Green Reimbursement *LLC*

Reimbursement Update

Massachusetts – Rhode Island HFMA

September 16, 2021

Agenda

- FY 2022 Medicare IPPS Final Rules
  - Payment Update & Highlights
  - Proposals Not Finalized
  - Wage Index
  - Uncompensated Care Payments
- CY 2022 Medicare OPPS Proposed Rule Highlights

FY 2022 Final Rules
Inpatient PPS
Payment Update

FY 2022 Final IPPS Rule Highlights

- Effective Oct. 1, 2021 – Sept. 30, 2022
- Issued on Aug. 2, 2021
  - Federal Register Published Aug. 13, 2021
  - Two-month implementation period
- Overall increase in payments of 2.6%
- Projected payment increase of $2.293 billion

- Use of pre-pandemic data
- Proposed payment policies not finalized
  - Disproportionate Share Payments
  - Medical Education
  - Organ Acquisition

FY 2021 Update Factors

Market Basket and Adjustments

- Market Basket Increase = 2.70%
  - Base PPS Rates
  - SCH & MDH Hospital Specific Amounts
  - TEFRA Rates
- Payment Penalties
  - Quality Penalty = 0.675%
  - EHR Penalty = 2.025%
- Payment Adjustments
  - Documentation & Coding = 0.50%
  - ACA Productivity Adjustment = -0.70%

Market Basket Update Calculation

	Full Update	Quality Penalty	EHR Penalty	Both Penalties
2022 Market Basket Increase	2.700%	2.700%	2.700%	2.700%
Less: Quality Penalty	0.000%	**-0.675%**	0.000%	**-0.675%**
Less: EHR Penalty	0.000%	0.000%	**-2.025%**	**-2.025%**
Net Market Basket Increase	2.700%	2.025%	0.675%	0.000%
Less: Productivity Adjustment	-0.700%	-0.700%	-0.700%	-0.700%
Add: Documentation & Coding	0.500%	0.500%	0.500%	0.500%
Other Adjustments	0.191%	0.191%	0.191%	0.191%
Net Market Basket Increase	2.691%	2.016%	0.666%	-0.009%
Total Penalty		0.675%	2.025%	2.700%
Number of Hospitals		68	97	24
Number of Hospitals in MA & RI		1	0	0

DRG Base Rates and Outliers

- Operating DRG
  - Increase of $160.40 per discharge
  - Increase of 2.69%
  - Labor / non-labor share
    - Change for Wage Index greater than 1.0
    - No change for Wage Index less than 1.0
- Capital DRG
  - Increase of $6.39
  - Increase of 1.37%
- Outlier Threshold
  - Increase of $1,937 per discharge
  - Increase of 6.67%
  - CMS Goal: Outliers = 5.1 % of total payments
  - FY 2020: Outliers = 5.47% of total payments

Operating DRG Base Rate (Wage Index > or = 1.0)				
	FY 22 Final	FY 21 Final	Change	% Change
Labor	4,138.28	4,071.57	66.71	1.64%
Non-Labor	1,983.43	1,889.74	93.69	4.96%
Operating DRG	6,121.71	5,961.31	160.40	2.69%
Labor %	67.60%	68.30%	-0.70%	-1.02%
Non-Labor %	32.40%	31.70%	0.70%	2.21%

Operating DRG Base Rate (Wage Index < 1.0)				
	FY 22 Final	FY 21 Final	Change	% Change
Labor (62%)	3,795.46	3,696.01	99.45	2.69%
Non-Labor (38%)	2,326.25	2,265.30	60.95	2.69%
Operating DRG	6,121.71	5,961.31	160.40	2.69%

Capital DRG Base Rate				
	FY 22 Final	FY 21 Final	Change	% Change
Capital DRG	472.60	466.21	6.39	1.37%

Outlier Threshold				
	FY 22 Final	FY 21 Final	Change	% Change
Outlier Threshold	30,988	29,051	1,937	6.67%

Labor Share Changes

- The labor share of the base DRG reduced from 68.3% to 67.6%
  - Updated market basket weights from 2014 to 2018

	2014-Based IPPS Market Basket Cost Weights	2018-Based IPPS Market Basket Cost Weights
Wages and Salaries	43.4	41.2
Employee Benefits	12.4	11.7
Professional Fees: Labor-Related	6.8	8.6
Administrative and Facilities Support Services	1.0	1.1
Installation, Maintenance, and Repair Services	2.4	2.4
All Other: Labor-Related Services	2.3	2.6
Total Labor-Related Share	**68.3**	**67.6**

Note: Detail may not add to total due to rounding.

