Issue Brief

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Final FY 2022 Medicare IPPS and LTCH PPS Update Released

The Centers for Medicare & Medicaid Services released the final rule to update both the Hospital Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2022. In addition to payment rate updates, the rule addresses many other items.

CMS is continuing its policies to address wage index disparities impacting low wage index hospitals. CMS is finalizing implementation of Section 9831 of the American Rescue Plan Act of 2021, which permanently established an imputed floor wage index policy. In addition, CMS is finalizing the regulations, which allows hospitals with a rural redesignation under the Act to reclassify through the Medicare Geographic Classification Review Board (MGCRB) using the rural reclassified area as the geographic area in which the hospital is located.

The rule includes policies related to new technology add-on payments. CMS is also finalizing its proposal to repeal the collection of market-based rate information on the Medicare cost report and the market-based MS-DRG relative weight methodology.

CMS is providing estimated and newly established performance standards for the Hospital Value-Based Purchasing Program, and updated policies for the Hospital Readmissions Reduction Program, Hospital Inpatient Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Long-Term Care Hospital Quality Reporting Program, and the PPS Exempt Cancer Hospital Reporting Program.

CMS is establishing new requirements and revising existing requirements for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program.

Additionally, due to the impact of the COVID-19 PHE on measure data used in the value-based purchasing programs, CMS is finalizing its proposal to suppress several measures in the Hospital VBP, HAC Reduction, and Hospital Readmissions Reduction Programs. As a result of these measure suppressions for the Hospital VBP Program CMS is also implementing a special scoring methodology for FY 2022 that results in a value-based incentive payment amount that matches the 2% reduction to the base operating DRG payment amount.

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The document is currently on public display at the Federal Register office and is scheduled for publication on Aug. 13. A display version is available at https://public-inspection.federalregister.gov/2021-16519.pdf.

The IPPS tables for this FY 2022 final rule are available on the CMS website 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."

The LTCH PPS tables for this FY 2022 final rule are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1752-F.

CMS provided the following table identifying various changes. We have modified, in many areas, the table's actual wording hoping to simply the material. (Page 28)

Provision Description	Description of Costs, Transfers, Savings and Benefits
Adjustment for MS-DRG Documentation and Coding Changes	CMS is making an adjustment of +0.5 percentage point to the standardized amount consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
Changes to the New COVID-19 Treatments Add-on Payment	In response to the COVID-19 PHE, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) under the IPPS for COVID-19 cases that meet certain criteria. "In order to continue to mitigate potential financial disincentives for hospitals to provide these new treatments, and to minimize any potential payment disruption immediately following the end of the PHE, CMS believes that the NCTAP should remain available for cases involving eligible treatments for the remainder of the fiscal year in which the PHE ends (for example, until Sept. 30, 2022)." Therefore, CMS is extending the NCTAP for all eligible products through the end of the fiscal year in which the PHE ends (for example, until Sept. 30, 2022), including for technologies/cases eligible for new technology add-on payments, with the new technology add-on payment reducing the amount of the NCTAP. "On one extreme, if all of the new COVID–19 treatments decrease the net cost of hospitalizations (for example, due to shortened lengths of stay), including the cost of the new treatment, below the Medicare payment for discharges after the end of the PHE and through the end of the fiscal year in which the PHE ends, then there would be no NCTAP made and no additional cost to the Medicare program as a result of this extension. On the other extreme, if all of the new COVID–19 treatments result in the net cost of hospitalizations that exceed the outlier threshold (for example, due to the cost of the new treatment) for discharges after the end of the PHE and through the end of the fiscal year in which the PHE ends, the cost to the Medicare program would be the sum over all such NCTAP cases of 0.65 times the outlier threshold for each case. Given it is unknown what the cost and utilization of inpatient stays using these new treatments will be, this is a cost but is not estimable. Therefore, it is not possible to quantify the impact of the extension of the NCTAP."

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Provision Description	Description of Costs, Transfers, Savings and Benefits
Implementation of Section 9831 of the American Rescue Plan Act of 2021 Imputed Floor Wage Index Policy for All-Urban States	CMS is implementing section 9831 of the American Rescue Plan Act of 2021 (ARA) which reinstates the imputed floor wage index policy for all-urban States effective for discharges on or after Oct. 1, 2021 (FY 2022) with no expiration date using the methodology described as in effect for FY 2018. Furthermore, section 1886(d)(3)(E)(iv)(III) of the Act provides that the imputed floor wage index shall not be applied in a budget neutral manner. CMS estimates the proposed implementation of section 9831 of the will result in an estimated cost of approximately $0.2 billion for FY 2022.
Medicare DSH Payment Adjustment and Additional Payment for Uncompensated Care	For FY 2022, CMS is updating its estimates of the three factors used to determine uncompensated care payments. CMS is continuing to use uninsured estimates produced by Office of the Actuary (OACT) as part of the development of the NHEA in conjunction with more recently available data that takes into consideration the effects of the COVID-19 pandemic in the calculation of Factor 2. CMS is using a single year of data on uncompensated care costs from Worksheet S–10 for FY 2018 to determine Factor 3 for FY 2022. CMS projects that the amount available to distribute as payments for uncompensated care for FY 2022 will decrease by approximately $1.4 billion. Note that CMS says the decrease will be $1.1 billion and not $1.4 billion – refer to page 2,213. This is the only place in this rule that CMS cites $1.4 billion.
Update to the IPPS Payment Rates and Other Payment Policies	Acute care hospitals are estimated to experience an increase of approximately $2.3 billion in FY 2022.
Update to the LTCH PPS Payment Rates and Other Payment Policies	Based on the best available data for the 363 LTCHs in CMS' database, CMS estimates that the changes to the payment rates and factors will result in an estimated increase in payments in FY 2022 of approximately $42 million.
Changes to the Hospital Readmissions Reduction Program	DRG reductions in payments are based on a hospital's risk-adjusted readmission rate during the performance period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG) surgery. CMS estimates that 2,500 hospitals will have their base operating DRG payments reduced by their determined estimated FY 2022 hospital-specific readmission adjustment. As a result, CMS estimates that the Hospital Readmissions Reduction Program will save approximately $521 million in FY 2022.
Value-Based Incentive Payments under the Hospital VBP Program	CMS estimates that there will be no net financial impact to the Hospital VBP Program for the FY 2022 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. Specifically for the FY 2022 program year, after applying the measure suppressions and special scoring policy, the estimated amount of base operating MS-DRG payment amount reductions and payback to hospitals is approximately $1.9 billion.

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Provision Description	Description of Costs, Transfers, Savings and Benefits
Changes to the HAC Reduction Program	A hospital's Total HAC Score and its ranking in comparison to other hospitals in any given year depend on several different factors. CMS is making no changes to the scoring methodology, which will continue to use the Winsorized z-score and equal measure weights approaches to determine the worst-performing quartile of hospitals. Any significant impact due to the HAC Reduction Program changes for FY 2022, including which hospitals will receive the adjustment, will depend on the actual experience of hospitals in the Program. For example, a hospital with poor performance during CY 2020 may move out of the worst-performing quartile status (that is, not receive a payment reduction) due to the measure suppression policy. In turn, this would lead to another hospital moving into the worst-performing quartile status. In a typical year, approximately 18% of hospitals experience a change in worst-performing quartile status from one year to the next. Preliminary analysis indicates the percentage of hospitals experiencing a change in worst-performing quartile status to be 17.2% due to the measure suppression policy.
Changes to the Hospital Inpatient Quality Reporting (IQR) Program	Across 3,300 IPPS hospitals, CMS estimates that the changes for the Hospital IQR Program will result in a total information collection burden increase of 2,475 hours associated with policies and updated burden estimates and a total cost increase of approximately $101,475 across a 4-year period from the CY 2022 reporting period/FY 2024 payment determination through the CY 2025 reporting period/FY 2027 payment determination.
Changes to the Medicare and Promoting Interoperability Program	Based on updated wage rates for 2019 from the Bureau of Labor Statistics, and an amended hourly staff usage from that of a lawyer to a medical records and health information technician role, CMS estimates that the finalized changes will result in a net decrease of $607,893 for the annual information collection burden (total cost) in CY 2022.
Market-Based MS-DRG Relative Weight Policy – Repeal	CMS is finalizing its proposal to repeal the requirement that hospitals report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its MA organization payers, by MS-DRG, for cost reporting periods ending on or after Jan. 1, 2021. CMS is also finalizing its proposal to repeal the market-based MS-DRG relative weight methodology adopted for calculating the MS-DRG relative weights effective in FY 2024.
Changes to the Medicare Shared Savings Program	CMS describes the estimated impacts of its changes to the Shared Savings Program to extend the flexibility for eligible ACOs to elect to "freeze" their participation level along the BASIC track's glide path for PY 2022. The net effect of offering this flexibility is estimated to be a $90 million reduction in Federal spending, with the reduction ranging from $50 to $140 million.

CMS also presents its traditional cost analysis table, which follows. "The net costs to the Federal Government associated with the policies finalized in this final rule are estimated at $2.293 billion."

Category	Transfers
Annualized Monetized Transfers	$2.293 billion
From Whom to Whom	Federal Government to IPPS Medicare Providers

COMMENT

This new and expanded table is helpful in understanding changes being made. Nonetheless, this is another huge rule extending 2,295 pages.

