TOYON ASSOCIATES, INC.

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FFY 2022 IPPS Proposed Rule

May 21, 2021

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FFY 2022 IPPS Proposed Rule

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Proposed IPPS Payments

COVID-19 PHE Data and FFY 2022 Rate Setting

FFY 2022 IPPS Proposed Rule

Base Rates

Base rate increase of 2.8%

- market basket +2.5%
- productivity adjustment -0.2%
- reversal of the MACRA coding adjustment of +0.5%
- Labor and Non-Labor percentages proposed at 67.6% and 32.4% respectively (in FFY 2021 the Labor was 68.3% and Non-Labor was 31.7%)

Proposed Rule (5/10/2021)

(For hospitals with WIF > 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 Proposed Labor-Related Rate	4,150.84	4,074.76	4,125.48	4,049.40	67.6%
FFY2022 Proposed NonLabor-Related Rate	1,989.46	1,952.99	1,977.30	1,940.83	32.4%
Net Oper IPPS Base Rate Change	3.0%				

(For hospitals with WIF <= 1.000)

Update Factor Components (Operating)	Full	IQR Only	EHR Only	Neither	Labor %
FFY2022 Final Labor-Related Rate	3,806.98	3,737.21	3,783.72	3,713.94	62.0%
FFY2022 Final NonLabor-Related Rate	2,333.31	2,290.54	2,319.06	2,276.29	38.0%
Net Oper IPPS Base Rate Change	3.0%				

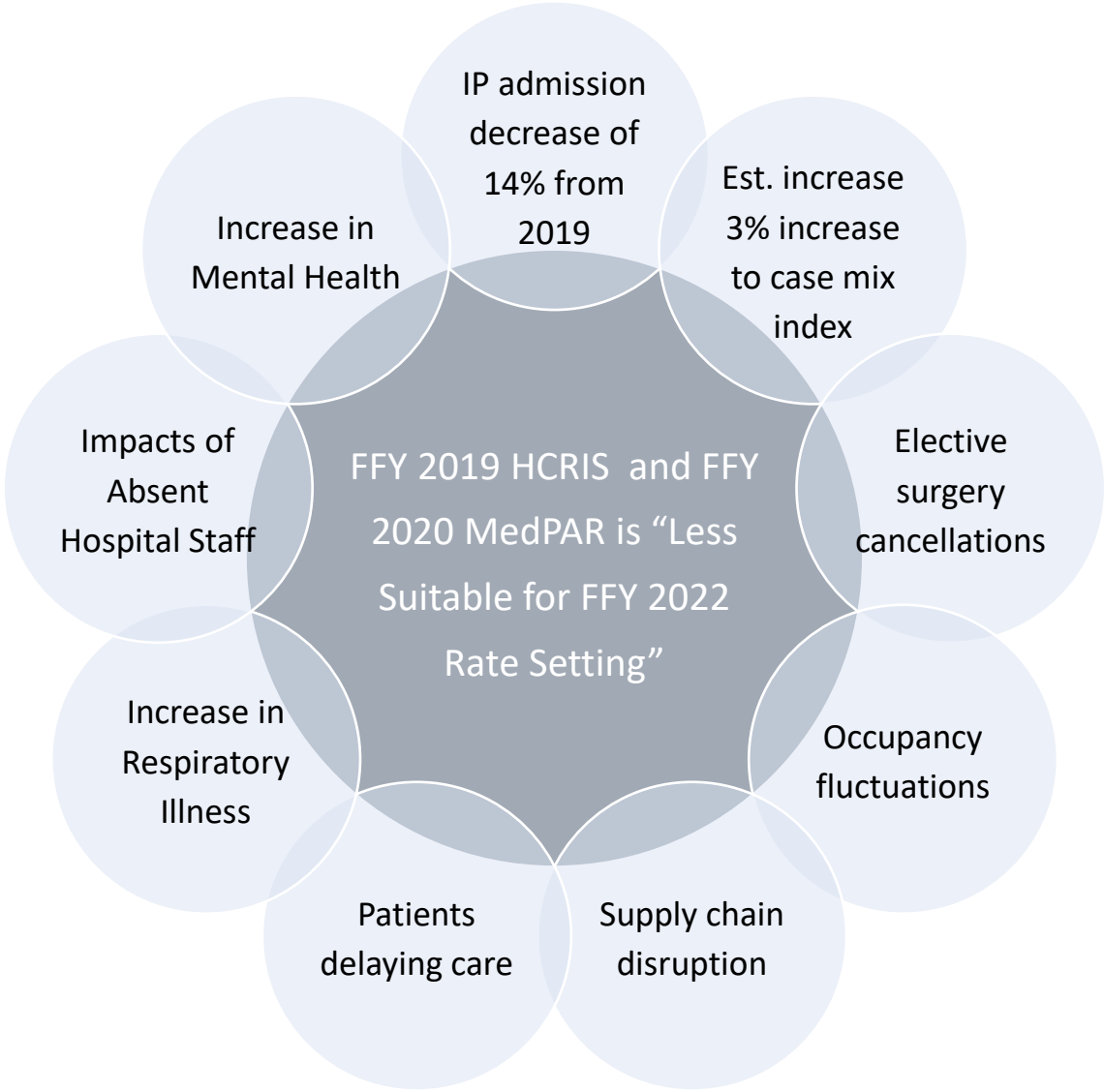
Update Factor Components (Capital)	All
FFY2021 CN Final Capital Rate	466.21
FFY2022 Proposed Capital Rate	471.89
Net Cap IPPS Base Rate Change	1.22%

FY21 CN Final Fixed Loss Operating Outlier Threshold	$29,064
FY22 Fixed Loss Operating Outlier Threshold	$32,680

FFY 2022 IPPS Proposed Rule

Projected Medicare FFS Payments

- **CMS proposes to use data before the PHE - FFY 2018 HCRIS and FFY 2019 MedPAR - for rate setting and projecting FFY 2022 Medicare IPPS payments**
- CMS notes the effects of COVID-19 are not expected to continue into FFY 2022 (per a CDC study on vaccinations)
- CMS provides alternative data with FFY 2019 and FFY 2020 MedPAR to assess data pre and post COVID-19



