Policy Update

CMS Releases FY 2022 IPPS Final Rule

Summary

On August 2, 2021, the Centers for Medicare and Medicaid Services (CMS) posted the FY 2022 Inpatient Prospective Payment System (IPPS) final rule. Effective October 1, 2021, the final rule updates Medicare payment policies and quality reporting programs relevant for inpatient hospitals, and seeks to address challenges related to the COVID-19 pandemic.

CMS stated that the FY 2022 IPPS final rule will be issued in multiple parts. The agency will address comments on proposals related to disproportionate share hospital payments, organ acquisition costs, and the Consolidated Appropriations Act, 2021 (CAA) provision concerning payments to hospitals for direct graduate medical education (GME) and indirect medical education in subsequent publications.

The final rule is available here. A CMS factsheet on the final rule is available here. The final rule is scheduled to be published in the *Federal Register* on August 13, 2021.

Key Takeaways

1. CMS estimates that the payment update and other rule changes will increase IPPS payments to hospitals in FY 2022 by approximately $2.3 billion. This estimate does not factor in changes in hospital admissions, real case-mix intensity or the mandatory sequestration adjustment.

2. The FY 2022 standardized amount for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and that are meaningful electronic health record (EHR) users will be $6,121.71, an increase of 2.7% compared to the final FY 2021 standardized amount.

3. CMS will use FY 2019 Medicare Provider Analysis and Review (MedPAR) data for the FY 2022 ratesetting process given the impact of the COVID-19 public health emergency (PHE) on inpatient utilization and case mix in FY 2020.

4. As a one-time exception, also because of pandemic impacts, CMS will provide a one-year extension for 13 technologies whose New Technology Add-on Payment (NTAP) period was scheduled to expire.

5. Hospitals will receive neutral payment adjustments under the Hospital Value-Based Purchasing (HVBP) Program for FY 2022.

6. CMS will address its proposal related to the CAA, including distribution of 1,000 new Medicare-funded medical residency positions, in subsequent parts of the final rule.

7. CMS outlines comments it received on its requests for information (RFIs) related to digital quality

measures and health equity, noting that it will make changes through separate and future notice-and-comment rulemaking as necessary.

Standardized Amount

Key Takeaway: CMS finalized a payment increase of 2.7% for hospitals that successfully participate in reporting programs.

The standardized amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies a variety of other statutorily mandated or inspired adjustments.

The standardized amount varies based on an individual hospital's participation in the Hospital IQR and EHR meaningful use programs. The FY 2022 standardized amount for hospitals that successfully participate in both programs is $6,121.71. This represents an increase of 2.7% over the final FY 2021 standardized amount ($5,961.19).

The 2.7% increase to the standardized amount reflects a 2.7 percentage market basket update, less a 0.7 percentage point productivity adjustment, plus a 0.5 percentage point positive adjustment for documentation and coding mandated by Section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 for FY 2018 through FY 2023. In addition to these statutory updates, the standardized amount is subject to budget neutrality adjustments discussed in the final rule. Hospitals that fail to submit quality data are subject to a -0.675% adjustment, and hospitals that fail to be meaningful EHR users are subject to a -2.025% adjustment.

FY 2022 standardized amounts, shown in the table below, are the sum of the labor-related and non-labor-related shares without adjustment for geographic factors. The labor-related share reflects the proportion of the federal base payment that is adjusted by a hospital's wage index. For FY 2022, CMS finalized as proposed the downward revision of labor-related share from 68.3% to 67.6%. This change is the result of a statutory requirement and should have limited impact on FY 2022 and future IPPS payment for most hospitals.

	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 Final Standardized Amount	$6,121.71	$6,000.17	$6,081.19	$5,959.67
FY 2021 Final Standardized Amount	$5,961.19	$5,856.40	$5,926.26	$5,821.47
Percent Change	2.7%	2.5%	2.6%	2.4%

Market-Based MS-DRG Relative Weight Methodology and Data Collection

Change in Methodology for Calculating MS-DRG Relative Weights

Key Takeaway: CMS repealed the policy that would use market-based data for calculating Medicare Severity Diagnosis Related Group (MS-DRG) relative weights, including its requirement to report Medicare Advantage data.