- CMS excluded certain labor costs from outside local market
  - Professional fees (legal, consulting, accounting, etc.): 36% reduction
  - Home Office and Related: 40% reduction
- Payment reductions
  - Massachusetts: 0.20% or $12.18 per case before case mix
  - Rhode Island: 0.09% or $5.55 per case before case mix

Low-Volume Hospitals

- FY 2020 – FY 2022
  - Qualifying criteria
    - Acute IPPS hospital
    - Fewer than 3,800 total discharges
    - Greater than 15 road miles from nearest IPPS hospital
  - Payment adjustment: Sliding scale
    - 25% add-on for 500 or fewer discharges
    - Decreases to 0% at 3,800 discharges
- FY 2023 and later – reverts to earlier rules
  - Qualifying criteria
    - Acute IPPS hospital
    - Fewer than 200 total discharges
    - Greater than 25 road miles from nearest IPPS hospital
  - Payment adjustment:
    - 25% add-on

Medical Education – IRIS Submission

- IME and GME counts on IRIS submission must match FTE counts reported on the cost report
  - Cost reports beginning on or after Oct. 1, 2021
  - Cost report rejections beginning on or after Oct. 1, 2022
- IRIS submission must utilize new XML format
  - Cost reports beginning on or after Oct. 1, 2021
  - Software not available through CMS
    - Must be purchased from approved vendors

FY 2022 New Technology Add-On Payments

Previously Approved Technologies

Technology	Payment Rate	Maximum Cases	Maximum Payment
Balversa	3,563.23	50	178,162
Jakafi	4,475.38	140	626,553
BAROSTIM Neo System	22,750.00	722	16,425,500
FETROJA (Cefiderocol)	7,919.86	6,355	50,330,710
Optimizer System	14,950.00	1,500	22,425,000
RECARBIO	3,532.78	762	2,691,978
Soliris	21,199.75	13,680	290,012,580
XENLETA	1,275.75	35,246	44,965,085
ZERBAXA	1,836.98	30,117	55,324,327
Azedra	98,150.00	400	39,260,000
Total		88,972	522,239,895

Extended Technologies (Not Discontinued)

Technology	Payment Rate	Maximum Cases	Maximum Payment
Cablivi	33,215.00	131	4,351,165
Elzonris	144,116.04	247	35,596,662
AndexXA	18,281.25	5,402	98,755,313
Spravato	1,014.79	6,400	6,494,656
Zemdri	4,083.75	2,500	10,209,375
T2 Bacterial Panel	97.50	37,639	3,669,803
ContaCT	1,040.00	69,336	72,109,440
Eluvia	3,646.50	2,453	8,944,865
Hemospray	1,625.00	12,700	20,637,500
IMFINZI/TECENTRIQ	6,875.90	4,296	29,538,866
NUZYRA	1,552.50	16,899	26,235,698
SpineJack System	3,654.72	1,572	5,745,220
Xospata	7,312.50	1,875	13,710,938
Total		161,450	335,999,499

FY 2022 New Technology Add-On Payments

Newly Approved – Traditional Pathway

Technology	Payment Rate	Maximum Cases	Maximum Payment
Rybrevant	$6,405.89	349	$2,235,656
Abecma	242,450.00	179	43,398,550
Stratagraft	44,200.00	261	11,536,200
Tecartus	242,450.00	15	3,636,750
Trilaciclib	5,526.30	435	2,403,941
Veklury	2,028.00	174,996	354,891,888
Zepzelca	8,622.90	778	6,708,616
Total		177,013	$424,811,600

Newly Approved – Breakthrough Pathway

Technology	Payment Rate	Maximum Cases	Maximum Payment
Ascope duodeno	$1,715.58	3,750	$6,433,425
Aprevo	40,950.00	1,261	51,637,950
Caption Guidance	1,868.10	2,592	4,842,115
Contepo	2,275.00	17,320	39,403,000
Exalt Model D	1,715.58	8,314	14,263,332
Fetroja	7,435.86	379	2,818,191
Harmony TPV	26,975.00	171	4,612,725
PRCFC	2,535.00	2,296	5,820,360
Recarbrio	8,299.64	928	7,702,066
Shockwave Coronary IVL	3,666.00	3,760	13,784,160
Total		40,771	$151,317,324

