FFY 2022 IPPS & CY 2022 OPPS Rule and Other Regulatory Updates & Hot Topics

BKD CPAs & Advisors

October 2021

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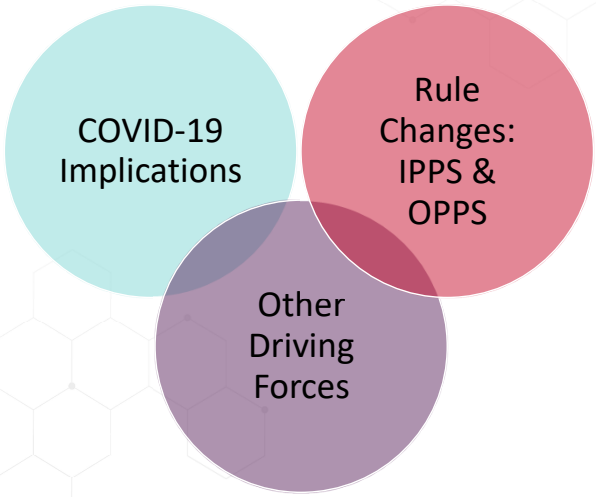
Agenda:
Where is Medicare Reimbursement Headed?



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COVID-19 Impacts – What Do We Know?

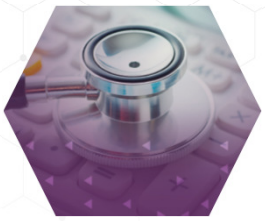
CLINICAL OUTCOMES & QUALITY MEASURES ARE CHANGING

- Hospital-Acquired Infections
- Acuity
- Readmission Rates
- Length of Stay
- Spending per Beneficiary
- Visitor Restrictions
- Etc.

COST OF CARE IS CHANGING

- Labor Cost Demands
- PPE Surge
- Infection Control
- Capacity Constraints
- Length of Stay
- Drug Prices
- Post-Acute Alternatives
- Delayed or Deferred Care

COVID-19 Impacts – What Do We Know?



- Impact for every provider is different
  - Geographic
  - Duration & Timing
  - Population Spread
  - Acuity
- Payment systems (including CMS) must adapt

Some Key Reimbursement Factors in Play

DRG Weights & Market Basket Update	Wage Index Factors & MGCRB Reclassifications	Value/Quality Factors	Low-Volume Add-On Payments
Volume Decline Adjustments	CAH/RHC Cost-Based Reimbursement	Reimbursable Bad Debts	Medicaid DSH Payments
Telehealth	Uncompensated Care Pool Factors	DSH Percentages & 340B Eligibility	Post-Acute Care Reimbursement

CMS Response in FY 2022 IPPS Final Rule… Perhaps Just the Starting Point

- DRG weights & outlier thresholds calibrated similarly to 2021 to avoid using data potentially impacted by COVID-19
- Continued payment for certain New Technologies & adding 10 additional for 2022 – Payment add-on for certain new COVID treatments (NCTAP) also continues until the end of PHE
- Sequestration remains suspended through December 31, 2021
- Anticipated payment increase of 2.5% for meaningful use & quality reporting hospitals to the standardized amount & capital rate – One more year of 0.5% Documentation & Coding Adjustment anticipated for 2023 rates

CMS Response in FY 2022 IPPS Final Rule … Perhaps Just the Starting Point

- Remove COVID-19 & Pneumonia Patients from Readmissions Calculations
- Neutralize Value-Based Payment (VBP) Adjustments (Positive & Negative)
- Remove Certain Metrics from VBP Scoring Along with Data from COVID Patients
- COVID Impacted Quarters Removed from HAC Calculations

CMS Response in FFY 2022 IPPS Final Rule – Wage Index

- Hint that a future event could result in the need to make sure wage index values due not decline but no direct reference
  - If receiving a transition factor adjustment in FFY 2021 due to CBSA designation change, those hospitals wage index factors will continue to not decrease by more than 5%
  - Other hospitals – no guardrail to factors for FFY 2022
- FFY 2023 data
  - CRP ending September 30, 2019 through August 31, 2020
  - Some periods including COVID, most without a full year

What else was in the final rules on wage index?

