

Medicare's Final FY 2022 IPPS Rules & Regulatory Updates

March 17, 2022

Breakout Session 1B

Final FY 2022 IPPS

- **Posted August 2nd**
- **Published August 13th Federal Register**
- **Copy at: <https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf>**

- **Tables**
 - **IPPS at:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. Click on the link on the left side of the screen titled, “FY 2022 IPPS Final rule Home Page” or “Acute Inpatient—Files for Download.”

 - **LTCHs at:** <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html> under the list item for Regulation Number CMS-1752-F

Comments

- **Major areas of rule**
 - **Using FY 2019 Data**
 - **Rates of Increase**
 - **Disproportionate share hospital (DSH)**
 - **MS-DRGS**
 - **New Technology**
 - **“Quality”**
 - **Rule was 2,295 pages (display copy)**
 - **Final is 842 pages**
 - **Addendum is excellent starting point to understand payment rate changes**

Corrections and Amendments FFY 2022 Final Rule

➤ CMS-1752-F2

- **Date of Display:** October 19, 2021
- **Date of Publication:** October 20, 2021

➤ CMS-1752-CN2

- **Date of Display:** November 29, 2021
- **Date of Publication:** November 30, 2021

➤ CMS-1752-FC3

- **Date of Display:** December 17, 2021
- **Date of Publication:** December 27, 2021

➤ CMS-1752-CN3

- **Date of Display:** January 26, 2022
- **Date of Publication:** January 27, 2022

Comments

➤ **CMS-1752-FC3**

- **Covers GME rulemaking first published in the Consolidated Appropriations Act**
- **Covers changes and clarifications of organ acquisition payments**

Use of FY 2019 Data in Lieu of 2020

- **Use of the FY 2019 Inpatient Hospital Utilization Data Instead of FY 2020 Data Due to the Covid-19 Public Health Emergency (PHE)**
- **Question: What will happen for FY 2023 and beyond?**
- **Extends new technology add-on payments for 14 technologies**
- **Extend “New Covid-19 Treatment Add-on Payment (NCTAP) through the end of the year in which the PHE ends”**

Impacts

- **Projected IPPS overall impact + \$1.1 billion**
- **Projected LTCH overall impact + \$42 million**

- **Be careful of the numbers, especially percentage changes**
- **Some CMS items say increase is \$1.4 billion, others \$1.1 billion**

Rate of Increase IPPS -- Market Basket

- MB is **2.7** percent -- proposed at +2.5 percent
- Offsets:
 - **-0.7%** for productivity per ACA – proposed -0.2 percent
- Add-on
 - **+0.5** for documentation and coding per 21st Century Cures Act and MACRA
- Net Increase **2.5 percent** – proposed at 2.3 percent

Other Update Factors

- VBP = 2.0 percent reduction to all -- \$1.9 billion (budget neutral) – “**Give back** 2.0 percent to all”
- HAC = 1.0 percent 25 worst [**766**] hospitals
- Readmissions = up to 3.0 percent [CMS estimates that 2,545 hospitals impacted—saving **\$521** million]
- DSH/UCC =
 - UCC - **\$1.1** billion decrease over FY 2021

FY 2022 IPPS Market Basket Increases Regarding Quality and EHR

- Currently the majority of hospitals are reporting quality and are considered meaningful EHR users.

FY 2022 IPPS

Market Basket Increases

Regarding Quality and EHR

- **Regarding failures to report quality and be a meaningful EHR user**
 - **No Quality –**
 - **$\frac{1}{4}$ of market basket $[0.25 \times 2.7 = -0.675]$**
 - **No EHR**
 - **$\frac{3}{4}$ of market basket $[0.75 \times 2.7 = -2.025]$**
- **Failure to not report quality or be an EHR user is in effect a zero rate of increase w/o other adjustments**

Labor Share/ Market Basket

- **CMS Revising Market Basket**
- **Larger Urban at: 67.6 percent from 68.3**
- **Other at: 62.0 percent unchanged by statute**