Changes in Top 14 MS-DRGs

MS-DRG	MS-DRG Title	Discharges	2021 Weights	2022 Weights	% Change
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	610,261	1.8682	1.8722	0.21%
291	HEART FAILURE & SHOCK W MCC	466,399	1.3409	1.2683	-5.41%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	359,905	1.8999	1.9003	0.02%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	156,077	1.0216	1.0263	0.46%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	149,990	1.3107	1.3120	0.10%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	145,611	1.2248	1.2261	0.11%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	136,999	0.7644	0.7658	0.18%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	129,626	1.1239	1.1251	0.11%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	128,722	0.7922	0.7940	0.23%
378	G.I. HEMORRHAGE W CC	127,141	0.9932	0.9935	0.03%
683	RENAL FAILURE W CC	126,958	0.8781	0.8793	0.14%
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	107,773	1.0182	1.0200	0.18%
682	RENAL FAILURE W MCC	103,536	1.4702	1.4727	0.17%
194	SIMPLE PNEUMONIA & PLEURISY W CC	102,467	0.8630	0.8639	0.10%

Market-Based MS-DRG Relative Weights

- Background
  - In FY 2021, CMS finalized rules requiring the following:
    - Report median negotiated charges for Medicare Advantage (MA) plans on the Medicare cost reports ending on or after Jan. 31, 2021
      - Data would be publicly available
      - Potential significant penalty for noncompliance
    - Rebase FY 2024 MS-DRG relative weights using MA payer-specific negotiated charges
  - Rules faced significant criticism and calls for repeal citing:
    - Usefulness of data
    - Relationship of negotiated payments to resource utilization
    - Reporting burden
  - Supporters felt the policy improved competition, empowered patients and reduced reliance on Chargemasters for rate setting
- CMS repealed the Market-Based MS-DRG regulations
  - Will consider comments in future policy

Proposals not Finalized

Disproportionate Share Payments

- Current Medicare DSH regulations state:
  - A patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
  - Effective with discharges occurring on or after January 20, 2000, for purposes of counting days, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

Disproportionate Share Payments

- CMS has addressed concerns with 1115(a)(2) Demonstration Projects
  - Uncompensated Care Pools – CMS asserts these programs:
    - Do not offer medical coverage benefits directly to individuals
    - Compensate hospitals for uninsured or underinsured care
  - Premium Assistance – CMS asserts:
    - These programs do not offer guaranteed insurance coverage for inpatient hospital services
    - Recipients may have higher income than traditional Medicaid patients
  - CMS believes days associated with these programs should be excluded from Medicare DSH but left the regulations unchanged
- Recent court decisions have ruled days for these programs should be counted
  - Patients are eligible for inpatient hospital services
    - The hospital has received payment
    - Patients are eligible for care at hospitals
  - Programs are 1115 demonstration projects, often with Medicaid matching funds

Disproportionate Share Payments

- CMS states findings in these decisions are not the intent of the regulation
  - Proposed revisions to regulations stating the days may be counted only when the patient
    - Is eligible for inpatient hospital services under an approved State Medicaid plan that includes coverage for inpatient hospital care on that day or
    - Directly receives inpatient hospital insurance coverage on that day under a waiver authorized under Section 1115(a)(2) of the Act
  - Proposed to eliminate 413.106(b)(4)(ii)

- CMS requested comments in Proposed Rules
- No changes implemented in Final Rules
- "Due 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."

Medical Education – Consolidated Appropriations Act of 2021

- Proposals from Consolidated Appropriations Act of 2021
  - CMS proposed the following:
    - 1,000 new residency slots
    - Expansion of Rural Training Tracks
    - Reset low GME Per Resident Amounts (PRA)
    - Reset low IME and/or GME FTE caps
  - CMS requested comments in Proposed Rules
  - No changes implemented in Final Rules
  - "Due to the number and nature of the comments that we received on our proposed policies, we intend to address the public comments in a separate document."

