Lone Star Chapter

FFY 2022 IPPS/CY 2022 OPPS Overview or

Everything You Thought You Didn't Want to Know or

Random Musings from Government Finance

January 21, 2022

Contents

Part I

Part II

MEMORIAL HERMANN

BaylorScott&White HEALTH

TOYON ASSOCIATES, INC.

FFY 2022 IPPS Final Rule – Correction Notice

Federal Register/ Vol. 86, No 200/Wednesday, October 20, 2021

- Errors in the Preamble
  - Typographical errors and omissions
- Errors in Regulations Text
  - Omitted revisions that were originally discussed in the preamble
- Errors in the Addendum
  - Excluded hospital that converted to a CAH (after cut-off date) – recalculation of WIF for rural Michigan
- Errors in the Appendices
  - Corrected FFY 2022 Budget Neutrality Factors
  - Updated Standardized amounts in Tables 1A, 1B, 1C (operating), and 1D (capital)

FFY 2022 IPPS Final Rule – Correction Notice

Federal Register/ Vol. 86, No 200/Wednesday, October 20, 2021

- Errors/Corrections to Files and Tables
  - Table 2 – now includes CAH that had converted after the cut-off date (1/24/21)
  - Table 3 – changes to rural Michigan Wage Index Factor
  - Table 4A – counties eligible for out-migration
  - Table 6B – new procedure codes
  - Table 6P – addition of 3 new procedure codes to table
  - Table 18 – UC DSH table is updated to reflect merger data

Part I

FFY 2022 IPPS Rate Setting

FFY 2022 Final Rule IPPS Update

Standard Rates

Net rate increase of 2.7%

CMS estimates increases of payments by $3.7 billion before $1.2 billion UC DSH decrease

market basket +2.7%

- productivity adjustment -0.7%
- Various adj – MS DRG, WI BNF, WI Reclass BNF, WI Lowest Quartile, Rural Hosp Demo, Transition BNF, Operating Outlier, MACRA +0.7%
- Labor and Non-Labor percentages at 67.6% and 32.4% respectively (in FFY 2021 the Labor was 68.3% and Non-Labor was 31.7%)

Final Rule (8/13/2021)

(For hospitals with WIF > 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 Final Labor-Related Rate	$4,138.28	$4,056.12	$4,110.89	$4,028.73	67.6%
FFY2022 Final NonLabor-Related Rate	$1,983.43	$1,944.06	$1,970.31	$1,930.93	32.4%
Net Oper IPPS Base Rate Change	2.7%				

(For hospitals with WIF <= 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 Final Labor-Related Rate	$3,795.46	$3,720.11	$3,770.34	$3,694.99	62.0%
FFY2022 Final NonLabor-Related Rate	$2,326.24	$2,280.06	$2,310.85	$2,264.67	38.0%
Net Oper IPPS Base Rate Change	2.7%				

Update Factor Components (Capital)	All
FFY2021 CN Final Capital Rate	$466.21
FFY2022 Proposed Capital Rate	$472.60
Net Cap IPPS Base Rate Change	1.37%

FY21 CN Final Fixed Loss Operating Outlier Threshold	$29,064
FY22 Fixed Loss Operating Outlier Threshold	$30,988

FFY 2022 Final Rule IPPS Update

Standard Rates

Net rate increase of 2.7%

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- Various adj – MS DRG, WI BNF, WI Reclass BNF, WI Lowest Quartile, Rural Hosp Demo, Transition BNF, Operating Outlier, MACRA +0.7%
- Labor and Non-Labor percentages at 67.6% and 32.4% respectively (in FFY 2021 the Labor was 68.3% and Non-Labor was 31.7%)

Final Rule - Correction Notice (10/20/21)

(For hospitals with WIF > 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 CN Final Labor-Related Rate	$4,138.24	$4,056.08	$4,110.85	$4,028.69	67.6%
FFY2022 CN Final NonLabor-Related Rate	$1,983.41	$1,944.04	$1,970.29	$1,930.91	32.4%
Net Oper IPPS Base Rate Change	2.7%				

(For hospitals with WIF <= 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 CN Final Labor-Related Rate	$3,795.42	$3,720.07	$3,770.30	$3,694.96	62.0%
FFY2022 CN Final NonLabor-Related Rate	$2,326.23	$2,280.04	$2,310.83	$2,264.65	38.0%
Net Oper IPPS Base Rate Change	2.7%				

Update Factor Components (Capital)	All
FFY2021 CN Final Capital Rate	$466.21
FFY2022 CN Final Capital Rate	$472.59
Net Cap IPPS Base Rate Change	1.37%

FY21 CN Final Fixed Loss Operating Outlier Threshold	$29,064
FY22 CN Final Fixed Loss Operating Outlier Threshold	$30,988

FFY 2022 Final Rule IPPS Update

Table 1a – 1c

FY 2022 FR Tables 1A-1E

TABLE 1A. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.00 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.025 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.325 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
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. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.00 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.025 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.325 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
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

TABLE 1C. FINAL RULE ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)

	Rates if Wage Index > 1		Hospital is a Meaningful EHR User and Wage Index Less Than or Equal to 1 (Update = 2.00)		Hospital is NOT a Meaningful EHR User and Wage Index Less Than or Equal to 1 (Update = 1.375)	
	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
National[1]	Not Applicable	Not Applicable	$3,795.46	$2,326.25	$3,770.34	$2,310.85

[1]For FY 2022, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

FFY 2022 Final Rule IPPS Update

Table 1a – 1c CN

FY 2022 FR Tables 1A-1E - CORRECTION NOTICE

TABLE 1A. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

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Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,138.24	$1,983.41	$4,056.08	$1,944.03	$4,110.85	$1,970.28	$4,028.70	$1,930.91

TABLE 1B. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

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Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,795.42	$2,326.23	$3,720.07	$2,280.04	$3,770.30	$2,310.83	$3,694.96	$2,264.65

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	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
National[1]	Not Applicable	Not Applicable	$3,795.42	$2,326.23	$3,770.30	$2,310.83

[1]For FY 2022, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

Program and Policy Impacts on Payments

- **National Capital Rate**

  The final FY 2022 capital rate is $472.60, a 1.37% increase over the FY 2021 rate of $466.21.

- **Outlier Threshold**

  Outlier threshold for FY 2022 of $30,988 (compared to the FY 2021 final threshold of $29,064).

- **Changes to Uncompensated Care DSH (UCC DSH)**

  CMS proposes to decrease Medicare UC DSH payments by $1.2 billion, to $7.2 billion in FFY 2022. This decrease is primarily due to estimated FFY 2022 DSH payments under the "empirical" method **- including data from the PHE - in the determination of "Factor 1".**

  In the Factor 1 calculation, CMS first determines Medicare DSH payments in the absence of UC DSH payments under the ACA (section 1886(r)(1) of the Act).

Quality-Based Reporting Programs and COVID-19

Value Based Purchasing (VBP)	As a result of the PHE, CMS has determined that there will be no net financial impact to the HVBP. **Factor will not increase nor decrease payment**
Hospital Readmissions Reduction Program	Measure suppression policy on the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization measure (NQF #0506) beginning with the FY 2023 program year; and
	Modifies the remaining five condition-specific readmission measures to exclude COVID-19 diagnosed patients from the measure denominators, beginning with the FY 2023 program year.
Hospital Acquired Condition Reduction Program	Establishes a measure suppression policy
	Suppress the third and fourth quarters of CY 2020 CDC National Healthcare Safety Network Healthcare-Associated Infection (HAI) and CMS PSI 90 data from performance calculations for the FY 2022 and FY 2023 program years.

Measurement Suppression

The FFY 2022 IPPS Final Rule is *"intended to ensure these programs do not reward or penalize hospitals based on circumstances caused by the PHE for COVID-19 that the measures were not designed to accommodate."*

New COVID-19 Treatments Add-on Payment (NCTAP)

- CMS approved 19 technologies that applied for new technology add-on payments for FY 2022.
  - CMS will also continue new technology add-on payments for 23 technologies which are currently receiving the add-on payment.
    - Ten of these remain within their newness period and for the remaining 13, CMS will use its exemptions and adjustment authority, for one year, under section 1886(d)(5)(I) of the Act due to the "unique circumstances" for FY 2022 rate setting due to the COVID-19 PHE.
  - In total there will be 42 new technologies eligible to receive add-on payments for FY 2022.
    - CMS estimates these payments to be $1.5bn, which is a 77% increase over FY 2021 spending.

Repeal of Market-Based Data Collection

Median Payer-Negotiated IP Charges for Medicare Advantage Organizations

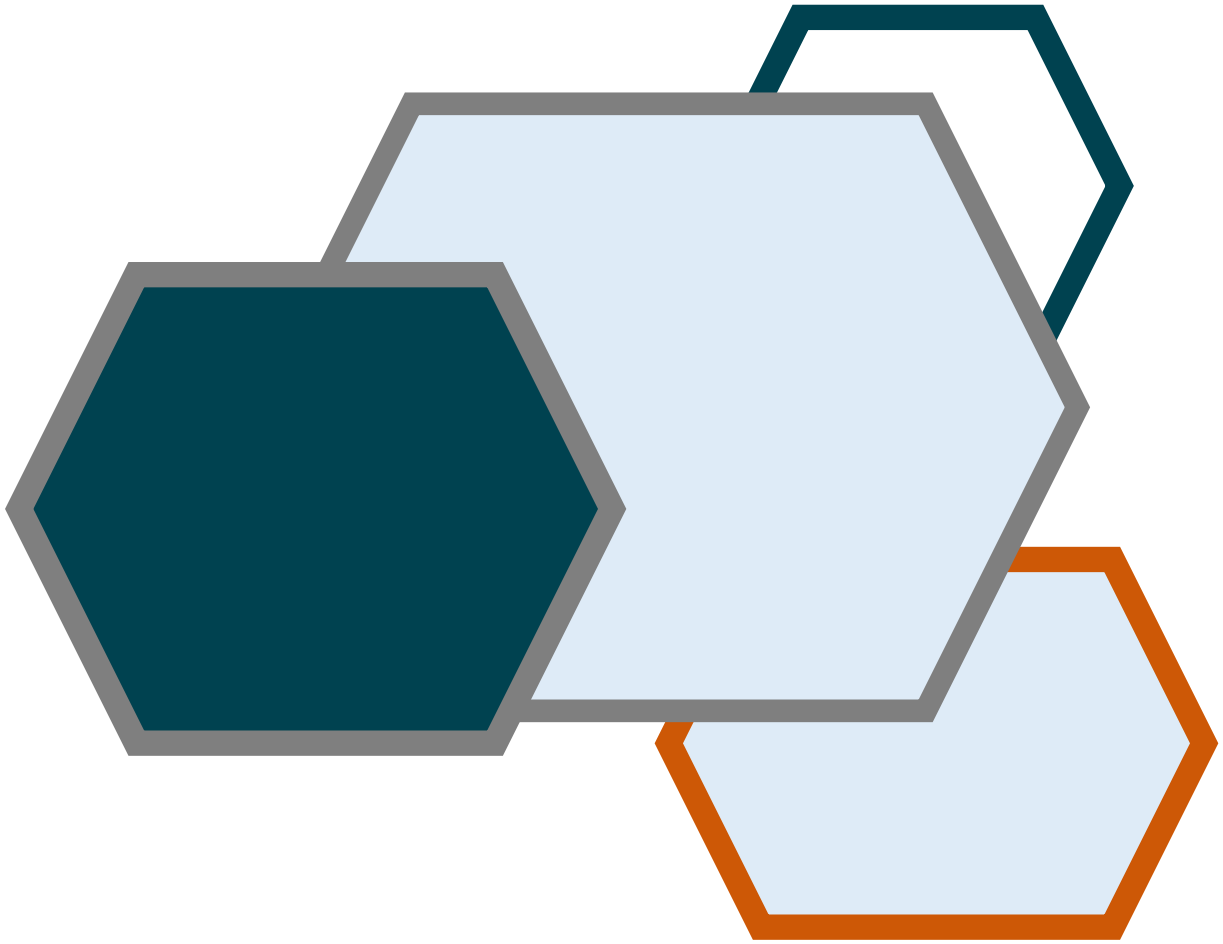
- Hospitals **do not have to report this information** (initially proposed for reporting periods ending on/after January 1, 2021)
- CMS's proposed Medicare cost report Worksheet S-12 is likely scrapped; however, hospitals still must follow price transparency regulations (https://www.cms.gov/hospital-price-transparency)

Market-Based MS-DRG Relative Weight Methodology

- Data would have set Medicare payment rates for hospitals for FFY 2024 and forward.
- CMS proposed to continue using existing rate-setting methodology for FYF 2024 and subsequent years.
- CMS is soliciting comment on alternative approaches or data sources that could be used in Medicare fee-for-service (FFS) rate setting

MS-DRG Coding Updates – FFY 2022

- MS-DRGs will use version 39 for FFY 2022
- Remapping of MS-DRGs from 166 -168 (Other Respiratory procedures) to 163 – 165 (Major Chest Procedures , No CC/MCC, CC, MCC respectively). CMS expanded the diagnosis code list for MS-DRG 951 (Other Factors Influencing Health Status).
- Tables on the CMS website under the IPPS FFY 2022 Final Rule page-code tables all start with 6
- Updates to MS DRG classifications and software page under IPPS for detail on Medicare Code Editor and DRG updates