Area Name	Wage Index FFY 2021	Proposed Wage Index FFY 2022	Final Wage Index FFY 2022
Rural Arkansas	0.7178	0.6965	0.7132
Fayetteville-Springdale-Rogers, AR	0.8364	0.8188	0.8271
Fort Smith, AR-OK	0.8342	0.7853	0.7998
Hot Springs, AR	0.8652	0.8437	0.8584
Jonesboro, AR	0.7946	0.7869	0.8002
Little Rock-North Little Rock-Conway, AR	0.8307	0.8192	0.8202
Pine Bluff, AR	0.7806	0.7856	0.7827

What else do we know about wage index?

FFY 2022

- National AHW is $46.52
- 2019 Occupational Mix Survey Utilized
  - 2022 is the next planned Occupational Mix Survey Year
- Imputed rural floor is reestablished – No Budget Neutrality Applied
- Low wage index policy continued, but uncertain for how long

What else do we know about wage index?

- FFY 2024
  - September 30, 2020 to August 31, 2021, year-ends all have COVID

DOCUMENT **DOCUMENT** DOCUMENT

  - Pay codes
  - Physician downtime
  - Contract labor

Did COVID change your eligibility?

Low Volume Adjustment

- FFY 2022 criteria unchanged
  - Fewer than 3,600 discharges
  - 15 miles apart from like hospital
- What impact has COVID had on volume?

NOTE: Without additional legislation, FFY 2023 criteria reverts to fewer than 200 discharges

Volume Decline

- Sole Community Hospital/Medicare Dependent Hospital
- 5% or greater drop in discharges beyond hospital's control
- What impact has COVID had on volume?

What about CAHs & RHCs reimbursement?

CAH struggles

- Justification of PRF funds
- Repayment of accelerated funds
- Potentially overstated interim rates if CRP has COVID downturn in volume
- Impact of misreporting COVID-19 related expenses on the cost report
- Potential differences between PRF reporting & cost report treatment

RHC

- CAA set a cost ceiling effective April 1, 2021
  - Hospital-based RHC under 50 beds based on 2019 cost per visit plus MEI
  - $100 for freestanding & hospital-based RHC over 50 beds with MEI increase to continue or new RHCs added after December 31, 2020
- Productivity exceptions
- Telehealth carve-out
- COVID Vaccines & anti-body testing

Medicare Physician Fee Schedule 2022 Proposed Rule Impact to RHCs

RHC Mental Health Services via Telehealth

- Definition of RHC encounter to include mental health furnished through telecommunications technology including audio-only
  - Previously only face-to-face mental health visits qualified
- Treated as normal RHC encounters & paid at all-inclusive rate
- Potential impacts to visit counts & cost per visit calculation on cost report if included in Final Rule

Where was CMS headed with organs?

- Proposed FFY 2022 IPPS rules
  - Limit organ acquisition costs
  - No longer count deceased donor organs procured at hospitals

35% livers & lungs **36% kidneys** **38% hearts**

41% pancreas **48% of intestines**

- Final FFY 2022 IPPS rules
  - Tabled for future rulemaking

Where was CMS headed with IME/GME?

- 1,000 new GME slots available to be distributed beginning in 2023
- Changes to FTE resident limits for GME & IME calculations for training in an accredited Rural Training Track
- Adjustments to PRA calculations & FTE resident limits for hospitals that had historically hosted a small number of residents for a short duration.
- CMS did not finalize any of these proposed policies & indicates that a Final Rule on these matters is forthcoming.

Did COVID impact FFY 2022 uncompensated care?

Overall 2022 UCC Pool is declining by $1.098B (13.24%) despite COVID

Audited S-10 results from 2018 establish UCC Pool distribution for most hospitals

Unless methodology changes, S-10 information from PHE time period will be incorporated into future UCC Pool calculations

- Recent court case upholds CMS ability to continue to use S-10 for UCC Pool calculations

What about DSH eligibility & 340B implications?