CMS calculates payment for a specific case under the IPPS by multiplying an individual hospital's geographically adjusted standardized amount per case by the relative weight for the MS-DRG to which the case is assigned. Each MS-DRG relative weight represents the average resources required to care for cases in that particular MS-DRG, relative to the average resources required to care for cases across all MS-DRGs. MS-DRG classifications and relative weights must be adjusted at least annually to account for changes in resource consumption.

In the FY 2021 IPPS rulemaking cycle, CMS finalized a new market-based methodology for estimating MS-DRG relative weights based on median payer-specific negotiated charge information collected on Medicare cost reports. This new methodology was scheduled to begin in FY 2024 without any phase-in period. It also was very controversial.

CMS has now reversed course, electing not to pursue this policy. CMS will instead maintain its existing methodology for determining MS-DRG weights for FY 2024 and beyond.

The agency also finalized a proposal to repeal the corresponding requirement that hospitals report on the Medicare cost report, ending on or after January 1, 2021, the median payer-specific negotiated charge by MS-DRG that a hospital has negotiated with all of its Medicare Advantage payers.

MS-DRG Changes

Key Takeaway: CMS finalized its proposal to use FY 2019 MedPAR data and the FY 2018 Healthcare Cost Report Information System file for analyzing MS-DRG changes and determining MS-DRG relative weights for FY 2022.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS typically relies on claims data captured in the MedPAR file and cost report data captured in the Healthcare Cost Report Information System file. In a traditional year, for ratesetting purposes, CMS uses the most recent data available at the time of rulemaking, which normally captures claims from discharges that occurred for the fiscal year two years prior to the fiscal year addressed in the rulemaking. For FY 2022, therefore, CMS normally would analyze data from FY 2020.

In light of the PHE, however, CMS believes that FY 2020 data would not accurately reflect utilization patterns, and therefore finalized its proposal to use FY 2019 MedPAR claims data in setting inpatient hospital payment rates for FY 2022.

New Technology Add-On Payments

Cost Criterion for NTAP

Key Takeaway: CMS finalized its proposal to use FY 2019 MedPAR data for establishing proposed FY 2023 threshold values.

Under the NTAP program, CMS provides additional payment for new medical services or technologies where the costs of the technology are not yet reflected in the MS-DRG weights. One criterion for assessing whether a new technology qualifies for an add-on payment is whether the charges for the technology meet or exceed certain threshold amounts. Historically, CMS has evaluated this cost criterion using threshold amounts established in the prior year's final rule.

Because of the pandemic's impact on utilization, CMS finalized its policy as proposed to use FY 2019 MedPAR data instead of FY 2020 MedPAR data. CMS made no changes to the other criteria it considers when evaluating a new technology's eligibility for add-on payments (*i.e.*, newness and substantial clinical improvement).

Extension for Technologies with Expiring NTAP Period

Key Takeaway: CMS finalized a one-year extension for technologies whose NTAP period was scheduled to expire.

The NTAP period normally includes the first two to three years that the product is on the market, after which the costs are captured in the MS-DRG weights. CMS evaluates the eligibility of new technologies for this additional payment annually based on their newness date (typically defined as the date of market entry). Under current policy, CMS only extends add-on payments for an additional year if the three-year anniversary for the newness date occurs in the latter half of the upcoming fiscal year.

As noted, CMS finalized its proposal to use FY 2019 MedPAR data for the FY 2022 ratesetting process for IPPS, rather than the FY 2020 MedPAR data. Because the FY 2019 MedPAR data may not fully reflect the costs of new technologies with expiring NTAP periods, CMS implemented a one-time NTAP extension for new technologies with expiring NTAP periods. This policy applies to 13 technologies and services.