Part I

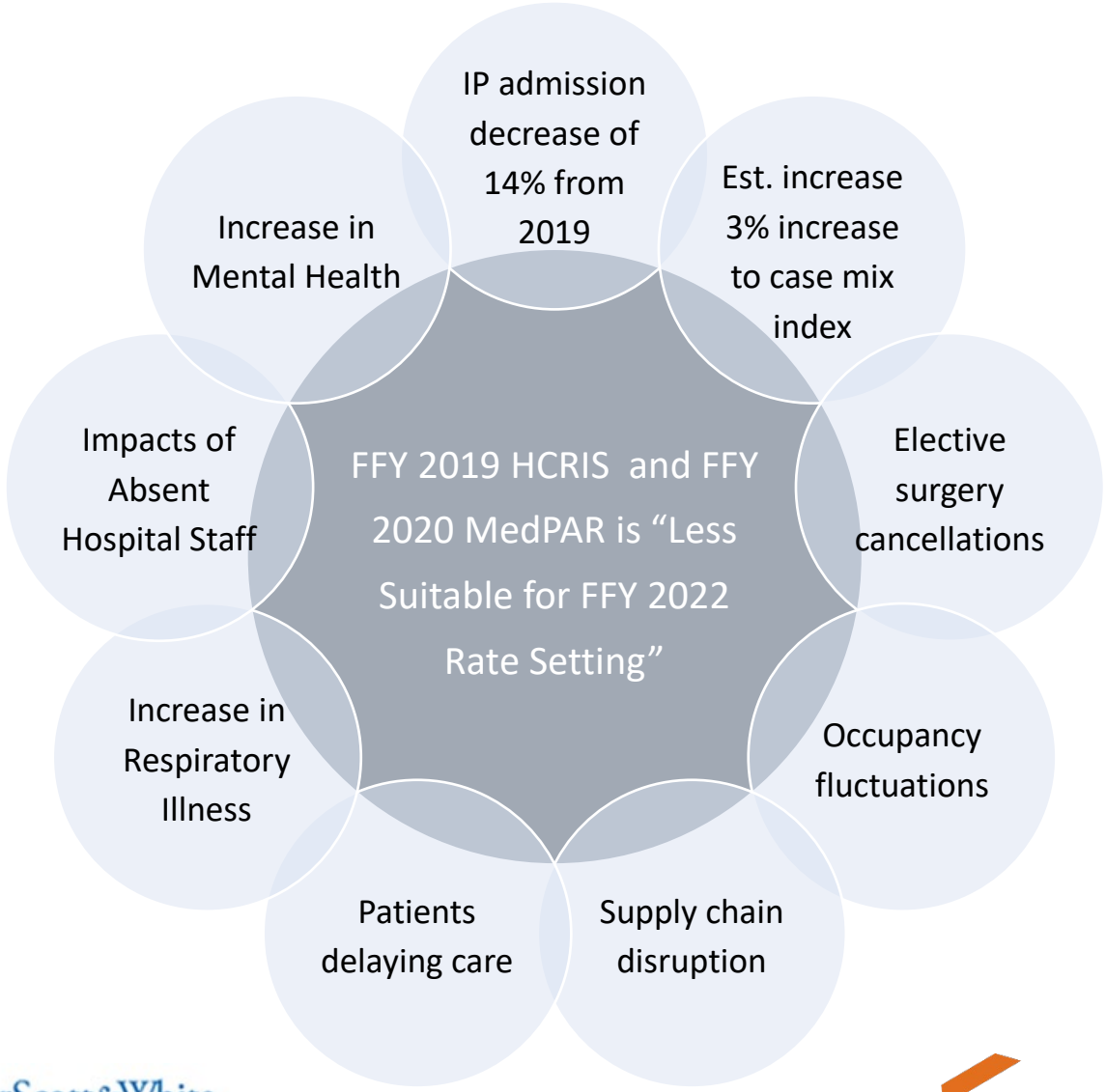
COVID-19 PHE Considerations

Rates Impact and Effects of PHE – COVID-19

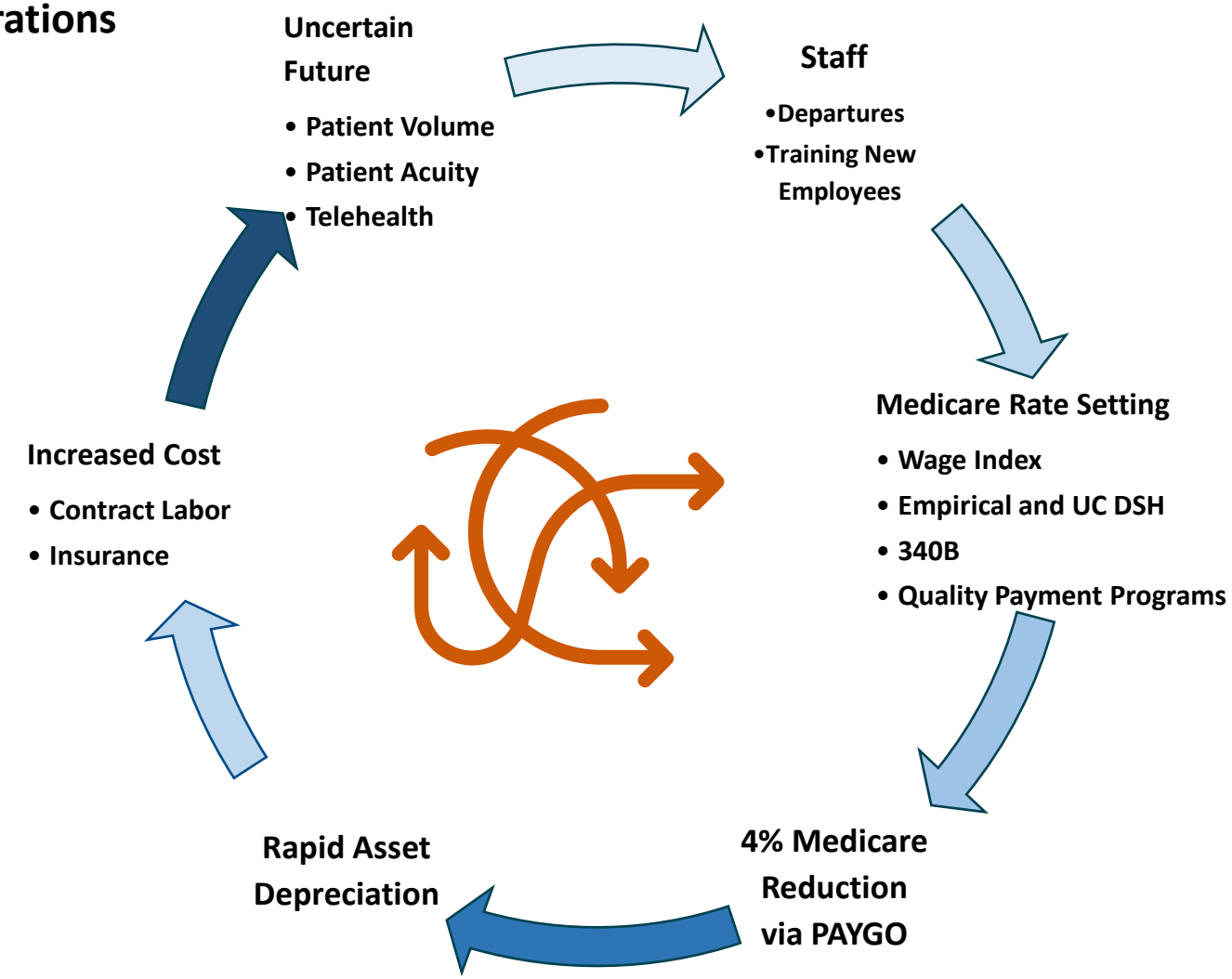
- CMS cites rates of vaccinations for projecting FFY 2022 payments and excluding data from the PHE.
- CMS' goal in rate setting - use the best available data overall. For FY 2022, ordinarily the best available full year of data to approximate the expected FY 2022 inpatient hospital utilization would be data from FY 2020.
- However, the FY 2020 data reflects changes in inpatient hospital utilization driven by the COVID-19 PHE.
- CMS as a result is using the FY 2019 data from prior to the COVID-19 PHE to approximate the expected FY 2022 inpatient hospital utilization.

COVID-19 PHE Considerations

- **CMS uses data before the PHE - FFY 2018 HCRIS and FFY 2019 MedPAR - for rate setting and projecting FFY 2022 Medicare IPPS payments**
- CMS notes the effects of COVID-19 are not expected to continue into FFY 2022 (per a CDC study on vaccinations)
- In the FFY 2022 IPPS Proposed Rule, CMS provided alternative data with FFY 2019 and FFY 2020 MedPAR to assess data pre and post COVID-19



COVID-19 PHE Considerations



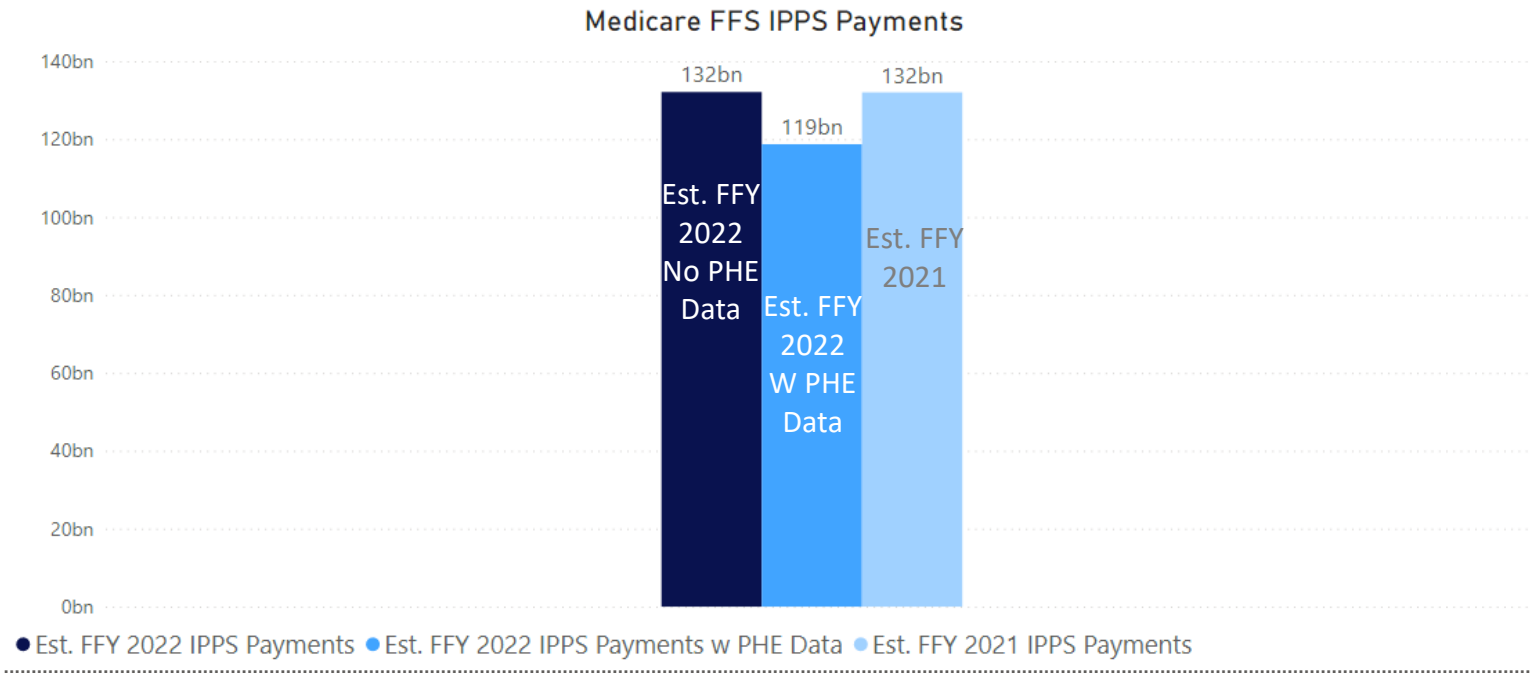
Part I

FFY 2022 IPPS Payment Breakdown

FFY 2022 Final Rule IPPS Update

National Payments with and without PHE Data

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE
8927011	7662031	1.65	1.70



Impact of COVID-19 is -$13 Billion (-10%) to Medicare IPPS Payments

*Estimated from the Medicare DRG Impact file for FFY 2022 IPPS Proposed and Final Rules**

FFY 2022 FR DATA: MARCH 2020 UPDATE OF FY 2019 MEDPAR, MARCH 2020 UPDATES OF PROVIDER SPECIFIC FILE (PSF) UNLESS INDICATED OTHERWISE, FY2017/FY2018 COST REPORT DATA

FFY 2022 ALT PR DATA: DECEMBER 2020 UPDATE OF FY 2020 MEDPAR, DECEMBER 2020 UPDATES OF PROVIDER SPECIFIC FILE, FY2017/FY2018 COST REPORT DATA

MEMORIAL HERMANN

BaylorScott&White HEALTH

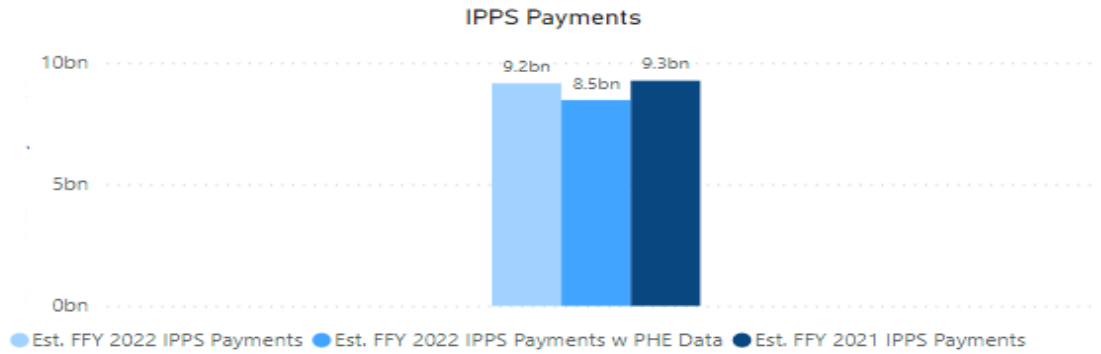
TOYON ASSOCIATES, INC.