We are providing select page numbering for items discussed in red. Our analysis does not follow the rule' organization, nor are all subject items addressed.

For many payment issues, the rule's Addendum (beginning on page 2,026) contains much concise and extremely useful payment information.

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I. CHANGES TO PROSPECTIVE PAYMENT RATES FOR HOSPITAL INPATIENT OPERATING COSTS FOR ACUTE CARE HOSPITALS FOR FY 2022 (PAGE 1,105 AND ADDENDUM PAGE 2,028)

Rate Update

The increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users will be 2%. This reflects a projected hospital market basket update of 2.7% reduced by a 0.7 percentage point multi-factor productivity (MFP) adjustment for a net increase of 2%. The proposed factors were 2.5% increase reduced by an MFP of 0.2% for a net increase of 2.3%.

Also included is a 0.5 percentage point adjustment required by Section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 (MARCA) for prior documentation and coding payment reductions. The 2.0 and 0.5 amounts result in an increase of 2.5%.

CMS displays four applicable percentage increases to the standardized amounts for FY 2022, as specified in the following table. The MARCA additional requirement is not reflected in the amounts below. (Page 1,107)

FY 2022 Applicable Percentage Increases for the 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
Market Basket Rate-of-Increase	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data	0	0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR	0	-2.025	0	-2.025
MFP Adjustment	0.7	-0.7	-0.7	-0.7
Applicable Percentage Increase Applied to Standardized Amount	2.00	-0.025	1.325	-0.7

Hospitals that fail to comply with the quality data submission requirements but are meaningful EHR users will receive an update of 1.325%. This update includes a reduction of one-quarter of the market basket update for failure to submit these data. (2.7 X (1.00-0.25, or 0.75) – 0.7 = 1.325)

Hospitals that do comply with the quality data submission requirements but are not meaningful EHR users would receive an update of -0.025%, which includes a reduction of three-quarters of the market basket update. (2.7 X (1.00-.075, or 0.25) – 0.7 = -0.025)

Furthermore, hospitals that do not comply with the quality data submission requirements and also are not meaningful EHR users would receive an update of -0.7%.

continued

Current Standardized Payment Rates

The current FY 2021 standardized payment amounts, as corrected in the Dec. 7, 2020, *Federal Register*, are as follows.

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	
Wage Index Greater Than 1.0000							
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,071.57	$1,889.74	$4,000.00	$1,856.52	$4,047.71	$1,878.67	$3,976.14	$1,845.45
Wage Index Equal to or Less Than 1.0000							
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,696.01	$2,265.30	$3,631.04	$2,225.48	$3,674.36	$2,252.02	$3,609.39	$2,212.20

The current (FY 2021) large urban labor rate is $4,071.57 and the non-labor rate is $1,889.74 for a total of $5,961.31 The other area labor rate is $3,696.01 and the non-labor component is $2,265.30 for a total of $5,961.31.

The following table (Page 2,094) illustrates the changes from the FY 2021 national standardized amount to the final FY 2022 national standardized amount. These amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors, etc. as shown below resulting in a gross payment rate of $6,389.57. This amount is further adjusted by multiplying the FY 2022 adjustments.

Changes from the FY 2021 Standardized Amounts to the Final FY 2022 Standardized Amounts

	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 2021 Geographic Reclassification Budget Neutrality (0.986616) 2. FY 2021 Operating Outlier Offset (0.949) 3. FY 2021 Rural Demonstration Budget Neutrality Factor (0.999626) 4. FY 2021 Lowest Quartile Budget Neutrality Factor *(0.997970)* 5. FY 2021 Transition Budget Neutrality Factor (0.998851)	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,319.35 Nonlabor (32.4%) $2,070.22 *(Combined labor and nonlabor = $6,389.57)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $3,961.53 Nonlabor (38%) $2,428.04 *(Combined labor and nonlabor = $6,389.57)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,319.35 Nonlabor (32.4%) $2,070.22 *(Combined labor and nonlabor = $6,389.57)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $3,961.53 Nonlabor (38%) $2,428.04 *(Combined labor and nonlabor = $6,389.57)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,319.35 Nonlabor (32.4%) $2,070.22 *(Combined labor and nonlabor = $6,389.57)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $3,961.53 Nonlabor (38%) $2,428.04 *(Combined labor and nonlabor = $6,389.57)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,319.35 Nonlabor (32.4%) $2,070.22 *(Combined labor and nonlabor = $6,389.57)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $3,961.53 Nonlabor (38%) $2,428.04 *(Combined labor and nonlabor = $6,389.57)*
FY 2022 Update Factor	**1.02**	**0.99975**	**1.01325**	**0.993**
FY 2022 MS-DRG Reclassification and Recalibration Budget Neutrality Factor	1.000107	1.000107	1.000107	1.000107

Changes from the FY 2021 Standardized Amounts to the Final FY 2022 Standardized Amounts				
	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 Wage Index Budget Neutrality Factor	1.000712	1.000712	1.000712	1.000712
FY 2022 Reclassification Budget Neutrality Factor	0.986737	0.986737	0.986737	0.986737
FY 2022 Rural Demonstration Budget Neutrality Factor	0.999361	0.999361	0.999361	0.999361
FY 2022 Low Wage Index Hospital Policy Budget Neutrality Factor	0.998035	0.998035	0.998035	0.998035
FY 2022 Operating Outlier Factor	0.949	0.949	0.949	0.949
Adjustment for FY 2022 Required under Section 414 of Pub. L. 114-10 (MACRA)	1.005	1.005	1.005	1.005
Totals	**$6,121.71**	**$6,000.17**	**$6,081.19**	**$5,959.67**
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 Nonlabor: $1,983.43**	**Labor: $4,056.12 Nonlabor: $1,944.05**	**Labor: $4,110.89 Nonlabor: $1,970.30**	**Labor: $4,028.74 Nonlabor: $1,930.93**
National Standardized Amount for FY 2022 if Wage Index is Less Than or Equal to 1.0000; Labor / Non-Labor Share Percentage (62 / 38)	**Labor: $3,795.62 Nonlabor: $2,326.25**	**Labor: $3,720.11 Nonlabor: $2,280.06**	**Labor: $3,770.34 Nonlabor: $2,310.85**	**Labor: $3,695.00 Nonlabor: $2,264.67**

The change between the final FY 2021 full market-basket rate of increase amount of $5,961.31 and the FY 2022 amount of $6,121.71 is $160.40, or a net increase of approximately 2.75%.

These amounts are before other adjustments such as the hospital value-based purchasing program, the hospital readmission program, and the hospital acquired conditions program.

COMMENT (PAGE 2,186)

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 process or did not choose to participate, but are meaningful EHR users.

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 that do submit quality information.

CMS says 24 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 that do not submit quality data.

Labor-Share (Page 1,053)

CMS is finalizing its proposal to use a labor-related share of 67.6% for discharges occurring on or after Oct. 1, 2021, for all hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.0000.

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Areas with wage index values equal to or less than 1.000 would remain at 62.0, as required by current law.

Outlier Payments (Page 2,055)

The material regarding the FY 2022 outlier payment is extensive.

While most of the data and variables for the fixed loss threshold remain the same from the proposed rule to this final rule, CMS is updating the wage index and other variables such as the applicable percentage increase. The applicable percentage increase may contribute to the slight increase in the final outlier threshold set forth in this final rule of $30,988 as compared to the proposed rule $30,967. (Page 2,083)

The current fixed-loss cost threshold for FY 2021 is $29,051.

For FY 2022, CMS incorporated a projection of outlier reconciliation dollars by targeting an outlier threshold at 5.12% [5.1% - (0.02%)]. Under this approach, CMS says it determined a threshold of $30,988 and calculated total outlier payments of $5,326,356,951 and total operating federal payments of $100,164,666,975.

COMMENT (PAGE 2,091)

CMS' current estimate, using available FY 2020 claims data, is that actual outlier payments for FY 2020 were approximately 5.47% of actual total MS-DRG payments. Therefore, the data indicate that, actual outlier payments relative to actual total payments is higher than projected for FY 2020.

Consistent with policy and CMS' "statutory interpretation" CMS has maintained since the inception of the IPPS, it does not make retroactive adjustments to outlier payments to ensure that total outlier payments in any year are equal to 5.1% of total MS-DRG payments.

Once again, CMS says "if we were to make retroactive adjustments to all outlier payments to ensure total payments are 5.1% of MS-DRG payments (by retroactively adjusting outlier payments),

we would be removing the important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment. Furthermore, we believe it is consistent with the statutory language at section 1886(d)(5)(A)(iv) of the Act not to make retroactive adjustments to outlier payments."

There is something illogical in the above statement. CMS believes any outlier reconciliations between actual payments and forecasts must be fashioned in a retroactive manner. There is no reason such adjustments can be made prospectively by simply adjusting future year's payment amounts by the prior year differences.

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Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2022 (Page 2,105)

CMS is adopting a FY 2022 federal capital rate of $472.60 for FY 2022. The current rate is $466.21. See table below. (Page 2,119)

	FY 2021	FY 2022	Change	Percent Change
Update Factor	1.0110	1.0080	1.0080	0.80
GAF/DRG Adjustment Factor	1.0008	1.0004	1.0004	0.04
Lowest Quartile Adjustment Factor	0.9927	0.9974	1.0047	0.47
Outlier Adjustment Factor	0.9466	0.9471	1.0005	0.05
Capital Federal Rate	$466.21	$472.60	1.0137	1.37

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2022 (Page 2,122)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

Accordingly, for FY 2022, the rate-of-increase percentage to be applied to the target amount for these hospitals would be the FY 2022 operating market basket update percentage increase of 2.7%.