The one-time extension of the NTAP period is also consistent with the proposed extension of the transitional pass-through period in the hospital outpatient setting.

NTAP Applications for FY 2022

Key Takeaway: CMS continues to see growth in the number of NTAP applications.

In the proposed rule, CMS discussed 37 NTAP applications. Following the withdrawal of some applications, CMS rendered decisions on 31 NTAP applications. Of these, 18 devices and drugs applied through the traditional pathway, and 13 went through alternative pathways (10 devices with breakthrough status and three products designated as qualified infectious disease products). Of the 31 applications discussed in the final rule, CMS approved 17 new services and technologies for the add-on payment.

There will be 40 technologies and services eligible for NTAP in FY 2022, taking into consideration the 13 new

technologies that received a one-time extension of their NTAP period, 10 new technologies that were approved in FY 2021 and will still be in their NTAP period in FY 2022, and the 17 newly approved technologies.

In response to the PHE and in light of the development of new drugs and biologics for COVID-19 treatment, CMS established a new COVID-19 treatment add-on payment (NCTAP), starting with discharges on or after November 2, 2020, that met certain criteria. Acknowledging the pandemic's continued financial impact on hospitals, CMS finalized its policy to continue the NCTAP for qualified technologies that do not qualify for the NTAP. The NCTAP remains in effect until the end of the fiscal year following the end of the PHE.

Hospital Inpatient Quality Programs and Initiatives

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital Readmissions Reduction Program (HRRP), HVBP Program, Hospital Acquired Condition (HAC) Reduction Program, Hospital IQR Program, Medicare and Medicaid Promoting Interoperability Programs, and the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. These programs feature a mix of financial rewards and penalties as well as the public release of quality data.

The final rule includes several policies impacting these programs. The changes are consistent with the agency's longstanding priority of reducing the number of quality measures (*e.g.*, Meaningful Measures Initiative). In general, CMS sought to lessen the burden of quality reporting during the pandemic and implement policies consistent with the Biden Administration's COVID-19 national strategy and commitment to advancing health equity.

HVBP Program

Key Takeaway: Hospitals will receive neutral payment adjustments under the HVBP Program for FY 2022.

CMS will suppress data for several quality measures in FY 2022. As a result, hospitals will receive a neutral payment adjustment under the HVBP for FY 2022.

Throughout the pandemic, CMS has implemented policies to reduce the burden of quality reporting and to mitigate negative impacts on quality scores due to pandemic-related circumstances beyond a provider's control. In that spirit, CMS finalized a proposal to suppress data from select quality measures that the agency believes may have been impacted by the pandemic. According to CMS, these measures were not designed to accommodate changes to clinical practice that hospitals may have implemented because of COVID-19 and therefore they believe they should not impact quality scores. As a result, suppressed measures will be excluded from quality scores. The impacted measures are listed in the table below.

Program	Measure	Year
HRRP	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506)	FY 2023
HAC Reduction Program	CDC National Healthcare Safety Network Healthcare-Associated Infection (HAI)	3-4Q of CY 2020
	CMS PSI 90	FY 2022-2023
HVBP Program	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare Spending Per Beneficiary (MSPB) and five HAI measures	FY 2022
	Pneumonia (PN) 30-Day Mortality Rate (MORT-30-PN)	FY 2023

CMS believes that as a result of the data suppression, there will be inadequate data available to calculate a total performance score for the HVBP Program, and therefore CMS will not calculate such score for FY 2022. Hospitals will not be rewarded or penalized under the HVBP Program in FY 2022. Instead, CMS will ensure that value-based payments equal the amount of the reduction made to hospital's base-operating MS-DRG payment amounts.

Adjustments to Inpatient Hospital Quality Programs and Initiatives

Key Takeaway: CMS finalized modest changes to its various quality programs. Some of these changes were made in response to the COVID-19 pandemic.