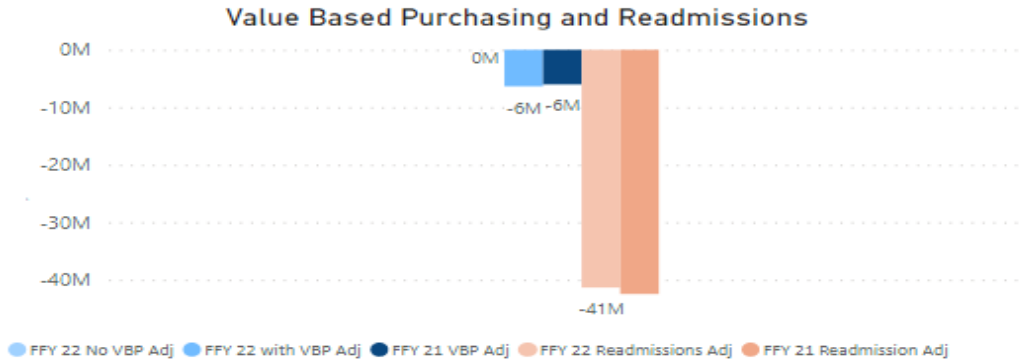
Breakdown of Payments in Texas

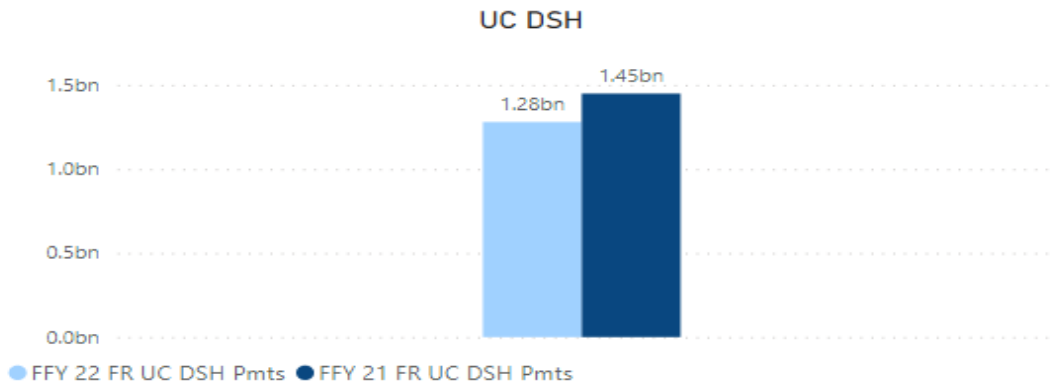
CBSA: All

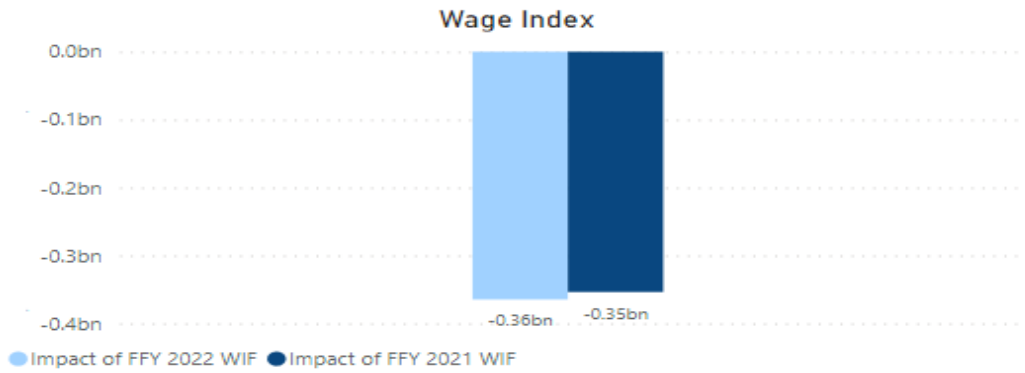
State: TX

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	FFY 21 MCR Discharges	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE	Average of FFY 21 CMI
616701	535696	616701	1.74	1.78	1.74





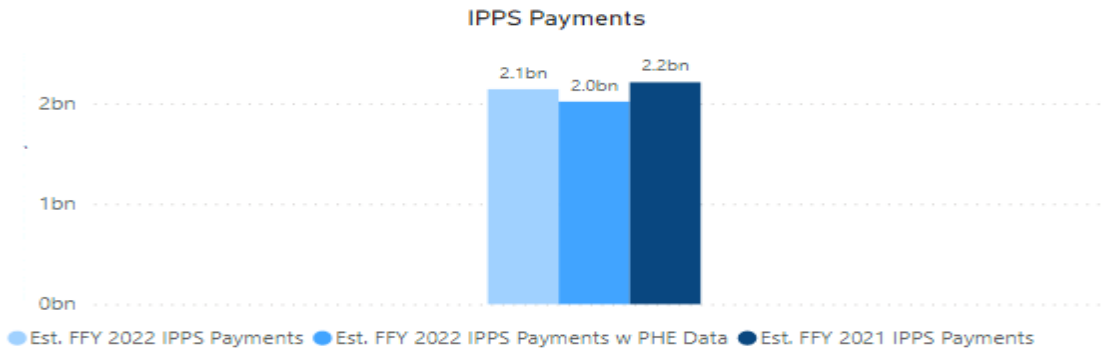


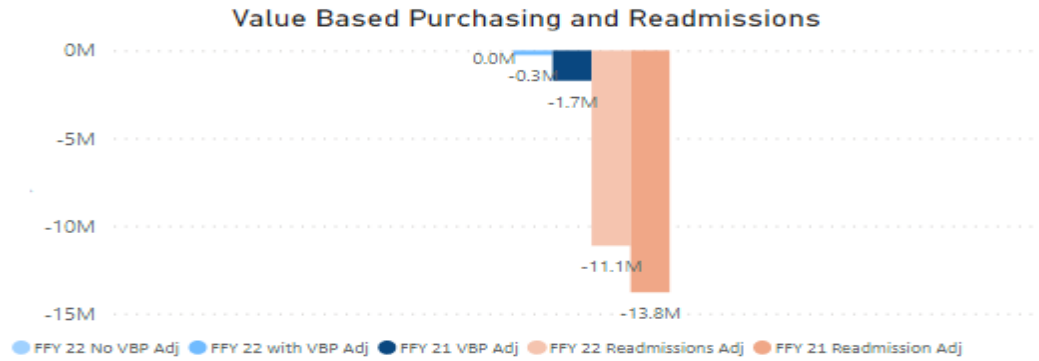


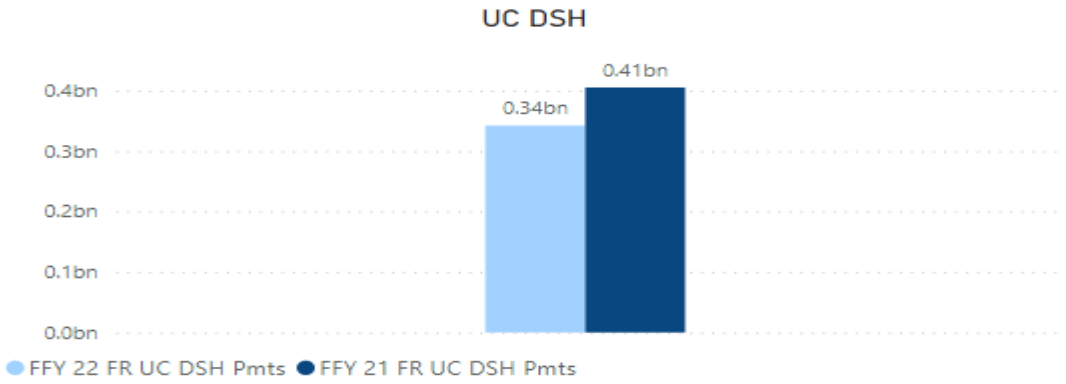
Breakdown of Payments in the Houston Area

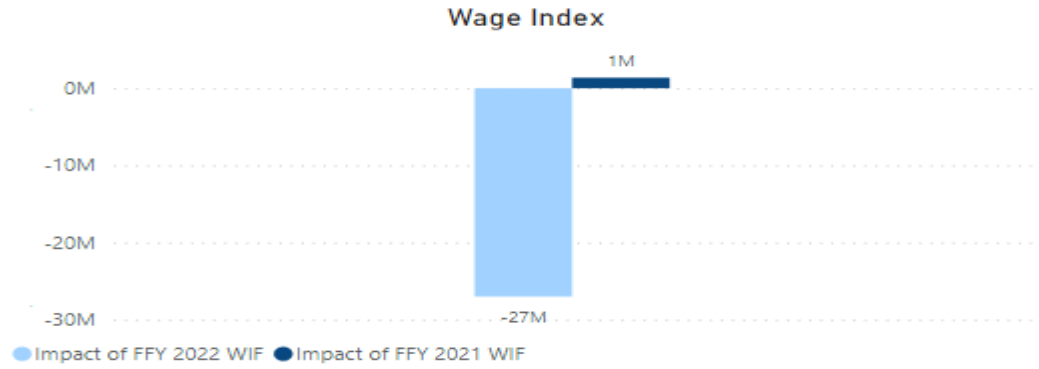
Houston-The Woodlands-Sugar Land, ... | TX

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	FFY 21 MCR Discharges	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE	Average of FFY 21 CMI
123295	109873	123295	1.80	1.87	1.80





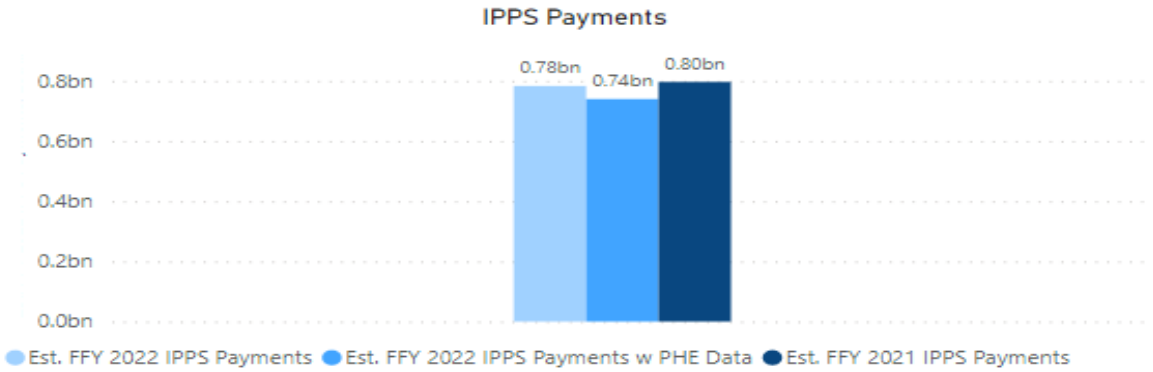


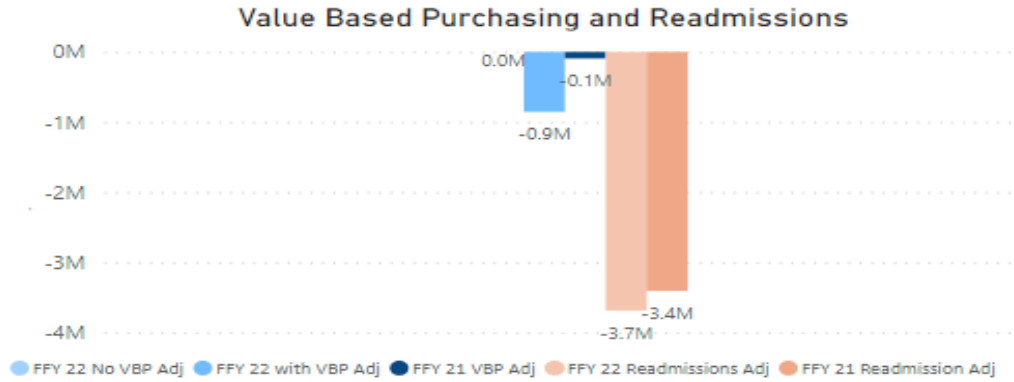


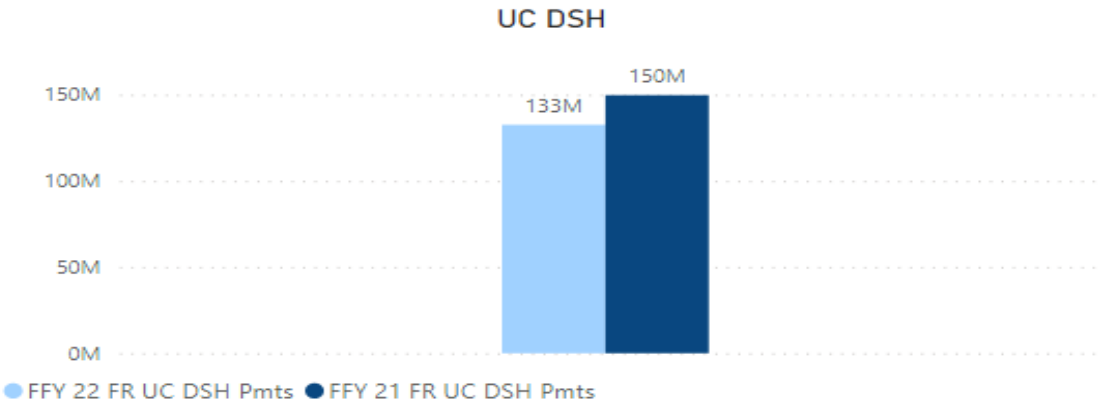
Breakdown of Payments in the Fort Worth Area