FY 2022 IPPS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2022 Base Rate after removing: 1. FY 2020 Geographic Reclassification Budget Neutrality (0.986616)	If Wage Index is Greater Than 1.0000: Labor (67.6%): \$4,319.35 Nonlabor (32.4%) \$2,070.22 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is Greater Than 1.0000: Labor (67.6%): \$4,319.35 Nonlabor (32.4%) \$2,070.22 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is Greater Than 1.0000: Labor (67.6%): \$4,319.35 Nonlabor (32.4%) \$2,070.22 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is Greater Than 1.0000: Labor (67.6%): \$4,319.35 Nonlabor (32.4%) \$2,070.22 <i>(Combined labor and non-labor = \$6,389.57)</i>
2. FY 2020 Operating Outlier Offset (0.949) 3. FY 2020 Rural Demonstration Budget Neutrality Factor (0.999626)	If Wage Index is less Than or Equal to 1.0000: Labor (62%): \$3,961.53 Non-labor (38%): \$2,428.04 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is less Than or Equal to 1.0000: Labor (62%): \$3,961.53 Non-labor (38%): \$2,428.04 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is less Than or Equal to 1.0000: Labor (62%): \$3,961.53 Non-labor (38%): \$2,428.04 <i>(Combined labor and non-labor = \$6,389.57)</i>	If Wage Index is less Than or Equal to 1.0000: Labor (62%): \$3,961.53 Non-labor (38%): \$2,428.04 <i>(Combined labor and non-labor = \$6,389.57)</i>

FY 2022 IPPS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
4. FY 2020 Lowest Quartile BN Factor (0.997970)				
5. FY 2020 Rural Demonstration Budget Neutrality Factor (0.998851)				

FY 2022 IPPS

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FY 2022 Update Factor	1.02	1.02	1.02	1.02
FY 2022 MS-DRG Recalibration BN	1.000107	1.000107	1.000107	1.000107
FY 2022 Wage Index BN	1.000712	1.000712	1.000712	1.000712
FY 2022 Reclassification BN	0.986737	0.986737	0.986737	0.986737
FY 2022 Rural Demonstration BN Factor	0.999361	0.999361	0.999361	0.999361

FY 2022 IPPS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2022 Low Wage Index BN	0.998035	0.998108	0.998108	0.998108
FY 2022 Operating Outlier Factor	0.949	0.949	0.949	0.949
Adjustment for FY 2022 Required under Section 414 (MACRA)	1.005	1.005	1.005	1.005
Total FY 2022 Rate	\$6,121.71	\$6,000.17	\$6,081.19	\$5,959.67

FY 2022 IPPS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
National Standardized Amount for FY 2022 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	Labor: \$4,138.28 Non-labor: \$1,983.43	Labor: \$4,056.12 Non-labor: \$1,944.05	Labor: \$4,110.89 Non-labor: \$1,970.30	Labor: \$4,028.74 Non-labor: \$1,930.93

FY 2022 IPPS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
National Standardized Amount for FY 2022 if Wage Index is less than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62.0/38.0)	Labor: \$3,795.46 Non-labor: \$2,326.25	Labor: \$3,720.11 Non-labor: \$2,280.06	Labor: \$3,770.34 Non-labor: \$2,310.85	Labor: \$3,695.00 Non-labor: \$2,264.67

FY 2022 IPPS

➤ FY 2021	FY 2022	Difference
▪ Large Urban		
\$4,071.57	\$4,138.28	
<u>1,889.74</u>	<u>1,983.43</u>	
\$5,961.31	\$6,121.71	\$160.40/ 2.69%
▪ Other		
\$3,696.01	\$3,795.46	\$160.40/ 2.69%
<u>2,265.30</u>	<u>2,326.25</u>	
\$5,961.31	\$6,121.71	

FY 2022 IPPS

- CMS says **97** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2022 because they are identified as **not** meaningful EHR users.
- CMS says that **68** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2022 because they **failed the quality** data submission.
- CMS says **24** hospitals are estimated to not receive the full market basket rate-of-increase for FY 2022 because they are identified as **both** not meaningful EHR users and do not submit quality data.

Documentation & Coding

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
 - Limits CMS reinstatement of offsets
 - CMS Offsets 3 years @ 0.8 = 2.4
 - CMS FY 2017 @ 1.5 = 1.5
 - Total = 3.9 percent to add-back
- **MACRA = 0.5 percent from FY 2018 through 2023**
 - Would total 3.0 percent
 - **Shortfall is 0.9 percent (3.9-3.0) = 0.9**

Documentation & Coding

- ***21st Century Cures Act*** limited FY 2018 add-back
- **Reduced FY 2018 from 0.5 to 0.4588**
- **Revised shortfall is now $[0.9 + .0402 (0.5 - 0.4588) = 0.0412] = 0.9412 \text{ percent}$ (0.9+.0412)**
- **FY 2021 add back is 0.5 percent**
- **FY 2022 add back will be 0.5 percent**
- **FY 2023 add back will be 0.5 percent**
- **FY 2024 – “GONE”**

Capital 2022

- Rate will increase to **\$472.60**
- Current is \$466.21

PPS Excluded Hospitals

- **Rate will increase 2.7 percent – full market basket**
- **Impacts**
 - **98 Children's Hospital**
 - **11 Cancer Hospitals**
 - **5 Hospitals outside 50 states & DC**
 - **18 Religious nonmedical health care institutions**
 - **1 Extended neoplastic disease hospital**

FY 2022 Outliers

- **Outlier fixed-loss cost threshold** for FY 2022 will equal the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, **plus \$30,988**
- Current is \$29,051
- CMS estimates FY 2020 payments at 5.47 percent
- CMS continues to dwell on inability to correct forecast errors. CMS believes the only way is retroactive.

