INSIGHTS FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

CMS RELEASES FINAL FY 2022 MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) REGULATIONS

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BDO

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At A Glance

The healthcare industry's navigation through this pandemic has pushed the system to take a new innovative look at patient care, cash and coordination and creativity to implement long-term solutions in the short term. Per BDO's 2021 Healthcare CFO Outlook Survey, healthcare organizations made decisions faster and they used that decisiveness to take actions that will shape the future of the industry. These CFOs outlined six initiatives to reshape healthcare due to the COVID-19 pandemic.

Increase in partnerships

Accelerate digital transformation

Increase consolidations

Increase focus on diversified revenue streams

Accelerate shift to value-based care

Drive product and service innovation

To continue to lead their organizations through the pandemic and focus on these initiatives, organizations will also need to focus on changing Medicare policies and updated payment rates, given the effects they will have on margins.

Each year the Centers for Medicare & Medicaid Services (CMS) publishes the proposed and then final rules for the Inpatient Prospective Payment System (IPPS), updating Medicare payment regulations and rates. The final rule for FY 2022 was released on August 2, 2021.

Highlights include:

- **Increase in IPPS payments** for FY 2022 is estimated to be $3.7 billion
- **Uncompensated care payments (UCC) and Disproportionate Share** payments are estimated to decrease by $1.4 billion. Acute care hospitals will receive an estimated increase in payments of $2.3 billion.
- **Reinstate the imputed floor wage index** for all urban states per Section 9831 of the American Rescue Plan Act of 2021 which is estimated to increase payments by $200 million in FY 2022
- **Graduate medical education payment revisions were introduced in the Consolidated Appropriations Act (CAA) of 2021. CMS has stated that due to the number and nature of comments, it will address the final decision in a separate document.**
- **Organ Acquisition payment policy to codify the Medicare usable organ counting policy to count only organs transplanted into Medicare patients. Changes to this policy were in the proposed rules. It has not been adopted in the final rule for 2022, but it will be reconsidered in future rule-making policies.**
- **Value based care changes** will affect Medicare payments as follows:
  - Hospital Readmissions Reduction (HRR) Program-DRG payments reduced impacting 2,500 hospitals for a total of $521 million
  - Hospital Acquired Conditions (HAC) Reduction Program-17.2% of hospitals will experience a change
  - Value Based Incentive based Payment Program (VBP)-Budget Neutral with an expected pool of $1.9 billion available for VBP incentives
  - Medicare Shared Savings Program (ACOs)-Freezing participation level to the BASIC Track will reduce Federal spending by an estimated $90 million
- **Inpatient Quality Increase the collection of information for Hospital Reporting (IQR) Program** will increase the burden of for 3,300 hospitals by 2,475 hours with the cost of $101,475 over a 4-year period from FY 2022 reporting period

Finalized Rates

Below is a table showing the final rate increases for FY 2022 based on four scenarios on whether the provider submits quality data and is a meaningful user of Electronic Health Records (EHR).

TABLE 1

FY 2022	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	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data per ACA	–	–	(0.675)	(0.675)
Adjustment for Failure to be a Meaningful EHR user per ACA	–	(2.025)	–	(2.025)
MFP Adjustment under Section per ACA	(0.7)	(0.7)	(0.7)	(0.7)
Applicable Percentage Increase to Standardized Amount	2.0	(0.025)	1.325	(0.7)
Documentation and Coding Adjustment – American Tax Payer Relief Act of 2012 (Section 414 of the Medicare Access and Chip Reauthorization Act of 2015)	0.5	0.5	0.5	0.5
Increase in Operating Rates	2.5	.475	1.825	0.2

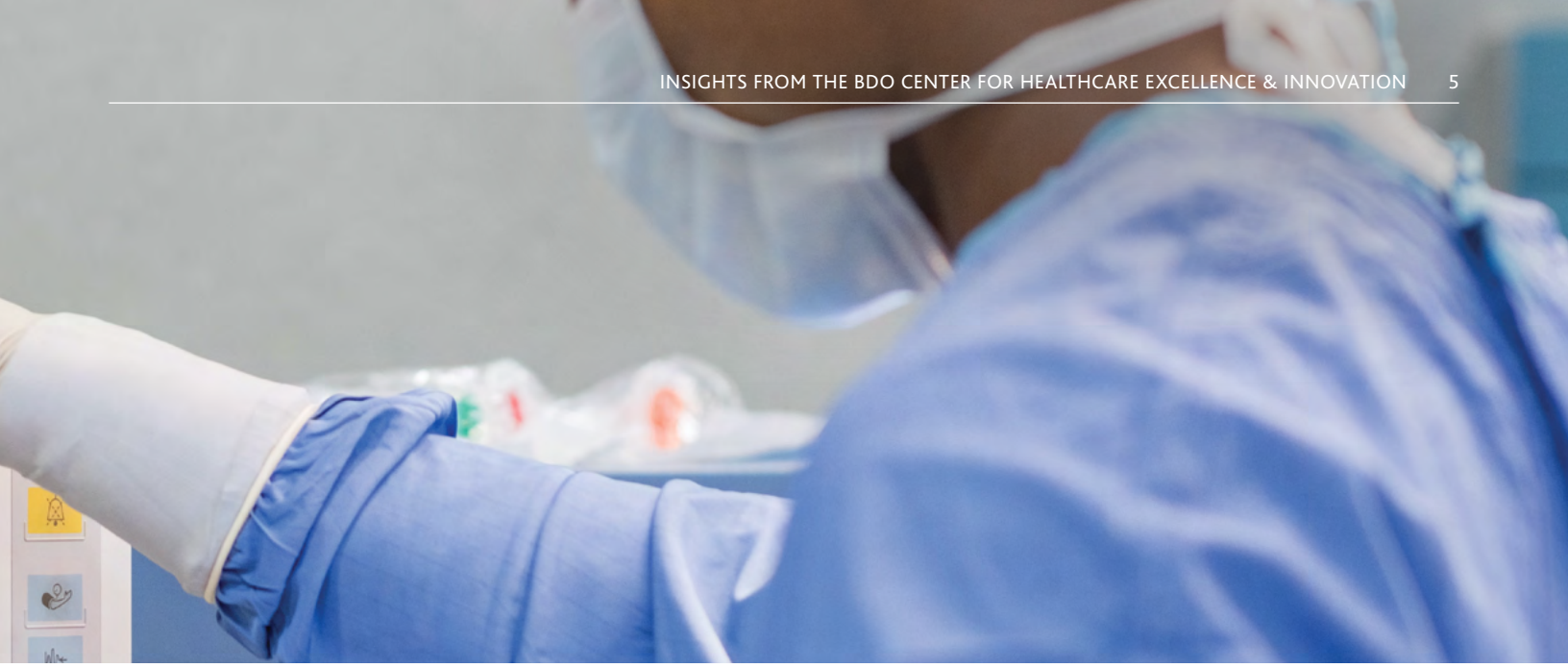


Table 1A shows the updated National Adjusted Operating Standardized amounts based on the rate updates per Table 1. For FY 2022, the full increase for a hospital that reports quality data and is a Meaningful EHR user will be 2.5%