Program	Brief Description	Final Policy
HRRP	HRRP reduces payments to hospitals with excess readmissions. A hospital's performance is based on six unplanned readmission measures. The annual payment reduction is capped at 3% (*i.e.*, payment adjustment factor of 0.97).	**Measure modification**: CMS finalized a proposal to exclude COVID-19-diagnosed patients from the denominator of five condition-specific measures in FY 2023.
HVBP Program	The HVBP Program withholds participating hospitals' Medicare payments by 2% and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.	**Measure removal**: CMS finalized a proposal to remove the Patient Safety and Adverse Events Composite (CMS PSI 90) measure beginning with the FY 2023 program year. This measure is also used in the HAC Reduction Program, and CMS believes this policy will reduce provider burden.

Program	Brief Description	Final Policy
Hospital IQR Program	Hospitals are required to report data on measures in order to receive the full annual percentage increase for IPPS services that would otherwise apply.	**Measure adoption**: CMS finalized a proposal to adopt the Maternal Morbidity Structural measure, the Hybrid Hospital Wide Mortality measure, the COVID-19 Vaccination Coverage Among Healthcare Professionals measure and two medication-related adverse event electronic clinical quality measures (eCQMs) for a variety of reporting periods. **Measure removal**: CMS proposed to remove five measures from the program and finalized a policy to remove three of the five measures. CMS declined to remove two of the measures based on stakeholder feedback.
Medicare and Medicaid Promoting Interoperability Programs	The Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established in 2011.	**Reporting period minimums**: For the Medicare Program in CY 2023, CMS finalized a proposal to continue the EHR reporting period of a minimum of any continuous 90-day period for new and returning participants. For CY 2024, CMS will increase the minimum to 180 days. **Measure changes**: CMS finalized a proposal to adopt two new eCQM measures and remove three eCQM measures. CMS also made several changes related to rules around attestation and reporting requirements.
PCHQR Program	The Affordable Care Act established this quality reporting program for prospective-payment-system-exempt cancer hospitals.	**Measure removal**: CMS finalized a proposal to remove the Oncology: Plan of Care for Pain – (NQF #0383) measure beginning with the FY 2024 program year. CMS concluded that it is no longer feasible to implement the measure due to recent changes by the measure steward.

Program	Brief Description	Final Policy
		Measure adoption: CMS finalized a proposal to adopt the COVID-19 Vaccination Coverage Among HCPs measure beginning with the FY 2023 program year. CMS believes that adoption of this measure is consistent with the Biden Administration's national COVID-19 strategy.

Wage Index

Low Wage Index Hospital Policy

Key Takeaway: CMS will maintain a policy that supports hospitals in low wage index areas.

Medicare payments to hospitals (and a variety of other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (*e.g.*, the perceived cost of labor is higher in New York City than it is in rural Oklahoma). CMS updates the wage index each year based on hospital cost report data and other inputs and policies.

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile. Affected hospitals had their wage index value increased by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals. CMS achieved budget neutrality for this change by adjusting the standardized amount applied across all IPPS hospitals.

CMS initially committed to maintain this policy for four years. FY 2022 will be the third of the four years the agency expects to keep this policy in effect.

Restoring the Imputed Wage Index "Rural Floor" for All-Urban States

Key Takeaway: Hospitals in four states, Puerto Rico and the District of Columbia will see a boost in their wage index resulting from legislation enacted in March 2021.

CMS calculates one wage index for each urban area and one for each rural area within each state. The Medicare statute provides that the wage index used to adjust hospital inpatient and outpatient payments for hospitals in an urban area cannot be less than the wage index applicable to hospitals in rural areas within that same state. Historically, this rule left a gap for three states that have no rural areas: New Jersey, Delaware and Rhode Island. Congress has periodically provided a patch for these three states. CMS on its own volition perpetuated this patch through FY 2018, but then allowed the policy to lapse.

The American Rescue Plan (ARP), enacted in March 2021, restored this imputed rural floor protection effective October 1, 2021, for all-urban states. In the proposed rule, however, CMS broadly interpreted the ARP change in a way that made it applicable to, and beneficial for, hospitals in Connecticut, Puerto Rico and the District of Columbia, in addition to New Jersey, Delaware and Rhode Island. CMS finalized this policy

consistent with its proposal.

