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FY 2022 Hospital IPPS/LTCH PPS Final Rule

Attorneys
Stephanie A. Webster
Alex J. Talley
Joshua Balk
Mara Sanders
Kathleen Swanson
Kelly Hamachi

On August 13, 2021, CMS published in the Federal Register the final rule for the federal fiscal year 2022 inpatient prospective payment system ("IPPS"). Earlier this year, just after the publication of the IPPS proposed rule, we circulated an alert summarizing certain aspects of CMS's proposals. Below is a quick summary of what occurred with each of these topics in the final rule. As discussed below, CMS decided not to finalize many of the more notable proposals in this final rule, instead stating it would address these topics in future publications. Otherwise, CMS adopted the majority of its proposals. Please feel free to reach out if you have any questions about any of these issues.

A. COVID-19-RELATED REIMBURSEMENT AND REPORTING

- **Extension of New COVID-19 Treatments Add-On Payment.** In the Final Rule, CMS adopted its proposed extension of the New COVID-19 Treatments Add-On Payment ("NCTAP") through the end of the fiscal year in which the public health emergency ends. The agency declined to finalize its proposal to discontinue the NCTAP for discharges on or after October 1, 2021 for any product that is approved for new technology add-on payments beginning FY 2022. Instead, the Final Rule extends NCTAP through the end of the FY in which the PHE ends for all eligible products. Additionally, CMS is reducing the NCTAP for an eligible case by the amount of any new technology add-on payments.

- **Inclusion of COVID-19 Vaccination Rates among Health Care Personnel in Hospital Inpatient Quality Reporting Program.** CMS finalized its proposal as written with one exception – the agency stated that it would report only the most recent quarter of HCP vaccination data. In the proposed rule, the agency planned to report vaccination rates using four rolling quarters of data.

- **Data Suppression Measures in Response to COVID-19: Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program and Hospital-Acquired Conditions Program.** CMS largely finalized as proposed the data suppression measures designed to account for COVID-19.

B. INDIRECT AND DIRECT GRADUATE MEDICAL EDUCATION

- **Proposals Implementing Consolidated Appropriations Act of 2021.** CMS declined to finalize these proposals implementing provisions of the Consolidated Appropriations Act of 2021 ("CAA") relating to changes to the IME and GME programs. These proposals addressed: 1) new GME and IME resident slots; 2) changes to the Rural Training Track Program; and 3) calculation of new FTE caps and per resident amounts for certain hospitals with low FTE caps and per resident amounts. The agency stated that "[d]ue to the number and nature of the comments that we received on the implementation of sections 126, 127 and 131 of the CAA of 2021 relating to payments to hospitals for direct GME and IME costs, we will address public comments associated with these issues in future rulemaking."

- **Proposed Requirements for IRIS Report Supporting Cost Report.** CMS adopted this requirement as proposed, except the agency included a one year grace period before cost reports are rejected for lack of compliance ("However, for cost reporting periods beginning on or after October 1, 2021 and before October 1, 2022, the cost reports will not be rejected if the total IME and GME FTEs (weighted and unweighted) on the submitted IRIS do not match the total related FTEs reported on the cost report.").

C. DISPROPORTIONATE SHARE HOSPITAL PAYMENT

- **Treatment of Medicare Part C Days in DSH calculation.** The final rule does not address the agency's August 2020 proposal to retroactively adopt the same treatment of Medicare Part C days in DSH payment calculation that was at issue in the *Allina* litigation.

- **DSH – Change in Policy on Section 1115 Waiver Days in Medicaid Fraction.** CMS declined to finalize its proposals related to Section 1115 waiver days. CMS stated that "[d]ue to the number and nature of the comments that we received on our proposal, we intend to address the public comments in a separate document."

- **DSH –Continued Reduction in Uncompensated Care Payments.** The general process for deriving estimates and making calculations was finalized, but there were several changes in the actual figures from the proposed to final rule:

    - Factor 1 decreased from $10.573 billion to $10.488 billion (CMS stated it did not believe excluding or mitigating the effect of COVID-19 was proper in this calculation)

    - CMS found that the estimated uninsured rate decreased from 10.1% to 9.6% in Factor 2 (CMS cited faster than expected employment recovery and improving economic outlook for the decrease)

    - As a result, the overall pool of DSH uncompensated care funds decreased from $7.627 billion to $7.192 billion

    - CMS finalized its proposal to use FY 2018 Worksheet S-10 data for Factor 3, but used a June 30 HCRIS update when it had proposed to use the March 31 HCRIS update

    - CMS will consider reverting back to using an average of multiple years data for calculation of Factor 3 in future years to address COVID-19 impacts on data

D. BAD DEBT

- **Requirement that State Medicaid Agencies Accept Enrollment of Medicare Suppliers/Providers.** CMS finalized this proposal, including a clarification that this policy also requires State Medicaid agencies to accept enrollment from out-of-state suppliers and providers.

E. WAGE INDEX AND GEOGRAPHIC RECLASSIFICATION

- **Reinstatement of the Imputed Rural Floor Wage Index for All-Urban States.** CMS adopted as final this proposal. The agency also updated the wage index calculations to incorporate the imputed rural floor, which it claimed to be unable to do in the proposed rule.

- **Changes Regarding Cancellations of Urban to Rural Reclassifications.** In the proposed rule, CMS presented two changes relating to requests to cancel a previously granted reclassification from urban to rural that would have had the effect of locking a hospital into its rural status for a longer period of time than under current rules. In the Final Rule, CMS adopted its first proposal requiring that a hospital's rural reclassification status be effective for at least one year before the hospital can submit a cancellation request. In contrast, CMS opted to delay and potentially revise its second proposal that would have made cancellation requests effective with the Federal fiscal year starting the calendar year after the calendar year in which the cancellation request is submitted. Meanwhile, the current rule on effective date of cancellation request remains in place, requiring only

that cancellation requests be submitted no less than 120 days prior to the end of a Federal fiscal year to become effective with the next Federal fiscal year.

- **Change to MGCRB Application Process for Hospitals Reclassified as Rural.** CMS finalized without modification the provisions of the interim final rule issued contemporaneously with the proposed rule.

F. ORGAN ACQUISITION

- **Proposed Changes Concerning Organ Acquisition Payment.** CMS declined to finalize any of the following proposed changes to the regulations governing organ acquisition reimbursement: 1) new definitions concerning organ acquisition payment; 2) codification of organ acquisition cost elements; 3) organ acquisition costs and Medicare's share; and 4) Medicare as a secondary payer for organ acquisitions. CMS stated that "[d]ue to the number and nature of the comments that we received on the organ acquisition payment policy proposals we will address public comments associated with these issues in future rulemaking."

G. NEGOTIATED MA RATE REPORTING AND RATE SETTING

- **Repeal of Requirement to Report Negotiated Rates with Medicare Advantage Organizations and Repeal of Associated Rate Setting Methodology.** CMS finalized this proposal and explained that hospitals were still required under the separate Hospital Price Transparency rule to publish pricing information about their services on their website.