TABLE 1A. National Adjusted Operating Standardized Amounts; Labor/Nonlabor (67.6% Labor Share/32.4% Nonlabor Share If Wage Index Is Greater Than 1)

Hospital Submitted Quality Data and is a Meaningful EHR User Update = 2.0%		Hospital Submitted Quality Data and is NOT a Meaningful EHR User Update = (0.025%		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User Update = 1.325%		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User Update = (0.7%)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,138.28	$1,983.43	$4,056.12	$1,944.05	$4,110.89	$1,970.30	$4,028.74	$1,930.93

TABLE 1B. National Adjusted Operating Standardized Amounts; Labor/Nonlabor (62% Labor Share/38% Nonlabor Share If Wage Index Is Less Than or Equal To 1)

Hospital Submitted Quality Data and is a Meaningful EHR User Update = 2.0%		Hospital Submitted Quality Data and is NOT a Meaningful EHR User Update = (0.025%)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User Update = 1.325%		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User Update = (0.7%)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,795.46	$2,326.25	$3,720.11	$2,280.06	$3,770.34	$2,310.85	$3,695.00	$2,264.67

The rate increases, coupled with other changes to IPPS payment policies, will increase IPPS operating payments by approximately 2.5%. The overall increase in IPPS payments in FY 2022 will be approximately $3.7 billion in increase Medicare payments in FY 2022 as shown in Table II. This increase is significantly driven by the increase in IPPS rates as shown in Table 1.

CAPITAL PAYMENTS

Per Table 1C, the capital rate increased by 1.3% to $472.60 for FY 2022 which will increase capital payments by $76,000,000 per Table 2.

TABLE 1C. Capital Standard Federal Payment Rate

	FY 2022 Rate	FY 2021 Rate
National	$472.60	$466.22

TABLE 2

Operating Payments	$ 2,774,000,000
DSH/Uncompensated Care	$ (1,400,000,000)
Capital Payments	$ 76,000,000
New Technology Add-On Payments	$ 650,000,000
Imputed Floor	$ 200,000,000
Estimated Increase in Payments	**$ 2,300,000,000**

The combined IPPS operating payment and uncompensated care payments increased by $2,300,000,000—it is important to note that this includes a $1.4 billion decrease in uncompensated care payments as outlined in the DSH and Uncompensated Care section of this summary.

The below summary of the FY 2022 IPPS Medicare rules will highlight the changes that will drive the increased rates and additional Medicare payments for FY 2022.

The impacts do not include the 2% Medicare sequestration reduction. This reduction began in FY 2013 and would have run through 2028 without legislation to discontinue this reduction or increase the length of time it is in effect. The Coronavirus Aid, Relief, and Economic Security (CARES) Act passed for COVID-19 relief for healthcare providers temporarily halted the sequestration reduction beginning May 1, 2020-Dec 31, 2020, thus extending the sequestration period through 2030 absent any further regulations. On April 15, 2021, President Biden signed into law a bill that extended the pause on the 2% sequestration cut through the end of 2021.