Medical Education – Consolidated Appropriations Act of 2021

- Proposal 1: 1,000 new residency slots
  - No more than 200 per year beginning in FY 2023
  - 10% of slots to each of the following categories:
    - Rural hospitals or hospitals treated as rural
    - Resident counts in excess of current caps
    - States with new medical schools or additional locations of existing schools
    - Hospitals in Health Professional Shortage Areas
  - Hospital Requirements
    - Must apply for new slots
    - No more than 25 per hospital
    - Must increase residency to new cap levels
  - Based on Section 126 of CAA

Medical Education – Consolidated Appropriations Act of 2021

- Proposal 2: Expansion of Rural Training Tracks
  - Increase in resident caps for expansion of qualifying RTTs
  - Only for expansion into new “spoke” of an existing RTT “hub”
  - Beginning Oct. 1, 2023
  - Excluding from three-year rolling average during first five years
  - Based on Section 127 of CAA

Medical Education – Consolidated Appropriations Act of 2021

- Proposal 3: Reset low or $0 GME Per Resident Amounts (PRA)
  - Hospital that trains residents between Dec. 27, 2020, and Dec. 26, 2025
  - Original PRA is based on FTE count of (A) less than 1 or (B) less than 3
  - New permanent PRA based on lower of
    - Actual GME costs per FTE or
    - Weighted average PRA of existing hospitals in the same CBSA
  - Based on Section 131 of CAA
- Proposal 4: Reset low FTE caps
  - Hospital that **begins** training residents between Dec. 27, 2020, and Dec. 26, 2025
    - Only new programs during this window
    - Programs in place before Dec. 27, 2020, are not eligible
  - Original FTE cap of (A) less than 1 or (B) less than 3
  - Replacement FTE cap generally based on existing methodology for new training hospitals
  - Based on Section 131 of CAA

Organ Acquisition Payments

- CMS proposed numerous revisions to definitions and policies
- Proposed policy changes:
  - Cost reports beginning on or after Oct. 1, 2021
  - Medicare Organs
    - Organs transplanted into Medicare beneficiaries, including Medicare Advantage
    - Organs where Medicare has second payer liability
    - Pancreata procured for islet cell acquisition
  - Donor Community Hospitals
    - May only bill Organ Procurement Organizations at cost
  - Numerous other technical changes

- No changes implemented in Final Rules
- "Due to the number and nature of the comments that we received on the organ acquisition payment policy proposals we will address public comments in future rulemaking."

Wage Index

Wage Index Highlights

- Used in Hospital IP & OP, SNF, HHA, ASC, Hospice, IRF, IPF & LTCH
- Final FY 2022 national AHW is $46.47
  - Proposed national AHW was $46.37
  - FY 2021 national AHW was $45.27
- No new CBSA definitions
- Transition Relief for wage index declines from FY 2021
  - Limited to hospitals affected by OMB CBSA updates implemented in FY 2021
  - 5% cap on decrease from FY 2021
  - Funded through budget neutrality adjustment to standardized amount

Rural Floor

- 269 hospitals receive rural floor across country
- Imputed rural floor returns
  - American Rescue Plan Act of 2021
  - Effective Oct. 1, 2021
  - No Expiration Date
  - Not budget neutral
  - Applies to states with no rural CBSAs or no rural hospitals
  - Rhode Island; Connecticut; Delaware; Washington, D.C.; New Jersey and Puerto Rico
  - $195 million benefit for 69 hospitals
- Frontier Floor
  - Applies to five frontier states: Montana, Nevada, North Dakota, South Dakota and Wyoming
  - Wage index set at 1.0000
  - $64 million benefit for 44 hospitals

Low Wage Index Policy

- Effective FY 2020 through FY 2023
- Increase wage index value for hospitals in lowest quartile
- Lowest wage index quartile threshold = 0.8437
  - Proposed Rule threshold was 0.8418
- Increase = 50% of difference between threshold and traditional wage index value, for example:
  - Traditional Wage Index Value = 0.6663
  - Increase = 0.0887 = [(0.8437 – 0.6663) X 50%]
  - Final Wage Index Value = 0.7550 = (0.6663 + 0.0887)
- Funded through budget neutrality adjustment to standardized amount

