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Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

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Related Change Request (CR) Number: 12373
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Related CR Transmittal Number: R10995CP
Implementation Date: October 4, 2021

Provider Types Affected

This MLN Matters Article is for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services they provide to Medicare patients in acute care hospitals and LTCHs.

Provider Action Needed

In this Article, you'll learn about:

- FY 2022 IPPS updates
- FY 2022 LTCH PPS updates
- Update to those hospitals that CMS excludes from the IPPS

Make sure your billing staff knows about the FY 2022 changes.

Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a Prospective Payment System (PPS) for Medicare payment of inpatient hospital services. Also, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required us to implement a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) for cost reporting periods beginning on or after October 1, 2002. CMS updates these PPSs annually. CR 12373 outlines those changes for FY 2022.

The following policy changes for FY 2022 went on display on August 2, 2021 and appeared in the Federal Register on August 13, 2021. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2021, through September 30, 2022, unless otherwise noted.

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We'll release new IPPS and LTCH PPS Pricer software packages that include the updated rates/factors/policies that are effective for claims with discharges occurring on or after October 1, 2021, through September 30, 2022. We'll install the new revised Pricer program timely to make sure payments for IPPS and LTCH PPS claims are accurate.

The FY 2022 Final Rule Data Files, FY 2022 Final Rule Tables, and FY 2022 MAC Implementation Files we reference in this Article are available on the FY 2022 IPPS Final Rule Homepage.

IPPS FY 2022 Update

A. FY 2022 IPPS Rates and Factors

See Tables 1A-C and Table 1D, respectively, of the FY 2022 IPPS/LTCH PPS Final Rule, available on the FY 2022 Final Rule Tables webpage for the Operating Rates/Standardized Amounts and the Federal Capital Rate,

Refer to MAC Implementation File 1 at FY 2022 MAC Implementation Files webpage for other IPPS factors, including:

- Applicable percentage increase
- Budget neutrality factors
- High Cost Outlier (HCO) threshold
- Cost-of-Living adjustment (COLA) factors

B. FY 2022 Puerto Rico Hospital Update Under the IPPS

For FY 2022, any subsection (d) Puerto Rico hospital that isn't a meaningful Electronic Health Record (EHR) user and not subject to an exception under Section 1886(b)(3)(B)(ix) of the Social Security Act will have a reduction applied to the applicable percentage increase. For the applicable operating standardized amount and corresponding update factor for hospitals in Puerto Rico, refer to Table 1C of the FY 2022 IPPS/LTCH PPS Final Rule, available on the FY 2022 Final Rule Tables webpage.

C. Medicare Severity-Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new ICD-10 MS-DRG Grouper, Version 39.0, software package effective for discharges on or after October 1, 2021. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 38.9, which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2021.

For discharges occurring on or after October 1, 2021, the Fiscal Intermediary Shared System

(FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2021, the Medicare Code Editor (MCE) selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the Grouper version. There are still 767 MS-DRGs for FY 2022. See the ICD-10 MS-DRG V39.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V39 manual on the MS-DRG Classifications and Software webpage for the complete list of FY 2022 ICD-10 MS-DRGs and Medicare Code Edits.

D. Replaced Devices Offered without Cost or with a Credit

For specified MS-DRGs, we reduce a hospital's IPPS payment when you implant a device that's replaced without cost or with a credit equal to 50% or more of the cost of the replacement device. We add new MS-DRGs to the list required by the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they're formed from procedures previously assigned to MS- DRGs already on the list.

We note that there's a typographical error for the last two MS-DRGs in the list of MS-DRGs subject to the policy in the FY 2022 IPPS/LTCH PPS proposed and final rules. The MS-DRGs displayed are 551 and 552 and we should've displayed MS-DRGs 521 and 522 instead.

E. Post-acute Transfer and Special Payment Policy

We aren't adding or removing any MS-DRGs subject to either the post-acute care transfer policy or the special payment policy. See Table 5 of the FY 2022 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs.