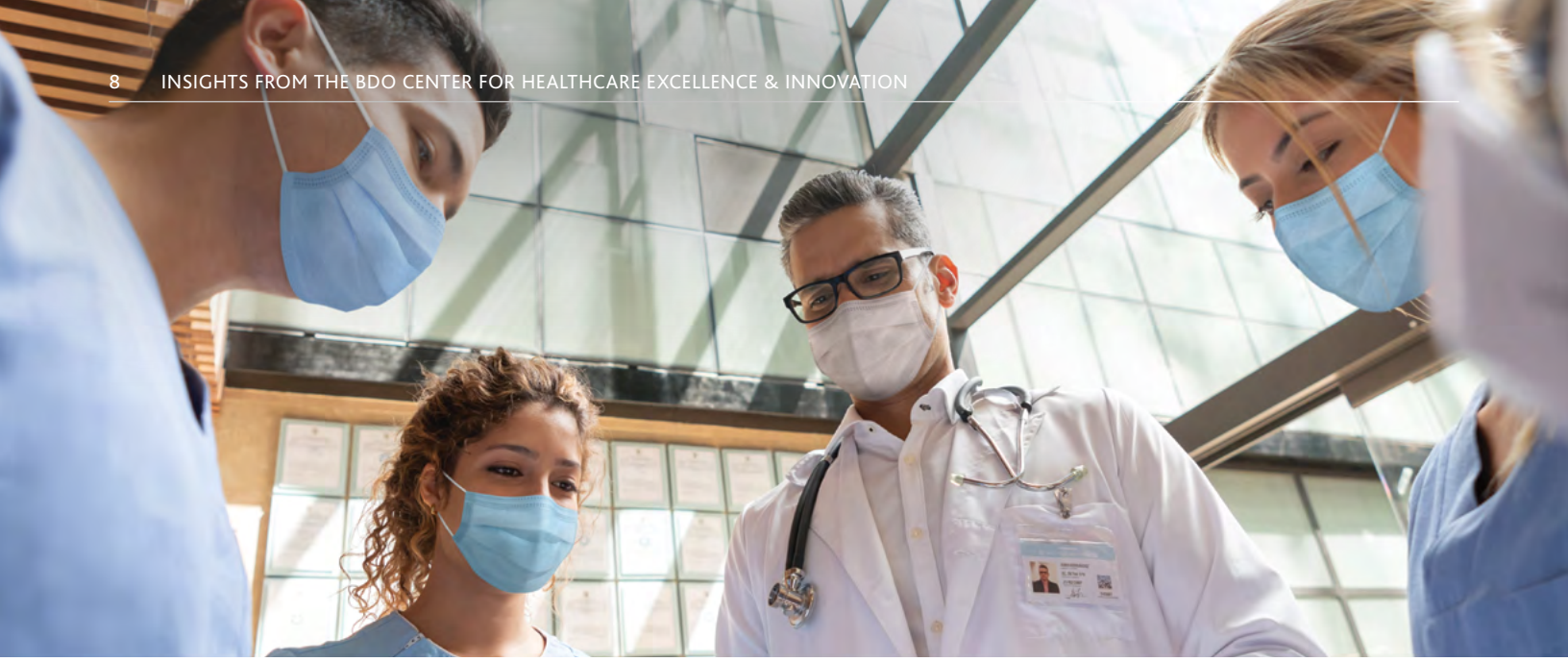
FY 2022 MS-DRG Relative Weights

FY 2007 ushered in a new era of relative DRG weights based on Medicare cost report data instead of charges. The data utilized in the cost-based weighting methodology for setting the MS-DRG weights are claims data from the FY 2019 MEDPAR file using diagnostic and procedure data for all Medicare inpatient bills and cost report data from the HCRIS data set that is three years prior to the IPPS fiscal year.

Consistent with using 2019 data for FY 2022, CMS will continue to use the FY 2021 final rule CCRs for FY 2022. The updated 19 national average cost to charge ratios (CCRs) based on FY 2018 Medicare cost report data and the MEDPAR file that will be utilized for updating FY 2021/2022 MS-DRGs are identified in Table 3. CCRS from FY 2019 and FY 2020 are presented for comparison purposes:

TABLE 3

	FY2019 Final 19 CCRs	FY2020 Final 19 CCRs	FY2021 & 2022 Final 19 CCRs
Routine Days	0.451	0.432	0.422
Intensive Days	0.373	0.358	0.345
Drugs	0.196	0.189	0.187
Supplies & Equipment	0.299	0.299	0.297
Implantable Devices	0.321	0.299	0.293
Therapy Services	0.312	0.297	0.288
Laboratory	0.116	0.109	0.106
Operating Room	0.185	0.173	0.167
Cardiology	0.107	0.098	0.094
Cardiac Catheterization	0.115	0.106	0.100
Radiology	0.149	0.140	0.136
MRI	0.076	0.072	0.070
CT Scans	0.037	0.034	0.034
Emergency Room	0.165	0.152	0.147
Blood	0.306	0.283	0.270
Other Services	0.355	0.346	0.344
Labor & Delivery	0.363	0.373	0.359
Inhalation Therapy	0.163	0.150	0.147
Anesthesia	0.081	0.077	0.071



MS-DRG Documentation and Coding Adjustment

The methodology for MS-DRG adoption in FY 2008 created an $11 billion overpayment due to documentation and coding that did not reflect real changes in case mix. The American Taxpayer Relief Act of 2012 (ATRA) required an adjustment to FY 2014-2017 to recoup this amount. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) instituted a 0.5% positive adjustment to Medicare payments for FY 2018-2023 to standardize the payments. The 0.5% adjustment is reflected in the market basket update per Table 1.

Market-Based MS-DRG Relative Weight Data Collection

POTENTIAL CHANGE IN METHODOLOGY FOR CALCULATING MS-DRG RELATIVE WEIGHTS

In the final rule for FY 2021, in an effort to bolster transparency initiatives and reduce reliance on a hospital's chargemaster, CMS finalized development of the market-based approach for MS-DRG weight calculation. CMS will mandate that hospitals report market-based payment rates for all payers for cost reporting periods ending on or after Jan 1, 2021. The information that is gathered will lead to a change in the method for calculating MS-DRG weights using market-based pricing. Under this proposal, hospitals would be required to report the following information on their Medicare cost report:

- The median payer-specific negotiated charge that the hospital has negotiated with all its Medicare Advantage (MA) organizations payers, by MS-DRG;

CMS believes that because hospitals are required to report the payer-specific negotiated charges under the Hospital Price Transparency Final Rule, the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.

CMS will institute the methodology for calculating the IPPS MS-DRG relative weights to incorporate this market-based rate information beginning in FY 2024 without a transition period.

In the final FY 2022 rule, CMS is repealing the reporting requirement to report this information on the Medicare cost report saving hospitals approximately 64,000 hours in administrative burdens. Therefore, they are also proposing to repeal the market basket -based MS-DRG weight methodology which was to go into effect in FY 2024. CMS will continue to use the current cost-based MS-DRG weight methodology for FY 2024 and future years.

Outlier Payment

Additional payments are made in addition to DRG payments for high-cost cases. To qualify for outlier payments, a case must have incurred costs that are more than the combined payment for the case including MS-DRG, IME, DSH uncompensated care and new technology payments plus the outlier threshold amount. The outlier amount will increase from $29,064 in FY 2021 to $30,988 for FY 2022 which will result in a decrease in outlier payments in FY 2022. The outlier threshold is estimated to result in outlier payments that are 5.10% of operating DRG payments and 5.31% of capital payments. In order to fund the operating and capital outlier payments, CMS will apply an adjustment of .949 to the operating standardized amount and 0.9471 to the capital federal rate.

Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital (DSH) payment methodology beginning in FY 2014. Also, beginning in FY 2014, DSH hospitals began receiving 25% of the amount they previously would have been reimbursed under the traditional Medicare DSH formula. The remaining 75% adjusted for the percent of uninsured will be paid through the uncompensated care reimbursement methodology outlined below and updated for FY 2022.

FACTOR 1

Estimate of 75% (100% minus 25%) of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year. FY 2022 estimated DSH spending of $13,984,752,728 is 7.82% lower than the FY 2021 spending of $15,170,673,476

$13,984,752,728 * 75 = $10,488,564,546 = Uncompensated Care Pool

$13,984,752,728 * 25 = $ 3,496,188,182 = Empirical DSH payments

FACTOR 2

The Affordable Care Act established Factor 2 in the calculation of the uncompensated care payment. Specifically, the Act provides that for FYs 2014, 2015, 2016 and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act, to that same percent for the year in question. In FY 2018 and forward, the act authorized the use of data sources other than CBO estimates to determine the uninsured percentage as determined by the Secretary based on data from the Census Bureau or other source determined appropriate by the Secretary and certified by the Chief Actuary of CMS. The Act also does not require that the percentage of individuals be limited to those under the age of 65 for FY 2018 and forward.