FY 2022 Wage Index

➤ **Data From 2018 Cost Reports**

- Cost Reports Beginning on or After October 1, 2017 and Before October 1, 2018
- Worksheet S-3, Parts II, III, IV, & V

➤ **CMS is extending the FY 2021 5% limit on AWI decreases for those hospitals that received the 5% transition limit in FY 2021.**

FY 2022 Wage Index

- **Will continue for AWI hospitals with AWI below 25th percentile by half the difference between specific hospital's AWI and 25th percentile AWI**
- **25th percentile at 0.8437**
 - Currently in Year 3 of 4 for Increase
- **Frontier Floor**
 - Montana, North Dakota, South Dakota, and Wyoming, covering 44 providers, will receive a frontier floor value of 1.0000

FY 2022 Wage Index

- **Rural Floor – urban hospitals with AWI below state rural average to state rural – 269 hospitals**

FY 2022 Wage Index

- **Implementation of Section 9831 of the American Rescue Plan Act of 2021 Imputed Floor Wage Index Policy for all Urban States**
 - CMS says the following states are considered as all urban—New Jersey, Rhode Island, Delaware, Connecticut, and the District of Columbia. CMS estimates that this provision will increase FY 2022 Medicare payments to hospitals located in all-urban States by approximately \$0.2 billion.

FY 2022 Wage Index

- **In January of 2021 OMB proposed the possibility of increasing the definition of urban from 50,000 to 100,000 residents**
- **Would be using data from the 2020 census.**
 - This would be the first change to definition of rural/urban since 1950.
 - Could potentially change roughly 140-150 MSAs from Metro to nonmetro status
 - Could potentially impact
 - DSH payments
 - Wage Index
 - Teaching payments

FY 2022 Occupational Mix

- Using FY 2019 survey
- FY 2022 occupational mix adjusted national average hourly wage is **\$46.47**– 2021 was \$45.23
- 2022 is a new submission year for occupational mix data
 - Nurses salaries are the main driver. Will CMS seek a hold harmless for “Pandemic Wages”?

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	\$44.45
National LPN and Surgical Technician	\$26.83
National Nurse Aide, Orderly, and Attendant	\$18.53
National Medical Assistant	\$19.50
National Nurse Category	\$37.42

MGCRB Reclassifications

- FY 2022 – 406 approved
- FY 2021 – 291
- FY 2020 – 243
- CMS says there are **940** hospitals reclassified for FY 2022
- 140 reclassified back to their geographic location
- Applications for FY 2024 to MGCRB are due by September 1, 2022.

FY 2022 IPPS

- **Urban to Rural Reclassification—Section 1886(d)(8)(E)**
 - Urban hospital may apply for rural status separate from MGRCB.
 - Some canceling so their AWI data excluded from rural AWI.
 - CMS says it's “manipulative.”
 - Will require these hospitals, if canceling to wait, at least a year.
 - Some are canceling so their AWI data is excluded from the rural AWI and then they plan to reapply again in the future.
- **The number of IPPS hospitals reclassifying from Urban to Rural continues to increase**
 - IME benefits.
 - MGCRB benefits
 - Potential 340B benefits

RRC FY 2022

- Using FY 2019 data – numbers from FY 2021 not changing
- FY 2022 – **Case-Mix**
- **National CMI 1.7049 for FY 2019 cost reporting periods or regional, if lower**

▪ New England (CT, ME, MA, NH, RI, VT)	1.4447
▪ Middle Atlantic (PA, NJ, NY)	1.5005
▪ South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5777
▪ East North Central (IL, IN, MI, OH, WI)	1.60875
▪ East South Central (AL, KY, MS, TN)	1.54085
▪ West North Central (IA, KS, MN, MO, NE, ND, SD)	1.62455
▪ West South Central (AR, LA, OK, TX)	1.74375
▪ Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7833
▪ Pacific (AK, CA, HI, OR, WA)	1.6913