FFY 2022 IPPS Proposed Rule

All Acute Care Hospitals

Description | Source	Est. Medicare FFS IPPS Payments	Discharges	Case-Mix Index	Readmission*	VBP*	HAC*
FFY 2022 IPPS Proposed Rule	$130bn	8.9m	1.6458	($593m)	($2.5m)	($369m)
FFY 2022 IPPS Proposed Rule ALT Data	$117bn	7.7m	1.7095	($529m)	($4.7m)	($329m)
FFY 2021 IPPS Final Rule (CN Update)	$132bn	8.9m	1.6454	($588m)	($1.8m)	($360m)
Variances:						
FFY 2022 IPPS PR vs. FFY 2022 ALT DATA	$13bn, 10%	1.2m, 16%	(0.0637)	($63m), (12%)	$2.2m, 48%	($40m), (12%)
FFY 2022 IPPS PR vs. FFY 2021 FR (CN)	($2bn), (1.5%)	0, 0%	0.0004	($5m), (1%)	($652K), (36%)	($9m), (3%)

FFY 2022 PR DATA: MARCH 2020 UPDATE OF FY 2019 MEDPAR, MARCH 2020 UPDATES OF PROVIDER SPECIFIC FILE (PSF) UNLESS INDICATED OTHERWISE, FY2017/FY2018 COST REPORT DATA

FFY 2022 ALT PR DATA: DECEMBER 2020 UPDATE OF FY 2020 MEDPAR, DECEMBER 2020 UPDATES OF PROVIDER SPECIFIC FILE, FY2017/FY2018 COST REPORT DATA

*PROXY DATA FROM THE FFY 2022 IPPS PROPOSED RULE (USES PRIOR FISCAL YEAR DATA, FFY 2021)

FFY 2022 IPPS Proposed Rule

Quality-Based Reporting Programs and COVID-19

Value Based Purchasing (VBP)

- Suppress HCAHPS, MSPB, and five HAI measures, for the FY 2022 program year
- Suppress the Pn 30-Day Mortality Rate (MORT-30-PN) measures measure for the FY 2023 program year
- Update baseline period for certain measures affected by the ECE granted in response to the COVID-19 PHE

Hospital Readmissions Reduction Program

- Adopt a measure suppression policy; and proposing to suppress the Hospital 30-Day, All-Cause, RSRR following Pn Hospitalization measure (NQF #0506) beginning with the FY 2023program year FFY 2023 Pn measure excluded
- HRRP and HAC ECEs would not "except" a facility from the quality program, but instead that the facility would be "excepted" from reporting data for the approved data-reporting period

Hospital Acquired Condition Reduction Program

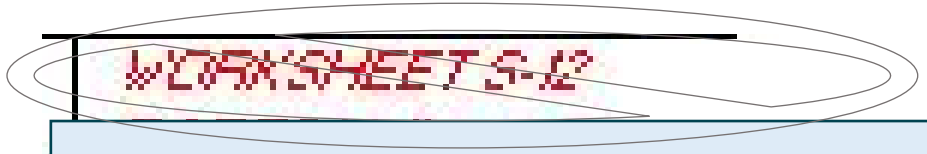
- Establish a measure suppression policy
- Suppress 3rd and 4th Qs of CY 2020 CDC National Healthcare Safety Network HAI and CMS PSI 90 data from performance calculations for the FY 2022 and FY 2023 program years

Measurement Suppression

The FFY 2022 IPPS Proposed Rule is *"intended to ensure these programs do not reward or penalize hospitals based on circumstances caused by the PHE for COVID-19 that the measures were not designed to accommodate."*

FFY 2022 IPPS Proposed Rule

Repeal of Market-Based Data Collection



Median Payer-Negotiated IP Charges for Medicare Advantage Organizations

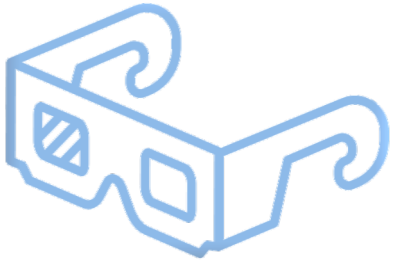
- Hospitals **do not have to report this information** (initially proposed for reporting periods ending on/after January 1, 2021)
- CMS's proposed Medicare cost report Worksheet S-12 is likely scrapped; however, hospitals still must follow price transparency regulations (https://www.cms.gov/hospital-price-transparency)

Market-Based MS-DRG Relative Weight Methodology

- Data would have set Medicare payment rates for hospitals for FFY 2024 and forward.
- CMS proposed to continue using existing rate-setting methodology for FYF 2024 and subsequent years.
- CMS is soliciting comment on alternative approaches or data sources that could be used in Medicare fee-for-service (FFS) rate setting

FFY 2022 IPPS Proposed Rule

Changes to the New COVID-19 Treatments Add-on Payment (NCTAP)



The NCTAP for certain technologies, is proposed by CMS to be extended through the end of the fiscal year in which the PHE ends (suggested date is September 30, 2022).*

CMS is also proposing to discontinue the NCTAP for discharges on or after October 1, 2021 for products approved for new technology add-on payments beginning FY 2022.

*NCTAP, began in November 2020 as CMS solution to lessen potential disincentives in providing new COVID-19 treatments throughout the pandemic

*NCTAP was established to pay hospitals the lesser of: (1) 65 percent of the operating outlier threshold for the claim; or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment, including the adjustment to the relative weight under section 3710 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act

**https://www.cms.gov/medicare/covid-19/ new-covid-19-treatments-add-payment-nctap*

Wage Index

Proposed Updates

FFY 2022 IPPS Proposed Rule

Wage Index Changes – Prior Year Policy Changes Refresher

Continuation of Prior Year Wage Index Policies

- Bottom Quartile Wage Index Increase – From FFY 2020
  - Continuation of increase to bottom quartile wage indexes (less than 0.8418 as proposed) through budget neutrality adjustment of 0.998108
- Statewide Rural Floor Calculation – From FFY 2020
  - Statewide rural floor wage indexes are calculated without the inclusion of "Section 401" hospitals, i.e., urban hospitals that are redesignated in the rural area for wage index purposes
- Changes to CBSA Designations per OMB Update – From FFY 2021
  - OMB Bulletin 18-04 revised certain CBSA designation – Urban counties became rural counties, rural counties became urban counties, and existing CBSAs split into new CBSAs
  - Notably impacting hospitals in Central New Jersey
- Transition Policy – From FFYs 2020 and 2021
  - In both years, CMS applied a "transition" policy which limited wage index decreases to no more than 5% from the prior year
    - Applied budget neutral to the standardized rates – 0.998851
  - Transition policy NOT applied in FFY 2022 but mentioned by CMS for public comment