F. New Technology Add-On Payment Policy

For FY 2022, 24 technologies are still eligible for new technology add-on payments and 17 technologies are newly eligible for new technology add-on payments. (One technology was granted conditional approval pending FDA marketing authorization. We'll issue more instructions if FDA gives marketing authorization in time for FY 2022 payments under the conditional approval policy.) For more information on FY 2022 new technology add-on payments for the technologies either continuing to receive payments or beginning to receive payments, refer to MAC Implementation File 8.

G. FY 2022 Labor Related Share

We use the labor-related share under the IPPS to decide the proportion of the national IPPS base operating payment rate to which we apply the area wage index. Hospitals get payment based on either a 62% labor-related share, or the labor-related share the Secretary estimates from time to time, depending on which labor-related share results in a higher payment. For FY 2022, we finalized an update to the labor-related share for discharges occurring on or after October 1, 2021. For all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.000, for FY 2022, we apply the wage index to the labor-related share of the operating national standardized amount using the updated labor-related share found in MAC

Implementation File 1.

H. Cost of Living Adjustment (COLA) Update for Hospitals Paid Under the IPPS

The IPPS incorporates a COLA for hospitals in Alaska and Hawaii. We've updated the COLAs for FY 2022. The COLAs effective for discharges occurring on or after October 1, 2021 are in the FY 2022 IPPS/LTCH PPS final rule and in MAC Implementation File 1. (We use the same COLA factors under the IPPS and the LTCH PPS for FY 2022.)

I. Updating the Provider Specific File (PSF) for Wage Index, Reclassifications, and Redesignations and Wage Index Changes and Issues

MACs will update their PSF by following the steps, in order, in MAC Implementation File 5 on the FY 2022 MAC Implementation File webpage, to find the proper wage index and other payments.

J. Multicampus Hospitals

We allocate the wages and hours to the Core-Based Statistical Area (CBSA) in which a hospital campus is located when a multicampus hospital has campuses in different CBSAs. Medicare bases payment to a hospital on the geographic location of the hospital facility where the discharge occurred. If a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital to show a subcampus in a different CBSA. This lets the MAC associate the right wage index with each campus's geographic location and use it for payment for Medicare discharges from each campus. Under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF (see MAC Implementation File 5).

K. Rural Referral Centers (RRCs)

Due to the COVID-19 Public Health Emergency (PHE), for FY 2022, we revised the regulations at 42 CFR 412.96(c)(1), (h)(1), (i)(1) and (i)(2) for the data we use to decide if the hospital meets the criteria for purposes for RRC classification. The MAC will use the hospital's CMI value based on discharges occurring during FY 2019 (that is, October 1, 2018 through September 30, 2019) to see whether a hospital meets the case mix index (CMI) criterion for purposes of RRC classification. For FY 2022, the MAC will use the hospital's number of discharges for its cost reporting period beginning in FY 2018 to see whether a hospital meets the discharges criterion for purposes of RRC classification.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2022

For FY 2022, a hospital must make a written request for low-volume hospital status that your MAC received no later than September 15, 2021. This allows for the applicable low-volume payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2021 (through September 30, 2022). Under this procedure, a hospital that qualified for the

low-volume hospital payment adjustment for FY 2021 may continue to get a low-volume hospital payment adjustment for FY 2022 without reapplying if it meets both the discharge and mileage criterion applicable for FY 2022.

Accordingly, for FY 2022, such a hospital must send written verification that its MAC received no later than September 15, 2021, stating that it meets the mileage criterion applicable for FY 2022. If a MAC gets a hospital's request for low-volume hospital status for FY 2022 after September 15, 2021, and if the MAC decides the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to decide the payment for the hospital's FY 2022 discharges. This is effective prospectively within 30 days of the date of the MAC's low-volume hospital status decision.

The regulations implementing the hospital payment adjustment policy are at 42 CFR 412.101.

M. Hospital Quality Initiative

See the list of hospitals getting the quality initiative bonus. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2022 under the Hospital IQR Program are in MAC Implementation File 3 available on the FY 2022 MAC Implementation Files webpage.