RRC FY 2022

➤ Discharges:

- From cost reports that began during FY 2018 – Discharges – 5,000

Low-Volume Hospitals

- **Low Volume adjustment reinstated from FY 2019 through FY 2022**
 - Hospital must be 15 miles from another section (d) hospital
 - Hospital must have 3,800 or fewer discharges
 - Discharges are Medicare and non-Medicare
- **Payment adjustment for those with 500 or fewer discharges is an additional 25 percent for each discharge**
- **Many hospitals are qualifying for Low-Volume adjustments for the first time.**

Low-Volume Hospitals

- **IF already approved no need to re-request**
- **Otherwise must request in writing and be RECEIVED by its MAC no later than September 1**
- **Low-Volume Hospital Payment Adjustment for those from 500 through 3,800 is formula based:**
 - Adjustment if 500 or less = 25 percent
 - Adjustment if more than 500 beds to 3800 beds = $0.25 - [0.25/3300] \times (\text{number of total discharges} - 500) = (95/330) - (\text{number of total discharges}/13,200)$.

IPPS DSH Formula

- Mandated by Section 3133 of ACA
- Splits system
 - 25 percent remains as old formula
 - 75 percent new
 - Uses 3 factors
 - **FY 2022 based on FY 2018 S-10**

DSH Factor One FY 2022

- **Determines 75 percent of what would have been paid under the old methodology**
- **Excluded hospitals**
 - MD waiver
 - SCH & MDHs paid on a hospital-specific basis
 - Hospitals in Rural Community Demo
 - IPPS hospitals that elect to participate in the Bundled Payments for Care Improvement Advanced Initiative (BPCI Advanced) model
 - IPPS hospitals that are participating in the Comprehensive Care for Joint Replacement Model

DSH Factor One FY 2022

- July 2021 **Office of the Actuary** estimate for Medicare DSH payments for FY 2022, without regard to the application of section 1886(r)(1) of the Act, is **\$13,984,752,728.99** -- proposed at \$14.098 billion
- The empirically justified Medicare DSH payments for FY 2022, with the application of section 1886(r)(1) of the Act, is approximately **\$3.496 billion** (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2022)
- **Factor One is \$10,488,564,546.74**

\$13,984,752,728.99 - \$3,496,188,182.25

**Proposed at (\$14,097,825,121.71 – \$3,524,456,280.43)=
\$10,573,368,841.28)**

DSH Factor Two FY 2022

- The calculation of the Factor 2 for FY 2022 using a weighted average of OACT's projections for CY 2021 and CY 2022 is as follows:
 - Percent of individuals without insurance for CY 2013: 14.0 percent.
 - Percent of individuals without insurance for CY 2021 9.8 percent.
 - Percent of individuals without insurance for CY 2021: 9.5percent.
 - Percent of individuals without insurance for FY 2022 (0.25 times 0.98) + (0.75 times 0.95): **9.6** percent

DSH Factor Two FY 2022

- Formula;
 - $|((0.096-0.14)/0.14)| = 1-0.3143 = 0.6857$ (68.57 percent).
 - Therefore, **the final Factor 2 for FY 2022 is 68.57 percent.**
- The final FY 2022 uncompensated care amount is $\$10,488,564,546.74 * 0.6857 = \mathbf{\$7,192,008,709.70}$.
- The **PROPOSED** amount available for uncompensated care payments for FY 2022 was **\$7,627,628,282.10**
- **The final amount is \$7,192,008,709.70**
 - **$(\$10,488,564,546.74 * 0.6857 = \$7,192,008,709.70)$**

DSH Factor Two FY 2022

- **According to the CBO, the number of uninsured in 2020 was said to be 31 million.**
- **In 2019, the percent increased to 10.9 percent from 10.4 percent in 2018.**

DSH Factor Two FY 2022

- The FY 2014 “pool” was \$9.033 billion
- The FY 2015 “pool” was \$7.648 billion
- The FY 2016 “pool” was \$6.406 billion
- The FY 2017 “pool” was \$6.054 billion
- The FY 2018 “pool” was \$6.767 billion
- The FY 2019 “pool” was \$8.273 billion
- The FY 2020 “pool” was \$8.351 billion
- The FY 2021 “pool” is \$8.290 billion
- The FY 2022 “pool” will be \$7.192 billion

DSH Factor Two FY 2022

➤ Formula;

- $1 - ((0.096 - 0.14) / 0.14) = 1 - 0.3143 = 0.6857$ (68.57 percent).
- Therefore, **the final Factor 2 for FY 2022 is 68.57 percent.**