FFY 2022 IPPS Proposed Rule

Wage Index Changes – Rural Redesignations

Reincarnation of Imputed Floor in "All-Urban" States

- Permanent reinstatement of the imputed rural floor in "All-Urban" States required by Section 9831 of the American Rescue Plan of 2021
  - Methodology consistent with last iteration of the imputed rural floor in FFY 2018 with exception of budget neutrality – Not applied budget neutral
  - "All-Urban" States include New Jersey, Delaware, Rhode Island, Washington D.C. and Connecticut

FFY 2022 Proposed Rule Imputed Floors		
CBSA #	**State**	**Imputed Wage Index Floor**
07	Connecticut	1.1606
08	Delaware	0.9998
09	Washington DC	1.1108
31	New Jersey	1.1625
40	Puerto Rico	0.3497
41	Rhode Island	1.1313

FFY 2022 IPPS Proposed Rule

Wage Index Changes – Rural Redesignations

Cancellation of Rural Status

- CMS proposing a change to the timing of a hospital's request to cancel a previously granted reclassification from urban to rural under 42 CFR § 412.103
  - First, CMS proposes that requests to cancel rural reclassification be submitted to the CMS Regional Office *no earlier than one calendar day after the date when the reclassification became effective* – This is a new requirement
  - Second, CMS proposes to replace an existing rule, which requires cancellations no later than 120 days prior to the end of the Federal Year (September 30th) to be effective at the beginning of the next Federal Year (October 1st), with a requirement that cancellation requests become effective in the Federal Year that begins in the Calendar Year after the Calendar Year when the request was submitted

Case Study:

- FYE December 31st Hospital A became a rural hospital on September 1, 2020 and wants to cancel its rural status as soon as possible
- Under the current rule, hospital would request cancellation no later than June 1, 2021 to be effective October 1, 2021
- Under the proposed rule, the hospital's request to cancel rural status on June 1, 2021 would not be effective until October 1, 2022, thus resulting in the hospital maintaining rural status for an additional 12 months

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Wage Index Changes – Rural Redesignations

Rural Hospitals treated as Rural for MGCRB Reclassifications

Medicare Geographic Reclassifications

An interim final rule (CMS-1762-IFC) released simultaneously with the proposed rule revises regulations* to allow hospitals with a rural redesignation to reclassify with the MGCRB using the rural reclassified area as the geographic area in which the hospital is located beginning with FFY 2023 reclassifications

Observation #1

This confirms a rural redesignated hospital can use the Statewide rural area for purposes of the "106% average hourly wage test" required for rural hospitals in comparison of its 3-year average hourly wage

Observation #2

"The 106% average hourly wage test" is not applicable for hospitals designed as rural referral centers, however this change may affect the ability for rural referral centers to reclassify to the nearest CBSA

*42 CFR § 412.230

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Wage Index Changes – Proposed WIF Variations

Top 10 Increases in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Proposed Rule*	Change from FFY 2021 WIF	Observation
1	Ithaca, NY	1.0714	0.1318	1 hospital controls CBSA
2	Bloomsburg-Berwick, PA	0.9664	0.1124	CBSA wages driven primarily by 1 hospital
3	Panama City, FL	0.8883	0.0697	Only 2 hospitals in CBSA
4	Lewiston, ID-WA	0.8491	0.0652	Only 1 hospital in CBSA
5	Elmira, NY	0.9471	0.0725	Only 1 hospital in CBSA
6	Rural Pennsylvania	0.8592	0.0643	Rural redesignations – Not impacting rural floor
7	Eau Claire, WI	1.0212	0.0737	CBSA wages driven primarily by 2 hospitals
8	Athens-Clarke County, GA	0.9252	0.0660	Only 2 hospitals in CBSA
9	Fayetteville, NC	0.8609	0.0597	CBSA wages driven primarily by 1 hospital
10	Mansfield, OH	0.8853	0.0564	Only 2 hospitals in CBSA

*Toyon can provide an evaluation of data per the April 2021 Public Use File (released after the FFY 2022 Proposed Rule) for your hospital(s).

FFY 2022 IPPS Proposed Rule

Wage Index Changes – Proposed WIF Variations

Top 10 Decreases in Wage Index Factor by CBSA

Rank #	CBSA Name	FFY 2022 WIF per Proposed Rule*	Change from FFY 2021 WIF	Observation
1	Rural Connecticut	0.9921	(0.2410)	Impact mitigated by IRF
2	Rural Idaho	0.8218	(0.1187)	Only 1 hospital in Rural ID
3	Bangor, ME	0.9183	(0.1096)	Only 2 hospitals in CBSA
4	Monroe, MI	0.8546	(0.0897)	Only 1 hospital in CBSA
5	Stockton, CA	1.3532	(0.1261)	Primarily due to hospital exclusion
6	Columbus, IN	1.0392	(0.0928)	Reclassification issue
7	Atlantic City-Hammonton, NJ	1.0570	(0.0931)	Only 2 hospitals in CBSA
8	Nassau County-Suffolk County, NY-CT	1.2483	(0.1058)	NYC hospitals not reclassified
9	Weirton-Steubenville, WV-OH	0.7329	(0.0605)	Only 2 hospitals in CBSA
10	Rural Utah	0.9552	(0.0734)	Rural redesignation reversal

*Toyon can provide an evaluation of data per the April 2021 Public Use File (released after the FFY 2022 Proposed Rule) for your hospital(s).