II. CHANGES TO THE HOSPITAL AREA WAGE INDEX (PAGE 958)

For FY 2022, CMS proposes to continue to use the OMB delineations that were adopted beginning with FY 2015 (based on the revised delineations issued in OMB Bulletin No. 13–01) to calculate the area wage indexes, with updates as reflected in OMB Bulletin Nos. 15–01, 17–01 and 18-04.

In connection with CMS' adoption in FY 2021 of the updates in OMB Bulletin 18-04, CMS adopted a policy to place a 5.0% cap, for FY 2021, 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.

After consideration of the comments CMS received to the proposed FY 2022 IPPS rule, CMS is applying an extended transition to the FY 2022 wage index for hospitals. Specifically, for hospitals that received the transition in FY 2021, CMS is continuing a wage index transition for FY 2022 under which CMS will apply a 5.0% cap on any decrease in the hospital's wage index compared to its wage index for FY 2021 to mitigate significant negative impacts of, and provide additional time for hospitals to adapt to, the CMS decision to adopt the revised OMB delineations. (Page 964)

The data for the FY 2022 wage indexes were obtained from Worksheet S-3, Parts II and III of the Medicare cost report (Form CMS-2552-10, OMB Control Number

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0938-0050 with expiration date March 31, 2022) for cost reporting periods beginning on or after Oct. 1, 2017, and before Oct. 1, 2018. (Page 967)

Occupational Mix Adjustment to the FY 2022 Wage Index (Page 986)

The FY 2022 occupational mix adjustment is based on the calendar year (CY) 2019 survey.

The FY 2022 Occupational Mix Adjusted National Average Hourly Wage is $46.52. (Page 986)

The final FY 2022 occupational mix adjusted national average hourly wage is $46.47.

The FY 2022 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows. (Page 990)

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

Application of the Rural Floor, Application of the State Frontier Floor, and Continuation of the Low Wage Index Hospital Policy

Rural Floor (Page 992)
By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS estimates that 269 hospitals will receive an increase in their FY 2022 wage index due to the application of the rural floor.

Imputed Floor (Page 994)
Based on data available for this rule, the following States would be all-urban States as defined in section 1886(d)(3)(E)(iv)(IV) of the Act, and thus hospitals in such States would be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2022: New Jersey, Rhode Island, Delaware, Connecticut, and Washington, D.C.

State Frontier Floor for FY 2022 (Page 1,001)
For FY 2022, 44 hospitals will receive the frontier floor value of 1.0000 for their FY 2022 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming. CMS notes that while Nevada meets the criteria of a frontier State, all hospitals within the State currently receive a wage index value greater than 1.0000.

Continuation of the Low Wage Index Hospital Policy, Proposed Budget Neutrality Adjustment (Page 1,002)
CMS says it will increase the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the

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25th percentile wage index value for that year across all hospitals (the low wage index hospital policy).

For purposes of the low wage index hospital policy, based on the data for this final rule, the 25th percentile wage index value across all hospitals for FY 2022 is 0.8437. The current amount is 0.8465.

Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications (Page 1,010)

The MGCRB had completed its review of FY 2022 reclassification requests. Based on such reviews, there are 406 hospitals approved for wage index reclassifications starting in FY 2022.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2022, hospitals reclassified beginning in FY 2020 or FY 2021 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period.

There were 243 hospitals approved for wage index reclassifications in FY 2020, and 291 hospitals approved in FY 2021. Of all the hospitals approved for reclassification for FY 2020, FY 2021, and FY 2022, based upon the review at the time of this rule, 940 hospitals are in a MGCRB reclassification status for FY 2022 (with 140 of these hospitals reclassified back to their geographic location).

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 1,019)

Table 2, available on the CMS website, includes the out-migration adjustments for the FY 2022 wage index. In addition, Table 4A contains a "List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act" consists of the following: A list of counties that are eligible for the out-migration adjustment for FY 2022 identified by FIPS county code, the FY 2022 out-migration adjustment, and the number of years the adjustment will be in effect.

Reclassification from Urban to Rural Under Section 1886(d)(8)(E) of the Act Implemented at 42 CFR 412.103 (Page 1,022)

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB.

In the FY 2017 IPPS/LTCH PPS final rule, CMS revised § 412.103(b) by adding paragraph (6) to add a lock-in date by which a hospital's application for rural status must be filed in order to be treated as rural in the wage index and budget neutrality calculations for payment rates for the next Federal fiscal year.

The hospital's application must be approved by the CMS Regional Office in accordance with the requirements of § 412.103 no later than 60 days after the public display date at the Office of the Federal Register of the IPPS proposed rule for the next Federal fiscal year.

By timing their applications to be approved after the lock-in date, certain hospitals are receiving a higher rural wage index without having their own data included in the rural wage index calculation. CMS says it believes "this practice of applying for and canceling rural reclassification to manipulate a State's rural wage index is detrimental to the stability and the accuracy of the Medicare wage index system."

continued

CMS' current policy of requiring cancellation requests be submitted not less than 120 day prior to the end of the federal fiscal year will remain in place while the agency evaluates alternative methods to obtain its policy goals. However, to address the potential for rural wage index manipulation in FY 2022 and future years, CMS is finalizing the proposed policy that rural reclassification be in effect for at least 1 year before cancellation can be requested. Specifically, CMS is adding §412.103(g)(4) to state that for all written requests submitted by hospitals on or after Oct., 1, 2021, to cancel rural reclassifications, a hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 1 calendar year after the effective date of the rural reclassification and not less than 120 days prior to the end of a federal fiscal year.

Finalization of Interim Final Rule (IFC) Comment Period on Provisions Related To Modification of Limitations on Redesignation by the Medicare Geographic Classification Review Board (Page 1,032)

CMS is finalizing the provisions of its May 10, 2021, IFC without modification to allow hospitals with a rural redesignation under section 1886(d)(8)(E) of the Act 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 FY 2023.

III. REBASING AND REVISING OF THE HOSPITAL MARKET BASKETS FOR ACUTE CARE HOSPITALS (PAGE 1,054)

COMMENT

This section extends some 50 pages in which CMS explains the basis, the data, and the elements the agency has used to update the hospital market basket from 2014 data to 2018 data.

Bottom line the labor share is being reduced from 68.3 to 67.6% for all hospitals in large urban areas, that is in areas with a wage index greater than 1.000. The current statute mandates that the labor portion of wage indexes in areas equal to or less than 1.000 remain at 62%.

IV. OTHER DECISIONS AND CHANGES TO THE IPPS OPERATING SYSTEM (PAGE 1,104)

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 1,112)

A rural hospital with less than 275 beds may be classified as an RRC if —

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Because of the COVID-19 impacts on FY 2020 data, CMS is using FY 2019 data. Therefore, the final values below are the same as those proposed.

continued

Rural hospitals with fewer than 275 beds can qualify for initial RRC status for cost reporting periods beginning on or after Oct. 1, 2021. They must have a CMI value for FY 2019 that is at least —

- 1.7049; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table.

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.4447
2	Middle Atlantic (PA, NJ, NY)	1.5005
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.60875
4	East North Central (IL, IN, MI, OH, WI)	1.62455
5	East South Central (AL, KY, MS, TN)	1.5577
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.54085
7	West South Central (AR, LA, OK, TX)	1.74375
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7833
9	Pacific (AK, CA, HI, OR, WA)	1.6913

A hospital must also have the number of discharges for its cost reporting period that began during FY 2017 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 1,119)

Currently, the low-volume hospital qualifying criteria provide that a hospital must have fewer 3,800 total discharges during the fiscal year, and the hospital must be located more than 15 road miles from the nearest "subsection (d)" hospital. These criteria will remain in effect through FY 2022.

Beginning with FY 2023, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011.

The Secretary shall determine the applicable percentage increase using a continuous, linear sliding scale ranging from an additional 25% payment adjustment for low-volume hospitals with 500 or fewer
discharges to a zero percent additional payment for low-volume hospitals with more than 3,800 discharges in the fiscal year.

Low-Volume Hospital Payment Adjustment = 0.25 – [0.25/3300] x (number of total discharges - 500) = (95/330) - (number of total discharges/13,200).

continued

In accordance with CMS' previously established process, a hospital must make a written request for low-volume hospital status that is received by its MAC by Sept. 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for low-volume hospital status in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges for the fiscal year beginning on or after Oct. 1 immediately following the request (that is, the start of the Federal fiscal year).

Under this process, a hospital receiving the low-volume hospital payment adjustment for FY 2021 may continue to receive a low-volume hospital payment adjustment for FY 2022 without reapplying if it continues to meet the applicable mileage and discharge criteria.

Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105) (Page 1,125)

The IME formula multiplier remains unchanged at 1.35.

V. PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHS) FOR FY 2022 (§ 412.106) (PAGE 1, 127)

Beginning with discharges in FY 2014, hospitals that qualified for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25% of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75% of uncompensated care payment is the product of three factors.

The 3 factors in determining the amount of such payments are as follows.