Wage Index Factors

Area	Home State	Wage Index Factor Rural Hospitals & Rural Floor FY 22 Final	FY 21 Final	Change	% Change
Massachusetts – Rural	MA	1.3221	1.3415	(0.0194)	-1.45%
Massachusetts – Floor	MA	1.2843	1.2673	0.0170	1.34%

Area	Home State	Hospitals in Natural CBSA FY 22 Final	FY 21 Final	Change	% Change
Barnstable, MA	MA	1.2843	1.2673	0.0170	1.34%
Boston, MA	MA	1.2843	1.2673	0.0170	1.34%
Other MA Urban Areas	MA	1.2843	1.2673	0.0170	1.34%
Providence	RI	1.1295	1.0163	0.1132	11.14%

Area	Home State	Reclassified Hospitals FY 22 Final	FY 21 Final	Change	% Change
MA Rural	MA	1.3221	1.3415	(0.0194)	-1.45%
Boston, MA	MA	1.2843	1.2673	0.0170	1.34%
Boston, MA	RI	1.1807	1.1922	(0.0115)	-0.96%
Worcester, MA	RI	1.1295	1.1283	0.0012	0.11%
Cambridge, MA	NH	1.0901	1.0961	(0.0060)	-0.55%

Reclassifications

- 406 new reclassifications for FY 2022
- 940 total hospitals reclassified in FY 2021
- FY 2023 geographic reclassification applications were due Sept. 1, 2021

- Rural Redesignations under 412.103
  - Effective Oct. 1, 2021, redesignations may be cancelled:
    - 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
  - Location for home market criteria for reclassifications
  - Location for prohibition on reclassifications to a lower wage area

Wage Index Data and Timeline

	FY 2022	FY 2023
Cost Reports Beginning From	10/1/2017	10/1/2018
Cost Reports Beginning Through	9/30/2018	9/30/2019

Deadline	FY 2022	FY 2023
Public Use Files Released (S-3 and Occ. Mix)	~~5/18/2020~~	5/24/2021
Revision Request received by MAC	~~9/3/2020~~	9/2/2021
MAC Desk Review Completion	~~11/16/2020~~	11/15/2021
Revised Public Use Files Released	~~1/29/2021~~	1/28/2022
Deadline for Error Correction & Revisions	~~2/16/2021~~	2/15/2022
MAC Corrections & Revisions	~~3/19/2021~~	3/18/2022
Request CMS Intervention	~~4/2/2021~~	4/1/2022
Proposed Rule Public Use Files Released	~~4/30/2021~~	4/29/2022
Request Correction of Errors	~~5/28/2021~~	5/27/2022
Final Rules Published	~~8/1/2021~~	8/1/2022
Effective Date	10/1/2021	10/1/2022

Occupational Mix Survey

- 2019 Occupational Mix Survey
  - Pay periods ending 1/1/19 – 12/31/19
  - Filed Sept. 3, 2020
  - Public Use File published Sept. 8, 2020
  - Utilized for FY 2022 – 2024 wage index
  - 3,028 surveys received (95% response rate)
- Changes from 2016 Survey
  - 52.9% of all CBSAs negatively impacted from 2019 Survey
  - Only 48.1% of urban areas benefit from 2019 Survey
  - Only 38.3% of rural areas benefit from 2019 Survey

Occupational Mix – National Data

Occupational Mix Average Hourly Wages by Nursing Category				
	Average Hourly Wage			
Occupational Mix Nursing Subcategory	2016	2019	Change	% Change
National RN	41.63	44.45	2.82	6.77%
National LPN and Surgical Technician	24.66	26.83	2.17	8.80%
National Nurse Aide, Orderly, and Attendant	16.96	18.53	1.57	9.26%
National Medical Assistant	18.21	19.50	1.29	7.08%
National Nurse Category	34.97	37.42	2.45	7.01%

Nursing Percentage for Application to Wage Index				
Category	2016	2019	Change	% Change
Nursing Category	42%	42%	0%	0%
All Other Occupations	58%	58%	0%	0%
Total	100%	100%	0%	0%