FFY 2022 IPPS Proposed Rule

Wage Index Changes – CY 2019 Occupational Mix Survey Application

Top 10 Positive MOMA Impacts

Rank #	CBSA	FFY 2022 MOMA per Proposed Rule*	Change from FFY 2021 MOMA (CY 2016 Survey)	Observation
1	St. Joseph, MO-KS	$2.48	$0.62	CBSA comprised of 1 hospital
2	St. Cloud, MN	$2.07	($0.11)	CBSA comprised of 1 hospital (SCH)
3	Muncie, IN	$2.00	$0.47	CBSA comprised of 1 hospital
4	Portland-South Portland, ME	$1.97	$0.98	MOMA impact driven primarily by 2 hospitals
5	Tuscaloosa, AL	$1.88	$0.22	CBSA wages driven primarily by 1 hospital
6	Longview, WA	$1.79	($0.89)	CBSA comprised of 1 hospital
7	Twin Falls, ID	$1.61	($0.86)	CBSA comprised of 1 hospital
8	MAINE	$1.60	$0.59	Only 1 rural hospital with negative MOMA
9	Goldsboro, NC	$1.57	$1.26	CBSA comprised of 1 hospital
10	East Stroudsburg, PA	$1.55	($0.09)	MOMA impact driven primarily by 2 hospitals

*Toyon can provide an evaluation of data per the April 2021 Public Use File (released after the FFY 2022 Proposed Rule) for your hospital(s).

FFY 2022 IPPS Proposed Rule

Wage Index Changes – CY 2019 Occupational Mix Survey Application

Top 10 Negative MOMA Impacts

Rank #	CBSA	FFY 2022 MOMA per Proposed Rule*	Change from FFY 2021 MOMA (CY 2016 Survey)	Observation
1	Santa Cruz-Watsonville, CA	($4.09)	($1.02)	Remains highest WIF in country
2	San Luis Obispo-Paso Robles, CA	($3.41)	$0.32	3 system hospitals comprise CBSA
3	Sacramento-Roseville-Folsom, CA	($2.74)	($0.08)	System hospitals comprise most of CBSA
4	Santa Rosa-Petaluma, CA	($2.71)	($0.18)	Only 1 hospital with positive MOMA
5	Oakland-Berkeley-Livermore, CA	($2.51)	($0.21)	No hospitals with positive MOMA
6	San Francisco-San Mateo-Redwood City, CA	($2.47)	($1.08)	Primary driver of WIF reduction in CBSA
7	Redding, CA	($2.37)	($0.13)	Wages driven primarily by 1 hospital
8	Modesto, CA	($2.36)	($0.50)	Wages driven primarily by 2 hospitals
9	San Jose-Sunnyvale-Santa Clara, CA	($2.19)	$0.36	Improvement from CY 2016 Survey
10	Stockton, CA	($2.02)	($0.05)	Does not account for excluded hospital

*Toyon can provide an evaluation of data per the April 2021 Public Use File (released after the FFY 2022 Proposed Rule) for your hospital(s).

Graduate Medical Education

Opportunities for New Teaching Slots

FFY 2022 IPPS Proposed Rule

1,000 IME | GME Cap Slots (American Rescue Plan Act)

- 200 cap slots per year available beginning 7/1/2023
- First year applications due 1/31/2022
- Statute limits new slots to 25 per hospital, but Proposal limit is just one slot per hospital per year (five total). Only one application allowed per hospital per year
- Significant advantage to hospitals located in a Health Professional Shortage Area (HPSA), based on HPSA severity score (1-25 scale for primary care or mental health)
    - https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Hospital must increase its resident count (establish or expand program) for awarded slots (cannot only use for existing shortage)
- Cannot use new slots in a Medicare affiliated group agreement until after 5th year
- 10% allocation of new cap slots to each of four categories of hospitals

FFY 2022 IPPS Proposed Rule

1,000 IME | GME Slots (American Rescue Plan Act)

10% Allocation to Four Categories of Hospitals (HPSA Ranking Applies Across All Four Categories)

1. Located in rural areas or treated as such (includes rural re-designated)
2. Training residents in excess of FTE cap (most recent cost report on/before 12/27/2020)
3. Located in states with new medical schools or additional locations / branches of existing medical schools (35 states + Puerto Rico)
4. Serving areas designated as primary care or mental Health Professional Shortage Areas (HPSAs)

Key Dates: Filing Deadline 1/31/2022 | Approval: 1/31/2023 | Payment: 7/1/2023

Prioritization by HPSA Score

0 (Low Severity) – 25 (High Severity)

Hospital Group	HPSA Score	FTEs Awarded Per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	25	1	50	150
50 hosps	24	1	50	100
50 hosps	21	1	50	50
80 hosps	19	0.625	50	0
Total (230 Hosps)			**200**	**0**

- or -

Prioritization by Number of Qualifying Categories (Alternative)

Rural | Over Cap | New Med School | HPSA

Hospital Group	Total Score	FTEs Awarded Per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	4	1	50	150
50 hosps	3	1	50	100
50 hosps	2	1	50	50
80 hosps	1	0.625	50	0
Total (230 Hosps)			**200**	**0**

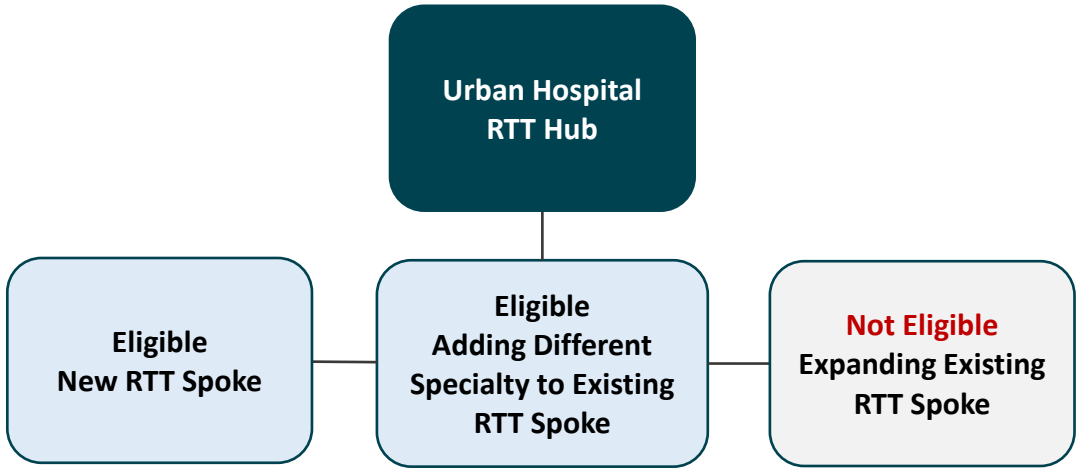
FFY 2022 IPPS Proposed Rule

Rural Training Track Cap Adjustment (American Rescue Plan Act)

