Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

AUGUST 2021

FFY 2022 MEDICARE IPPS FINAL RULE – CMS-1752-F

On Aug. 13, the Centers for Medicare & Medicaid Services (CMS) published the federal fiscal year (FFY) 2022 Inpatient Prospective Payment System (IPPS) final rule, effective Oct. 1, 2021 through Sept. 30, 2022. The final rule increases IPPS payments by 2.5% in FFY 2022. Due to the volume of comments received, CMS will address proposals related to organ acquisition costs and the provision of the Consolidated Appropriations Act of 2021 (CAA) related to direct graduate medical education (GME) and indirect medical education (IME) payments to hospitals in future rulemaking.

Repeal of Market-Based Charge Data on Cost Report and MS-DRG Data Collection and Weight Calculation: CMS repealed the FFY 2021 IPPS final rule requirement for hospitals to report median payer-specific negotiated charges with Medicare Advantage organizations on the Medicare cost report. CMS also repealed the subsequent policy to recalculate MS-DRG relative weights based on those data.

Use of FFY 2019 Data: CMS typically uses the most recent full year of data available to calculated IPPS rates. Normally CMS would use FFY 2020 data to calculate FFY 2022 IPPS rates; however, due to the COVID-19 public health emergency (PHE), CMS will use FFY 2019 data.

IPPS Market Basket Update: CMS finalized a 2.7% market basket update (proposed at 2.5%), a 0.7 percentage point productivity reduction (proposed at 0.2 percentage points), and a 0.5 percentage point increase to partially restore cuts made under the American Taxpayer Relief Act (ATRA) of 2012. The market basket update for hospitals that fail to submit quality data will decrease by an additional one-quarter percentage point, and hospitals that do not meet meaningful use requirements are subject to a three-quarter percentage point reduction to the initial market basket.

FFY 2022	Hospital submitted quality data and is a Meaningful EHR user	Hospital submitted quality data and is NOT a Meaningful EHR user	Hospital DID NOT submit quality data and is a Meaningful EHR user	Hospital DID NOT submit quality data and is NOT a Meaningful EHR user
Percentage increase applied to standardized amount	2.0%	-0.025%	1.325%	-0.7%

Additionally, CMS finalized its proposal to rebase and revise the IPPS operating market basket, IPPS capital market basket, and the national labor-related and non-labor-related shares to reflect a 2018 base year.

National Standardized Amounts: The table below summarizes proposed standardized amounts. For FFY 2022, CMS finalized a labor-related share of 62% for IPPS hospitals with wage index

values less than or equal to 1.0000, and a labor-related share of 67.6% for IPPS hospitals with wage index values greater than 1.0000.

Wage Index	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
<= 1.0000	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
> 1.0000	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

CMS finalized a capital standard federal payment rate of $472.60.

COVID-19 Add-On Payment: CMS will extend the New COVID-19 Treatments Add-on Payment (NCTAP) for eligible products that are not approved for new technology add-on payments (NTAPs) through the end of the FFY in which the COVID-19 PHE ends (i.e., Sept. 30 of the year in which the PHE ends). CMS did not finalize discontinuing the NCTAP for discharges on or after Oct. 1, 2021 for products approved for NTAPs beginning FFY 2022. Instead, hospitals may receive both the NCTAP and the traditional NTAP for qualifying patient stays with any new NTAP reducing the amount of the NCTAP. This payment policy ends at the conclusion of the FFY in which the PHE ends.

NTAPs: Because CMS finalized using FFY 2019 data in developing FFY 2022 relative weights, it also finalized a one-year extension of NTAPs for 13 technologies for which the NTAP was to expire in FFY 2022. These technologies include AndexXa™, Cablivi®, ContaCT, Eluvia Drug-Eluting Vascular Stent System, ELZONRIS®, Esketamine (SPRAVATO®), Hemospray, IMFINZI/TECENTRIQ, NUZYRA, Spinejack, T2 Bacteria Test Panel, XOSPATA®, and ZEMDRI™.