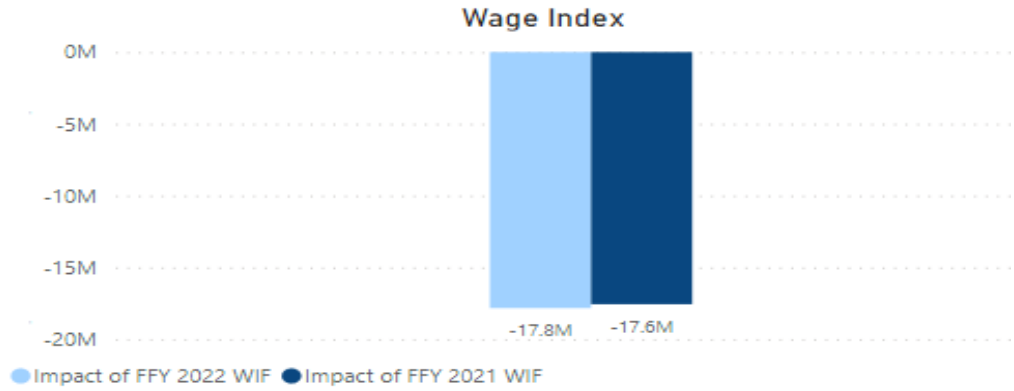
Fort Worth-Arlington-Grapevine, TX | TX

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	FFY 21 MCR Discharges	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE	Average of FFY 21 CMI
52939	48133	52939	1.90	1.86	1.90







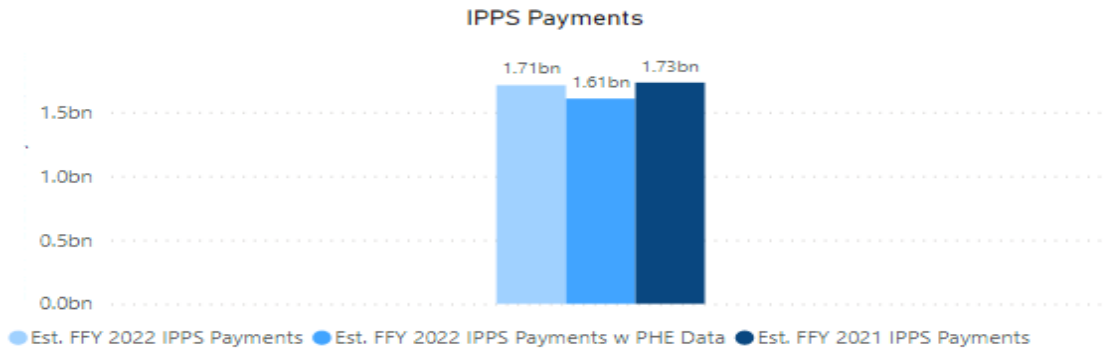


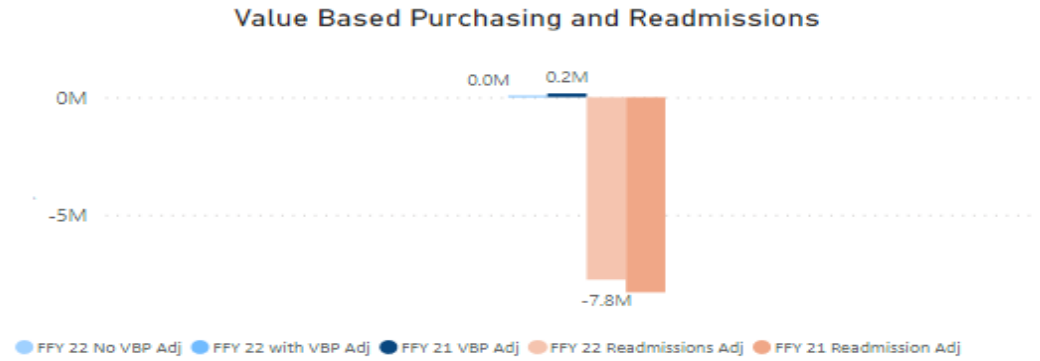
Breakdown of Payments in the Dallas Area

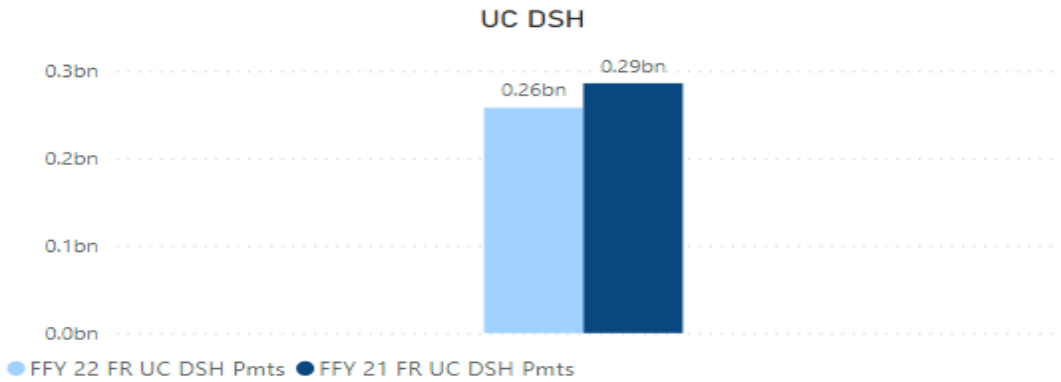
Dallas-Plano-Irving, TX

TX

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	FFY 21 MCR Discharges	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE	Average of FFY 21 CMI
104871	90822	104871	1.98	1.96	1.98



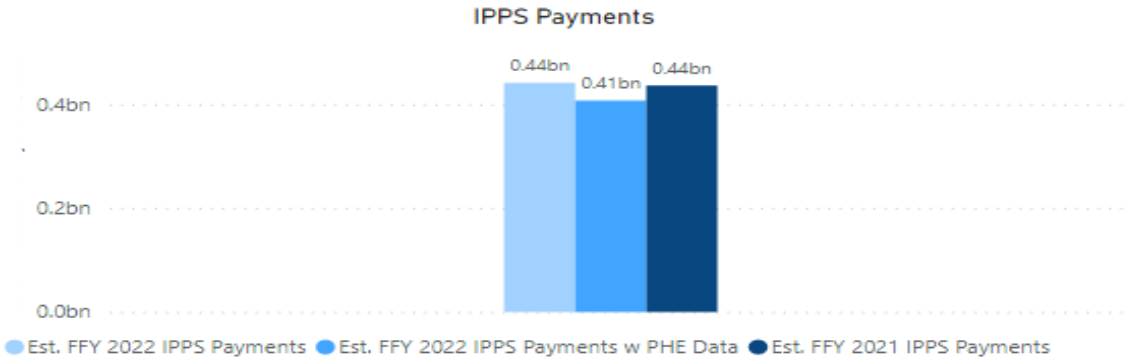


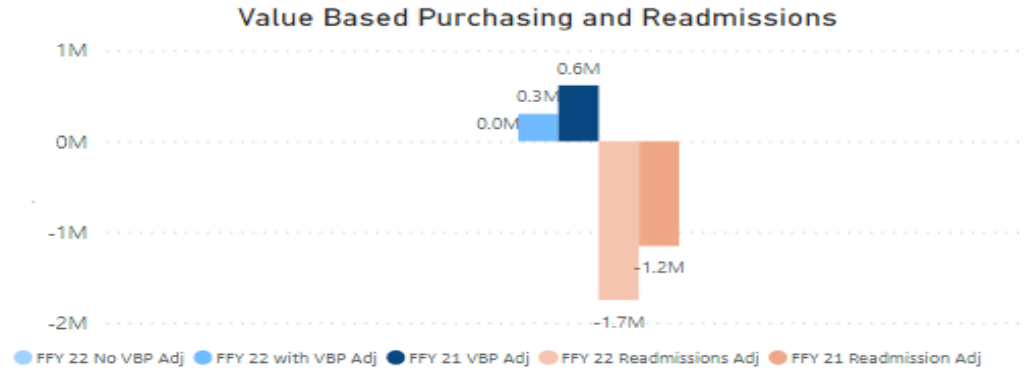


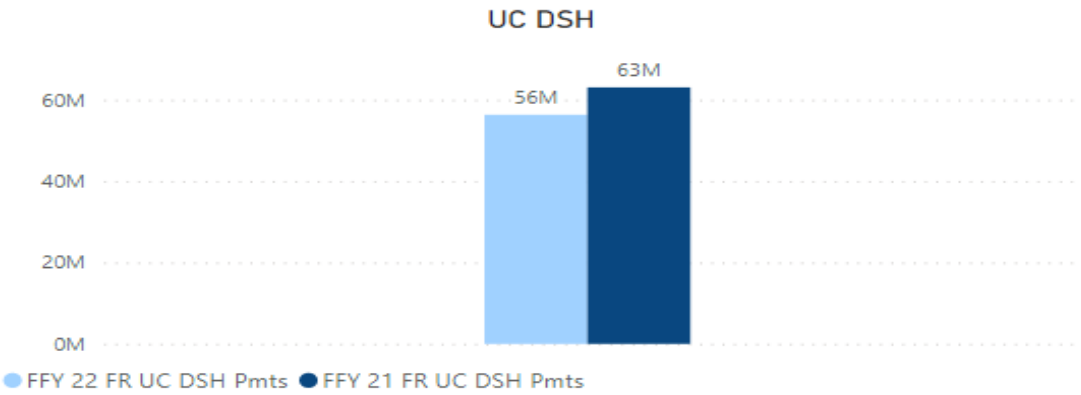
Breakdown of Payments in Rural Texas

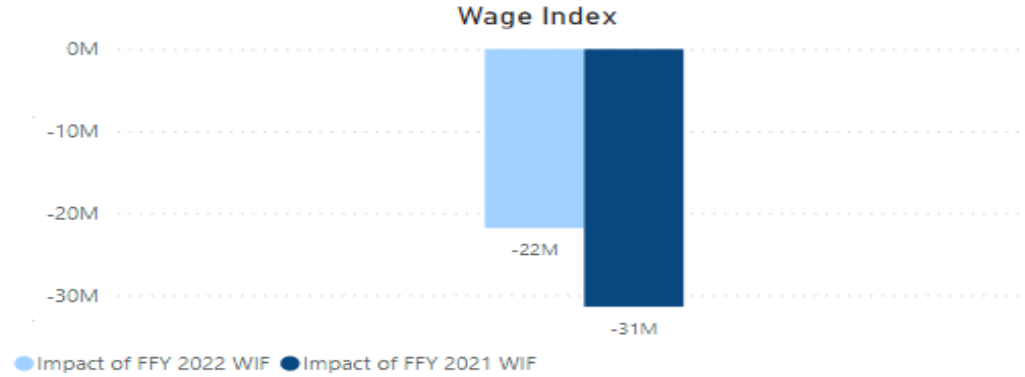
TEXAS | TX

FFY 22 MCR Discharges No PHE	FFY 22 MCR Discharges w PHE	FFY 21 MCR Discharges	Average of FFY 22 CMI No PHE	Average of FFY 22 CMI w PHE	Average of FFY 21 CMI
39487	33970	39487	1.28	1.37	1.28









Part I

FFY 2022

LTCH Payment Breakdown

LTCH Changes for FFY 2022

- 2.2% Market basket update (LTCHs that DO NOT SUBMIT quality data receive base rate less 2%)
- FFY 2022 standard federal rate = $44,713.67 ($43,755.34 in FFY 2021)
- FFY 2022 Labor-related share of payment 67.9% (decrease from FFY 2021 when it was 68.1%)
- FFY 2022 Outlier fixed loss threshold $33,015 ($30,515 for FFY 2021)
- FFY 2022 site-neutral fixed loss threshold $30,988 from $29,051 for FFY 2021

*https://www.govinfo.gov/content/pkg/FR-2020-11-10/pdf/FR-2020-11-10.pdf

Part I

FFY 2022

OPPS Summary

OPPS Update

- July 19, 2021, CY 2022 OPPS Proposed Rule is released; November 2, 2021, Final Rule published
- CMS proposed to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.3 percent. **Final 2.0 (2.7 MB less 0.7 productivity)**
- CMS is also updating the ASC rates for CY 2022 by 2.3 percent. The proposed update applies to ASCs meeting relevant quality reporting requirements. **Final 2.0 (2.7 MB less 0.7 productivity)**
  - These changes are based on the projected hospital market basket increase of 2.5 percent with a 0.2 percentage point productivity adjustment.