Greater Flexibility and Benefits for Rural Training Track (RTT) Programs

New Cap Slots for Urban and Rural Hospitals

- Cost Reports beginning on or after 10/1/2022
- Urban hospitals with existing RTTs can add subsequent RTT programs
- Urban hospitals (Hub) with an existing RTT program can add additional rural hospitals (spokes) to the existing program
- Both the urban and rural hospital can get RTT cap adjustments regardless of whether program is “new”
- Regardless of specialty (must be accredited by the ACGME); separate “1-2 format” accreditation not required
- At least 50% of training must occur in rural areas
- RTT FTEs are exempt from the FTE 3-year rolling average during the 5-year growth window



FFY 2022 IPPS Proposed Rule

Low Resident Count (American Rescue Plan Act)

Establishing New Per Resident Amounts (PRAs) and FTE Caps for Certain Hospitals

Intended to Help Hospitals With Small PRAs or Caps Created Based on Minimal Teaching Activity

Category A Hospitals

- As of 12/27/2020 has a PRA or cap established based on a resident count of 1.0 FTE (or less) from a cost reporting period beginning before 10/1/1997
- PRA and caps re-set after hospital trains at least 1.0 FTE on after 12/27/2020 and before 12/26/2025

Category B Hospitals

- As of 12/27/2020 has a PRA or cap established after 10/1/1997 based on a resident count of no more than 3.0 FTEs
- Rest after hospital trains at least 3.0 FTEs on after 12/27/2020 and before 12/26/2025

PRAs for New and Existing Programs

- For hospitals training between 1.0 and 3.0 FTEs, CMS Proposes that the PRA and caps will be determined using existing rules for new programs. For new PRAs, the program does not have to be new.
- Hospitals with GME affiliation agreements will have PRA established when less than 1.0 is trained.
- Future new PRAs and caps will not be set unless hospital trains at least 1.0 FTE.

FTE Cap Adjustment for <u>New Programs Only</u>

- Caps established when a hospital begins training for the first time after 12/27/2020 and before 12/26/2025.
- Cap is set using existing rules for new programs.

Organ Acquisition

Cost-Based Reimbursement

FFY 2022 IPPS Proposed Rule

Organ Acquisition Cost-Based Reimbursement

- All organ acquisition policies with consistent terminology at 42 C.F.R. Part 413, subpart L (incl. existing organ and kidney acquisition pmt regs)
- Applies to existing elements of kidney acquisition costs to all organs and includes additional changes applying to kidney acquisition only
  - E.g., costs for registration of a beneficiary for a kidney transplant and costs for registration of a beneficiary for a non-renal transplant
- Codification of Standard Acquisition Charges (SACs) for Transplant Hospitals (TH) | Hospital Based Organ Procurement Organizations (HOPO)
  - Registration fee limitation to (Organ Procurement and Transplantation Network) OPTN based on reasonable cost principles
  - Surgeon fees are "included as kidney acquisition costs only when the kidney excision occurs with a cadaveric donor"
    - When a living donor enters the hospital for the actual kidney excision, surgeon fees for excising the kidney are not included as kidney acquisition costs
- Toyon recommends the industry consider commenting how this Proposal impacts operations, and future implications/plans on securing organs for patients

Note: Medicare's current reimbursement uses acquisition costs multiplied by the ratio of Medicare usable organs to total usable organs (on the Medicare cost report)

FFY 2022 IPPS Proposed Rule

Organ Acquisition Cost-Based Reimbursement

#	Proposed list of 12 Organ Acquisition Costs, Covered by Medicare Part A
1	Tissue typing, including tissue typing furnished by independent laboratories
2	Donor and beneficiary evaluation
3	Excising organ other costs, such as general routine and special care services provided to the donor
4	Operating room and other inpatient ancillary services applicable to the donor
5	Preservation and perfusion costs
6	Organ Procurement and Transplantation Network (OPTN) registration fees
7	Surgeons' fees for excising cadaveric organs
8	Transportation of excised organ to TH
9	Costs of organs acquired from other hospitals or OPOs
10	Hospital costs normally for OP costs re organ excisions (donor and recip. tissue typing, work-up, and related services prior to admission)
11	Costs of services for organ excisions, rendered by residents and interns not in approved teaching programs
12	All pre-admission services applicable to organ excisions (lab., electroenc., surgeons' fees for cadaveric excisions, for organ excisions incl. the costs of phys. services)

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Organ Acquisition Reimbursement

Services Not Considered Organ Acquisition Costs

- CMS proposes to establish rules identifying costs that are non-reimbursable which may be incurred during organ acquisition and transplant
- Including, not limited to:
  - burial and funeral expenses for cadaveric donors
  - costs associated with transportation of a living or cadaveric donor
  - costs incurred prior to a potential donor being declared brain dead
  - fees or in-center payments for donor referrals
  - costs associated with OPO sponsored seminars where continuing education credits are given
  - certain costs incurred for administrator's duties associated with professional organizations

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Medicare's Proposed Share of Organ Acquisition Reimbursement

- To determine whether a recipient is a Medicare patient, **CMS is proposing to change its means of the identification of each donor beneficiary**
  - CMS states this verification will ensure the TH/OPO organ acquisition costs are more accurately applied to the Medicare program
- CMS proposes changes to OPOs and their reporting requirements, total usable organs for THs/OPOs will now be included into one of ten subcategories
  - CMS states these categories will more accurately explain various situations, including "organs transplanted into non-Medicare beneficiaries." Organs not transplanted into Medicare patients are accounted to determine Medicare usable organs
  - Additionally, CMS further proposes policy changes on organ acquisition charges for kidney-paired exchanges in section k on page 25669 (600 of 721) of the Proposed Rule, ***included in the Addendum of this presentation***

