppress certain program data from FY 2022, FY 2023, and FY 2024 HAC Reduction Programs.
- Updating the regulatory text to reflect that Hospital Compare has been renamed Care Compare.
- Clarifying the ECE policy.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

Given the measure suppression policy changes to the Hospital VBP finalized and described below, CMS finalized its proposal to revise the scoring and payment methodology for the FY 2022 program such that hospitals will not receive Total Performance Scores. Instead, CMS will award each hospital a payment incentive multiplier that results in a 2% value-based incentive payment (equal to the amount withheld for the fiscal year). CMS estimates the amount of base operating MS-DRG payment amount reductions and payback to hospitals is approximately $1.9 billion for FY 2022. Other finalized policy changes include:

- Establishing a measure suppression policy for the duration of the COVID-19 PHE.
- Suppressing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCHAPS), Medicare Spending Per Beneficiary (MSPB), and five Healthcare-Associated Infection (HAI) measures for the FY 2022 program year.

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- Suppressing the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia (PN) Hospitalization for the FY 2023 program year.
- Removing the CMS Patient Safety and Adverse Events Composite measures beginning with FY 2023.
- Updating the baseline periods for certain measures affected by the ECE granted in response to the COVID-19 PHE.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

CMS finalized policy changes to the MSSP to allow eligible accountable care organizations (ACOs) participating in the BASIC track's glide path the option to forgo automatic advancement to the next level of risk and potential reward for performance year (PY) 2022. Such eligible ACOs could instead elect to remain in the same risk/reward level in which it participated in PY 2021. For PY 2023, ACOs that elect to defer advancement in PY 2022 will be automatically advanced to the level of the glide path in which it would have participating during PY 2023 if it had automatically advanced to the required level for FY 2022.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

CMS finalized several changes to the IQR program, including:

- Adopting five new measures:
  - Maternal Morbidity Structural Measure, beginning with a shortened reporting period from October 1, 2021 through December 31, 2021, affecting the FY 2023 payment determination.
  - Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures, in a stepwise fashion beginning with voluntary reporting starting July 1, 2022, followed by mandatory reporting from July 1, 2023 through June 30, 2024.
  - COVID-19 Vaccination Coverage among Health Care Personnel, beginning with a shortened reporting period from October 1, 2021 through December 31, 2021, and with quarterly reporting beginning with the FY 2024 payment determination.
  - Hospital Harm-Severe Hypoglycemia of Electronic Clinical Quality Measures (eCQM).
  - Hospital Harm-Severe Hyperglycemia of eCQM.
- Removing three measures, all beginning with the FY 2026 payment determination:
  - Exclusive Breast Milk Feeding.
  - Admit Decision Time to ED Departure Time for Admitted Patients.
  - Discharged on Statin Medication eCQM.
- Requiring hospitals to use certified technology updated consistent with the 2015 Edition Cures Update and clarifying that certified technology must support the reporting requirements for all available eCQMs.
- Requiring that hybrid measures comply with the same certification requirements as eCQMs.
- Extending the effect of the education review process for chart-abstracted measures beginning with validations affecting the FY 2024 payment determination.

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LTCH QUALITY REPORTING PROGRAM

CMS finalized several changes to the IQR program, including:

- Adding the COVID-19 Vaccination Coverage Among Healthcare Personnel Measure.
- Updating the denominator for the Transfer of Health (TOH) Information to the Patient-Post Acute Care (PAC) quality measures.
- Publicly reporting Quality Measures with fewer than the standard numbers of quarters due to the COVID-19 PHE exemptions.
- Publicly reporting the Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay measure beginning with the March 2022 Care Compare refresh or as soon as technically feasible.
- Publicly reporting the Ventilator Liberation Rate for the PAC LTCH QRP measure beginning with the March 2022 Care Compare refresh or as soon as technically feasible.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

CMS finalized several changes to the Medicare Promoting Interoperability Program, including:

- Continuing the minimum EHR reporting period of any continuous 90-day period for new and returning eligible hospitals and CAHs for CY 2023 and increasing to any continuous 180-day period for CY 2024.
- Maintaining the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional while increasing its available bonus from 5 points to 10 points for the CY 2022 reporting period.
- Adding a new Health Information Exchange Bi-Directional Exchange measure as a yes-no attestation to the HIE objective as an optional alternative to the two existing measures beginning with the CY 2022 reporting period.
- Requiring reporting a "yes" on four of the existing Public Health and Clinical Data Exchange Objective measures or requesting the applicable exclusions.
- Adding a new measure to the Protect Patient Health Information objective that requires eligible hospitals and CAHs to attest to having completed an annual assessment of SAFER Guides beginning with the CY 2022 reporting period.
- Removing the attesting statements 2 and 3 from the Promoting Interoperability Program's prevention of information blocking requirement.
- Increasing the minimum required score for the objectives and measures from 50 points to 60 points in order to be considered a meaningful EHR user.
- Adopting two new eCQMs to the measure set beginning with the reporting period in CY 2023 and removing three eCQMs from the measures set beginning with the CY 2024 reporting period.