OPPS Update (cont'd)
Price Transparency Rule Modifications

- Proposed Increase in Civil Monetary Penalties (CMP); **held in Final**
  - Scaled by bed size (range $109,500 to $2,007,500 per hospital)
  - 30 or less beds; Fine = $300 per day
  - 31-550 beds; Fine = $310 to $5500 per day (maximum penalty $2,007,500)
  - 551 or greater beds; Fine = $2,007,500 per hospital
- Proposing to Deem State Forensic Hospitals as Having Met Requirements; **held in Final**
- Proposing to Prohibit Additional Specific Barriers to Access to the Machine-Readable File; **addressed by directing to webstandards.hhs.gov**
- Clarifications and Seeking Comment for future rule making:
  - Considerations for 'best practice' online price estimator tools;
  - Improving expectations related to 'plain language' descriptions of shoppable services;
  - Methods to identify and highlight exemplar hospitals; and
  - Improving standardization of the machine-readable files.

OPPS Update (cont'd)

- Outlier Threshold
  - 15% increase to $6,100 from $5,300; **final $6,175**
- Inpatient Only (IPO) List; **CMS to continue to refine**
  - Reinstated the IPO List, CY 2021 IPO List was to be phased-out over a 3 year period
  - Just under 300 muscoskeletal procedures were removed in CY 2021
  - These procedures were added back for CY 2022
  - CMS also reinstated 2 year RAC exemption for procedures removed from IPO list
- 340B purchased drugs will continue to remain at ASP less 22.5% (JG Modifier claims)
- Excepted and Non-Excepted Clinic Visits –
  - hospitals will continue to receive 40% of OPPS payments at off-campus PBDs; **held in Final**

OPPS Update (cont'd)

- CY 2022 Telehealth
- Temporary Telehealth Codes (Category 3)
  - Retained through end of CY 2023 due to PHE COVID-19
  - Observation CPTs 99217, 99224-99226
  - Discharge Day CPTs 99315-99316
  - Established Patient Home Visit CPTs 99349-99350
- Mental Health Services
  - Must present an in-person visit within 6 months date of telehealth service
  - Home of patient is permissible site for evaluation, diagnosis, and treatment
  - Audio-only may be approved

Part II

Medicare Disproportionate Share (DSH) Uncompensated Care and Empirical Payments

FFY 2022 IPPS Final Rule

Medicare UC DSH Payments and UC Cost

Trend of UC DSH Payments and UC Cost (UCC)

Hospitals are reporting more UCC while the UC DSH fund is decreasing

Final FFY 2020	Final FFY 2021	Final FFY 2022
National Fund: $8.4bn	National Fund: $8.3bn	National Fund: $7.1bn
FFY 2015 UCC: $33.0bn	FFY 2017 UCC: $35.6bn	FFY 2018 UCC: $37.0bn
25% Reimbursement	25% Reimbursement	21% Reimbursement

- The $1.2 billion decrease from FY 2021 to FFY 2022 is primarily due the “Factor 1” step of DSH payments
- FFY 2022 national funding is adjusted by data from the PHE (notably discharges and Medicaid enrollment)

FFY 2022 IPPS Final Rule

UC DSH Pool

Uncompensated Care Factors	Final FFY 2022	Proposed FFY 2022	FFY 2021	FFY 2020
Base Year Empirical DSH (Before Update Factors)	$13,882,000,000	$13,931,000,000	$14,000,400,000	$13,981,000,000
Projected DSH Payments (After Update Factors)	$13,984,752,729	$14,097,825,122	$15,170,673,476	$16,583,455,657
FYI - Impact of Updates ($)	*$102,752,729*	*$166,825,122*	*$1,170,273,476*	*$2,602,455,657*
FYI - Impact of Updates (%)	*0.74%*	*1.20%*	*8.36%*	*18.61%*
Projected DSH Payments (After Updates)	$13,984,752,729	$14,097,825,122	$15,170,673,476	$16,583,455,657
75% of Available UC DSH Funds	75.00%	75.00%	75.00%	75.00%
Gross Uncompensated Care Pool (**Factor 1**)	$10,488,564,547	$10,573,368,842	$11,378,005,107	$12,437,591,743
Uninsured Population Reduction (**Factor 2**)	68.57%	72.14%	72.86%	67.14%
Adjusted UC Pool Available	**$7,192,008,710**	**$7,627,628,282**	**$8,290,014,521**	**$8,350,599,096**
Change from Prior Year ($)	*($1,098,005,811)*	*($662,386,239)*	*($60,584,575)*	*$77,726,649*
Change from Prior Year (%)	*-13.24%*	*-7.99%*	*-0.73%*	*0.94%*

FFY 2022 IPPS Final Rule

Medicare DSH Uncompensated Care – New Changes

Interim Payments

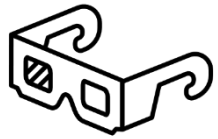
- Due to the PHE, CMS proposes to distribute interim UC DSH payments based on Medicare discharges from two years of data (FFY 2018 and FFY 2019), as opposed to three years (FFY 2018, FFY 2019 and FFY 2020)

New S-10 Trims

- CMS also proposes new trims to exclude rare cases hospitals do not have audited FFY 2018 Worksheet S-10 data and are not currently projected to be DSH eligible

Medicare UC DSH Payments and UC Cost

Looking Ahead



FY 2023 UC DSH Payments

Audit of FFY 2019 UCC underway with December 31, 2021 Deadline

Some FFY 2019 UC cost data under audit for FFY 2023 is impacted by the PHE data, i.e., for FYE 6/30/2020 hospitals.

FFY 2023 and Beyond

Evaluation of UC Cost Data in HCRIS for impact of PHE COVID-19 data in UC DSH payments.

FFY 2022 IPPS Final Rule

UC DSH Update Factors

	A	B	C	D	E	F= B*C*D*E	
FFY	Base Year Amt	Update	Discharges	Case-Mix	Other	Total	Est DSH Pmts (bns)
FFY 2022 IPPS Final Rule:							
2018	13.882						
2019		1.0185	0.9700	1.0090	1.0176	1.0144	14.0820
2020		1.0310	0.8570	1.0380	0.9912	0.9091	13.8010
2021		1.0290	1.0130	1.0290	0.9662	1.0364	13.2670
2022		1.0250	1.0590	0.9675	1.0038	1.0541	13.9850
FFY 2021 IPPS Final Rule:							
2017	14.004						
2018		1.0181	0.9830	1.0180	1.0336	1.0530	14.7470
2019		1.0185	0.9660	1.0090	1.0204	1.0129	14.9370
2020		1.0131	0.8910	1.0390	1.0196	0.9731	14.5360
2021		1.0290	1.0360	0.9830	0.9960	1.0437	15.1710
Variance: FFY 2022 IPPS Final Rule vs. FFY 2021 Final Rule:							
2017	(0.12)						
2019		0.0000	0.0040	0.0000	(0.0028)	0.0015	(0.8550)
2020		0.0179	(0.0340)	(0.0010)	(0.0284)	(0.0640)	(0.7350)
2021		0.0000	(0.0230)	0.0460	(0.0298)	(0.0073)	(1.9040)

Draft Proposed Transmittal 17

New S-10 Cost Report Instructions and Clarifications

- CMS proposed new (Transmittal 17) Worksheet S-10 reporting instructions and clarifications in the November 10, 2020 Federal Register (85 FR 71653)*
- Notable proposed changes to worksheet S-10 UC cost are discussed in further detail on Toyon's website at:
  - https://www.toyonassociates.com/2021/03/18/uncompensated-care-dsh/
    - This article was used as part of Toyon's contribution to the American Health Lawyers 2021 Institute on Medicare and Medicaid Payment issues
- In the FFY 2022 IPPS Final Rule, CMS thanks stakeholders for their comments on the PRA package and states the Agency will respond to industry comments in a separate Federal Register document.
- It is likely Transmittal 17 instructions will be reissued for comment in the near future.

*https://www.govinfo.gov/content/pkg/FR-2020-11-10/pdf/FR-2020-11-10.pdf

Draft Proposed Transmittal 17

New S-10 Cost Report Instructions and Clarifications

Federal Register Volume 85, Number 218 - Tuesday November 10, 2020
CMS-2552-10 Transmittal 17.

1 Clarification of Uninsured Accounts

CMS allows reporting of "charges for insured patients that were determined uninsured for the entire hospital stay…and amounts represent(ing) the insured patient's liability for medically necessary hospital services…"

2 Medically Necessary Services

CMS proposes Charity is…*"from a hospital's policy to provide all or a portion of* ***medically necessary*** *health care services free of charge to patients who meet the hospital's charity care policy or FAP…"*

3 Shift to Acute Care Costs Only

CMS Proposes UC Costs to exclude UC costs from subacute settings…*"Do not include charges for services provided by any other part of the hospital complex, e.g., psychiatric unit, SNF, HHA, ESRD, etc."*

4 CARES HRSA Uninsured Program

CMS references CARES PRF T&Cs for Worksheet S-10 Reporting that "*Hospitals that received HRSA Uninsured PRF payments…must not include the patient charges for those services..*"

5 Inferred Patient Discount

CMS instructs providers to Report Charges from patients *"with coverage from an entity/insurer that does not have a contractual or inferred contractual relationship"*

…inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient)…

6 Proposed DSH Listing Formats (and MCR BD)

CMS proposes exhaustive listing formats for cost report submission, departing from existing industry standards used for audit. Prior comments to CMS recommended to omit or strongly change these formats.

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Draft Proposed Transmittal 17 CMS Proposed UC Cost Report Exhibits*

Existing Audit Templates	Industry already adapted and established queries to the templates from prior year (e.g., CMS Attachment E)
Snap-Shot in Time	The results of these [comprehensive] exhibits may change during the time of audit. Is it necessary to produce so much information at cost report filing?
Write-Off Dates	The write-off date request may not cover accounts that have many transactions and write-off dates spanning across multiple years
Bad Debt Calculation	CMS requests hospitals compute bad debt by adjudicating the account**, as opposed to reporting the actual bad debt write-off determined by the hospital and existing query(s)
Bad Debt Recoveries	There is no explicit area for collection of bad debt recoveries

*Charity care and bad debt exhibits (Exhibits 3B and 3C) are proposed as the standard for submitting UC data with the Medicare cost report (cost reports on/after October 1, 2020)

** Hospitals calculate a physician ratio using charges. Next apply the ratio to total payments, discounts and allowances. This is subtracted from hospital charges to arrive at the bad debt amount

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BaylorScott&White HEALTH

TOYON ASSOCIATES, INC.

S-10 Audit Observations

*Audit efficiency requires the use of standard templates.

1 **Fixing Systematic Issues**
MACs provided hospitals opportunity to resubmit data if systematic reporting issues were identified

2 **Sampling Variation**
Some MACs request hundreds of accounts, while others requested "pilot" samples to determine if further testing is needed

3 **Timing Variation***
Some audits lingered into December and January, leaving providers little time to provide support

4 **S-10 and Concurrent Audits***
The S-10 audits for every DSH hospital are new, and are not always aligned with the timing of other audits (wage index)

5 **Rapid Audit Pace During COVID-19**
FFY 2019 audit request shortly after FFY 2018 concluded, and hospitals continue to deal with COVID-19

6 **Hospital and Audit Teams**
Audit teams and hospital teams change, causing redundancies in the process

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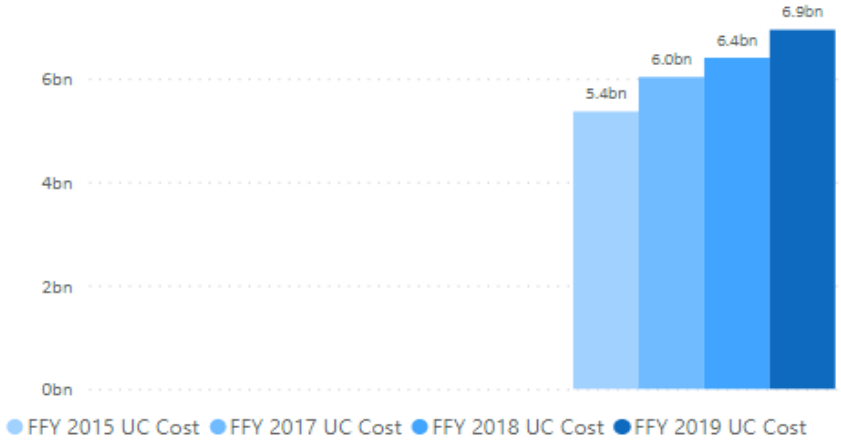
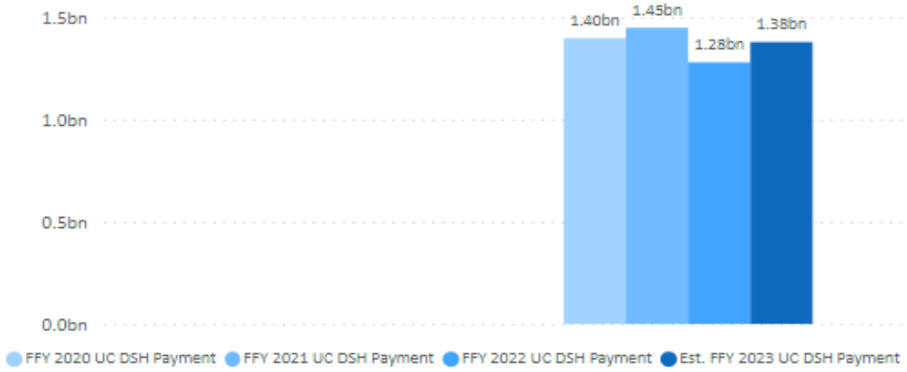
UC DSH Trend Analysis: Texas