Disproportionate Share (DSH)

Uncompensated Care and Empirical Payments

FFY 2022 IPPS Proposed Rule

Medicare DSH Uncompensated Care

- **CMS proposes to decrease Medicare UC DSH payments by $662m, to $7.6bn in FFY 2022**
  - This decrease is primarily due to a step in the "Factor 1" determination of DSH payments
  - FFY 2022 national funding is adjusted by data from the PHE (notably discharges and Medicaid enrollment)
- **Toyon estimates at least $1bn in additional national FFY 2022 funding if CMS applied the same update factors in FFY 2022 as it did in 2021**
- **Recommendation**: Toyon recommends hospitals comment that data from the COVID-19 PHE should not be used in establishing national UC DSH Funding in FFY 2022. Example language includes:
  - *Hospital/Health System requests when CMS compute FFY 2022 empirical DSH payments (as part of the "Factor 1" calculation), these estimated payments are not adjusted by data representative of the COVID-19 Public Health Emergency (data in table "Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline"). The Discharge Factor update proposed for FFY 2022 includes uncommon data from the COVID-19 PHE, and the "other" factor assumes new Medicaid enrollees are healthier than average Medicaid recipients and; therefore, use fewer hospital services during the PHE. As stated in this Proposed Rule, data from the COVID-19 PHE is less suitable for FFY 2022 rate setting, and a number of measurements for value-based purchasing, readmissions, and hospital acquired conditions adjustments have been suppressed. Hospital/Health System respectively requests PHE data is also omitted/suppressed from the Factor 1 calculation of empirical DSH payments used to determine FFY 2022 Uncompensated Care Funding. The exclusion of these estimates will provide industry leaders additional time to evaluate national funding needs, considering the on-going impact of COVID-19 to beneficiaries and the hospitals providing care.*

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Medicare DSH Uncompensated Care

Uncompensated Care Factors	*Proposed* FFY 2022	FFY 2021	FFY 2020	FFY 2019
Base Year Empirical DSH (Before Update Factors)	$13,931,000,000	$14,000,400,000	$13,981,000,000	$13,230,000,000
Projected DSH Payments (After Update Factors)	$14,097,825,122	$15,170,673,476	$16,583,455,657	$16,339,055,838
FYI - Impact of Updates ($)	*$166,825,122*	*$1,170,273,476*	*$2,602,455,657*	*$3,109,055,838*
FYI - Impact of Updates (%)	*1.20%*	*8.36%*	*18.61%*	*23.50%*
Projected DSH Payments (After Updates)	$14,097,825,122	$15,170,673,476	$16,583,455,657	$16,339,055,838
75% of Available UC DSH Funds	75.00%	75.00%	75.00%	75.00%
Gross Uncompensated Care Pool (**Factor 1**)	$10,573,368,842	$11,378,005,107	$12,437,591,743	$12,254,291,879
Uninsured Population Reduction (**Factor 2**)	72.14%	72.86%	67.14%	67.51%
Adjusted UC DSH Funding Available	**$7,627,628,282**	**$8,290,014,521**	**$8,350,599,096**	**$8,272,872,447**
Change from Prior Year UC DSH Funding ($)	*($662,386,239)*	*($60,584,575)*	*$77,726,649*	*$1,506,178,178*
Change from Prior Year UC DSH Funding (%)	*-8.68%*	*-0.73%*	*0.93%*	*18.21%*

FFY 2022 IPPS Proposed Rule

Medicare DSH Uncompensated Care Factor 1 Calculation

	FFY 2018	FFY 2017	Variance
Base Year DSH Pmts	13.9310	14.0004	(0.0694)
Update Factor*	**FFY 22 Proposed**	**FFY 21 Final**	**Variance**
2019	1.0185	1.0185	0.0000
2020	1.0310	1.0131	0.0179
2021	1.0290	1.0290	0.0000
2022	1.0280		
Discharge Factor	**FFY 22 Proposed**	**FFY 21 Final**	**Variance**
2019	0.9700	0.9660	0.0040
2020	0.8530	0.8910	(0.0380)
2021	0.9680	1.0360	(0.0680)
2022	1.0750		
Case-Mix Factor	**FFY 22 Proposed**	**FFY 21 Final**	**Variance**
2019	1.0090	1.0090	0.0000
2020	1.0380	1.0390	(0.0010)
2021	0.9980	0.9830	0.0150
2022	1.0050		
Other Factor	**FFY 22 Proposed**	**FFY 21 Final**	**Variance**
2019	1.0179	1.0204	(0.0025)
2020	1.0023	1.0196	(0.0173)
2021	0.9754	0.9960	(0.0206)
2022	1.0122		
Adj DSH Pmts	**FFY 22 Proposed**	**FFY 21 Final**	**Variance**
2019	14.1360	14.9370	(0.8010)
2020	12.9330	14.5360	(1.6030)
2021	12.5410	15.1710	(2.6300)
2022	14.0980		

Annual UC DSH Fund starting point in Factor 1

- **The Discharge Factor** accounts for changes in the number of Medicare fee-for-service (FFS) inpatient hospital discharges...for Proposed FFY 2022, FY 2020 to FY 2022 reflect the estimated impact of the COVID-19 pandemic
- **The Case Mix factor** figures for FY 2019 and FY 2020 are based on actual data adjusted by a completion factor…for Proposed FFY 2022, FY 2020 and FY 2021 have been adjusted for the estimated impact of the COVID-19 pandemic
- **The "Other" factor** includes other adjustments to Medicare DSH estimates (Medicaid expansion)…for Proposed FFY 2022, the ''Other'' column also includes the estimated impacts on Medicaid enrollment from the COVID-19 pandemic

UC DSH Fund is next adjusted at 75% of this amount, after above applied updates

*The Update Factor includes annual adjustments for Market Basket, ACA Payment Reductions, Multifactor Productivity, and Documentation and Coding.