The criteria that was set for determining a data source are as follows:

- The source accounts for the full U S population
- Comprehensively accounts for both public and private health insurance coverage
- Utilized data from the Census Bureau
- Timeliness of the estimates
- Continuity of the estimates over time
- Accuracy of estimates
- Availability of projections

The source determined in FY 2018 that meets these criteria is data from CMS' Office of the Actuary (OACT), derived as part of the development of the National Health Expenditure Accounts (NHEA) which represents official estimates of the economic activity within healthcare according to CMS. This data estimated the uninsured rate for 2013 was 14% and for 2022 is 9.60%.

Based on this information the calculation of Factor 2 for FY 2022 is as follows:
1-((0.096-0. 14)/0.14) =1- .3143=0.6857

FACTOR 3 – FY 2021

Factor 3 is a hospital-specific value that identifies the share of the estimated uncompensated care amount for each hospital receiving Medicare DSH payments.

The hospital's Cost of Uncompensated care is from the Medicare cost report, WS S-10 Ln 30-comprised of the following elements:

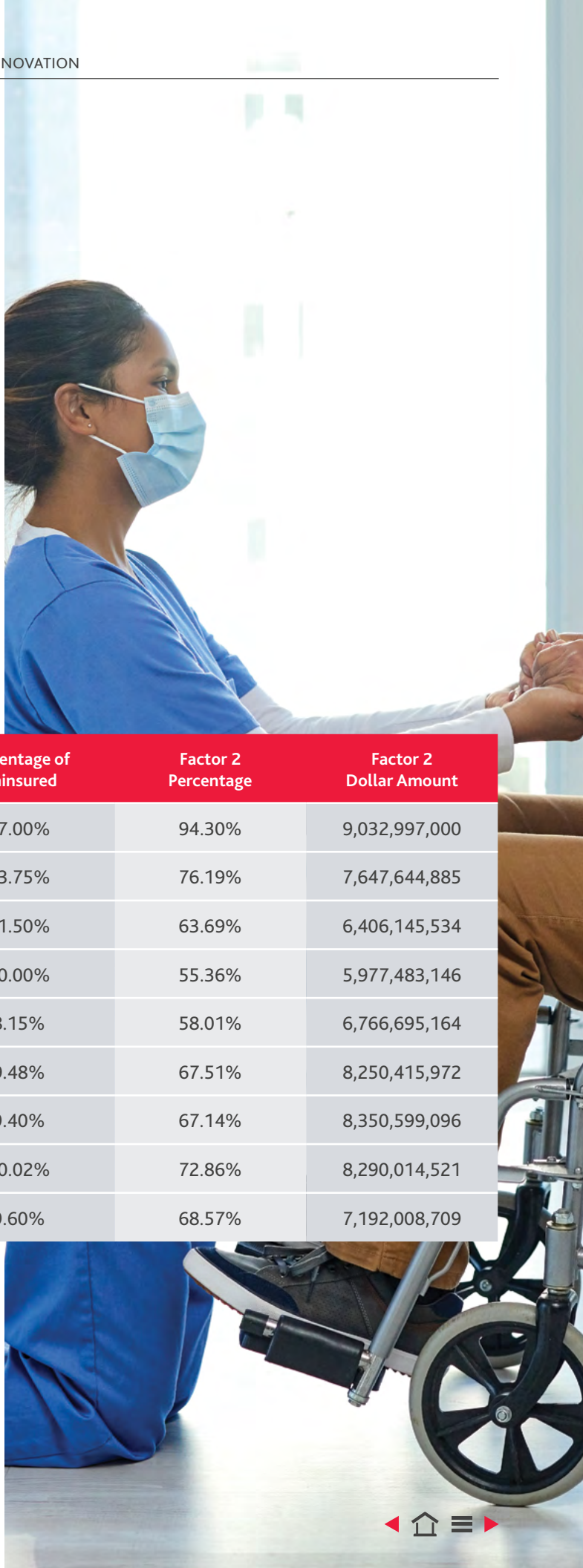
- Cost of charity care (Line 23)
- Non-Medicare and non-reimbursable Medicare bad debt (Line 29)

CMS proposes the data from FY 2018 Medicare cost reports will be used as these are the most recent audited data and the results of those audits are available for FY 2022. The methodology of using one year of data will continue.

Below is a summary of the three factors used for the uncompensated care payments since FY 2014:

FYE	DSH Estimate	Factor 1 (75% of total DSH)	Percentage of Uninsured	Factor 2 Percentage	Factor 2 Dollar Amount
2014	12,772,000,000	9,579,000,000	17.00%	94.30%	9,032,997,000
2015	13,383,462,196	10,037,596,647	13.75%	76.19%	7,647,644,885
2016	13,411,096,528	10,058,322,396	11.50%	63.69%	6,406,145,534
2017	14,396,635,710	10,797,467,782	10.00%	55.36%	5,977,483,146
2018	15,552,939,524	11,664,704,643	8.15%	58.01%	6,766,695,164
2019	16,294,703,939	12,221,027,954	9.48%	67.51%	8,250,415,972
2020	16,583,455,657	12,437,591,743	9.40%	67.14%	8,350,599,096
2021	15,170,673,476	11,378,005,107	10.02%	72.86%	8,290,014,521
2022	13,984,752,728	10,488,564,546	9.60%	68.57%	7,192,008,709

The projected decrease in payments for UCC for FY 2022 from FY 2021 is $1.1 billion which is a 13.24 percent decrease in payments for UCC. Estimated traditional DSH payments are projected to decrease by approximately $300 million. The UCC and DSH combined decrease in payments equates to a $1.4 billion reduction in payments.



Medicare Bad Debts

Medicare beneficiaries are responsible for their share of related covered services in the form of deductibles and coinsurance Medicare provides reimbursement for Medicare bad debt created when Medicare beneficiaries cannot pay the deductible and coinsurance amounts. An allowable Medicare bad debt must meet all the criteria set forth in Section 413.89(e) and the Provider Reimbursement Manual (PRM), Chapter 3, Section 308 Congress passed legislation implementing a moratorium stopping the HHS Secretary from making changes to Medicare bad debt reimbursement policies that were in effect on Aug 1, 1987. This prohibition was known as the Bad Debt Moratorium. The moratorium was repealed by Congress in the Middle-Class Tax Relief and Job Creation Act of 2012, effective for cost reporting periods beginning on or after Oct 1, 2012. With no prohibition in place, in FY 2021, CMS clarified Medicare bad debt policies that have generated litigation and questions over the past years. The changes updated and put into code longstanding Medicare bad debt principles by revising Section 413.89, Bad Debts, Charity and Courtesy allowances. The following is a summary of the amended Medicare bad debt policies codified in FY 2021. Details of each issue can be found in BDO's insight article on CMS FY 2021 Medicare IPPS regulations dated October 2020.