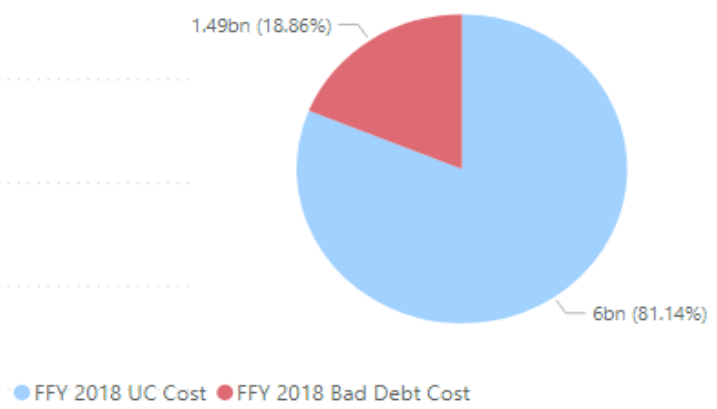
I. UC Cost Trend FFY 2015 Through Filed FFY 2019



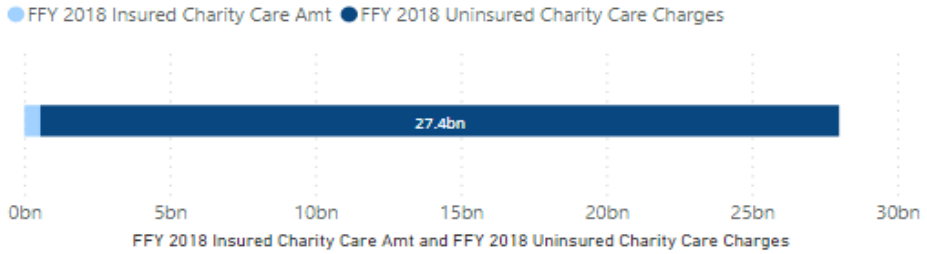
II. UC DSH Payment Trend FFY 2020 Through Est. FFY 2023



III. Relationship of CC and BD from FFY 2018



IV. Insured CC % ot Total CC from FFY 2018



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Empirical DSH Section 1115 Waiver Days

Medicaid Fraction

- (numerator): inpatient days eligible for Medicaid, but not entitled to benefits under Medicare Part A, divided by (denominator) the hospital's total number of inpatient days in the same period
- Medicaid represents patients eligible for inpatient services under a Title XIX state approved plan

Section 1115 Waiver Days

- Patients under an approved Section 1115 Waiver plan can be claimed in the numerator of the Medicaid fraction
- Section 1115 days can only be claimed if the patient directly received inpatient hospital insurance coverage on that day under an approved waiver
- Section 1115 days can not be included if the hospital received payment from an uncompensated care pool

Recommendation

- Hospitals need to document and be prepared to support that the patient received inpatient insurance coverage during audit
- Expect the MAC to scrutinize these days. When presenting the DSH patient listing for the audit, this patient population should be separated on their own tab to reduce audit risk

Part II

Wage Index Update

Wage Index Changes – Prior Year Policy Changes Refresher

Continuation of Prior Year Wage Index Policies

- Bottom Quartile Wage Index Increase – From FFY 2020
  - Continuation of increase to bottom quartile wage indexes (less than 0.8418 as proposed) through budget neutrality adjustment of 0.998108
- Statewide Rural Floor Calculation – From FFY 2020
  - Statewide rural floor wage indexes are calculated without the inclusion of "Section 401" hospitals, i.e., urban hospitals that are redesignated in the rural area for wage index purposes
- Changes to CBSA Designations per OMB Update – From FFY 2021
  - OMB Bulletin 18-04 revised certain CBSA designation – Urban counties became rural counties, rural counties became urban counties, and existing CBSAs split into new CBSAs
  - Notably impacting hospitals in Central New Jersey
- Transition Policy – From FFYs 2020 and 2021
  - In both years, CMS applied a "transition" policy which limited wage index decreases to no more than 5% from the prior year
    - Applied budget neutral to the standardized rates – 0.998851
  - Transition policy NOT applied in FFY 2022 but mentioned by CMS for public comment

Wage Index Changes – Rural Redesignations

Reincarnation of Imputed Floor in "All-Urban" States

- Permanent reinstatement of the imputed rural floor in "All-Urban" States required by Section 9831 of the American Rescue Plan of 2021
  - Methodology consistent with last iteration of the imputed rural floor in FFY 2018 with exception of budget neutrality – Not applied budget neutral
  - "All-Urban" States include New Jersey, Delaware, Rhode Island, Washington D.C. and Connecticut

FFY 2022 Proposed Rule Imputed Floors		
CBSA #	**State**	**Imputed Wage Index Floor**
07	Connecticut	1.2029
08	Delaware	1.0714
09	Washington DC	1.1130
31	New Jersey	1.1542
40	Puerto Rico	0.3453
41	Rhode Island	1.1295

Wage Index Changes – Rural Redesignations

Cancellation of Rural Status

- CMS proposing a change to the timing of a hospital's request to cancel a previously granted reclassification from urban to rural under 42 CFR § 412.103
  - First, CMS proposes that requests to cancel rural reclassification be submitted to the CMS Regional Office *no earlier than one calendar day after the date when the reclassification became effective* – This is a new requirement
  - Second, CMS proposes to replace an existing rule, which requires cancellations no later than 120 days prior to the end of the Federal Year (September 30th) to be effective at the beginning of the next Federal Year (October 1st), with a requirement that cancellation requests become effective in the Federal Year that begins in the Calendar Year after the Calendar Year when the request was submitted

Case Study:

- FYE December 31st Hospital A became a rural hospital on September 1, 2020 and wants to cancel its rural status as soon as possible
- Under the current rule, hospital would request cancellation no later than June 1, 2021 to be effective October 1, 2021
- Under the proposed rule, the hospital's request to cancel rural status on June 1, 2021 would not be effective until October 1, 2022, thus resulting in the hospital maintaining rural status for an additional 12 months

Wage Index Changes – Rural Redesignations

Rural Hospitals treated as Rural for MGCRB Reclassifications

Medicare Geographic Reclassifications

An interim final rule (CMS-1762-IFC) released simultaneously with the proposed rule revises regulations* to allow hospitals with a rural redesignation to reclassify with the MGCRB using the rural reclassified area as the geographic area in which the hospital is located beginning with FFY 2023 reclassifications

Observation #1

This confirms a rural redesignated hospital can use the Statewide rural area for purposes of the "106% average hourly wage test" required for rural hospitals in comparison of its 3-year average hourly wage

Observation #2

"The 106% average hourly wage test" is not applicable for hospitals designed as rural referral centers, however this change may affect the ability for rural referral centers to reclassify to the nearest CBSA

*42 CFR § 412.230

FFY 2022 IPPS Final Rule

Wage Index Changes – Proposed WIF Variations

Top 10 Increases in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Proposed Rule*	Change from FFY 2021 WIF	Observation
1	Ithaca, NY	1.0714	0.1318	1 hospital controls CBSA
2	Bloomsburg-Berwick, PA	0.9664	0.1124	CBSA wages driven primarily by 1 hospital
3	Panama City, FL	0.8883	0.0697	Only 2 hospitals in CBSA
4	Lewiston, ID-WA	0.8491	0.0652	Only 1 hospital in CBSA
5	Elmira, NY	0.9471	0.0725	Only 1 hospital in CBSA
6	Rural Pennsylvania	0.8592	0.0643	Rural redesignations – Not impacting rural floor
7	Eau Claire, WI	1.0212	0.0737	CBSA wages driven primarily by 2 hospitals
8	Athens-Clarke County, GA	0.9252	0.0660	Only 2 hospitals in CBSA
9	Fayetteville, NC	0.8609	0.0597	CBSA wages driven primarily by 1 hospital
10	Mansfield, OH	0.8853	0.0564	Only 2 hospitals in CBSA

Wage Index Changes – Proposed WIF Variations

Top 10 Decreases in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Proposed Rule*	Change from FFY 2021 WIF	Observation
1	Rural Connecticut	0.9921	(0.2410)	Impact mitigated by IRF
2	Rural Idaho	0.8218	(0.1187)	Only 1 hospital in Rural ID
3	Bangor, ME	0.9183	(0.1096)	Only 2 hospitals in CBSA
4	Monroe, MI	0.8546	(0.0897)	Only 1 hospital in CBSA
5	Stockton, CA	1.3532	(0.1261)	Primarily due to hospital exclusion
6	Columbus, IN	1.0392	(0.0928)	Reclassification issue
7	Atlantic City-Hammonton, NJ	1.0570	(0.0931)	Only 2 hospitals in CBSA
8	Nassau County-Suffolk County, NY-CT	1.2483	(0.1058)	NYC hospitals not reclassified
9	Weirton-Steubenville, WV-OH	0.7329	(0.0605)	Only 2 hospitals in CBSA
10	Rural Utah	0.9552	(0.0734)	Rural redesignation reversal

Wage Index Changes – CY 2019 Occupational Mix Survey Application

Top 10 Positive MOMA Impacts

Rank #	CBSA	FFY 2022 MOMA per Proposed Rule*	Change from FFY 2021 MOMA (CY 2016 Survey)	Observation
1	St. Joseph, MO-KS	$2.48	$0.62	CBSA comprised of 1 hospital
2	St. Cloud, MN	$2.07	($0.11)	CBSA comprised of 1 hospital (SCH)
3	Muncie, IN	$2.00	$0.47	CBSA comprised of 1 hospital
4	Portland-South Portland, ME	$1.97	$0.98	MOMA impact driven primarily by 2 hospitals
5	Tuscaloosa, AL	$1.88	$0.22	CBSA wages driven primarily by 1 hospital
6	Longview, WA	$1.79	($0.89)	CBSA comprised of 1 hospital
7	Twin Falls, ID	$1.61	($0.86)	CBSA comprised of 1 hospital
8	MAINE	$1.60	$0.59	Only 1 rural hospital with negative MOMA
9	Goldsboro, NC	$1.57	$1.26	CBSA comprised of 1 hospital
10	East Stroudsburg, PA	$1.55	($0.09)	MOMA impact driven primarily by 2 hospitals

Wage Index Changes – CY 2019 Occupational Mix Survey Application

Top 10 Negative MOMA Impacts

Rank #	CBSA	FFY 2022 MOMA per Proposed Rule*	Change from FFY 2021 MOMA (CY 2016 Survey)	Observation
1	Santa Cruz-Watsonville, CA	($4.09)	($1.02)	Remains highest WIF in country
2	San Luis Obispo-Paso Robles, CA	($3.41)	$0.32	3 system hospitals comprise CBSA
3	Sacramento-Roseville-Folsom, CA	($2.74)	($0.08)	System hospitals comprise most of CBSA
4	Santa Rosa-Petaluma, CA	($2.71)	($0.18)	Only 1 hospital with positive MOMA
5	Oakland-Berkeley-Livermore, CA	($2.51)	($0.21)	No hospitals with positive MOMA
6	San Francisco-San Mateo-Redwood City, CA	($2.47)	($1.08)	Primary driver of WIF reduction in CBSA
7	Redding, CA	($2.37)	($0.13)	Wages driven primarily by 1 hospital
8	Modesto, CA	($2.36)	($0.50)	Wages driven primarily by 2 hospitals
9	San Jose-Sunnyvale-Santa Clara, CA	($2.19)	$0.36	Improvement from CY 2016 Survey
10	Stockton, CA	($2.02)	($0.05)	Does not account for excluded hospital

Part II
Graduate Medical Education

Three New Laws
Enacted by Congress in the Consolidated Appropriations Act of 2021 (CAA)

- ***Sec. 126***, - allocates one thousand new residency slots over the next five years to teaching hospitals;
- ***Sec. 127***, stresses changes to the rural training track (RTT) rules to increase flexibility in the partnership of both rural and urban hospitals, potential to expand RTT programs in specialties other than family medicine; and
- ***Sec. 131***, discusses scenarios when hospitals may be able to reset their per resident amount (PRA) and/or full-time equivalent (FTE) caps.

Per FFY 2022 IPPS Proposed Rule (Waiting….)

1,000 IME | GME Cap Slots (American Rescue Plan Act)

- 200 cap slots per year available beginning 7/1/2023
- First year applications due 1/31/2022
- Statute limits new slots to 25 per hospital, but Proposal limit is just one slot per hospital per year (five total). Only one application allowed per hospital per year
- Significant advantage to hospitals located in a Health Professional Shortage Area (HPSA), based on HPSA severity score (1-25 scale for primary care or mental health)
  - https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Hospital must increase its resident count (establish or expand program) for awarded slots (cannot only use for existing shortage)
- Cannot use new slots in a Medicare affiliated group agreement until after 5th year
- 10% allocation of new cap slots to each of four categories of hospitals

Per FFY 2022 IPPS Proposed Rule (CAA 126) (Waiting….)