N. Hospital-Acquired Condition (HAC) Reduction Program

The HAC Reduction Program requires the HHS Secretary to adjust payments to hospitals that rank in the worst-performing 25% of all subsection (d) hospitals with respect to HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (the worst-performing quartile) will be subject to a 1% payment reduction. This payment adjustment applies to all Medicare fee-for-service (FFS) discharges for that FY.

We didn't make the list of providers subject to the HAC Reduction Program for FY 2022 public in the final rule, because hospitals had until mid-September 2021 to notify us of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Correction period. Updated hospital-level data for the HAC Reduction Program will be made public on the Provider Data Catalog website in January 2022.

O. Hospital Value-Based Purchasing (VBP) Program

For FY 2022, we won't adjust payments for any hospital in the Hospital VBP Program.

P. Hospital Readmissions Reduction Program (HRRP)

We expect to post the HRRP payment adjustment factors for FY 2022 soon in Table 15 of the FY 2022 IPPS/LTCH PPS final rule. Hospitals not subject to a reduction under the HRRP in FY 2022 (such as Maryland hospitals) have an HRRP payment adjustment factor of 1.0000. For FY 2022, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

In the FY 2022 IPPS/LTCH PPS Final Rule, we finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. We'll continue interim uncompensated care payments on the claim as an estimated per claim amount to the hospitals that we project to get Medicare DSH payments in FY 2022. The estimated Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are in the Medicare DSH Supplemental Data File for FY 2022.

We'll reconcile the interim estimated uncompensated care payments paid on a per-claim basis at cost report settlement with the total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File.

Hospitals without prospective FY 2022 Factor 3 calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)

For FY 2022, new hospitals for uncompensated care payment purposes (hospitals with CCNs established after October 1, 2018) that we find to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2021 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation is in the FY 2022 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, multiply Factor 3 by the total uncompensated care payment amount finalized in the FY 2022 IPPS Final Rule to find the total uncompensated care payment amount to be paid to the hospital, if we find the hospital to be DSH eligible at cost report settlement. For FY 2022, we consider Puerto Rico hospitals that don't have an FY 2013 report as new hospitals and they would be subject to this new hospital policy, as well.

Note: It's possible that there'll be additional new hospitals during FY 2022 and those wouldn't be available for listing on the Medicare DSH Supplemental Date File.

In the FY 2022 final rule, we introduced an additional trim for hospitals we didn't project to be DSH eligible for purposes of interim uncompensated care payments. Like new hospitals, the hospitals affected by this new trim don't have a Factor 3 listed in the Medicare DSH Supplemental File. If we ultimately find your hospital as DSH eligible at cost report settlement, then your MAC would calculate a Factor 3 from the hospital's FY 2022 cost report's Worksheet S-10 line 30 divided by the national uncompensated care cost denominator.

For FY 2022, newly merged hospitals (those that have a merger during FY 2022 or mergers not known at the time of development of the final rule) will have their interim uncompensated care payments reconciled at cost report settlement by their MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

Under policy adopted in the FY 2021 final rule and continued in the FY 2022 final rule, if a hospital submits a request to its MAC, for a **lower** per-discharge interim uncompensated care payment amount, including a reduction to 0, **once** before the beginning of the Federal FY and or **once** during the Federal FY, then the MAC will review the request. The hospital must give supporting documentation showing there would likely be a significant recoupment (for example, 10% or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if we don't lower the per-discharge. Examples include, but aren't limited to:

- A request showing a large projected increase in discharges during the FY to support reduction of its per-discharge uncompensated care payment amount
- A request that we reduce its per-discharge uncompensated care payment amount to 0 midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital

Your MAC will evaluate the request for strictly reducing the per-discharge uncompensated payment amount and the supporting documentation before the beginning of the Federal FY or for a midyear request when the 3-year average of discharges is lower than hospital's projected FY 2022 discharges. After reviewing the request and the supporting documentation, if the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to **lower** the per-discharge amount either to the amount the hospital requested or another amount the MAC feels appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how we reconcile the total uncompensated care payment amount at cost report settlement. We still reconcile the interim uncompensated care payments made to the hospital during the FY after the end of the year to make sure the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal FY.