Calculation of Factor 1 for FY 2022 (Page 1,136)

This factor represents CMS' estimate of 75% (100% minus 25%) of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The Office of the CMS Actuary's (OACT) July 2021 estimate of 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. The proposed amount was $14.098 billion.

Therefore, the estimate of empirically justified Medicare DSH payments for FY 2022, with the application of section 1886(r)(1) of the Act, is $3,496,188,182.25 (or 25% of the total amount of estimated Medicare DSH payments for FY 2022).

CMS is adopting that Factor 1 for FY 2022 will be $10,488,564,546.74, which is equal to 75% of the total amount of estimated Medicare DSH payments for FY 2022 ($13,984,752,728.99 minus $3,496,188,182,25).

Calculation of Factor 2 for FY 2022 (Page 1,151)

OACT estimates that the uninsured rate for the historical, baseline year of 2013 was 14.0% and for CYs 2021 and 2022 is 10.2% and 10.1%, respectively. "The projected rates of uninsurance for CY 2021 and 2022 reflect the estimated impact of the COVID–19 pandemic. As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates."

- Percent of individuals without insurance for CY 2013: 14.0%.

continued

- Percent of individuals without insurance for CY 2021: 9.8%.
- Percent of individuals without insurance for CY 2022: 9.5%.
- Percent of individuals without insurance for FY 2022 (0.25 times 0.098) + (0.75 times 0.095): 9.6%.
- |((0.096-0.14)/0.14)| = 1-0.3143 = 0.6857 (68.57%). Therefore, the final Factor 2 for FY 2022 is 68.57%.
- The final FY 2022 uncompensated care amount is $10,488,564,546.74* 0.6857 = $7,192,008,709.70.

The following shows the 75% yearly amounts for DSH payments.

- 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

The pool amount for FY 2022 will be $1.098 billion or 13.24% less than the current FY 2021 amount. (Page 2,213)

CMS notes, "The changes in projected FY 2022 uncompensated care payments from payments in FY 2021 are driven by a decrease in Factor 1 and a decrease in Factor 2, as well as by a decrease in the number of hospitals projected to be eligible to receive DSH in FY 2022 relative to FY 2021. Factor 1 has decreased from the FY 2021 final rule's Factor 1 of $11.378 billion to this FY 2022 final rule's Factor 1 of $10.489 billion, while the percent change in the percent of individuals who are uninsured (Factor 2) has decreased from 72.86% to 68.57%. Based on the changes in these two factors, the impact analysis found that, across all projected DSH eligible hospitals, FY 2022 uncompensated care payments are estimated at approximately $7.192 billion, or a decrease of approximately 13.24% from FY 2021 uncompensated care payments (approximately $8.290 billion). While these changes will result in a net decrease in the amount available to be distributed in uncompensated care payments, the projected payment decreases vary by hospital type."

Calculation of Factor 3 for FY 2022 (Page 1,161)

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 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 (Page 1,211)

continued

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.

VI. CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (PAGE 60)

COMMENT

This is another extensive and detailed section regarding MS-DRGs and coding. The section is nearly 400 pages. The material that follows is but a guide for the items being addressed. To fully comprehend the changes requires an in-depth review of the changes being proposed. Most page numbers below refer to the items CMS has reviewed.

A. FY 2022 MS-DRG Documentation and Coding Adjustment (Page 61)

CMS is implementing a positive 0.5 percentage point adjustment to the standardized payment amounts for FY 2022. This will constitute a permanent adjustment to payment rates.

B. Changes to Specific MS-DRG Classifications (Page 65)

(1). Discussion of Changes to Coding System and Basis for FY 2022 MS-DRG Updates

a. Conversion of MS-DRGs to the International Classification of Diseases, 10th Revision (ICD-10) (Page 65)

CMS is making the FY 2022 ICD-10 MS-DRG GROUPER and Medicare Code Editor (MCE) Software Version 39, the ICD-10 MS-DRG Definitions Manual files Version 39 and the Definitions of Medicare Code Edits Manual Version 39 available to the public at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.

b. Non-CC Subgroup (Page 75)

In the FY 2021 IPPS/LTCH PPS final rule, CMS finalized its proposal to expand the existing criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG. Specifically, CMS finalized the expansion of the criteria to include the Non-CC subgroup for a three-way severity level split.

CMS is, as proposed, delaying the application of the Non-CC subgroup criteria to existing MS-DRGs with a three-way severity level split until FY 2023.

(2). Pre-MDC: MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell Therapy (Page 76)

CMS is finalizing its proposal to assign the listed procedure codes describing CAR T-cell, non-CAR T-cell and other immunotherapies to Pre-MDC MS-DRG 018 and to modify the title to "Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies" to better reflect the cases reporting the administration of non-CAR T-cell therapies and other immunotherapies.

continued

(3). MDC 03 (Diseases and Disorders of Ear, Nose and Throat) (Page 92)
CMS is finalizing its proposal to reassign procedure codes 0JB60ZZ, 0JB70ZZ, and 0JB80ZZ describing excision of subcutaneous tissue of chest, back, or abdomen from MS-DRGs 140, 141, and 142 to MS–DRGs 143, 144, and 145 for FY 2022.

(4). MDC 04 (Diseases and Disorders of the Respiratory System) (Page 101)
CMS is adopting its proposal, with modification, to reassign 31 listed procedure codes as shown in Table 6P.2b describing laser interstitial thermal therapy (LITT) of various body parts to the more clinically appropriate MDCs and MS-DRGs for FY 2022. (Page 107)

CMS is finalizing its proposal to remove procedure codes 0DQ50ZZ, 0DQ53ZZ, 0DQ54ZZ, 0DQ57ZZ, and 0DQ58ZZ describing repair of the esophagus from the logic in MDC 04 for FY 2022. (Page 110)

CMS is finalizing the reassignment of 26 procedure codes (9 procedure codes describing repair of pulmonary or thoracic structures, and 17 procedure codes describing procedures performed on the sternum or ribs) , as listed in Table 6P.2c, from MS-DRGs 166, 167, and 168 to MS-DRGs 163, 164, and 165 in MDC 04 for FY 2022. (Page 117)

(5). MDC 05 (Diseases and Disorders of the Circulatory System) (Page 118)
CMS is, as proposed, finalizing its proposal to reassign ICD-10-PCS codes 02HA0RJ, 02HA3RJ, and 02HA4RJ from MDC 05 in MS-DRG 215 to MS-DRGs 216, 217, 218, 219, 220 and 221 in MDC 05, without modification, effective Oct. 1, 2021. (Page 121)

CMS is maintaining the current structure of MS-DRGs 280 through 285. CMS is also proposing to modify the GROUPER logic to allow cases reporting diagnosis code I21.A1 (Myocardial infarction type 2) as a secondary diagnosis to group to MS-DRGs 222 and 223 when reported with qualifying procedures. (Page 147)

CMS is reassigning ICD-10-CM diagnosis code B33.24 from MDC 18 in MS DRGs 865 and 866 (Viral Illness with and without MCC, respectively) to MDC 05 in MS DRGs 314, 315, and 316 (Other Circulatory System Diagnoses with MCC, with CC, and without CC/MCC, respectively). (Page 150)

CMS will maintain the assignment of codes 02L70CK, 02L70DK, and 02L70ZK that describe the open occlusion of the left atrial appendage in MS–DRGs 273 and 274, without modification, for FY 2022. (Page 155)

For FY 2022, CMS is revising the surgical hierarchy for the MS-DRGs in MDC 05 to sequence MS-DRGs 231-236 (Coronary Bypass) above MS-DRGs 228 and 229. (Page 172)

(6). MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) (Page 187)
CMS is adding three procedure code combinations describing removal and replacement of the right knee joint that CMS inadvertently omitted from the logic to MS-DRGs 461, 462, 466, 467, and 468 in MDC 08 and MS-DRGs 628, 629, and 630 in MDC 10 and is adding 11 additional code combinations listed that were provided by a commenter to the logic for MSDRGs 628, 629, and 630 in MDC 10 for FY 2022. (Page 191)

CMS is finalizing its proposal to maintain the structure of MS-DRGs 515, 516, and 517; MS-DRGs 907, 908, and 909; and MSDRGs 957, 958, and 959 for FY 2022. (Page 202)

continued

(7). MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Chronic Renal Replacement Therapy (CRRT)
CMS is not creating new MS-DRGs for cases reporting the use of continuous renal replacement therapy. (Page 216)

(8). MDC 16 (Diseases and Disorders of Blood, Blood Forming Organs and Immunologic Disorders) (Page 216)
ANDEXXA® (coagulation factor Xa (recombinant), inactivated-zhzo)

CMS is not making any MS-DRG changes for cases involving the intravenous administration of ANDEXXA® for FY 2022. (Page 228)

Cytokine Release Syndrome (CRS) Logic

CMS is finalizing its proposal to assign diagnosis code T80.82XA to MDC 16 (Diseases and Disorders of Blood, Blood Forming Organs, and Immunologic Disorders) in MS-DRGs 814, 815, and 816. CMS is also finalizing its proposal to revise the structure of MS-DRGs 814, 815, and 816 by removing the logic that includes a principal diagnosis of T80.89XA with a secondary diagnosis of any CRS code from MS-DRGs 814, 815, and 816 effective FY 2022. (Page 223)

(9). MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms): Inferior Vena Cava Filter Procedures (Page 234)
Based on the results of CMS analysis, for FY 2022, CMS will maintain the current structure of MS-DRGs 829 and 830. (Page 239)

(10). Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (Page 239)
CMS is finalizing its proposal to add procedure codes 0W310ZZ, 0W313ZZ, and 0W314ZZ describing bleeding in the cranial cavity to MDC 01 in MS-DRGs 23, 24, 25, 26, and 27 for FY 2022. (Page 245)

CMS will reassign procedure codes 0JB60ZZ, 0JB70ZZ, and 0JB80ZZ describing excision of subcutaneous tissue from the chest, back, and abdomen, respectively, from MS-DRGs 981, 982, and 983 to MS-DRGs 987, 988, and 989 for FY 2022. (Page 247)

CMS is reassigning procedure code 0T9D0ZZ from MS-DRGs 981, 982, and 983 (Extensive O.R. Procedures Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 987, 988, and 989 (Non-extensive O.R. Procedures Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) for FY 2022. (Page 250)

COMMENT

Beginning with item 11 below, rather than discussing all issues, only page numbers identifying the start of the discussion of the item is presented.