1,000 IME | GME Slots (American Rescue Plan Act)

10% Allocation to Four Categories of Hospitals (HPSA Ranking Applies Across All Four Categories)

1. Located in rural areas or treated as such (includes rural re-designated)
2. Training residents in excess of FTE cap (most recent cost report on/before 12/27/2020)
3. Located in states with new medical schools or additional locations / branches of existing medical schools (35 states + Puerto Rico)
4. Serving areas designated as primary care or mental Health Professional Shortage Areas (HPSAs)

Key Dates: Filing Deadline 1/31/2022 | Approval: 1/31/2023 | Payment: 7/1/2023

Prioritization by HPSA Score

0 (Low Severity) – 25 (High Severity)

Hospital Group	HPSA Score	FTEs Awarded Per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	25	1	50	150
50 hosps	24	1	50	100
50 hosps	21	1	50	50
80 hosps	19	0.625	50	0
Total (230 Hosps)			**200**	**0**

- or -

Prioritization by Number of Qualifying Categories (Alternative)

Rural | Over Cap | New Med School | HPSA

Hospital Group	Total Score	FTEs Awarded Per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	4	1	50	150
50 hosps	3	1	50	100
50 hosps	2	1	50	50
80 hosps	1	0.625	50	0
Total (230 Hosps)			**200**	**0**

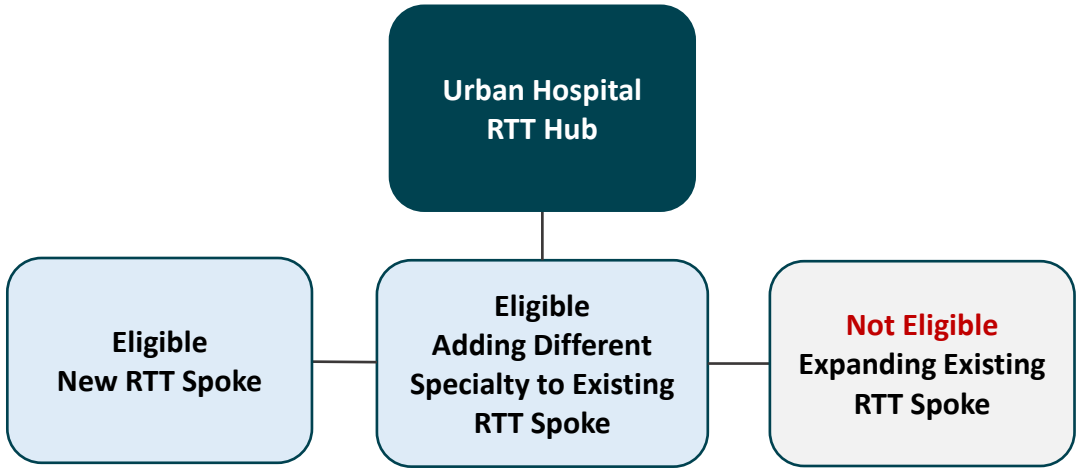
Per FFY 2022 IPPS Proposed Rule (CAA 127) (Waiting….)

Rural Training Track Cap Adjustment (American Rescue Plan Act)

Greater Flexibility and Benefits for Rural Training Track (RTT) Programs

New Cap Slots for Urban and Rural Hospitals

- Cost Reports beginning on or after 10/1/2022
- Urban hospitals with existing RTTs can add subsequent RTT programs
- Urban hospitals (Hub) with an existing RTT program can add additional rural hospitals (spokes) to the existing program
- Both the urban and rural hospital can get RTT cap adjustments regardless of whether program is “new”
- Regardless of specialty (must be accredited by the ACGME); separate “1-2 format” accreditation not required
- At least 50% of training must occur in rural areas
- RTT FTEs are exempt from the FTE 3-year rolling average during the 5-year growth window



Per FFY 2022 IPPS Proposed Rule (CAA 131) (Waiting….)

Low Resident Count (American Rescue Plan Act)

Establishing New Per Resident Amounts (PRAs) and FTE Caps for Certain Hospitals

Intended to Help Hospitals With Small PRAs or Caps Created Based on Minimal Teaching Activity

Category A Hospitals

- As of 12/27/2020 has a PRA or cap established based on a resident count of 1.0 FTE (or less) from a cost reporting period beginning before 10/1/1997
- PRA and caps re-set after hospital trains at least 1.0 FTE on after 12/27/2020 and before 12/26/2025

Category B Hospitals

- As of 12/27/2020 has a PRA or cap established after 10/1/1997 based on a resident count of no more than 3.0 FTEs
- Rest after hospital trains at least 3.0 FTEs on after 12/27/2020 and before 12/26/2025

PRAs for New and Existing Programs

- For hospitals training between 1.0 and 3.0 FTEs, CMS Proposes that the PRA and caps will be determined using existing rules for new programs. For new PRAs, the program does not have to be new.
- Hospitals with GME affiliation agreements will have PRA established when less than 1.0 is trained.
- Future new PRAs and caps will not be set unless hospital trains at least 1.0 FTE.

FTE Cap Adjustment for <u>New Programs Only</u>

- Caps established when a hospital begins training for the first time after 12/27/2020 and before 12/26/2025.
- Cap is set using existing rules for new programs.

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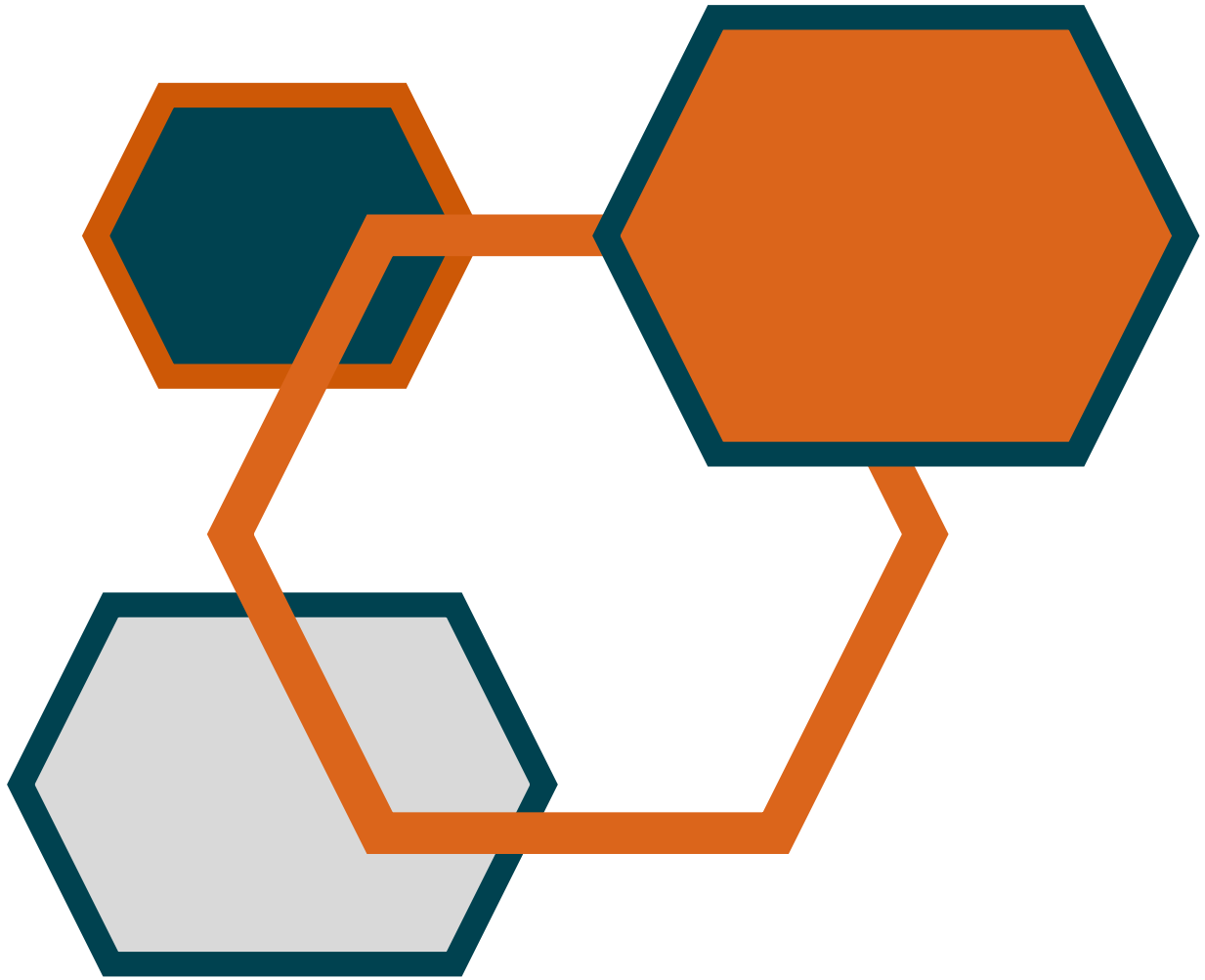

Part II

Organ Acquisition

Cost Based Reimbursement

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FFY 2022 IPPS Proposed Rule

Organ Acquisition Cost-Based Reimbursement (Waiting….)

- All organ acquisition policies with consistent terminology at 42 C.F.R. Part 413, subpart L (incl. existing organ and kidney acquisition pmt regs)
- Applies to existing elements of kidney acquisition costs to all organs and includes additional changes applying to kidney acquisition only
  - E.g., costs for registration of a beneficiary for a kidney transplant and costs for registration of a beneficiary for a non-renal transplant
- Codification of Standard Acquisition Charges (SACs) for Transplant Hospitals (TH) | Hospital Based Organ Procurement Organizations (HOPO)
  - Registration fee limitation to (Organ Procurement and Transplantation Network) OPTN based on reasonable cost principles
  - Surgeon fees are “included as kidney acquisition costs only when the kidney excision occurs with a cadaveric donor”
    - When a living donor enters the hospital for the actual kidney excision, surgeon fees for excising the kidney are not included as kidney acquisition costs
- It is recommendend the industry consider commenting how this Proposal impacts operations, and future implications/plans on securing organs for patients

Note: Medicare’s current reimbursement uses acquisition costs multiplied by the ratio of Medicare usable organs to total usable organs (on the Medicare cost report)

FFY 2022 IPPS Proposed Rule – (Waiting….)

Organ Acquisition Cost-Based Reimbursement

#	Proposed list of 12 Organ Acquisition Costs, Covered by Medicare Part A
1	Tissue typing, including tissue typing furnished by independent laboratories
2	Donor and beneficiary evaluation
3	Excising organ other costs, such as general routine and special care services provided to the donor
4	Operating room and other inpatient ancillary services applicable to the donor
5	Preservation and perfusion costs
6	Organ Procurement and Transplantation Network (OPTN) registration fees
7	Surgeons' fees for excising cadaveric organs
8	Transportation of excised organ to TH
9	Costs of organs acquired from other hospitals or OPOs
10	Hospital costs normally for OP costs re organ excisions (donor and recip. tissue typing, work-up, and related services prior to admission)
11	Costs of services for organ excisions, rendered by residents and interns not in approved teaching programs
12	All pre-admission services applicable to organ excisions (lab., electroenc., surgeons' fees for cadaveric excisions, for organ excisions incl. the costs of phys. services)

FFY 2022 IPPS Proposed Rule – (Waiting….)

Organ Acquisition Reimbursement

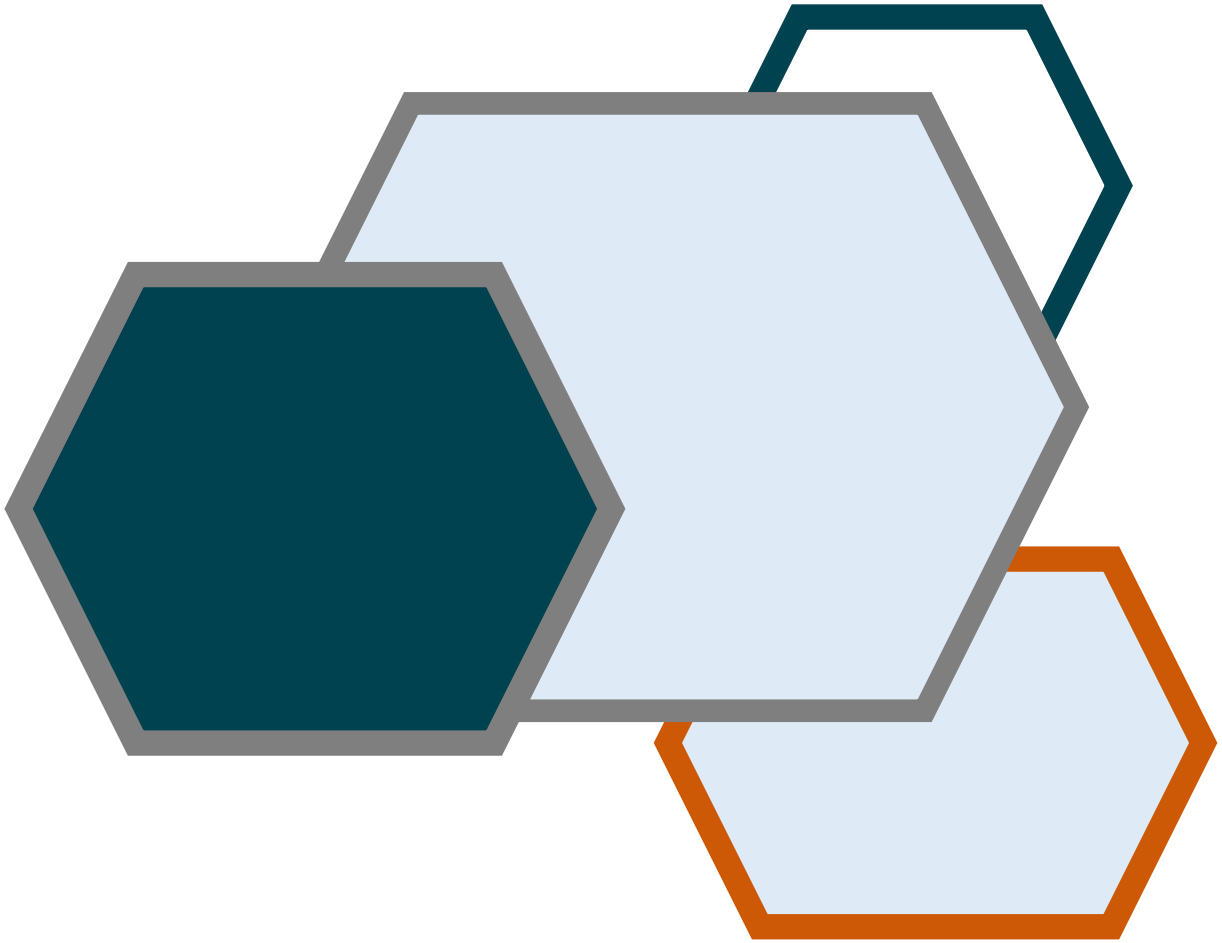
Services Not Considered Organ Acquisition Costs

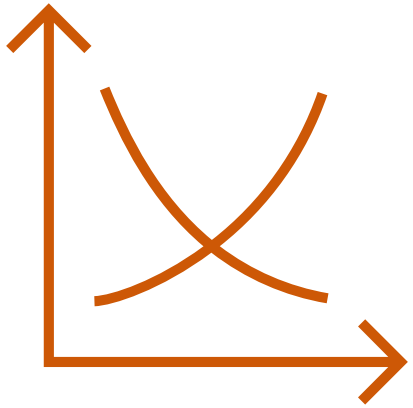
- CMS proposes to establish rules identifying costs that are non-reimbursable which may be incurred during organ acquisition and transplant
- Including, not limited to:
  - burial and funeral expenses for cadaveric donors
  - costs associated with transportation of a living or cadaveric donor
  - costs incurred prior to a potential donor being declared brain dead
  - fees or in-center payments for donor referrals
  - costs associated with OPO sponsored seminars where continuing education credits are given
  - certain costs incurred for administrator's duties associated with professional organizations

FFY 2022 IPPS Proposed Rule – (Waiting….)