- Volatility in Medicaid/Medical Assistance inpatient volumes is occurring
- DSH % calculations are changing based on these results
- Reimbursement & 340B eligibility need to be closely watched
- **Consideration of Section 1115 waiver days in the DSH calculations continues**

Other Items of Note in IPPS Rules

CMS finalized its repeal of the reporting requirement related to Medicare Advantage negotiated rates in the cost report

Certain Required Quality Data Added and Removed – Adding Vaccination Coverage Among Healthcare Providers

Several RFIs issued including:

- Advancing to Digital Quality Measurement
- Closing the Health Equity Gap in CMS Hospital Quality Programs

LTCH Reimbursement Updates

- Increased in Standard Federal Rate of 1.9%, also computed similarly to 2021 due to PHE
- Changes to high cost outlier calculations finalized to raise the fixed-loss threshold to $33,015
- Similar DSH reductions are being seen compared to IPPS
- Certain changes also seen to quality reporting metrics
- Overall anticipated increase in reimbursement of 0.9% per discharge anticipated for all LTCH providers – Increase of $42M Nationally

SNF Reimbursement Updates

Market basket increase of 1.2% with no PDPM Parity Adjustment

Value Based Payment Adjustments Continue – Unlike IPPS

3-Day Qualifying Hospital Stay has been waived for certain criteria

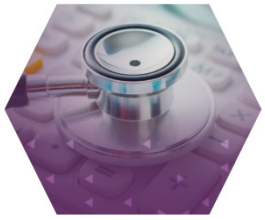
100-Day Limit on Medicare SNF Stay has been waived for certain criteria

OPPS Proposed Rules

- Payment rates anticipated to increase 1.8% overall
- Rural Sole Community enhanced payment of 7.1% continues
- APC Weights based on claims before PHE
- 340B Drug reimbursement continues at ASP minus 22.5%
- Reinstating procedures to remove items from Inpatient Only List & reinstating 2-midnight rule indefinite exemption
- RFI for Rural Emergency Hospital designation & criteria
- Radiation Oncology Payment Model – 90 Day Episodes
- Increasing Hospital Price Transparency Requirements & Penalties

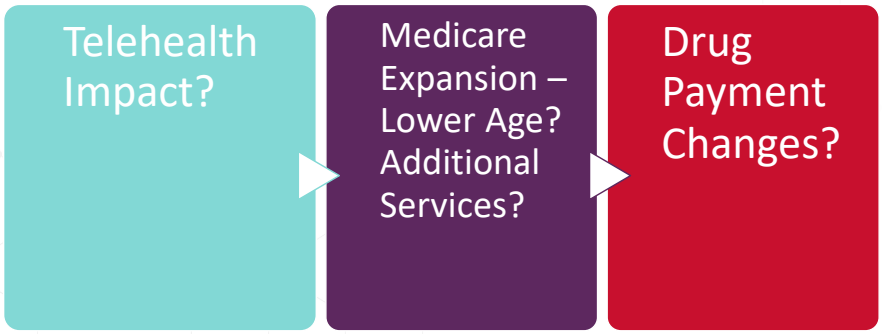
Other Reimbursement Related Matters

- GME Decision in Milton S. Hershey Medical Center v Becerra
- NAHE payment concerns continue based on recent reopening trends
- Recent Report by Medicare trustees shows challenging financial picture for the program
- Sequestration Moratorium Through December 31, 2021



Other Reimbursement Related Matters

Current Pending Major Bills



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Impact of COVID-19 on Telehealth Adoption

- Telehealth defined as 2-way telecommunication technologies to provide clinical health care through a variety of remote methods
  - Historically restrictive in terms of how delivered & who could be reimbursed
  - Person receiving service located in a designated rural area
- 1135 waiver authority & Coronavirus Preparedness and Response Supplemental Appropriations Act expanded benefit on temporary & emergency basis
  - Medicare can pay for office, hospital, & other visits starting March 6, 2020
  - Physicians, nurse practitioners, clinical psychologists, & licensed clinical social workers can provide telehealth services
- Modern Healthcare reported telemedicine grew from less than 1% of primary care visits to nearly 43.5% from February to April 2020

Types of Virtual Services

Three main types of virtual services can be provided to Medicare beneficiaries

- Medicare Telehealth Visits – visit with provider using telecommunication system between provider & patient
- Virtual Check-Ins – brief check in with provider via telephone or other telecommunication device
- E-Visits – communication between patient & provider via online patient portal

Potential Future Impacts

- Telemedicine may become a standard service offered across all care settings
- Patients may choose providers, health systems, & hospitals based on telemedicine access
- Organizations that embrace telemedicine may see increases in total visits & revenue
- Telemedicine may be utilized more often for preventative or nonemergent care
- Specialists may be able to greater utilize telemedicine & increase access to care

How Can Providers Respond?