- The final FY 2022 uncompensated care amount is $\$10,488,564,546.74 * 0.6857 = \mathbf{\$7,192,008,709.70.}$

DSH Factor Two FY 2022

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- The **final amount** is **\$7,192,008,709.70**
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DSH Factor Two FY 2022

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- The FY 2022 “pool” will be \$7.192 billion

DSH Factor Two FY 2022

- The FY 2021 “pool” is \$8.290 billion
- The FY 2022 “pool” will be \$7.192 billion
- Difference of **-\$1.098 billion**
- ***Or 13.24 percent lower than the current total pool.***

DSH Factor Three FY 2022

- Factor 3 is “equal to the percent, for each subsection (d) hospital, that represents the quotient of (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).”

DSH Factor Three FY 2022

➤ Calculation of Factor 3 for FY 2022

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

Given that, the FY 2018 Worksheet S-10 data are the most recent available audited data. CMS says on balance, that the FY 2018 Worksheet S-10 data are the best available data to use for calculating Factor 3 for 2022.

DSH Factor Three FY 2022

- CMS says, “it intends to use the respective March HCRIS for future final rules, because we believe audited Worksheet S-10 data from FY 2019 reports will be available before the development of the FY 2023 proposed rule and final rule.” Per Discharge Amount of Interim Uncompensated Care Payments. A hospital’s total uncompensated care payment amount for the applicable fiscal year, is divided by the hospital’s historical 3-year average of discharges computed using the most recent available data to determine the uncompensated care payment per discharge for that fiscal year.
- CMS is finalizing its proposal to modify the methodology used to estimate a hospital’s average number of discharges to be based on FY 2018 and FY 2019 historical discharge data, rather than a 3-year average that includes data from FY 2018, FY 2019, and FY 2020.

IME / GME Final Rule

- **IME Multiplier Unchanged at 1.35 – by law**

Interim Final Rule for GME

- **Clarification of Distribution of additional residency caps**
 - Hospitals in rural areas or that are treated as being in rural areas.
 - Hospitals must be over their cap
 - Must be in states with new medical schools
 - Must serve areas designated as Health Professional Shortage Areas(HPSAs)- **This will be prioritized**
- **No more than 5 FTE's will be awarded per hospital per year.**
 - 200 positions per year for 5 years – 1000 total

Interim Final Rule for GME

➤ **Determination of Hospitals in a rural area**

- Hospital with its main campus located in an area outside of an urban CBSA would be considered a rural hospital
 - An exception is an urban hospital with a 412.103 designation. For the purposes of this Act, your urban hospitals will be considered rural.
 - Furthermore, as a 412.103 provider you will also be granted DGME, which is an exception from other 412.103 new residency slots.

Interim Final Rule for GME

- **“Demonstrated Likelihood” of Filling the positions**
 - May be able to create a New Residency program
 - May be able to expand an Existing Residency program
- **In either case the hospital must not have sufficient room under its existing FTE cap and the hospital intends to create or expand within the first 5 training years.**

Interim Final Rule for GME

- **Determination of Hospitals in states with New Medical Schools or additional locations and branch campuses**
 - 35 states and 1 territory would be considered for this determination.
 - Virginia, West Virginia and North Carolina are included in the 35.
 - The full list is now published

Interim Final Rule for GME

- **Ability to reset caps for hospitals with a cap of 1 or 3 FTE**
 - If your 1996 cap was set at 1.0 or lower you may restart your cap buildup phase
 - If your post 1996 cap was set at 3.0 or lower you may restart your cap buildup phase.
 - You have 5 years 12/27/20-12/26/205 to start your IRP

Organ Transplants

- **Agency keeps saying it would like to move away from cost based reimbursement. However, the rules published attempt enforce reasonable cost payments**
- **Keeps the definition of organs to human kidney, liver, heart, lung, pancreas or intestine(or multivisceral organs when transplanted at the same time as an intestine)**
- **Specifies administrative and general costs that MAY be allowable**
 - This can be a highly specialized area of review for many providers.

340b

- **Agency continues the 28.5% payment cuts to the 340b program. It is now in year 4 of payment cuts.**
- **Lower courts have upheld the payments cuts**
- **December of 2021, arguments have been held in the Supreme Court to reverse the cuts**
- **Currently HRSA has no authority to extend or make provisions for hospitals that do not qualify as a DSH provider at 11.75% or 8%**
 - What they have done under emergency orders is to grant immediate reinstatement for covered entities if they lost eligibility due to lower numbers due to the ongoing Covid pandemic. This means no 3 month lead time with enrollment.



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