Additionally, the following technologies will receive NTAPs because they still qualify as new under the NTAP criteria: AZEDRA®, BAROSTIM NEO System, BALVERSA™, Jakafi®, FETROJA®, Optimizer® System, RECARBRIO™, Soliris®, XENLETA™, and ZERBAXA®

Changes to MS-DRG Diagnosis Codes: CMS proposed changing the severity level designation for all unspecified diagnosis codes to Non-Complication/Comorbidity (Non-CC) if there are other codes available in the relevant code subcategory that further specify the anatomic site. This would have changed the designation of 3,490 unspecified diagnosis codes from CC or Major CC (MCC) to Non-CC. However, CMS decided to maintain the severity level designation of all "unspecified" diagnosis codes, and instead finalized an edit: Unspecified Code Medicare Code Editor (MCE). CMS stated this edit provides additional time to educate coders on updated coding guidelines. The full list of unspecified diagnosis codes is in Table 6P.2a on the CMS website.

Coding System Maintenance: CMS finalized an additional implementation date for ICD-10-CM and ICD-10-PCS code updates. Beginning April 1, 2022, CMS will implement updates on April 1 in addition to annual October 1 updates.

Wage Index: In the FFY 2021 IPPS final rule, CMS adopted a policy placing a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FFY 2020 in response to the adoption of Office of Management and Budget Bulletin No. 18-04. The intent of this policy was to ensure that a hospital's final wage index for FFY 2021 would not be less than 95% of its final wage index for FFY 2020 (see IHA's FFY 2021 IPPS summary for more information). This cap was set to expire at the end of FFY 2021; however, CMS finalized extending this policy through FFY 2022 in response to the COVID-19 PHE.

CMS also finalized continuing the FFY 2020 low-wage-index hospital policy. This budget neutral policy increases the wage index for hospitals with a wage index value below the 25th percentile. CMS increases the wage index for such hospitals by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile value for all hospitals.

The table below displays FFY 2022 final wage index information for Illinois hospitals:

Core Based Statistical Area	Wage Index	Geographic Adjustment Factor (GAF)	Reclassified Wage Index	Reclassified GAF	State Rural Floor	FY 2022 Average Hourly Wage
Bloomington	0.9258	0.9486	0.8779	0.9147		43.3348
Cape Girardeau	0.8433	0.8898				38.1451
Carbondale	0.8433	0.8898				37.8591
Champaign-Urbana	0.8781	0.9148	0.8781	0.9148		40.8740
Chicago-Naperville-Evanston	1.0326	1.0222	1.0183	1.0125		48.3286
Danville	0.9523	0.9671	0.9418	0.9598		44.5726
Decatur	0.8467	0.8923				39.6323
Elgin	1.0164	1.0112	1.0014	1.0010		47.5721
Kankakee	0.8837	0.9188	0.8671	0.9070		41.3619
Lake County	1.0504	1.0342	1.0504	1.0342		47.1363
Peoria	0.8493	0.8942	0.8493	0.8942		39.6656
Rock Island	0.8433	0.8898	0.8433	0.8898		38.6143
Rockford	0.9933	0.9954	0.9790	0.9856		46.4908
St. Louis	0.9422	0.9600	0.9422	0.9600		44.1019
Springfield	0.9020	0.9318	0.8847	0.9195		42.2212
Rural	0.8433	0.8898	0.8296	0.8799	0.8433	39.4708

Finally, CMS permanently reinstated a minimum area wage index for hospitals in all-urban states per Section 9831 of the American Rescue Plan Act of 2021. This "imputed rural floor" increases the wage index for the all-urban states of Connecticut, Delaware, the District of Columbia, New Jersey and Rhode Island. This reinstated policy is not to be budget neutral, and thus does not require reductions to the standardized amount.