Wage index changes are often controversial because historically they have been implemented in a budget-neutral fashion, which means the benefit given to some hospitals comes at the expense of others. The ARP spent new money to implement this change, so the benefit to hospitals in all-urban areas will not come at the expense of others.

Urban-to-Rural Reclassification

Key Takeaway: CMS finalized changes to make it harder for hospitals to withdraw from urban-to-rural reclassification.

Medicare regulations allow hospitals geographically located in urban areas to seek to be redesignated to rural areas of their state for Medicare payment purposes. In recent years, litigation has broadened the availability and appeal of redesignation, and as a result CMS has seen an increase in the number of hospitals seeking urban-to-rural reclassification. CMS also has seen hospitals attempting to time these reclassifications to favorably impact the wage index in their state. CMS has taken steps in recent years to try to minimize these maneuvers and their impact. This year the agency proposed two technical but notable rule changes to the same effect, and finalized one of those changes.

CMS regulations will now provide that requests to cancel rural reclassifications cannot be made earlier than one year after the reclassification effective date. For example, a hospital that was approved to receive a rural reclassification effective October 1, 2021, could not request to cancel that reclassification until October 1, 2022. This change will require hospitals to maintain rural designation for at least one year before asking to cancel that designation.

CMS also proposed to eliminate the current rule that a request to cancel must be made 120 days prior to the end of the hospital's fiscal year, and that such cancelation will be effective beginning with the hospital's next fiscal year. CMS proposed to instead require that a hospital approved for rural reclassification (and which does not receive an additional reclassification) would have its data included in the calculation of the rural wage index for at least one federal fiscal year before the rural reclassification status could be canceled. CMS decided not to finalize this policy at this time based on comments received. The agency undoubtedly will revisit this concern and propose further changes in the future.

Transitional Stop-Loss

Key Takeaway: CMS will continue stop-loss protection for hospitals that received that protection in FY 2021.

For FY 2021, CMS provided stop-loss protection for hospitals experiencing a wage index decrease resulting from implementation of new metropolitan areas. CMS imposed a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2020 so that a hospital's final wage index for FY 2021 would not be less than 95% of its final wage index for FY 2020. This was intended to be a one-time, one-year policy, but in the proposed rule CMS solicited comments on whether it should extend this policy into FY 2022 in recognition of the ongoing challenges hospitals face with regard to the COVID-19 pandemic.

CMS received comments encouraging an extension and therefore decided to extend this policy into FY 2022, but only for hospitals that received the transition protection in FY 2021. CMS will maintain budget neutrality by adjusting the standardized amount applied across all IPPS hospitals.

Graduate Medical Education

Key Takeaway: CMS deferred finalizing GME provisions to a future publication.

In the proposed rule, CMS addressed provisions to implement Sections 126, 127 and 131 of the CAA, which expanded opportunities for hospitals to receive Medicare GME funding. These provisions would have:

- Expanded and allocated 1,000 additional Medicare-funded GME full time equivalent (FTE) resident positions over a five-year period
- Expanded opportunities for hospitals participating in Rural Training Track programs to receive additional Medicare-funded GME FTE resident positions
- Provided opportunities for hospitals that previously hosted residents for short rotations to receive additional Medicare-funded GME FTE resident positions and increases in their Medicare "per-resident" payment amount.

In the final rule, CMS deferred addressing these provisions to a future publication, citing the number and nature of comments received on this topic.

Rural Community Hospital Demonstration

Key Takeaway: CMS extended the rural community hospital (RCH) demonstration for five years, as required by CAA.

Legislation enacted in 2003 required CMS to establish a "demonstration" program whereby certain eligible rural hospitals would be paid under a reasonable cost-based methodology for a defined period of time. Congress has extended and expanded this program several times. Twenty-six hospitals currently participate in the RCH demonstration.