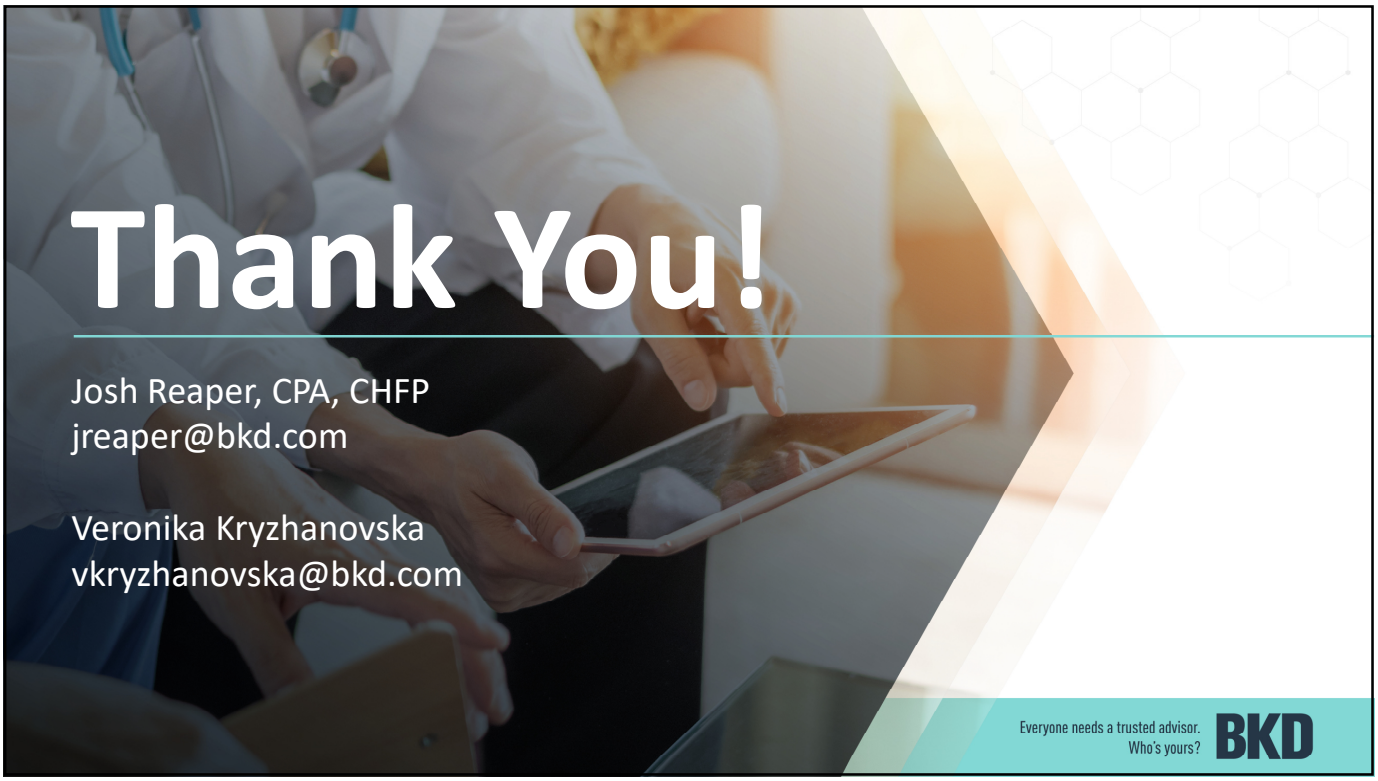
Heightened Focus on Accurately Reporting Cost Report & Quality Data

- Wage Index Drivers – Contract Labor, Physician Time Studies, Pay Codes, etc.
- Patient Statistics May Drive Payment Variables (DSH, LVA, etc.)
- **It is Often Unknown How Current Data May Be Used in the Future** – Volume Decline Adjustment Considerations, Base Rates, etc.

How Can Providers Respond?

Review Potential CMS Designations

- Volume Fluctuations may drive eligibility criteria (SCH, MDH, etc.)
- Competitor changes may drive eligibility criteria
- Wage index changes may alter impact of designation as rural or MGCRB options
- New option for small PPS & CAH hospitals—Rural Emergency Hospital status


Thank You!
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