1. **Definition of non-indigent beneficiary**
2. **Billing Timeliness**
3. **Recoveries**
4. **Collection Efforts**
5. **Indigency Determination**
6. **Accounting Standard -Topic 606**
7. **Dual Eligible Account** – Medicare beneficiaries enrolled in Medicare and who also have full Medicaid coverage are dual eligible patients. Some patients in this category have full coverage while others have partial Medicaid coverage, meaning Medicaid will pay all or a partial amount of the Medicare cost sharing. To be considered a reasonable collection effort:

- Must bill state Medicaid program to determine no other source but the patient would be responsible for the medical bill; this has long been referred to as the "must bill" policy
- The provider must provide the Medicaid remittance advice (RA) from the state Medicaid program referred to as the "RA requirement"
- The amount the state is obligated to pay will not be included as allowable Medicare bad debt. This is true regardless of whether payment was made, or an RA is provided indicating Medicaid has no obligation to pay

- If no Medicaid remittance advice is available due to state's processes not generating a Medicaid remittance advice, submit the following:
  - State's Medicaid notification it has no obligation to pay
  - Evidence of the amount the state should be responsible to pay
  - Beneficiary's Medicaid eligibility

In FY 2022, CMS is finalizing new regulations around states responsibilities in providing documentation on Medicare cost sharing for Medicare beneficiaries also enrolled in Medicaid. Medicare cost sharing is made up of the following elements:

- Medicare PT A and B premiums
- Coinsurance and deductible
- Cost incurred even if such costs are not covered by Medicaid

States are permitted to limit payment for Medicare cost sharing based on the "lesser-of" policy States would pay cost sharing up to the amount a State would pay under the State Medicaid plan. If the claim is paid under the lesser of policy, providers cannot bill beneficiaries for the remaining Amount. They are permitted to include as a Medicare bad debt if they meet the requirements of 42 CFR 413.89 Under 42 CFR 413.89, State Medicaid cost sharing responsibilities must be excluded from Medicare bad debt. In order to determine this amount the provide must bill the state and must obtain a Medicaid remittance advice (RA) that identifies the cost sharing obligations.

Under regulations, States are required to process Medicare claims to determine Medicare cost sharing even if the Medicaid State plan does not allow claims for certain providers. Some states have not allowed these certain providers to enroll if they are explicitly not included in the State plan. This has precluded providers from claiming as Medicare bad debt the allowable amount due to the absence of a Medicaid RA.

CMS is finalizing policy to clarify State obligations for processing claims for Medicare cost-sharing by outlining these responsibilities in regulations

- State Medicaid programs must accept enrollment of all Medicare-enrolled provides and supplies, even those not eligible to enroll
- Sole purpose of this enrollment is so providers can submit, adjudicate and identify cost sharing claims and provide Medicaid RA
- State Medicaid programs should be in compliance with section 455.410(d) in time to process cost sharing claims for dual eligible patients with dates of services beginning January 1, 2023
- Updates to State's systems would be eligible for a 90/10 Federal medical assistance (FMAP) percentage
- CMS reserves the right to propose enforcement penalties for non-compliance in future rule making

FY 2022 Wage Index

The IPPS labor portion of the payments are adjusted for differences in hospital's cost of labor which is known as the wage index adjustment. In updating prospective payments to hospitals, the standardized amounts need to be adjusted for differences in wage levels in a geographic area when compared to the national average hospital wage level. The wage index information utilized for FY 2022 is from cost report periods beginning in FY 2018. The occupational mix information will be from the 2019 Occupational Mix Survey. FY 2022 occupational mix adjusted national average hourly wage is $46.47.

CORE BASED STATISTICAL AREAS (CBSA)

CMS utilizes CBSA's delineations as labor markets from the Office of Management and Budget (OMB) from 2015. This information is based on 2010 census data. Based on updates from OMB Bulletin 18-04 in FY 2021 there were several new market delineations that had significant impacts on wage index in FY 2021. CMS will continue a 5 percent cap on decreases in the hospital's wage index for FY 2022 for hospitals receiving a transition wage index in 2021 due to OMB bulletin 18-04.

On March 6, 2021, bulletin 20-01 was released by the OMB providing updates to OMB 18-04 issued in September of 2018. Bulletin 20-01 provides updated information on statistical areas since September 2018 These updates will be incorporated into FY 2022 labor market areas.

CONTINUATION OF THE LOW WAGE INDEX HOSPITAL POLICY

In FY 2020, CMS adopted a policy to provide an opportunity to low wage index hospitals to increase compensation by increasing their wage index values. The goal is to decrease disparities between high wage and low wage hospitals. The policy was to be budget-neutral based on an adjustment to the standardized amounts for all hospitals. The phase- in period for this was four years to allow these increases to be reflected in the wage index calculation. This policy is to continue in FY 2022. Hospitals with a wage index value below the 25-percentile would be increased by half the difference between the final wage index value for the hospital and the 25-percentile wage index value for all hospitals. The FY 2022 25-percentile wage index value for all hospitals is .8437. The process will again be budget-neutral by applying a factor to the standardized amount. Similar to FY 2020, a 5% cap is placed on any decrease in a hospital's wage index due to any reason causing the decline so the hospital's final wage index for FY 2021 will not be less than 95% of its FY 2020 wage index value. The 5% cap on decreases was for 2021 only. CMS is extending the cap in FY 2022 for hospitals that had the transition in FY 2021.

IMPUTED RURAL FLOOR

The imputed floor was established to ensure that urban hospitals in areas with no rural areas could utilize the rural floor provision preventing urban hospital's wage index could not be lower than rural areas of the same state. This provision was allowed to expire in FY 2018. The provision was reestablished through section 9831 of the American Rescue Plan Act that Congress passed in March 2021 and continue in FY 2022.