(11). Operating Room (O.R.) and Non-O.R. Issues (Page 254)

- Open Drainage of Subcutaneous Tissue and Fascia (Page 259)
- Open Drainage of Maxilla and Mandible (Page 265)
- Thoracoscopic Extirpation of Pleural Cavities (Page 268)
- Open Pleural Biopsy (Page 271)
- Percutaneous Revision of Intraluminal Devices (Page 272)
- Occlusion of Left Atrial Appendage (Page 273)
- Arthroscopic Drainage of Joints (Page 276)

continued

- Arthroscopic Irrigation of Joints (Page 279)
- Percutaneous Reposition with Internal Fixation (Page 280)
- Open Insertion and Removal of Spacer into Shoulder Joint (Page 282)
- Open/Percutaneous Extirpation of Jaw (Page 284)
- Open Extirpation of Subcutaneous Tissue and Fascia (Page 285)
- Open Revision and Removal of Devices from Subcutaneous Tissue and Fascia (Page 287)
- Open Insertion of Feeding Device (Page 288)
- Laparoscopic Insertion of Feeding Tube (Page 292)
- Endoscopic Fragmentation and Extirpation of Matter of Urinary Tract (Page 294)
- Endoscopic Removal of Ureteral Stent (Page 299)
- Endoscopic/ Transorifice Inspection of Ureter (Page 300)
- Endoscopic Biopsy of Ureter and Kidney (Page 302)
- Transorifice Insertion of Ureteral Stent (Page 303)
- Percutaneous Insertion of Ureteral Stent (Page 304)
- Endoscopic Dilation of Urethra (Page 305)
- Open Repair of the Scrotum (Page 307)
- Drainage of Vestibular Gland (Page 308)
- Transvaginal Repair of Vagina (Page 310)
- Percutaneous Tunneled Vascular Access Devices (Page 312)

(12). Changes to the MS-DRG Diagnosis Codes for FY 2022 (Page 313)

The net result of changes to the Version 39 ICD-10 MS-DRG MCC/CC list, for the 72,621 diagnosis codes in the ICD-10-CM classification, would be a decrease of 507 (3,278 – 2,771) codes designated as an MCC, a decrease of 2,983 (14,679 – 11,696) codes designated as a CC, and an increase of 3,490 (58,154 – 54,664) codes designated as a Non-CC. (Page 323)

CMS is maintaining the severity level designation of all "unspecified" diagnosis codes currently designated as a CC or MCC where there are other codes available in that code subcategory that further specify the anatomic site for FY 2022. (Page 339)

The following tables associated with this final rule reflect the finalized severity levels under Version 39 of the ICD-10 MS-DRGs for FY 2022 and are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

- Table 6I. — Complete MCC List--FY 2022;
- Table 6I.1—Additions to the MCC List--FY 2022;
- Table 6I.2—Deletions to the MCC List--FY 2022;
- Table 6J. — Complete CC List--FY 2022;
- Table 6J.1—Additions to the CC List--FY 2022; and
- Table 6J.2—Deletions to the CC List--FY 2022.

(13). Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Page 359)

CMS is making available on the CMS website the following tables associated with this final rule.

- Table 6A.—New Diagnosis Codes–FY 2022;

continued

- Table 6B.—New Procedure Codes–FY 2022;
- Table 6C.—Invalid Diagnosis Codes–FY 2022;
- Table 6D.—Invalid Procedure Codes–FY 2022;
- Table 6E.—Revised Diagnosis Code Titles–FY 2022;
- Table 6F.—Revised Procedure Code Titles–FY 2022;
- Table 6G.1.— Secondary Diagnosis Order Additions to the CC Exclusions List–FY 2022;
- Table 6G.2.— Principal Diagnosis Order Additions to the CC Exclusions List–FY 2022;
- Table 6H.1.— Secondary Diagnosis Order Deletions to the CC Exclusions List–FY 2022;
- Table 6H.2.— Principal Diagnosis Order Deletions to the CC Exclusions List—FY 2022;
- Table 6I.— Complete MCC List–FY 2022;
- Table 6I.1.— Additions to the MCC List–FY 2022;
- Table 6I.2. —Deletions to the MCC List–FY 2022;
- Table 6J.— Complete CC List–FY 2022;
- Table 6J.1.— Additions to the CC List–FY 2022;
- Table 6J.2.— Deletions to the CC List–FY 2022; and
- Table 6K.— Complete List of CC Exclusions–FY 2022

(14). Changes to the Medicare Code Editor (MCE) (Page 362)

(15). Changes to Surgical Hierarchies (Page 377)

CMS is finalizing the surgical hierarchy for the MS-DRGs in MDC 05 as illustrated in the table for the surgical hierarchy within Appendix D MS–DRG Surgical Hierarchy by MDC and MS–DRG of the ICD–10 MS–DRG Definitions Manual Version 39, without modification, for FY 2022.

(16). Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems (Page 384)

COMMENT

It is very difficult navigating the many MS-DRG sections. The changes in our item 11 regarding O.R. and Non-O.R are actually numbered the same as the headings reflected in the rule. That is, Percutaneous Tunneled Vascular Access Devices is number item 26 by CMS. At the conclusion of its discussion, the next item is number 12 -Changes to the MS-DRG Diagnosis Codes for FY 2022. One would expect the next item to be number 27. To help the reader, we have not numbered the individual components in section 11 above.

VII. ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2022 (PAGE 439)

COMMENT

The new technology material is the longest section of this rule extending some 518 pages. It contains much detail about each item's technical components and its application process. It appears more focused to manufactures than to hospitals. Hospitals need to know which new technologies are covered by Medicare. Most do not need to know the extensive and complex developmental issues.

FY 2022 Status of Technologies Approved for FY 2021 New Technology Add-On Payments (Page 456)

continued

CMS' policy is that a medical service or technology may continue to be considered "new" for purposes of new technology add-on payments within 2 or 3 years after the point at which data begin to become available reflecting the inpatient hospital code assigned to the new service or technology.

CMS will continue the new technology add-on payment for FY 2022 for those technologies that were approved for the new technology add-on payment for FY 2021 and which would still be considered "new" for purposes of new technology add-on payments for FY 2022.

CMS notes that the table below is the same table used in the proposed rule except for 2 items.

Based on updated information, the maximum new technology add-on payment for Jakafi® for FY 2022 would be $4,475.38 as reflected in the table below. (Page 458)

Azedra® is still new for FY 2022 and is eligible to continue new technology add-on payments for FY 2022 since the 3-year anniversary date of the entry of Azedra® onto the U.S. market (May 21, 2022) will occur in the second half of FY 2022. Therefore, CMS is including Azedra® in the table below. (Page 459)

Continuation of Technologies Approved for FY 2021 New Technology Add-on Payments Still Considered New for FY 2022

	Technology	FDA/ Newness Start Date	NTAP Start Date	NTAP Status for FY 2022	Maximum NTAP Amount for FY 2022	Coding Used to Identify Cases Eligible for NTAP
1	Balversa™	4/12/2019	10/1/2019	Continue because 3-year anniversary date (4/12/2022) will occur in the second half of FY 2022	$3,563.23	XW0DXL5
2	Jakafi®	5/24/2019	10/1/2019	Continue because 3-year anniversary date (4/12/2022) will occur in the second half of FY 2022	$4,096.21	XW0DXT5
3	Barostim NEOTMSystem	08/16/2019	10/1/2020	Continue because 3-year anniversary date (8/16/2022) will occur in the second half of FY 2022	$22,750.00	0JH60MZ in Combination with 03HK0MZ or 03HL0

continued

Continuation of Technologies Approved for FY 2021 New Technology Add-on Payments Still Considered New for FY 2022						
	Technology	FDA/ Newness Start Date	NTAP Start Date	NTAP Status for FY 2022	Maximum NTAP Amount for FY 2022	Coding Used to Identify Cases Eligible for NTAP
4	FETROJA® (Cefiderocol)	11/19/2019 commercially available in US 2/24/2020	10/1/2020	Continue because 3-year anniversary date (2/24/2023) will occur after FY 2022	$7,919.86	XW03366 or XW04366
5	Optimizer® System	10/23/2019	10/1/2020	Continue because 3-year anniversary date (10/23/2022) will occur after FY 2022	$14,950.00	0JH60AZ, 0JH63AZ, 0JH80AZ or 0JH83AZ
6	RECARBRIO™	07/16/2019 commercially available in US 1/6/2020	10/1/2020	Continue because 3-year anniversary date (1/6/2023) will occur after FY 2022	$3,532.78	XW033U5 or XW043U5
7	Soliris®	06/27/2019	10/1/2020	Continue because 3-year anniversary date (6/27/2022) will occur in second half of FY 2022	$21,199.75	XW033C6 and XW043C6
8	XENLETA™	08/19/2019 commercially available in US 9/10/2019	10/1/2020	Continue because 3-year anniversary date (9/10/2022) will occur in the second half of FY 2022	$1,275.75	XW03366, XW04366 or XW0DX66
9	ZERBAXA®	06/03/2019	10/1/2020	Continue because 3-year anniversary date (6/3/2022) will occur in the second half of FY 2022	$1,836.98	XW03396 or XW04396
10	Azedra®	05/21/2019	10/1/2019	Continue because 3-year anniversary date (5/21/2022) will occur in the second half of FY 2022	$98,150.00	XW033S5 and XW043S5

continued

Extend New Technology Add-On Payments A (Page 462)

The following table lists the technologies for which CMS is finalizing a 1-year extension of new technology add-on payments for FY 2022, including the newness start date, new technology add-on payment start date, maximum add-on payment amount, and coding assignments.