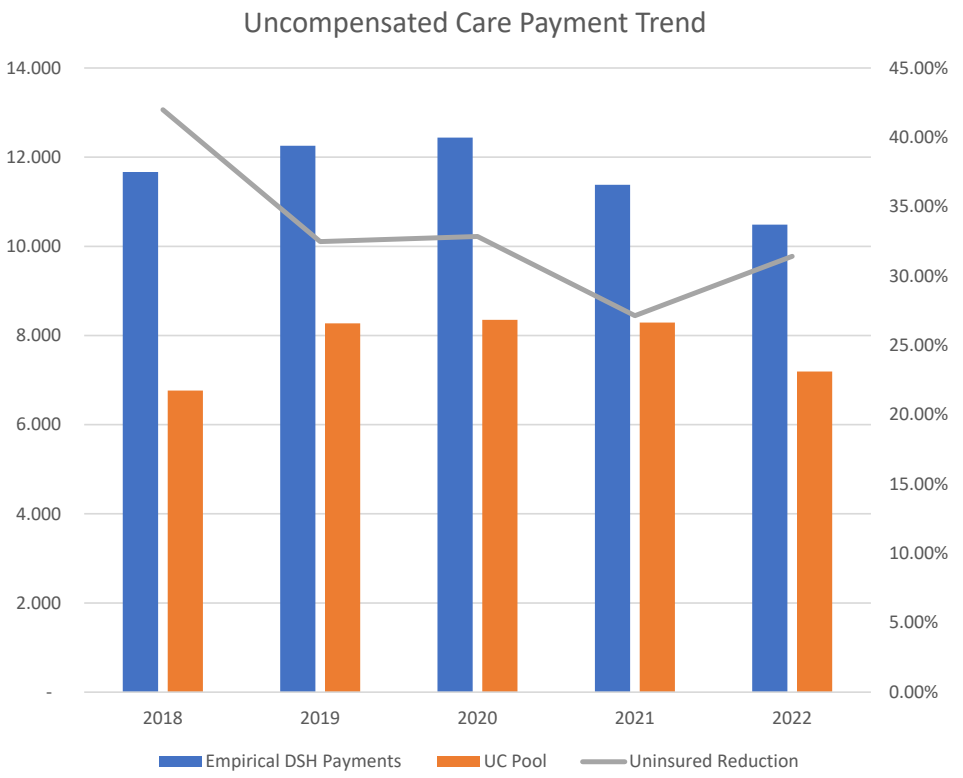
Uncompensated Care Payments

Uncompensated Care Payment

	Final					FY 2022		
	2018	2019	2020	2021	2022	Final	Proposed	Change
Estimated National DSH Payments (Billions)	15.553	16.339	16.584	15.171	13.985	13.985	14.098	(0.113)
Less: 25% Empirical DSH Payments (Billions)	(3.888)	(4.085)	(4.146)	(3.793)	(3.496)	(3.496)	(3.525)	0.028
Factor 1: Uncompensated Care Pool (Billions)	11.665	12.254	12.438	11.378	10.489	10.489	10.574	(0.085)
Factor 2: Reduction in Uninsured	41.99%	32.49%	32.86%	27.14%	31.43%	31.43%	27.86%	3.57%
Net Uncompensated Care Pool (Billions)	6.767	8.273	8.351	8.290	7.192	7.192	7.628	(0.436)
Factor 3: Sample Hospital % of UC Care	0.037%	0.037%	0.037%	0.037%	0.037%	0.037%	0.037%	0.000%
Hospital Uncompensated Care Payment (Millions)	2.510	3.068	3.097	3.075	2.667	2.667	2.829	(0.162)

Uncompensated Care Payment Trends

Year	Empirical DSH Payments (75% in $ billions)	Reduction in Uninsured	Uncompensated Care Pool (in $ billions)
2018	11.665	41.99%	6.767
2019	12.254	32.49%	8.273
2020	12.438	32.86%	8.351
2021	11.378	27.14%	8.290
2022	10.489	31.43%	7.192



Uncompensated Care Payment: Factor 1

FY 2022 Final Rules:

Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline						
FY	Update	Discharges	Case-Mix	Other	Total	Estimated DSH Payment (in billions)*
2019	1.0185	0.97	1.009	1.0176	1.0144	14.082
2020	1.031	0.857	1.038	0.9912	0.9091	12.801
2021	1.029	1.013	1.029	0.9662	1.0364	13.267
2022	1.025	1.059	0.9675	1.00375	1.0541	13.985

*Rounded.