Disproportionate Share Hospital (DSH) Payment Changes: For FFY 2022, CMS will distribute approximately $7.2 billion in uncompensated care payments (CMS estimated $7.63 billion in uncompensated care payments under the proposed rule). This is a decrease of $1.1 billion from

FFY 2021. CMS will use Worksheet S-10 from hospitals' FFY 2018 Medicare cost reports to distribute these funds.

Medicare Promoting Interoperability Program: CMS finalized several changes to the Medicare Promoting Interoperability Program for eligible hospitals and Critical Access Hospitals (CAHs).

CMS will continue the minimum 90-day electronic health record (EHR) reporting period for calendar year (CY) 2023 Medicare Promoting Interoperability Program for new and returning eligible hospitals and CAHs. However, for CY 2024 CMS will require a minimum continuous 180-day EHR reporting period for new and returning hospitals and CAHs.

For the CY 2022 reporting period CMS will maintain the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional, but increase the associated available bonus points from 5 to 10.

CMS finalized adding the Health Information Exchange (HIE) Bi-Directional Exchange measure as a yes/no attestation to the Health Information Exchange Objective beginning in CY 2022. This measure will be an optional alternative to two existing measures: the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.

CMS will also require hospitals and CAHs to answer "yes" on four of the existing Public Health and Clinical Data Exchange Objective measures or request an applicable exclusion. Eligible hospitals and CAHs must also attest to completing an annual assessment of all nine guides in the SAFER Guides measure under the Protect Patient Health Information objective. CMS also removed attestation statements 2 and 3 from the Promoting Interoperability Program's prevention of information blocking attestation requirement.

CMS increased the minimum required scoring threshold for the objectives and measures from 50 points to 60 points (out of 100) to be considered a meaningful EHR user.

CMS did not finalize its proposal to require eligible hospitals and CAHs to ensure patients have indefinite access to their health information (Provide Patients Electronic Access to Their Health Information measure). CMS may revisit modifications to this measure in the future.

Hospital Quality Reporting Measure Suppression Policy: CMS finalized measure suppression policies for the Hospital Value-Based Purchasing (VBP), Hospital-Acquired Condition (HAC) Reduction, Hospital Readmissions Reduction (HRRP), Skilled Nursing Facility VBP, and End-Stage Renal Disease (ESRD) Quality Incentive programs. Under this policy, CMS may suppress the use of measure data affected by the COVID-19 PHE and that the agency determines will significantly affect quality scores. CMS intends for this policy to neither penalize nor reward hospitals based on circumstances caused by the COVID-19 PHE. The finalized factors include:

1. Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years.
2. Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.
3. Rapid or unprecedented changes in:

a. Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
b. The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.

4. Significant national shortages or rapid or unprecedented changes in healthcare personnel; medical supplies, equipment, or diagnostic tools or materials; or patient case volumes or facility-level case mix.

Details specific to the HAC, RRP and VBP Programs follow.

HAC: CMS will suppress performance data from the third and fourth quarters of CY 2020 Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) and CMS patient safety indicator (PSI) 90 data when calculating performance for FFYs 2022 and 2023. Instead, CMS will base total HAC scores for FFYs 2022 and 2023 on the following applicable periods:

- FFY 2022 CMS PSI 90 measure: 18-month period from July 1, 2018 through December 31, 2019;
- FFY 2022 CDC NHSN HAI measures: 12-month period from January 1, 2019 through December 31, 2019;
- FY 2023 CMS PSI 90 measure: 12-month period from July 1, 2019 through December 31, 2019 and January 1, 2021 through June 30, 2021;
- FFY 2023 CDC NHSN HAI measures: 12-month period from January 1, 2021 through December 31, 2021.

RRP: CMS will suppress the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization measure (NQF #0506) beginning with the FFY 2023 program year. CMS will also modify the remaining five condition-specific readmission measures to exclude COVID-19 diagnosed patients from the measure denominators. These measures include:

- Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0505);
- Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2515);
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891);
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure Hospitalization (NQF #0330); and
- Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSSR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551).