Medical Education

Approved teaching hospitals are paid for their medical education training programs for direct costs and indirect costs as outlined below.

GRADUATE MEDICAL EDUCATION (GME)

Hospitals with an approved teaching program are paid for direct costs of GME based on the weighted number of residents and Medicare patient load (percentage of the hospital's Medicare inpatient days) in the Medicare cost reporting period and the hospital's per resident amount.

INDIRECT MEDICAL EDUCATION (IME) PAYMENT ADJUSTMENT FACTOR

Teaching hospitals receive an add on payment to their DRG payment to reimburse hospitals for the increased cost of treatment compared to non-teaching hospitals. The IME formula has a multiplier factor used to calculate the IME payment. The factor is set each year by statute. The factor has been 1.35 for discharges occurring since FY 2008. The factor for FY 2022 will continue to be 1.35. CMS estimates that by utilizing this factor for FY 2022, IPPS IME payments will increase by 5.5% for every 10% increase in a hospital's resident to bed ratio.

CHANGES TO MEDICARE TEACHING HOSPITALS PROVISIONS BASED ON THE CONSOLODATED APPROPRIATIONS ACT OF 2021

The policy will not be finalized as CMS will address this in a separate document; however, the ACT addresses the following provisions:

1. 1000 new slots-No more than 200 new slots in any fiscal year starting in 2023 over a five-year period
2. Change to determination of GME per resident amounts and FTE limits for hospitals hosting a small number of residents for a limit amount of time

Provisions of the distribution of these slots:

1. 10% or more of the spots must be made available to the following hospitals
   - Rural area hospitals or being treated as rural for IPPS
   - Hospitals over their FTE cap
   - Located in areas with new medical schools
   - Areas designated as Health Professional Shortage Areas
2. Cap of 25 additional positions per facility
3. Facilities must agree to use all slots that are distributed to the hospital

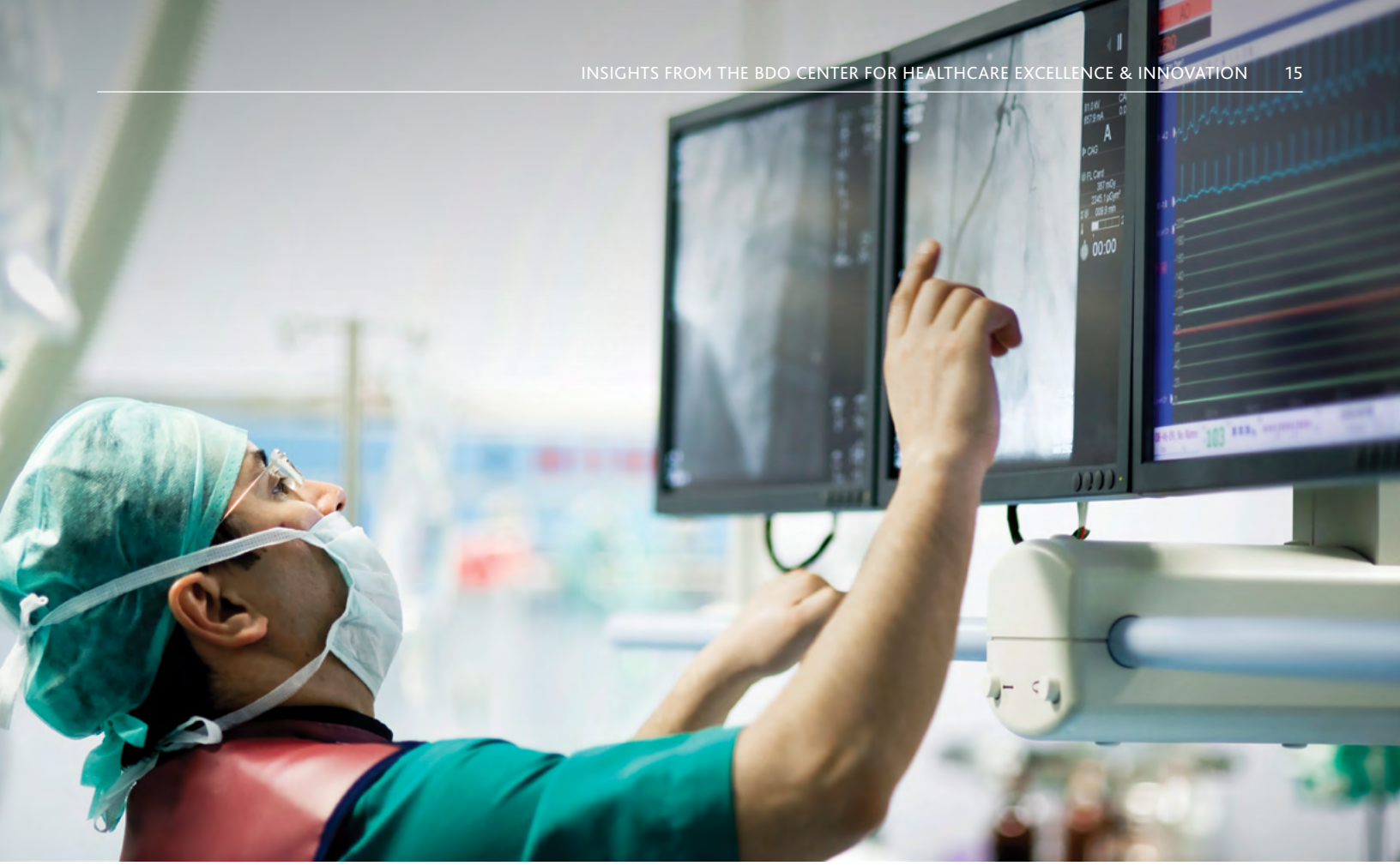
Low Volume Hospitals

Hospitals meeting certain criteria for low volume status would receive an additional payment under IPPS starting in FY 2005. When this payment was first established, a hospital had to have less than 200 total discharges and be located more than 25 road miles from the nearest hospital. The regulations were amended for FYs 2019-2022. For these FYs the hospital must have less than 3,800 total discharges and be more than 15 miles from the nearest hospital. The hospitals will receive an additional 25% payment adjustment based on the total per discharge payments including capital, DSH, IME and outlier payments for hospitals with 500 or fewer discharges and reduced based on a linear sliding scale for hospitals with more discharges with a complete elimination of this payment for hospitals with more than 3,800 discharges in a fiscal year. In FY 2023, the low-volume criteria and payment will revert to the requirements in effect prior to FY 2011. The requirement is fewer than 200 discharges and be located more than 25 miles from the nearest hospital.