The CAA required a 15-year extension period (*i.e.*, an additional five years beyond the current extension period). CMS proposed to extend the RCH demonstration as required by the statute and finalized a five-year extension for each of the participating hospitals. Because of the varying participation periods for the currently participating hospitals, the end date of the RCH demonstration for the hospital with the last end date will be June 30, 2028. CMS also finalized the IPPS budget neutrality calculation methodology necessary to maintain the budget neutrality of the RCH demonstration program during the CAA extension period.

Long-Term Care Hospitals

Key Takeaway: CMS made no major policy changes concerning long-term care hospitals (LTCHs).

LTCHs are acute care facilities providing care to patients with average stays of more than 25 days. LTCHs are excluded from payment under the IPPS and are instead paid under the LTCH prospective payment system. CMS routinely updates the LTCH prospective payment system concurrent with the IPPS updates. For FY 2022, CMS proposed and finalized routine payment adjustments and updates, but no major policy changes.

Changes to Medicare Shared Savings Program

Key Takeaway: CMS finalized its proposal to provide additional flexibility on the risk timeline for certain Accountable Care Organization (ACOs).

CMS finalized its policy to allow eligible ACOs participating in the BASIC track's glide path option to forgo automatically increasing levels of risk and potential reward for performance year (PY) 2022. Under this new provision, an eligible ACO may elect to remain in the same level of the BASIC track's glide path in which it participated during PY 2021. For PY 2023, however, an ACO that elects this deferral option will be automatically advanced to the level in which it would have participated during PY 2023 (unless the ACO elects to advance more quickly before the start of PY 2023).

Advancing to Digital Quality Measurement RFI

Key Takeaway: CMS aims to move fully to digital quality measurement in its quality reporting and value-based purchasing programs by 2025.

As part of its Meaningful Measures Framework, CMS previously outlined a path to update and align its quality measures across its different reporting programs. The proposed rule included an RFI on a four-stage plan to transition CMS's quality measurement enterprise to be fully digital by 2025.

Comments outlined in the final rule noted general support for the movement to digital quality measures but questioned the resources and timeline necessary to fully transition by 2025. CMS did not make updates to specific program requirements on this issue in the final rule, and will address any changes in future rulemaking.

Health Equity RFI

Key Takeaway: CMS responded to comments to advance health equity in the Medicare program.

As part of the Biden Administration's commitment to advancing health equity, and in response to the Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, the proposed rule included an RFI on how to close the health equity gap in CMS quality programs.

The Administration has included similar RFIs related to health equity in other recently proposed rules. We anticipate that the Administration in general, and CMS in particular, will continue this focus on health equity in future policy decisions.

In the proposed rule, CMS asked stakeholders to provide information about how the agency can improve reporting and application of health disparity data related to social risk factors and race and ethnicity. Specifically, the agency requested public feedback on:

+ Potential future stratification of quality measure results by race and ethnicity as well as other factors
+ Improvements to demographic data collection, including expansion of data elements and improving interoperability
+ Creation of a Hospital Equity Score in order to synthesize results across multiple social risk factors.

In the final rule, CMS responded to stakeholder comments but stated that any potential public reporting of health equity measures would be addressed in future rulemaking. The agency noted that it intended to provide future confidential feedback reports to providers on quality measure performance, broken out by race and ethnicity, but did not provide a timeline or specifics for this additional information.

Conclusion

Overall, the policies adopted in the final rule largely mirror CMS's initial proposals. One surprise is that instead of one final rule, CMS will release additional publications to address the more than 6,500 public comments the agency received on the proposed rule. The issues that remain to be determined range from organ acquisition costs to GME funding. The delay in many ways reflects the sentiment of public comments and may be welcomed by stakeholder groups, as many of the issues are complex not only in terms of policy implication but also in terms of technicalities and implementation details.

For more information, contact Emily Cook, Deborah Godes, Sheila Madhani, Mara McDermott, Drew McCormick, Kristen O'Brien, Susan Xu or Eric Zimmerman.

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