VBP: CMS will suppress most VBP measures for FFY 2022, including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures, Medicare Spending per Beneficiary, and five healthcare associated infection measures. CMS adopted a special scoring

and payment rule for the FFY 2022 program year, providing neutral payment adjustments for hospitals in the FFY 2022 program year. CMS will still calculate and report measure scores publicly where appropriate.

For the FFY 2023 program year, CMS will suppress the Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate Following Pneumonia (PN) Hospitalization measure (MORT-30-PN). CMS will also permanently remove the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) measure (NQF #0531) from the VBP.

Finally, beginning with the FFY 2023 program year, CMS will exclude COVID-19 diagnosed patients (primary or secondary diagnosis) from the denominators for the following measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (NQF #0229); and
- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550).

Inpatient Quality Reporting (IQR) Program: Hospitals that do not submit quality data or fail to meet all Hospital IQR Program requirements are subject to a one-quarter percentage point reduction in their IPPS payment update. CMS adopted five new IQR measures, including:

- COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning Oct. 1, 2021 and affecting the calendar year (CY) 2021 reporting period/FFY 2023 payment determination;
- Maternal Morbidity Structural Measure beginning with a shortened CY 2021 reporting period/FFY 2023 payment determination;
- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality with Claims and Electronic Health Record Data (NQF #3502) measure with voluntary reporting running from July 1, 2022 through June 30, 2023 and mandatory reporting beginning July 1, 2023 affecting FFY 2026 payment determination;
- Hospital Harm-Severe Hypoglycemia eCQM (NQF #3503e) beginning with the CY 2023/FFY 2025 payment determination; and
- Hospital Harm-Severe Hyperglycemia eCQM (NQF #3533e) beginning with the CY 2023/FFY 2025 payment determination.

CMS also finalized removing three hospital IQR measures, including:

- Exclusive Breast Milk Feeding (PC-05) (NQF #0480) beginning with the CY 2024 reporting period/FFY 2026 payment determination;
- Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497) beginning with the CY 2024 reporting period/FFY 2026 payment determination; and

- Discharged on Statin Medication (STK-06, NQF #0439) beginning with the CY 2024 reporting period/FFY 2026 payment determination.

CMS did not finalize proposals to remove Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) or Death Among Surgical Inpatients with Serious Treatable Conditions (CMS PSI-40).

Finally, CMS will require hospitals to use certified EHR technology updated with the 2015 Edition Cures Update beginning with the CY 2023 reporting period/FFY 2025 payment determination. CMS clarified that certified technology must support the reporting requirements for all available eCQMs.

Interim Final Rule with Comment: In tandem with this IPPS proposed rule, CMS issued an interim final rule with comment period (IFC) to modify limitations on redesignation by the Medicare Geographic Classification Review Board (MGCRB) to comply with the decision in *Bates County Memorial Hospital v. Azar*, 464 F. Supp. 3d 43 (D.D.C. 2020) (CMS-1762-IFC). The IFC revised regulation at Social Security Act § 412.230, allowing hospitals with rural redesignation under Section 1886(d)(8)(E) to reclassify under the MGCRB using the rural reclassified area as the geographic area in which the hospital is located effective with reclassifications beginning with FFY 2023.

Further, prior to this IFC, hospitals with rural redesignations were not permitted to use the rural area's wage data for purposes of reclassifying under the MGCRB. Beginning with FFY 2022 applications that were denied due to this previous policy, CMS will now apply the new IFC policy and allow such hospitals to apply for redesignation using the rural area's wage data.

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Sources:
Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program. May 10, 2021. Available from: https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Accessed August 16, 2021.

Centers for Medicare & Medicaid Services. FY 2022 IPPS Final Rule Home Page. Available from: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Tables. Accessed August 16, 2021.