	Technology	FDA/Newness Start Date	NTAP Start Date	NTAP Status for FY 2022	Maximum NTAP Amount for FY 2022	Coding Used to Identify Cases Eligible for NTAP
1	Cablivi®	02/06/2019	10/01/2019	One year extension; 3-year anniversary date (2/6/2022) will occur prior to the second half of FY 2022	$33,215.00	XW013W5, XW033W5 and XW043W5
2	Elzonris™	12/21/2018	10/01/2019	One year extension;3-year anniversary date (12/21/2021) will occur prior to the second half of FY 2022	$144,116.04	XW033Q5 and XW043Q5
3	AndexXa™	05/03/2018	10/01/2018	One year extension; 3-year anniversary date (5/3/2021) will occur prior to the second half of FY 2022	$18,281.25	XW03372 or XW04372
4	Spravato®	3/5/2019	10/01/2019	One year extension; 3-year anniversary date (3/5/2022) will occur prior to the second half of FY 2022	$1,014.79	XW097M5
5	Zemdri®	6/25/2018	10/01/2018	One year extension; 3-year anniversary date (6/25/2021) will occur prior to the second half of FY 2022	$4,083.75	XW033G4 and XW04G4

continued

	Technology	FDA/Newness Start Date	NTAP Start Date	NTAP Status for FY 2022	Maximum NTAP Amount for FY 2022	Coding Used to Identify Cases Eligible for NTAP
6	T2 Bacteria® Panel	05/24/2018	10/01/2019	One year extension; 3-year anniversary date (5/24/2021) will occur prior to the second half of FY 2022	$97.50	XXE5XM5
7	ContaCT	02/13/2018 (commercially available 10/01/2018)	10/01/2020	One year extension; 3-year anniversary date (10/1/2021) will occur prior to the second half of FY 2022	$1,040.00	4A03X5D
8	Eluvia™ Drug-Eluting Vascular Stent System	09/18/2018 commercially available in US 10/04/2018	10/01/2020	One-year extension; 3-year anniversary date (10/04/2021) will occur prior to the second half of FY 2022	$3,646.50	X27H385, X27H395, X27H3B5, X27H3C5, X27J385, X27J395, X27J3B5, X27J3C5, X27K385, X27K395, X27K3B5, X27K3C5, X27L385, X27L395, X27L3B5, X27L3C5
9	Hemospray®	05/07/2018 (commercially available 07/01/2018)	10/01/2020	One-year extension; 3-year anniversary date (07/01/2021) will occur prior to the second half of FY 2022	$1,625.00	XW0G886 and XW0H886
10	IMFINZI®/ TECENTRIQ®	Imfinzi: 03/27/2020 Tecentriq: 03/18/2019 Newness date is 3/18/2019 for both	10/01/2020	One-year extension; 3-year anniversary date (03/18/2022) will occur prior to the second half of FY 2022	$6,875.90	Imfinzi XW03336 or XW04336 Tecentriq XW033D6 or XW043D6

continued

Technology		FDA/Newness Start Date	NTAP Start Date	NTAP Status for FY 2022	Maximum NTAP Amount for FY 2022	Coding Used to Identify Cases Eligible for NTAP
11	NUZYRA®	10/02/2018 (commercially available 02/01/2019)	10/01/2020	One-year extension; 3-year anniversary date (0(2/01/2022) will occur prior to the second half of FY 2022	$1,552.50	XW033B6 or XW043B6
12	SpineJack® System	08/30/2018 (commercially available 10/11/2018)	10/01/2020	One-year extension; 3-year anniversary date (10/11/2021) will occur prior to the second half of FY 2022	$3,654.72	XNU0356 and XNU4356
13	Xospata®	11/28/2018	10/01/2019	One-year extension; 3-year anniversary date (11/28/2021) will occur prior to the second half of FY 2022	$7,312.50	XW0DXV5

FY 2022 Applications for New Technology Add-On Payments (Traditional Pathway) (Page 472)

CMS received 26 applications for new technology payments under the traditional pathway process for FY 2022.

Four applicants withdrew their applications prior to the issuance of the FY 2022 IPPS/LTCH PPS proposed rule. Five applicants, Iovance Biotherapeutics, Omeros Corporation, Mallinckrodt Pharmaceuticals, Janssen Biotech, Inc., and Vericel withdrew their applications for lifileucel, narsoplimab, TERLIVAZ (terlipressin), ciltacabtagene autoleucel, and Nexobrid respectively, prior to the issuance of this FY 2022 IPPS/LTCH PPS final rule. In addition, in accordance with the regulations under § 412.87(c), applicants for new technology add-on payments must have FDA approval or clearance by July 1 of each year prior to the beginning of the fiscal year for which the application is being considered. One applicant, Ischemia Care, LLC for ISC-REST, did not receive FDA approval for its technology by July 1, 2021. Therefore, ISC-REST is not eligible for consideration for new technology add-on payments for FY 2022. A discussion of the 16 remaining applications is presented below. Seven are approved and 9 are not approved.

- a. Aidoc Briefcase for PE –not approved (Page 472)
- b. RYBREVANT™ (amivantamab) – approved, the maximum new technology add-on payment for a case involving the use of RYBREVANT™ is $6,405.89 for FY 2022. (Page 497)

continued

- c. Breyanzi® (lisocabtagene maraleucel) – not approved (Page 518)
- d. COSELA (trilaciclib) – approved, the maximum new technology add-on payment for a case involving the use of COSELA™ is $5,526.30 for FY 2022. (Page 550)
- e. Ellipsys® Vascular Access System – not approved (Page 571)
- f. ENSPRYNG™ (satralizumab-mwge) – not approved (Page 578)
- g. ABECMA® (idecabtagene vicleucel) – approved, the maximum new technology add-on payment for a case involving the use of ABECMA® is $272,675.00 for FY 2022. (Page 604)
- h. INDIGO Aspiration System with Lightning Aspiration Tubing – not approved (Page 626)
- i. Olumiant® (baricitinib) – not approved (Page 649)
- J. Pure-Vu® System—not approved (Page 660)
- k. Rapid ASPECTS – not approved (Page 682)
- l. Steripath® MicroTM Blood Collection System – not approved (Page 718)
- m. StrataGraftTM Skin Tissue – approved, the maximum new technology add-on payment for a case involving the use of StrataGraft™ is $44,200 for FY 2022. (Page 745)
- n. Tecartus™ (brexucabtagene autoleucel) – approved, the maximum new technology add-on payment for a case involving the use of TECARTUS® is $259,350 for FY 2022. (Page 773)
- o. VEKLURY® (remdesivir) – approved, the maximum new technology add-on payment for a case involving the use of VEKLURY® is $2,028 for FY 2022. (Page 810)
- p. ZEPZELCA™ (lurbinectedin) – approved, the maximum new technology add-on payment for acase involving the use of ZEPZELCA™ is $8,622.90 for FY 2022. (Page 836)

FY 2022 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 869)

CMS received 17 applications for new technology payments under the alternative pathway process. Two applicants withdrew their applications for the Neovasc Reducer™ and Thoraflex™ Hybrid Device prior to the issuance of this final rule. Two applicants, BONESUPPORT Inc. (the applicant for CERAMENT® G) and Phagenesis Ltd. (the applicant for the Phagenyx® System), did not meet the deadline of July 1, 2021 for FDA approval or clearance of the technology and, therefore, the technologies are not eligible for consideration for new technology add-on payments for FY 2022. A one application was withdrawn prior to the proposed rule.

Therefore, of the 12 remaining applications, 9 technologies received a Breakthrough Device designation from FDA and 3 were designated as a QIDP by FDA.

a. Alternative Pathway for Breakthrough Devices

(1) Aprevo™ Intervertebral Body Fusion Device (Page 872)

continued

The maximum new technology add-on payment for a case involving the use of the aprevo™ Intervertebral Body Fusion Device will be $20,475 for FY 2022 (that is 65% of the average cost of the technology).