FY 2022 Proposed Rules:

Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline						
FY	Update	Discharges	Case-Mix	Other	Total	Estimated DSH Payment (in billions)*
2019	1.0185	0.97	1.009	1.0179	1.0147	14.136
2020	1.031	0.853	1.038	1.0023	0.9150	12.933
2021	1.029	0.968	0.998	0.9754	0.9696	12.541
2022	1.028	1.075	1.005	1.0122	1.1242	14.098

*Rounded.

Uncompensated Care Payment: Factor 2

	Final Rule		Proposed Rule		Change in
	Estimate	Weighted	Estimate	Weighted	Estimate
CY 2021 Uninsured %	9.80%	2.50%	10.20%	2.55%	-0.40%
CY 2022 Uninsured %	9.50%	7.10%	10.10%	7.58%	-0.60%
FY 2022 Uninsured %		9.60%		10.10%	-0.50%
2013 Uninsured %		14.00%		14.00%	0.00%
Change in Uninsured		4.40%		3.90%	0.50%
% Change in Uninsured		31.43%		27.86%	3.57%
Factor 2: 1 - % Change in Uninsured		68.57%		72.14%	-3.57%

Uncompensated Care Payment: Factor 3

- Hospital allocation percentage
  - Utilizes FY 2018 Worksheet S-10 Uncompensated Care Data
    - CMS audited uncompensated care data representing 99.6% of payments
    - Hospital data from June 2021 HCRIS file
    - FY 2016 uncompensated care data not utilized
      - FY 2015 data used for FY 2020
- Impact on Providers
  - Total UCP payments decrease of 0.73%
  - Rural hospital payment decrease of 5.7%
  - Urban hospital payment decrease of 0.39%

Uncompensated Care Payment: Interim Payments

- Existing Policy: Uncompensated care payment amount divided by three-year discharge average
- Finalized Policy for FY 2022: Payment amount divided by two-year discharge average
  - FY 2018 & FY 2019
  - FY 2020 excluded due to impacts of COVID-19

CY 2022 Proposed Rules
Outpatient PPS
Payment Update

CY 2022 Proposed OPPS Rule Highlights

- Effective Jan. 1, 2022 – Dec. 31, 2022
- Issued on July 19, 2021
  - Federal Register Published Aug. 4, 2021
- Comments due Sept. 17, 2021

- Overall payment increase of 1.84%
  - Market basket increase of 2.5%, less 0.2% productivity adj.
  - Reduction in pass through payments and outliers of 0.46%
- Projected payment increase of $1.35 billion
- Total OPPS expenditures will increase $10.8 billion
- OPPS Conversion factor increases to $84.457
  - CY 2021 conversion factor is $82.797
- ASC Conversion factor increases to $50.043
  - CY 2021 conversion factor is $48.952

Price Transparency

- Proposal to increase penalties and compliance with Price Transparency rules
  - Conforms to Competition Executive Order issued July 9, 2021
  - CMS steps for noncompliance, in order
    - Provide written notice of violations
    - Request corrective action plan if material violation
    - Impose civil money penalty for noncompliance with action plan

Number of Beds	Penalty Per Day	Full-Year Penalty
30 or fewer beds	$300 per hospital	$109,500 per hospital
31 to 550 beds	$310 to $5,500 per hospital ($10.00 per bed)	$113,150 to $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Other Items

- Proposal to reinstate Inpatient Only (IPO) list
  - Adds back 228 services removed in CY 2021 policy
  - Selective removal of procedures
  - Soliciting comments on future updates
- 2-Midnight Rule Medical Review
  - Rescind indefinite exemption resulting from CY 2021 elimination of IPO list
  - Implement two-year exemption for service removed from IPO on or after Jan. 1, 2021
- 340B Acquired Drugs
  - Continue to pay Adjusted Sales Price minus 22.5%

Other Items

- Rural Emergency Hospital Provider Type
  - New provider type from Section 125 of CAA, effective Jan. 1, 2023
  - Criteria
    - Convert from Critical Access Hospital or Rural Hospital
    - Less than 50 beds
    - Do not provide acute inpatient hospital services
    - Furnish Emergency Department and Observation services
    - May provide Mental Health or other services
  - Payment
    - 105% of Outpatient PPS Rates
    - Additional Facility Payment
    - Ambulance
    - Distinct Part Skilled Nursing Facility
  - CMS requesting comments

Green Reimbursement *LLC*

Thank You

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