FFY 2022 IPPS Proposed Rule

Medicare DSH Uncompensated Care Payments

Verification of Worksheet S-10 Uncompensated Care Cost

- Toyon recommends hospitals verify FFY 2018 audited UC Cost as compared to UC Cost used in the FFY 2022 Proposed Rule (to develop each hospital's "Factor 3" and ultimate UC DSH payment)
  - CMS applied Worksheet UC Cost from HCRIS data through February 19, 2021 for Proposed FFY 2022 UC DSH payments
  - CMS intends to use **March 2021 HCRIS** for the FFY2022 final rule and the respective March updates **for all future final rules**
  - CMS also states it may consider the use of more recent data that may become available after March 2021, but prior to the development of the final rule, if appropriate
- Hospital comments (due to MAC mishandling of UC Cost from Worksheet S-10, including merger and acquisition data) may be directed to Section3133DSH@cms.hhs.gov
- Hospitals have 60 days from the date of public display of the FFY2022 IPPS/LTCH PPS proposed rule in the **Federal Register** (no later than 5 p.m. EDT on June 28, 2021) for comments
- Please contact Fred Fisher at fred.fisher@toyonassociates.com for a UC Cost analysis for your hospital(s)

FFY 2022 IPPS Proposed Rule

Proposed S-10 Cost Report Instructions

- CMS proposed new Worksheet S-10 reporting instructions and clarifications in the November 10, 2020 Federal Register (85 FR 71653)*
- Notable proposed changes to worksheet S-10 UC cost are discussed in further detail on Toyon's website at:
  - https://www.toyonassociates.com/2021/03/18/uncompensated-care-dsh/
    - This article was used as part of Toyon's contribution to the American Health Lawyers 2021 Institute on Medicare and Medicaid Payment issues
  - **Notable proposed changes to S-10 UC reporting include:**
    - **Shift to short-term hospital services only**
    - **Split between patient coinsurance, copayment deductibles vs. other patient liabilities**
    - **Clarification on the reporting of implicit price concessions and inferred contractual relationships**
    - **New reporting tables for Charity Care and Bad Debt information**
- In the FFY 2022 IPPS Proposed Rule, CMS thanks stakeholders for their comments on the PRA package and states the Agency will respond to industry comments in a separate Federal Register document
- Toyon **recommends** hospitals comment to CMS requesting the Agency postpone its proposed instructions allow providers more time to adapt to the operational changes and prepare for the impact of these changes

*https://www.govinfo.gov/content/pkg/FR-2020-11-10/pdf/FR-2020-11-10.pdf

FFY 2022 IPPS Proposed Rule

Medicare DSH Uncompensated Care – Proposed Changes

Interim Payments

Due to the PHE, CMS proposes to distribute interim UC DSH payments based on Medicare discharges from two years of data (FFY 2018 and FFY 2019), as opposed to three years (FFY 2018, FFY 2019 and FFY 2020)

New S-10 Trims

CMS also proposes new trims to exclude rare cases hospitals do not have audited FFY 2018 Worksheet S-10 data and are not currently projected to be DSH eligible

Empirical DSH
Section 1115 Waiver Days

Medicaid Fraction

- (numerator): inpatient days eligible for Medicaid, but not entitled to benefits under Medicare Part A, divided by (denominator) the hospital's total number of inpatient days in the same period
- Medicaid represents patients eligible for inpatient services under a Title XIX state approved plan

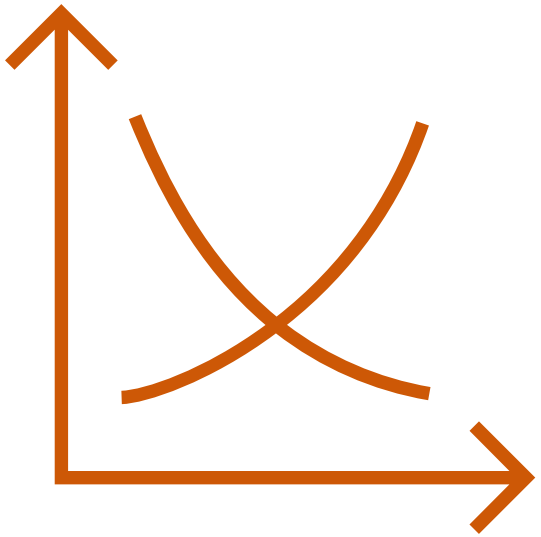
Section 1115 Waiver Days

- Patients under an approved Section 1115 Waiver plan can be claimed in the numerator of the Medicaid fraction
- Section 1115 days can only be claimed if the patient directly received inpatient hospital insurance coverage on that day under an approved waiver
- Section 1115 days can not be included if the hospital received payment from an uncompensated care pool

Recommendation

- Hospitals need to document and be prepared to support that the patient received inpatient insurance coverage during audit
- Expect the MAC to scrutinize these days. When presenting the DSH patient listing for the audit, this patient population should be separated on their own tab to reduce audit risk

Medicare Bad Debt



Dual Eligible Cost-Sharing

Medicare/Medicaid Bad Debt

State Enrollment

Enrollment

- State Medicaid Programs must accept enrollment of all Medicare-enrolled providers and suppliers for purposes of processing Medicare/Medicaid dual eligible claims for cost sharing liability
- State Medicaid Programs must comply for dates of services beginning January 1, 2023

Must Bill Policy

- Hospital still must bill and receive an adjudicated remit from the Medicaid Program prior to writing off the unpaid balance
- The new enrollment allows additional opportunity for hospitals to claim Medicare bad debt on the cost report