R. Outlier Payments

IPPS Statewide Average Cost-to-Charge Ratios (CCRs)

Tables 8A and 8B contain the FY 2022 Statewide average operating and capital Cost-to-Charge ratios (CCRs) for urban and rural hospitals. Per the regulations in 42 CFR 412.84(i)(3)(iv)(C) for FY 2022, we use statewide average CCRs in the following instances:

- New hospitals that haven't yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that hasn't accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18)
- Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. We recalculate this mean annually. We publish the annual notice of prospective payment rates in accordance with 42 CFR 412.8(b).

- Hospitals for whom the MAC gets accurate data with which to calculate either an operating or capital CCR (or both) aren't available

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per the instructions in Chapter 3, Section 20.1.2.1 of the Medicare Claims Processing Manual.

Use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

S. Payment Adjustment for CAR T-cell Clinical Trial and Expanded Access Use Immunotherapy Cases

We make an adjustment to the payment amount for clinical trial and expanded access use immunotherapy cases that group to MS-DRG 018. We'll adjust payment for such discharges by adjusting the MS-DRG weighting factor by a factor of 0.17 for FY 2022.

Under this policy, we apply a payment adjustment to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there's expanded access use of immunotherapy. However, when the chimeric antigen receptor (CAR) T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, we won't apply the payment adjustment in calculating the payment for the case.

To notify the MAC of a case where:

- There was expanded access use immunotherapy of CAR T-cell therapy or other immunotherapy products, you may enter a Billing Note NTE02 "Expand Acc Use" on the electronic claim 837I or a remark "Expand Acc Use" on a paper claim

- The CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), you may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim

LTCH PPS FY 2022 Update

A. FY 2022 LTCH PPS Rates and Factors

The FY 2022 LTCH PPS Standard Federal Rates are in Table 1E. Other FY 2022 LTCH PPS Factors are in MAC Implementation File 2.

We've updated the LTCH PPS Pricer with the Version 39 MS-LTC-DRG table, weights, and factors, effective for discharges occurring on or after October 1, 2021, and on or before September 30, 2022.

B. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires us to notify LTCHs of their Discharge Payment Percentage (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which got LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. Your MAC will notify you of your DPP upon settlement of the cost report.

C. LTCH Quality Reporting (LTCHQR) Program

Under the LTCHQR Program for FY 2022, we continue to reduce the annual update to a standard federal rate by 2.0 percentage points if you don't submit quality reporting data in accordance with the LTCHQR Program for that year.

D. PSF

LTCH Statewide Average CCRs

Table 8C contains the FY 2022 Statewide average LTCH total CCRs for urban and rural LTCHs. For FY 2022, we use statewide average CCRs in the following instances:

- New hospitals that haven't submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that hasn't accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18).
- LTCHs with a total CCR in excess of the applicable maximum CCR threshold (that's, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR). For the FY 2022 LTCH total CCR ceiling, refer to MAC Implementation File 2.
- Any hospital for which data to calculate a CCR isn't available

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per the instructions in Chapter 3, Section 150.24 of the Medicare Claims Processing Manual. Use of a total CCR of 0.0 or any other alternative CCR requires approval from CMS Central Office.

LTCH Labor Market Areas and Wage Indexes

The policy that applied a 5% cap on LTCH wage index decreases has expired.

E. COLA under the LTCH PPS

We've updated the COLAs for FY 2022. The COLAs effective for discharges occurring on or after October 1, 2021, are in MAC Implementation File 2.

Note: We use the same COLA factors under the IPPS and the LTCH PPS for FY 2022.

Hospitals Excluded from the IPPS

In the FY 2022 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2022 of 2.7%.

More Information

We issued CR 12373 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
October 27, 2021	Initial article released.