Quality Star Rating Program

Under the Hospital Star rating structure, CMS reports on measures comparing hospitals and publishes this information on the Hospital Compare website. This reporting has caused issues with hospitals regarding how the data is developed. Hospitals have expressed these concerns and CMS had committed to modifications. In the CY 2021 OPPS/ASC final rule, CMS finalized the methodology to calculate Star Ratings for FY 21 and subsequent years:

- Updated calculation of ratings to a more simplified methodology such as adopting a simple average of scores instead of the variable model
- Reduce total measure groups from seven to five
- Increase comparability of star ratings by peer grouping hospitals which will reduce provider burdens, improve predictability of the star ratings and increase comparability between hospitals



Hospital Readmissions Reduction Program (HRRP)

This program reduces a hospital's Operating DRG payment for excess readmissions for certain conditions exceeding expected levels FY 2022's reduction and those of fiscal years going forward will be based on a hospital's risk adjusted readmission rates over a three-year period for the following unplanned readmissions:

- Acute myocardial infarction (AMI)
- Heart failure (HF)
- Pneumonia
- Chronic obstructive pulmonary disease (COPD)
- Elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA)
- Coronary artery bypass graft (CABG) surgery

The annual reduction is capped at 3% for a payment adjustment factor of 97. CMS estimated 2,500 hospitals will have their base operating DRG payments reduced by their FY 2022 hospital-specific payment adjustment factors. The estimated saving of this program in FY 2022 will be approximately $521 million.

Value-Based Incentive Payments Under the Hospital VBP Program

The VBP Program provides hospitals with value-based incentives based on performance measures in a respective year. The payments are funded for FY 2022 based on a reduction of 2% to the base operating DRG payment for discharges occurring for that year. The pool of money will fund incentive payments based on a hospital's Total Performance Score (TPS). The payments are budget-neutral which means the total amount available for these payments must equal the reduced payments in that year. FY 2022 available pool for VBP incentives will be approximately $1.9 billion.

Hospital Acquired Conditions (HAC) Reduction Program

The HAC program provides hospitals an incentive to reduce hospital acquired conditions. The 1% reduction applies to hospitals that rank in the worst performing quartile (25%) of all hospitals.

Hospital Inpatient Quality Reporting Program (IQR)

The IQR is a pay-for-reporting quality program. Hospitals that fail to comply with these requirements receive reduced payments. FY 2022 changes includes:

- Add 5 new measures and eliminate 3 measures
- Revise requirements of electronic file submission
- Further details at qualitynet cms gov/inpatient/iqr

Organ Procurement

NOT IMPLEMENTED IN FY 2022

Organ acquisition costs are paid for by Medicare on a reasonable cost basis and excluded from the inpatient hospital prospective diagnosis-related group (DRG) payments. The proposed rule proposes to codify existing policies and provide clarifications into Medicare regulations. Transplant hospitals (TH) receive Medicare reimbursement for organ acquisition costs, transplant surgery, inpatient and post-transplant costs for Medicare recipients through different mechanisms. Costs for transplant surgery and other follow up care are covered by DRG payments. Organ acquisition costs that are associated with transplants are paid on a reasonable cost basis. Medicare determines reimbursement for organ acquisition costs based on the ratio of Medicare usable organs to total usable organs. Other payment methodologies for certain organizations:

- Organ Procurement Organizations (OPO)-Participates in organ procurement from deceased donors-payment is based on reasonable cost principles
- Histocompatibility Laboratories-conducts lab services for compatibility between donor organs and recipients while preparing for transplants-Reimbursed for services on a reasonable cost basis

When CMS refers to organ acquisition this encompasses a human kidney, liver, heart, lung pancreas and intestine. These organ definitions will be proposed to be codified through the 2022 rule making process. Organs procured for research are not counted as a Medicare organ in Medicare's share of organ acquisition costs.

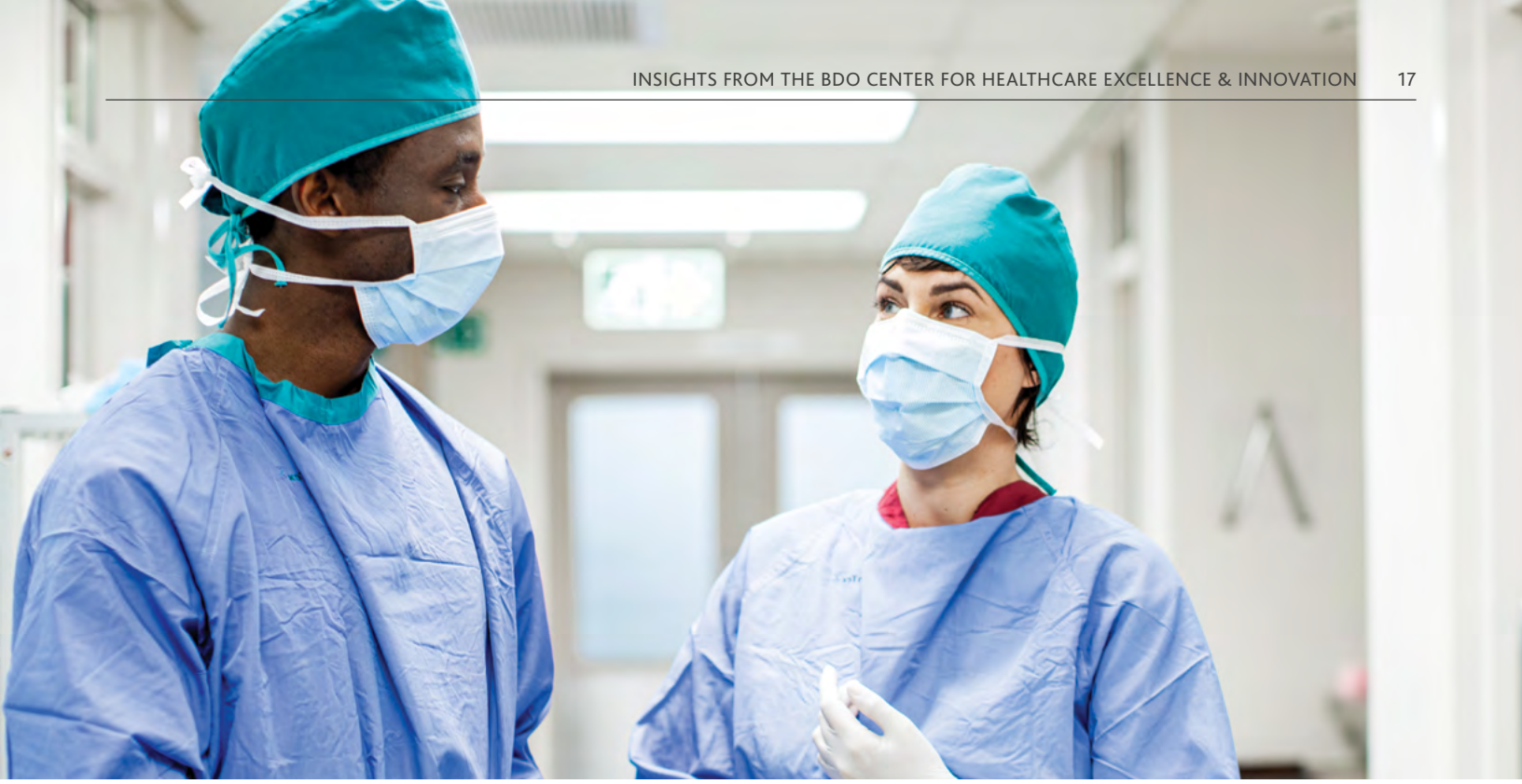
CMS is also proposing to codify that costs incurred for the acquisition of organs from a living donor or cadaveric donor by either a hospital or OPO are appropriate organ acquisition costs for reimbursement. CMS is recommending changing existing regulations identifying appropriate acquisition costs by removing the current list at section 412.100(b) and adding the following with revisions to section 413.402(b).