Snapshot

WHO

- All providers and suppliers billing for Medicare/Medicaid Bad Debt

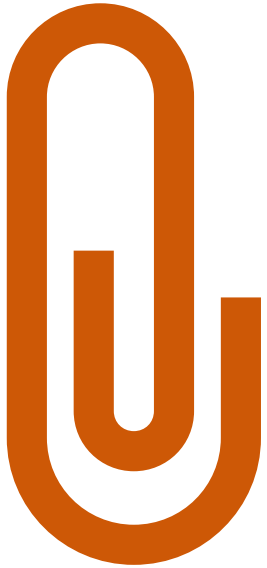
WHAT

- State Medicaid Programs must accept enrollment

WHY

- CMS hopes this leads to a reduction in future bad debt appeals

Addendum



Key References

Organ Acquisition Tables

Table X.B.-02. Summary of Kidney Paired Donation Exchange Example				
	TH A	**TH B**	**TH C**	**TH D**
Recipient	Recipient A	Recipient B	Recipient C	Recipient D
# of Evaluations	Evaluates 3 potential donors before Donor A is identified	Evaluates 2 potential donors before Donor B is identified	Evaluates 3 potential donors before Donor C is identified	Evaluates 3 potential donors before Donor D is identified
Donor	Donor A	Donor B	Donor C	Donor D
Donor Description	Recipient A and Donor A do not match each other but agree to a KPD exchange	Recipient B and Donor B do not match each other but agree to a KPD exchange	Recipient C and Donor C do not match each other but agree to a KPD exchange	Recipient D and Donor D do not match each other but agree to a KPD exchange
KPD Match	Recipient A matches with Donor C	Recipient B matches with Donor D	Recipient C matches with Donor A	Recipient D matches with Donor B
After Match	TH A performs additional tests and procures kidney from Donor A for TH C	TH B does not procure kidney from Donor B for TH D. Donor B travels to TH D	TH C procures kidney from Donor C for TH A	TH D procures kidney from Donor D for TH B. Donor B travels to TH D for kidney procurement.

Organ Acquisition Tables

Table X.B.-03. Summary of Accounting for Kidney Pair Donation Example				
	Accounting			
Cost of evaluations	**$12,000 incurred by TH A**	**$9,000 incurred by TH B**	**$15,000 incurred by TH C**	**$20,000 incurred by TH D**
Counting Medicare usable kidneys	2 Medicare usable kidneys; 1 kidney procured/sent and 1 kidney received/transplanted	1 Medicare usable kidneys; 1 kidney received/transplanted	2 Medicare usable kidneys; 1 organ procured/sent and 1 kidney received/transplanted	2 Medicare usable kidneys; 1 kidney procured/sent and 1 kidney procured/transplanted
Donor costs procuring, packaging, transporting kidney to recipient THs	TH A bills TH C $18,000 for costs incurred to procure Donor A's kidney	No bills sent to TH D.	TH C bills TH A $10,000 for costs incurred to procure Donor C's kidney	TH D bills TH B $14,000 for costs incurred to procure Donor D's kidney
Donor costs procuring, packaging, transporting kidney bill by Donor THs	TH A receives a bill from TH C for $10,000 for costs incurred to procure Donor C's kidney	TH B receives a bill from TH D for $14,000 for costs incurred to procure Donor D's kidney	TH C receives a bill from TH A for $18,000 for costs incurred to procure Donor A's kidney	No bills received from TH B. TH D claims all costs after initial evaluation for Donor B.
Kidney acquisition costs recorded on MCR	$12,000 evaluation costs of TH A; $18,000 for costs billed to TH C; $10,000 billed from TH C	$9,000 evaluation costs of TH B; $14,000 billed from TH D	$15,000 evaluation costs of TH C; $10,000 for costs billed to TH A; $18,000 billed from TH A.	$20,000 evaluation costs of TH D; $14,000 for costs billed to TH B; $8,000 for costs incurred to procure Donor B's kidney at TH D.
Subtotal	**$40,000**	**$23,000**	**$43,000**	**$42,000**
Offset on MCR amts received from recipient TH. Amts in ( ) are negative	($18,000) Received from TH C	No payment received from TH D	($10,000) received from TH A	($14,000) received from TH B
Net cost MCR	**$22,000**	**$23,000**	**$33,000**	**$28,000**

FFY 2022 IPPS Proposed Rule

Comments

Comments must be sent to CMS no later than 5p.m. EDT on June 28, 2021, at the applicable address provided in each section of the Proposed Rule or submitted electronically at http://www.regulations.gov. When commenting, please refer to file code CMS-1752-P https://www.regulations.gov/docket/CMS-2021-0070

Other Rules, Transmittals, and Articles Recently Published

Inpatient Psych Facility PPS FFY2022 Proposed Rule [CMS-1750-P] (Display Copy available 4/7/2021; FR Publish Date 4/13/2021)

Fact Sheet Link

Federal Register Link

- Per diem base rate increase from $815.22 to $833.50.
- Total estimated payments to IPFs are estimated to increase by 2.3% or $90 million in FY 2022 relative to IPF payments in FY 2021.
- For FY 2022, CMS is proposing to update the IPF PPS payment rates by 2.1% based on the proposed IPF market basket update of 2.3%, less a 0.2 percentage point productivity adjustment.

Inpatient Rehab Facility PPS FFY2022 Proposed Rule [CMS-1748-P] (Display Copy available 4/7/2021; FR Publish Date 4/12/2021)

Fact Sheet Link

Federal Register Link

- Standard payment conversion factor increase from $16,856 to $17,273.
- CMS is proposing the adoption of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure to require IRFs to report COVID-19 HCP vaccinations in their facilities.

Long-Term Care Hospital PPS Proposed Rule [CMS-1752-P] (Display Copy available here 4/27/2021; FR Publish Date 5/11/2021) – Published as part of the IPPS Acute Care Hospital Proposed Rule

Fact Sheet Link

Federal Register Link

- LTCH-PPS payments expected to increase by 1.4% or $52M.
- LTCH PPS payments for FY 2022 for discharges paid the site neutral payment rate are expected to increase by 3 percent. CMS estimates that discharges paid the site neutral payment rate will represent approximately 25 percent of all LTCH cases and 10 percent of all LTCH PPS payments in FY 2022.

Skilled Nursing Facility FFY2021 PPS Proposed Rule [CMS-1746-P] (Display Copy available 4/8/2021; FR Publish Date 4/15/2021)

Fact Sheet Link

Federal Register Link

- Increase in unadjusted Federal per diem rates of 1.3%
- CMS is proposing to rebase and revise the SNF market basket to improve payment accuracy under the SNF PPS by proposing to use a 2018-based SNF market basket to update the PPS payment rates, instead of the 2014-based SNF market basket.

Thank you

More Information on the FFY 2022 IPPS Proposed Rule at:

toyonassociates.com/2021/05/15/inpatient-prospective-payment-system-proposed-rule-ffy2022/

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