Medicare's Proposed Share of Organ Acquisition Reimbursement

- To determine whether a recipient is a Medicare patient, **CMS is proposing to change its means of the identification of each donor beneficiary**
  - CMS states this verification will ensure the TH/OPO organ acquisition costs are more accurately applied to the Medicare program
- CMS proposes changes to OPOs and their reporting requirements, total usable organs for THs/OPOs will now be included into one of ten subcategories
  - CMS states these categories will more accurately explain various situations, including "organs transplanted into non-Medicare beneficiaries." Organs not transplanted into Medicare patients are accounted to determine Medicare usable organs
  - Additionally, CMS further proposes policy changes on organ acquisition charges for kidney-paired exchanges in section k on page 25669 (600 of 721) of the Proposed Rule, ***included in the Addendum of this presentation***





Medicare Bad Debt

Dual Eligible Cost-Sharing

Medicare/Medicaid Bad Debt

State Enrollment

Enrollment

- State Medicaid Programs must accept enrollment of all Medicare-enrolled providers and suppliers for purposes of processing Medicare/Medicaid dual eligible claims for cost sharing liability
- State Medicaid Programs must comply for dates of services beginning January 1, 2023

Must Bill Policy

- Hospital still must bill and receive an adjudicated remit from the Medicaid Program prior to writing off the unpaid balance
- The new enrollment allows additional opportunity for hospitals to claim Medicare bad debt on the cost report

Snapshot

WHO

- All providers and suppliers billing for Medicare/Medicaid Bad Debt

WHAT

- State Medicaid Programs must accept enrollment

WHY

- CMS hopes this leads to a reduction in future bad debt appeals

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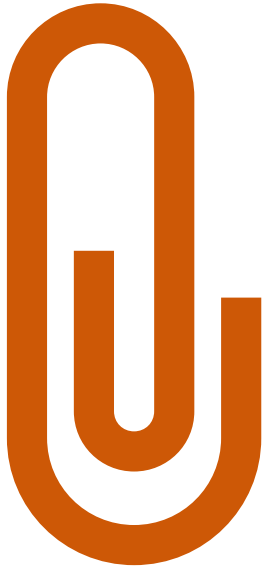
Addendum



Key References

Organ Acquisition Tables

Table X.B.-02. Summary of Kidney Paired Donation Exchange Example				
	TH A	**TH B**	**TH C**	**TH D**
Recipient	Recipient A	Recipient B	Recipient C	Recipient D
# of Evaluations	Evaluates 3 potential donors before Donor A is identified	Evaluates 2 potential donors before Donor B is identified	Evaluates 3 potential donors before Donor C is identified	Evaluates 3 potential donors before Donor D is identified
Donor	Donor A	Donor B	Donor C	Donor D
Donor Description	Recipient A and Donor A do not match each other but agree to a KPD exchange	Recipient B and Donor B do not match each other but agree to a KPD exchange	Recipient C and Donor C do not match each other but agree to a KPD exchange	Recipient D and Donor D do not match each other but agree to a KPD exchange
KPD Match	Recipient A matches with Donor C	Recipient B matches with Donor D	Recipient C matches with Donor A	Recipient D matches with Donor B
After Match	TH A performs additional tests and procures kidney from Donor A for TH C	TH B does not procure kidney from Donor B for TH D. Donor B travels to TH D	TH C procures kidney from Donor C for TH A	TH D procures kidney from Donor D for TH B. Donor B travels to TH D for kidney procurement.

Organ Acquisition Tables

Table X.B.-03. Summary of Accounting for Kidney Pair Donation Example				
	Accounting			
Cost of evaluations	**$12,000 incurred by TH A**	**$9,000 incurred by TH B**	**$15,000 incurred by TH C**	**$20,000 incurred by TH D**
Counting Medicare usable kidneys	2 Medicare usable kidneys; 1 kidney procured/sent and 1 kidney received/transplanted	1 Medicare usable kidneys; 1 kidney received/transplanted	2 Medicare usable kidneys; 1 organ procured/sent and 1 kidney received/transplanted	2 Medicare usable kidneys; 1 kidney procured/sent and 1 kidney procured/transplanted
Donor costs procuring, packaging, transporting kidney to recipient THs	TH A bills TH C $18,000 for costs incurred to procure Donor A's kidney	No bills sent to TH D.	TH C bills TH A $10,000 for costs incurred to procure Donor C's kidney	TH D bills TH B $14,000 for costs incurred to procure Donor D's kidney
Donor costs procuring, packaging, transporting kidney bill by Donor THs	TH A receives a bill from TH C for $10,000 for costs incurred to procure Donor C's kidney	TH B receives a bill from TH D for $14,000 for costs incurred to procure Donor D's kidney	TH C receives a bill from TH A for $18,000 for costs incurred to procure Donor A's kidney	No bills received from TH B. TH D claims all costs after initial evaluation for Donor B.
Kidney acquisition costs recorded on MCR	$12,000 evaluation costs of TH A; $18,000 for costs billed to TH C; $10,000 billed from TH C	$9,000 evaluation costs of TH B; $14,000 billed from TH D	$15,000 evaluation costs of TH C; $10,000 for costs billed to TH A; $18,000 billed from TH A.	$20,000 evaluation costs of TH D; $14,000 for costs billed to TH B; $8,000 for costs incurred to procure Donor B's kidney at TH D.
Subtotal	**$40,000**	**$23,000**	**$43,000**	**$42,000**
Offset on MCR amts received from recipient TH. Amts in ( ) are negative	($18,000) Received from TH C	No payment received from TH D	($10,000) received from TH A	($14,000) received from TH B
Net cost MCR	**$22,000**	**$23,000**	**$33,000**	**$28,000**

FFY 2022 IPPS Final Rule

Wage Index Changes – WIF Variations (HFMA Region 9 - Arkansas)

Top 5 Variations (+/-) in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Final Rule (CMS Table 3)*	Change from FFY 2021 WIF	% Increase / Decrease in WIF
1	Fort Smith, AR-OK	0.7998	(0.0344)	-4.12%
2	Texarkana, TX-AR	0.8181	(0.0260)	-3.08%
3	Little Rock-N. Little Rock-Conway, AR	0.8202	(0.0105)	-1.26%
4	Memphis, TN-MS-AR	0.8458	(0.0102)	-1.19%
5	Jonesboro, AR	0.9471	0.0055	0.69%

*WIF does not include bottom-quartile wage index adjustment, which is factored into WIFs lower than 0.8437.

FFY 2022 IPPS Final Rule

Wage Index Changes – WIF Variations (HFMA Region 9 - Mississippi)

Top 5 Variations (+/-) in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Final Rule (CMS Table 3)*	Change from FFY 2021 WIF	% Increase / Decrease in WIF
1	Hattiesburg, MS	0.7365	(0.0151)	-2.01%
2	Rural Mississippi	0.7209	(0.0130)	-1.77%
3	Memphis, TN-MS-AR	0.8458	(0.0102)	-1.19%
4	Gulfport-Biloxi, MS	0.7434	(0.0084)	-1.12%
5	Jackson, MS	0.8139	0.0015	0.18%

*WIF does not include bottom-quartile wage index adjustment, which is factored into WIFs lower than 0.8437.

FFY 2022 IPPS Final Rule

Wage Index Changes – WIF Variations (HFMA Region 9 - Louisiana)

Top 5 Variations (+/-) in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Final Rule (CMS Table 3)*	Change from FFY 2021 WIF	% Increase / Decrease in WIF
1	Monroe, LA	0.7395	(0.0330)	-4.27%
2	Houma-Thibodaux, LA	0.7008**	(0.0157)	-2.19%
3	Shreveport-Boosier City, LA	0.8031	(0.0157)	-1.92%
4	Hammond, LA	0.8121	(0.0094)	-1.14%
5	Lake Charles, LA	0.7698	0.0085	1.12%

*WIF does not include bottom-quartile wage index adjustment, which is factored into WIFs lower than 0.8437.

**Houma-Thibodaux, LA WIF is subject to the Louisiana statewide rural floor in FFY 2022.

FFY 2022 IPPS Final Rule

Wage Index Changes – WIF Variations (HFMA Region 9 - Oklahoma)

Top 5 Variations (+/-) in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Final Rule (CMS Table 3)*	Change from FFY 2021 WIF	% Increase / Decrease in WIF
1	Fort Smith, AR-OK	0.7998	(0.0344)	-4.12%
2	Enid, OK	0.8458	(0.0187)	-2.16%
3	Oklahoma City, OK	0.8702	(0.0126)	-1.43%
4	Tulsa, OK	0.8367	(0.0008)	-0.10%
5	Rural Oklahoma	0.7758	0.0040	0.52%

*WIF does not include bottom-quartile wage index adjustment, which is factored into WIFs lower than 0.8437.

FFY 2022 IPPS Final Rule

Wage Index Changes – WIF Variations (HFMA Region 9 - Texas)

Top 5 Variations (+/-) in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Final Rule (CMS Table 3)*	Change from FFY 2021 WIF	% Increase / Decrease in WIF
1	Rural Texas**	0.9085	0.0950	11.68%
2	Midland, TX	0.8458	(0.0669)	-7.44%
3	Beaumont-Port Arthur, TX	0.8702	(0.0403)	-4.68%
4	Longview, TX	0.8367	0.0323	3.97%
5	Victoria, TX	0.7758	(0.0296)	-3.41%

*WIF does not include bottom-quartile wage index adjustment, which is factored into WIFs lower than 0.8437.

**Rural Texas WIF is separate from Texas statewide rural floor (0.8061).

Other Rules, Transmittals, and Articles Recently Published

Inpatient Psych Facility PPS FFY2022 Final Rule [CMS-1750-F] (Display Copy available 7/29/2021 FR Publish Date 8/4/2021)

Fact Sheet Link

Federal Register Link

- Per diem base rate increase from $815.22 to $832.94.
- Total estimated payments to IPFs are estimated to increase by 2.0% or $80 million in FY 2022 relative to IPF payments in FY 2021.
- For FY 2022, CMS will update the IPF PPS payment rates by 2.0% based on the proposed IPF market basket update of 2.7%, less a 0.7 percentage point productivity adjustment.

Inpatient Rehab Facility PPS FFY2022 Proposed Rule [CMS-1748-F] (Display Copy available 7/29/2021; FR Publish Date 8/4/2021)

Fact Sheet Link

Federal Register Link

- Standard payment conversion factor increase from $16,856 to $17,176.
- Total estimated payments to IRFs are estimated to increase by 1.9% or $130 million in FY 2022 relative to IRF payments in FY 2021.

Long-Term Care Hospital PPS Proposed Rule [CMS-1752-F] (Display Copy available here 8/2/2021; FR Publish Date 8/11/2021) – Published as part of the IPPS Acute Care Hospital Proposed Rule

Fact Sheet Link

Federal Register Link

- LTCH-PPS payments expected to increase by 1.1% or $42M.
- LTCH PPS payments for FY 2022 for discharges paid the site neutral payment rate are expected to increase by 3 percent. CMS estimates that discharges paid the site neutral payment rate will represent approximately 25 percent of all LTCH cases and 10 percent of all LTCH PPS payments in FY 2022.

Skilled Nursing Facility FFY2021 PPS Proposed Rule [CMS-1746-F] (Display Copy available 7/29/2021; FR Publish Date 8/4/2021)

Fact Sheet Link

Federal Register Link

- Increase in unadjusted Federal per diem rates of 1.2%
- CMS is revising the SNF market basket to improve payment accuracy under the SNF PPS by proposing to use a 2018-based SNF market basket to update the PPS payment rates, instead of the 2014-based SNF market basket.

Thank you

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