HEALTHCARE REGULATORY ROUND-UP

FY2022 Medicare Inpatient Prospective Payment System Proposed Rule

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FY2022 Inpatient PPS Proposed Rule

- Payment update/area wage index
- Disproportionate share payments
- Price transparency
- Graduate medical education
- COVID-19 add-on payment
- Changes to quality reporting program
- Value-based payment programs
- Modifications to Medicare Shared Savings Program
- Closing the equity gap

Payment Update/Area Wage Index

Payment update

- Operating payments
  - Increase in base rate of 2.8 percent
    - Increase based on 2019 data
    - Assumes meaningful user of EHRs and submits quality measure data
    - Base rate would be $6,140.29 (current $5,961.31)
    - Labor share for hospitals with wage index >1=67.8 (current 68.3)
- Capital payments
  - Base rate of $471.89 (current $466.21)

Area wage index

- Rural floor calculation excludes reclassified urban hospitals
- Continues lower quartile adjustment
  - Scheduled to run for four years beginning FY2020
  - Hospitals in bottom quartile receive adjustment equal to half the difference in actual wage index and the 25th percentile value for all hospitals
- Imputed rural floor (all urban states)

Disproportionate Share Payments

Uncompensated care pool

- Decrease from 2021 - $660 million

Uses FY2018 cost reports to distribute funds

- Single-year data

Determining Medicaid fraction

- Proposes to redefine “eligible for Medicaid”
- Would exclude patient days reimbursed through an uncompensated care pool under Section 1115 waiver

Price Transparency

CMS had proposed worksheet S-12 in FY2021

- Worksheet would capture Medicare Advantage negotiated rates at the MS-DRG level
- Would then use this information to set relative weights beginning in FY2024

Now proposes to withdraw new data collection

- Will continue using cost to set relative weights
- Not implementing reduces administrative burden

Graduate Medical Education

- Provision of Consolidated Appropriations Act
  - Increased spend of $1.8B
  - Distribution of 1000 residency slots
    - FY2023-2027 – distributes 200 slots each year
    - Applications for new slots due by January 31 of the year preceding the distribution
  - Eligibility classes –
    - Located in a rural area/reclassified as rural
    - Training in excess of its cap
    - Located in a state with a new medical school or branch
    - Serves areas designated as health professional shortage area

New COVID-19 Treatment Add-on Payment

- Created to incentivize hospitals to use drug or biological product approved for treatment of COVID-19 not eligible for new technology add-on payment
- Since 11/2/2020, hospitals have received NCTAP equal to the lesser of (1) 65% percent of the operating outlier threshold for the claim or (2) 65% of the amount by which the costs of the case exceed the standard DRG payment (including CARES Act add-on)
  - If new treatment approved for new technology add-on payment for FY22, NCTAP will expire on 09/30/21
  - If not approved for FY22, NCTAP will continue through 9/30/22 (assuming PHE ends by that date)
- CMS also proposes 1-year extension of new technology add-on payments for 14 technologies which otherwise would have expired in FY2022.

Changes to Quality Reporting

Eliminated measures

- Death among surgical inpatients with serious treatable complications
- Exclusive breast milk feeding
- Admit decision time to ED departure time for admitted patients
- Anticoagulation therapy for atrial fibrillation/flutter
- Discharge on statin medication

Proposed additions

- Maternal morbidity structural
- COVID-19 vaccination coverage among healthcare personnel
- Hybrid hospital-wide all-cause risk-standardized mortality
- Hospital harm-severe hypoglycemia
- Hospital harm-sever hyperglycemia

Value-Based Payment Programs

Hospital Value-Based Purchasing Program

- Neutral payment adjustment for all hospitals for FY2022
- Suppress pneumonia 30-day mortality measure for FY2023
- Eliminate PSI 90 beginning with FY2023

Hospital-Acquired Conditions Reduction Program

- Suppress third and fourth quarter 2020 data for 2022/2023
- Because first and second quarter reporting waived, results in single year performance data only

Hospital Readmission Reduction Program

- Suppress pneumonia readmission measure
- Exclude COVID diagnosed patients from remaining 5 measures

COVID-19 Blip

- 2020 claims data shows significant decreases in utilization, including preventive services
  - Recently-released Medicaid/CHIP data
- When will utilization patterns return to “normal?”
- Managing long-term impact
  - Baselines for quality performance measures
  - Baselines for total cost of care
  - Any other measure based in part on prior years’ data

Medicare Shared Savings Program

- ACOs presently participating in the BASIC track's glide path may forgo automatic advancement to next level in 2022
  - Option for 163 ACOs now participating in upside only to avoid downside risk
  - For 2021, 74% of eligible ACOs exercised similar option
- Extreme and uncontrollable circumstances policy remains in place through end of PHE (avoid repayment of losses)

Closing the Equity Gap

- CMS seeking comment on -
  - Measuring hospital equity using imputation algorithm to enhance existing administrative data quality for race and ethnicity until self-reported information is sufficiently available
  - Collecting minimum set of demographic data elements upon hospital admission
  - Developing hospital health equity score measure similar to Health Equity Summary Score used for Medicare Advantage contracts/plans.

What's Not Included

- MedPAC's Hospital Value-Based Incentive Program
- Post-pandemic hospital-at-home model
- Rural Emergency Hospital Program
- No Surprises Act
- Treatment of Provider Relief Fund distributions for cost-reporting purposes

Comments Due June 28

- https://www.regulations.gov/document/CMS-2021-0070-0002/comment
- Support proposal, object to proposal (with reasons), offer alternatives, raise questions/concerns
- Don’t rely on others to voice your opinions

Questions:

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