(2) aScope™ Duodeno (Page 881)
The maximum new technology add-on payment for a case involving the use of the aScope™ Duodeno or EXALT™ Model D will be $ 1,715.59 for FY 2022 (that is 65% of the case-weighted average cost of both technologies).

(3) Caption Guidance™ (Page 886)

The maximum new technology add-on payment for a case involving the use of the Caption Guidance™ system will be $1,868.10 for FY 2022 (that is 65% of the average cost of the technology).

(5) EXALT™ Model D Single-Use Duodenoscope (Page 894)

The maximum new technology add-on payment for a case involving the use of the EXALT™ Model D Single-Use Duodenoscope or aScope™ Duodeno will be $1,715.59 for FY 2022 (that is 65% of the case-weighted average cost of both technologies).

(6) FUJIFILM EP-7000X System (Page 899)

CMS says that no new technology add-on payment will be made for the FUJIFILM EP-7000X System.

(7) Harmony™ Transcatheter Pulmonary Valve (TPV) System (Page 909)

The maximum new technology add-on payment for a case involving the use of the Harmony™ Transcatheter Pulmonary Valve (TPV) System will be $26,975 for FY 2022 (that is 65% of the average cost of the technology).

(10) INTERCEPT Fibrinogen Complex (PRCFC) (pathogen reduced cryoprecipitated fibrinogen complex) (Page 916)

The maximum new technology add-on payment for a case involving the use of INTERCEPT Fibrinogen Complex, is $2,535 for FY 2022 (that is 65% of the average cost of the technology).

(11) RECELL® Autologous Cell Harvesting Device (Page 921)

Because the RECELL® Autologous Cell Harvesting Device will not be within the newness period for FY 2022 and is therefore ineligible to receive new technology add-on payments, CMS is not approving new technology add-on payments for the RECELL® Autologous Cell Harvesting Device for FY 2022.

(12) Shockwave C2 Intravascular Lithotripsy (IVL) System (Page 925)

The maximum new technology add-on payment for a case involving the use of the Shockwave C2 Intravascular Lithotripsy (IVL) System is $3,666 for FY 2022 (that is 65% of the average cost of the technology).

COMMENT

Yes, CMS does not list numbers 4, 8, and 9 above and has not approved numbers 6, 11, and 13.

b. Alternative Pathways for Qualified Infectious Disease Products (QIDPs) (Page 930)

(1) CONTEPO™ (fosfomycin) (Page 930)

Subject to CONTEPO receiving marketing authorization by July 1, 2022, the maximum new technology add-on payment for a case involving the use of

continued

CONTEPO™ will be for $2,625 for FY 2022 (that is 75% of the average cost of the technology).

(2) FETROJA® (cefiderocol) (Page 936)

The maximum new technology add-on payment for a case involving the use of FETROJA® for the HABP/VABP indication is $8,579.84 for FY 2022 (that is 75% of the average cost of the technology).

(3) RECARBRIO™ (imipenem, cilastatin, and relebactam) (Page 940)

The maximum new technology add-on payment for a case involving the use of the RECARBRIO™ for the treatment of HABP/VABP is $9,577 for FY 2022 (that is 75% of the average cost of the technology).

COMMENT

Without a doubt, this is the most technical aspect of this rule. It's also the longest at more than 500 pages.

VIII. HOSPITAL READMISSIONS REDUCTION PROGRAM: PROPOSED UPDATES AND CHANGES (§§ 412.150 THROUGH 412.154) (PAGE 1,219)

The Hospital Readmissions Reduction Program currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery program.

CMS will suppress the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506) and provide information on technical specification updates for the remaining five condition/procedure-specific readmission measures to exclude COVID-19 diagnosed patients from the measure denominators beginning in FY 2023.

CMS notes that the FY 2022 applicable period for this measure would only be affected by a shortened performance period (July 1, 2017 through Dec. 1, 2019) that does not use data from the COVID-19 PHE. Therefore, CMS has determined that it is not necessary to suppress this measure for the FY 2022 program year.

A hospital subject to the Hospital Readmissions Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

CMS estimates that 2,500 hospitals will have their base operating DRG payments reduced by their determined proxy FY 2022 hospital-specific readmission adjustment. (Page 2,217)

IX. HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: POLICY CHANGES (PAGE 1,274)

The Hospital VBP Program adjusts payments to IPPS hospitals for inpatient services based on their performance on an announced set of measures. CMS will:

- CMS is finalizing its proposals to suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Medicare Spending Per Beneficiary (MSPB) and five healthcare-associated infection (HAI) measures, as well as changing the scoring and payment methodologies for the FY 2022 program year.

continued

- CMS will not award hospitals a total performance score (TPS), and will instead award hospitals a payment incentive multiplier that results in a value-based incentive payment amount that is equal to the amount withheld for the fiscal year (2.0%). That is, each hospital will receive a 2.0% reduction to its base operating DRG payment amount for each FY 2022 discharge and will then receive a value-based incentive payment percentage that will result in a value-based incentive payment amount that is equal to the 2.0% withheld. Under these finalized policies, the impact for every hospital under the Hospital VBP Program will be a net percentage payment adjustment of zero. (Page 2,219)

CMS is also finalizing its proposal to suppress the MORT-30-PN measure for the FY 2023 program year.

X. HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM (PAGE 1,355)

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to reduce payment by one percent for "applicable hospitals," which are subsection (d) hospitals that rank in the worst performing quartile on select measures of hospital-acquired conditions.

In the FY 2022 IPPS/LTCH PPS final rule, CMS is:

- Establishing a measure suppression policy which will 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.

The previously finalized measures, with their full measure names, are shown in the table below.

HAC Reduction Program Measures for FY 2021 and Subsequent Years		
Short Name	Measure Name	NQF #
CMS PSI 90	CMS Patient Safety and Adverse Events Composite (PSI)	0531
CAUTI	CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	CDC NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
CLABSI	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus(MRSA) Bacteremia Outcome Measure	1716

CMS is not proposing to adopt or remove any measures.

continued

XI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (PAGE 1,502)

This title appears to be a new banner from CMS regarding overall inpatient quality programs, including the Hospital Inpatient Quality Reporting (IQR) program.

CMS' table of contents identifies the following components:

- In section IX.A., advancing to digital quality measurement and the use of Fast Healthcare interoperability Resources (FHIR) in hospital quality programs;
- In section IX.B., closing the health equity gap in CMS hospital quality programs;
- In section IX.C., the Hospital IQR Program;
- In section IX.D., the PCHQR Program; and
- In section IX.E., the LTCH QRP.

Hospital IQR program (Page 1,561)

CMS will adopt the following new measures: (Page 1,563)

- A new Maternal Morbidity Structural Measure, which will assess hospital participation in a statewide or national perinatal Quality Improvement initiative and implementation of safety practices or bundles. This measure will encourage hospitals to standardize protocols addressing obstetric emergencies and complications arising during pregnancy and childbirth, beginning with a shortened CY 2021 reporting period/FY 2023 payment determination (Page 1564);
- Adoption of the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure with Claims and Electronic Health Record Data (NQF#3502) Voluntary from July 1, 2022 through June 30, 2023, and Mandatory Beginning July 1, 2023 through June 30, 2024, affecting the FY 2026 Payment Determination and Subsequent Years (Page 1,577);
- Adoption of the COVID-19 Vaccination Coverage Among HCP Measure Beginning with Shortened Reporting Period from Oct. 1, 2021 through Dec. 31, 2021, Affecting the CY 2021 Reporting Period/FY 2023 Payment Determination, and for Subsequent Years (Page 1,604);
- Two medication-related adverse event electronic clinical quality measures (eCQMs) (Hospital Harm-Severe Hypoglycemia eCQM (NQF #3503e) and Hospital Harm-Severe Hyperglycemia eCQM (NQF #3533e)) beginning with the CY 2023 reporting period/FY 2025 payment determination. (Page 1,629 & 1,642)

In addition, CMS proposed removing five measures from the Hospital IQR. It will now remove 4 and retain one. (Page 1,654)

- The Exclusive Breast Milk Feeding (NQF #0480) beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS is finalizing the removal of this measure because of the availability of a measure that is more strongly associated with patient outcomes. Specifically, in keeping with the agency's focus on maternal health, CMS is finalizing the adoption of the Maternal Morbidity Structural Measure; (Page 1,659);
- Admit Decision Time to Emergency Department (ED) Departure Time for Admitted Patients (NQF #0497) beginning with the CY 2024 reporting period/FY 2026 payment

continued

determination. CMS is finalizing the removal of this measure because the costs associated with the measure outweigh the benefit of its continued use in the program; (Page 1,665)

- Discharged on Statin Medication eCQM (STK-06) (NQF #0439), beginning with the CY 2024 reporting period/FY 2026 payment determination. While CMS continues to believe that ensuring appropriate pharmacotherapy for stroke patients is an important topic, within the Hospital IQR Program portfolio of stroke measures, CMS identified STK-06 as appropriate for removal. (Page 1,681)
- Discharged on Statin Medication (STK-06) (Page 1,681)
- Anticoagulation Therapy for Atrial Fibrillation/Flutter eCQM (STK-03) or the Death Rate Among Surgical Inpatients with Serious Treatable Complications (PSI-04). CMS is not finalizing its proposal to remove the Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) eCQM. (Page 1,668 & 1,681)

Additionally, beginning with the CY 2023 reporting period/FY 2025 payment determination, CMS is finalizing the requirement for hospitals to use certified EHR technology that has been updated consistent with the 2015 Edition Cures Update and is clarifying that certified technology must support the reporting requirements for all available eCQMs.