- Tissue typing
- Donor and recipient evaluation
- Other cost associated with excising organs, such as general routine and special care services applicable to the donor
- Preservation and perfusion costs
- Operating room and other ancillary services applicable to donor
- Surgeon's fees for excising cadaveric organs
- Transportation of excised organ
- Costs of organs acquired from other hospitals or OPOs
- Hospital costs normally classified as outpatient costs applicable to organ excisions
- Cost of services applicable to organ excisions which are rendered by residents and interns not in approved teaching programs
- Pre-admission services applicable to organ excisions including lab, and physician services

One of the reason's CMS is seeking to codify these rules as well as others not specifically outlined here is because Medicare organ policy presumes organs are procured that are suitable for transplant. This results in Medicare overpaying for organ transplants by paying for an organ that may be transplanted into non-Medicare patients. CMS is proposing to add language that says organs are deemed suitable for transplant when an OPO or TH designates it for transplant prior to the donor entering the hospital operating room for surgical excision. OPO's and TH's incur costs to procure organs whether they are suitable for transplant or not. This proposed rule will add a stipulation that OPOs and THs must account costs associated with recovered organs and unrecovered organs in separate appropriate cost centers by organ type.

CMS estimates the impact of the changes to codify the Medicare usable organ count to include only organs transplanted into Medicare beneficiaries as well as the other changes with allowable costs to be $230 million in FY 2022, $1.74 billion over 5 years and $4.150 billion over 10 years

Changes to this policy were in the proposed rules, however, they were not adopted for the final rule for 2022. They will be reconsidered in future rule making policies. Organ Procurement hospitals will need to keep this policy on their radar as they prepare their strategic plans.



LTCH PPS Payment Rates

LTCHs have been reimbursed under a structure that pays an LTCH PPS standard federal payment when the site-neutral payment criteria are met for exclusion. If the criteria for exclusion from site-neutral payments are not met, they will be paid on a site-neutral payment rate. For FY 2022 there are no changes to the exclusion criteria. These exclusions include:

- Cases do not have primary diagnosis related to psychiatric or rehab (the DRG criterion)
- Case must be preceded by a discharge from an acute care hospital which included at least a three-day stay in an intensive care unit (the ICU criterion)
- Case must be preceded by discharge from an acute care hospital and the LTCH discharge must be based on at least 96 hours of ventilator services in the LTCH (the ventilator criterion)

An LTCH will be paid the PPS standard federal rate if the DRG criterion is met and either the ICU or the ventilator criterion is met.

The changes by CMS will decrease by approximately $42 million This amount is made up of the following changes:

- LTCH standard federal payment rate increased by an estimated $31 million
- LTCH site-neutral payment rate will increase payments by $11 million

LTCH Site-Neutral Payments	$ 11 million
LTCH PPS Payments	$ 31 million
Overall LTCH Payment Decrease	**($ 42 million)**

Critical Access Hospitals (CAHS)

The Frontier Community Health Integration Project (FCHIP) demonstration allows entities to develop and test new models of care to improve access to better delivery of acute care, extended care and other healthcare services to Medicare beneficiaries without an increase in costs. This was to be budget neutral. The baseline period for the budget neutrality measurement was from Aug 1, 2016 through July 31, 2019 The program allows models of care under telehealth, skilled nursing services and ambulance services. CAHs were selected for participation with the goal of budget neutrality that will produce savings through reduced transfers and admissions to other healthcare providers. If the baseline period analysis of claims and other documents such as Medicare cost reports shows increased payments over the three-year period, CMS would recoup these expenditures by reducing payments to all CAHs. In FY 2022, based on the budget neutrality analysis, CMS has determined the budget neutrality requirement had been met. For FY 2022, CMS will not propose a budget neutrality payment offset to CAHs payments.

BDO Takeaways

Per the **2021 BDO Healthcare CFO Outlook Survey**, 52% of healthcare CFOs made faster decisions during the pandemic leading to healthcare organizations taking decisive, quick action to shape the future of their organizations and the healthcare industry.

The following six actions will be taken to shape this future:

- Increase partnerships across the healthcare ecosystem
- Accelerated digital transformation
- Increase consolidation
- Increase focus on diversified revenue streams
- Accelerate shift to value- based care
- New product service innovation

By focusing on and improving the above initiatives, healthcare organizations should be able to pivot more efficiently and focus on the changes from the FY 2022 regulations to evolve and determine strategic paths to implement new reimbursement methodologies for FY 2022 which will assist healthcare leaders concerned about government reimbursement to look at innovative ideas to reduce expenses, enhance reimbursement and improve overall margins.

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