The table beginning on page 1,686 summarizes the previously finalized and newly proposed Hospital IQR Program measure set for the FY 2023 payment determination.

The table on page 1,687 summarizes the previously finalized and newly proposed Hospital IQR Program measure set for the FY 2024 payment determination.

Updates to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (Page 1,754)

The PCHQR Program collects and publishes data on applicable quality measures. CMS is removing the Oncology Plan of Care for Pain – Medical Oncology and Radiation Oncology (NQF #0383) (PCH-15) measure. This measure is being removed because it is not feasible to implement the measure specifications because the measure steward has decided to revert to a previous version of the measure and will no longer maintain the specifications for this measure as it is currently used in the PCHQR Program.

CMS is also codifying existing PCHQR Program policies in its regulations, and adopting the COVID-19 Vaccination Coverage Among Healthcare Personnel measure. (Page 1,760)

Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (Page 1,786)

The LTCH QRP is a pay-for-reporting program. LTCHs that do not meet LTCH QRP reporting requirements are subject to a two-percentage points reduction in their annual percentage unit.

In the FY 2022 IPPS/LTCH PPS final rule, CMS is:

- Finalizing the COVID-19 Vaccination Coverage Among Healthcare Personnel Measure;
- Finalizing updates to the denominator for the Transfer of Health (TOH) Information to the Patient-Post Acute Care (PAC) quality measure;
- Finalizing its proposal to publicly report Quality Measures with fewer than the standard numbers of quarters due to COVID-19 PHE exemptions;

continued

- Finalizing its proposal to publicly report the Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay measure beginning with the March 2022 Care Compare refresh or as soon as technically feasible; and
- Finalizing its proposal to publicly report the Ventilator Liberation Rate for the PAC LTCH QRP measure beginning with the March 2022 Care Compare refresh or as soon as technically feasible.

Other

CMS has addressed 2 other quality aspects. The first pertains to "Closing the Health Equity Gap, and the second concerns "The Future of Digital Quality Measurement." Please review the rule for more information.

XII. CHANGES TO THE PAYMENT RATES FOR THE LTCH PPS FOR FY 2022 (PAGE 2, 124)

Updates to the Payment Rates for the LTCH PPS for FY 2022

CMS is establishing an annual update to the LTCH PPS standard federal payment rate of 1.9%. (Page 2,125)

The LTCH PPS standard federal payment rate for FY 2021 is $43,755.34. (Page 2,125)

CMS is establishing an LTCH PPS standard Federal payment rate of $44,713.67 2022 (calculated as $43,755.34 x 1.019 x 1.002848) for FY 2022. For LTCHs that fail to submit quality reporting data for FY 2022, in accordance with the requirements of the LTCH QRP under section 1866(m)(5) of the Act, CMS is establishing an LTCH PPS standard Federal payment rate of $43,836.08 (calculated as $43,755.34 x 0.999 (1.9-2.0%) x 1.00284 (Budget Neutrality factor) for FY 2022.

The FY 2022 wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS web site.

CMS is adopting a total labor related share for FY 2022 of 67.9%. The current value is 68.1%. (Page 2,132)

Adjustment for High-Cost Outlier (HCO) Cases (Page 2,140)

CMS did not propose any changes to the methodology for calculating the proposed applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases.

The fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875% of 8% (that is, 7.975%) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

CMS is finalizing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2022 of $33,015 that would result in estimated outlier payments projected to be equal to 7.975% of estimated FY 2022 payments for such cases. The current amount is $27,195.

High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Approximately 75% of LTCH cases were paid the LTCH PPS standard Federal payment rate and approximately 25% of LTCH cases were paid the site neutral payment rate for discharges occurring in FY 2019.

continued

CMS says it continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2022 is the IPPS fixed-loss amount, which is $30,998.

FINAL COMMENTS

One can appreciate the need and burden to carefully review these rules. But the sheer size makes it more and more difficult each year. Again, too much old history and redundancy are creating excessive material.

There are too many items that cannot be covered in this analysis. This analysis has not discussed a number of issues relating to eCQMs, timing reporting, validations, some related quality items, the Medicare Shared Savings Program, and the Medicare Promoting Interoperability Program.

We note that CMS is increasing its referrals to readers to older Federal Register cites for additional information. While this is an excellent way to help reduce printed historical information. The process is cumbersome. The CMS cites are not web linked. You cannot simply click on the reference to find the material.

The following items are important and are applicable to most, if not all, items in this rule.

Use of the FY 2019 Inpatient Hospital Utilization Data Instead of FY 2020 Data Due to the COVID-19 Public Health Emergency

CMS is proposing to use FY 2019 data, prior to the COVID-19 PHE to approximate the expected FY 2022 inpatient hospital utilization.

Establishment of Measure Suppression Policy in Response to COVID-19 PHE in Certain Value-Based Purchasing Programs

In response to the impact of the COVID-19 PHE, CMS is proposing a measure suppression policy in the Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, and Hospital Value-Based Purchasing (VBP) Program that would allow CMS to suppress the use of measure data if the agency determines that circumstances caused by the COVID-19 PHE have affected those measures and the resulting quality scores significantly.

TABLES (PAGE 2, 170)

The following IPPS tables for this rule are generally available on the CMS website at http://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."

- Table 2. Case-Mix Index and Wage Index Table by CCN—FY 2022 Proposed Rule
- Table 3. Wage Index Table by CBSA—FY 2022 Proposed Rule
- Table 4A. List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2022 Final Rule
- Table 4B. List of Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR Counties)—FY 2022 Final Rule

continued

- Table 5. List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay—FY 2022
- Table 6A. New Diagnosis Codes—FY 2022
- Table 6B. New Procedure Codes—FY 2022
- Table 6C. Invalid Diagnosis Codes—FY 2022
- Table 6D Invalid Procedure Codes—FY 2022
- Table 6E. Revised Diagnosis Code Titles--FY 2022
- Table 6F. Revised Procedure Code Titles
- Table 6G.1. Secondary Diagnosis Order Additions to the CC Exclusions List—FY 2022
- Table 6G.2. Principal Diagnosis Order Additions to the CC Exclusions List—FY 2022
- Table 6H.1. Secondary Diagnosis Order Deletions to the CC Exclusions List—FY2022
- Table 6H.2. Principal Diagnosis Order Deletions to the CC Exclusions List—FY2022
- Table 6I.1. Additions to the MCC List—FY 2022
- Table 6I.2. Deletions to the MCC List—FY 2022
- Table 6J.1. Additions to the CC List—FY 2022
- Table 6J.2. Deletions to the CC List—FY 2022
- Table 6K. Complete list of CC Exclusions—FY 2022
- Table 6P. ICD-10-CM and ICD-10-PCS Codes for MS-DRG Change—FY 2022 (Table 6P contains multiple tables, 6P.1a. through 6P.4a., that include the ICD-10-CM and ICD-10-PCS code lists relating specific MS-DRG changes).
- Table 7A. Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2019 MedPAR Update--March 2020 GROUPER Version 38 MS-DRGs
- Table 7B. Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2019 MedPAR Update--2020 GROUPER Version 39 MS-DRGs
- Table 8A. FY 2022 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
- Table 8B. Final FY 2022 Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals
- Table 18. Final FY 2022 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this FY 2022 proposed rule are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1752-P:

- Table 8C. Proposed FY 2022 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)

continued

- Table 11. Proposed MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from Oct. 1, 2020 through Sept. 30, 2021
- Table 12A. LTCH PPS Wage Index for Urban Areas for Discharges Occurring from Oct. 1, 2021 through Sept. 30, 2022
- Table 12B. LTCH PPS Wage Index for Rural Areas for Discharges Occurring from Oct. 1, 2021 through Sept. 30, 2022

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

DRG WEIGHTS

The following table identifies those MS-DRGs with 100,000 or more discharges from the final rule's tables 5 and 7B.

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS) RELATIVE WEIGHTING FACTORS					
MS-DRG	MS-DRG Title	Discharges	Final FY 2021 Weights	Final FY 2022 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	107,773	1.0182	1.0200	0.177%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	145,611	1.2248	1.2261	0.106%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	129,626	1.1239	1.1251	0.107%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	149,990	1.3107	1.3120	0.099%
194	SIMPLE PNEUMONIA & PLEURISY W CC	102,467	0.8630	0.8639	0.104%
291	HEART FAILURE & SHOCK W MCC	466,399	1.3409	1.2683	-5.414%
378	G.I. HEMORRHAGE W CC	127,141	0.9932	0.9935	0.030%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	136,999	0.7644	0.7658	0.183%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	359,905	1.8999	1.9003	0.021%
682	Renal FAILURE W MCC	103,536	1.4702	1.4727	0.170%
683	RENAL FAILURE W CC	126,958	0.8781	0.8793	0.137%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	128,722	0.7922	0.7940	0.227%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	610,261	1.8682	1.8722	0.214%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	156,077	1.0216	1.0263	0.460%

These 14 MS-DRGs contain 2.851 million discharges. The DRG with the second most occurring discharges – DRG 470 – will lose 5.414%. This is a significant change payment wise.

This is the first time that almost all DRG weights are increasing in value albeit very small increases.