CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10995	**Date: September 16, 2021**
	Change Request 12373

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 26, 2021. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

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

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2022 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

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I. GENERAL INFORMATION

A. 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. In addition, 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 that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. This Change Request (CR) outlines those changes for FY 2022.

B. Policy: 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.

New IPPS and LTCH PPS Pricer software packages will be released 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. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

The FY 2022 Final Rule Data Files, FY 2022 Final Rule Tables, and FY 2022 MAC Implementation Files referenced throughout this CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use these files (when not otherwise specified) which are available at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

Alternatively, the files on the webpage listed above are also available on the CMS website at http:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, “FY 2022 IPPS Final Rule Home Page” or the link titled “Acute Inpatient--Files for Download” (and select ‘Files for FY 2022 Final Rule’).

IPPS FY 2022 Update

A. FY 2022 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to 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 other IPPS factors, including applicable percentage increase, budget neutrality factors, High Cost Outlier (HCO) threshold, and Cost-of-Living adjustment (COLA) factors, refer to MAC Implementation File 1 available on the FY 2022 MAC Implementation Files webpage.

B. FY 2022 Puerto Rico Hospital Update Under the IPPS

Section 1886(n)(6)(B) of the Act was amended to specify that the adjustments to the applicable percentage increase under section 1886(b)(3)(B)(ix) of the Act apply to subsection (d) Puerto Rico hospitals that are not meaningful electronic health record (EHR) users, effective beginning FY 2022. Accordingly, for FY 2022, requires that any subsection (d) Puerto Rico hospital that is not a meaningful EHR user as defined in section 1886(n)(3) of the Act and not subject to an exception under section 1886(b)(3)(B)(ix) of the Act will have a reduction applied to the applicable percentage increase.

Therefore, beginning with FY 2022 for Puerto Rico hospitals, MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction) in the PSF if the hospital is subject to a reduction due to NOT being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user. MACs will be notified which Puerto Rico hospitals will be subject to the reduction for FY 2022 under separate cover.

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 International Classification of Diseases Tenth Revision (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. Medicare contractors received the GROUPER documentation August 2021.

For discharges occurring on or after October 1, 2021, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors received the MCE documentation in August 2021. Note that the MCE version continues to match the Grouper version.

CMS maintained the number of 767 MS-DRGs for FY 2022. For more information regarding MS-DRG revised title descriptions, refer to MAC Implementation File 6 available on the FY 2022 MAC Implementation Files webpage.

See the ICD-10 MS-DRG V39.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V39 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software) 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

A hospital's IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS- DRGs that were already on the list.

See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2022. There were no MS-DRG changes under this policy for FY 2022. However, we note that there was a typographical error for the last two MS-DRGs displayed 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 in association with the proposed and final rule are 551 and 552 and should have instead displayed MS-DRGs 521 and 522.

E. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2022 have been evaluated against the general post-acute care transfer policy criteria using the FY 2020 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review no MS-DRGs will be added to or removed from the list of 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 available on the FY 2022 Final Rule Tables webpage.

F. New Technology Add-On Payment Policy

For FY 2022, 24 technologies continue to be 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. Additional instructions will be issued if FDA marketing authorization is granted in time for FY 2022 payments under the conditional approval policy.) For more information on FY 2022 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or beginning to receive payments, refer to MAC Implementation File 8 available on the FY 2022 MAC Implementation Files webpage.

G. FY 2022 Labor Related Share

The labor-related share under the IPPS is used to determine the proportion of the national IPPS base operating payment rate to which the area wage index is applied. Under current law, hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

For FY 2022, we finalized an update to the labor-related share estimated from time to time by the Secretary 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, the wage index will be applied to the labor-related share of the operating national standardized amount using the updated labor-related share found in MAC Implementation File 1 available on the FY 2022 MAC Implementation Files webpage. No MAC action is necessary as Pricer will apply the updated labor-related share for FY 2022.

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

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. We have updated the COLAs for FY 2022. The COLAs effective for discharges occurring on or after October 1, 2021 can be found in the FY 2022 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 1 available on the FY 2022 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2022.) MACs shall update the COLAs in Data Element 22 (COLA) of the PSF for hospitals located in Alaska and Hawaii based on the updated COLAs in MAC Implementation File 1.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

MACs shall update the PSF by following the steps, in order, in the file on the FY 2022 MAC Implementation File webpage ("Instructions to Fill Out the PSF for the Wage Index and

Reclassifications.pdf" in MAC Implementation File 5) to determine the appropriate wage index and other payments. We note, the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" includes steps to update the PSF to ensure that IPPS payments for hospitals located in Lugar counties are determined based upon the urban area to which they are redesignated, and that an urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes, including the capital IPPS.

New for FY 2022: For hospitals listed in Table 2 on the CMS website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page, CMS is providing a spreadsheet by provider that can be used as a guide to fill in the PSF based on the information available at the time of the FY 2022 IPPS final rule. Since this spreadsheet is based on a hospital's geographic and reclassification information at the time of the FY 2022 IPPS Final Rule, it should only be used as a guide. The spreadsheet should NOT be relied upon as the final source to update the PSF (as more recent geographic or reclassification information for a hospital may become available subsequent to the development of the final rule). The file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" in MAC Implementation File 5 contains complete details filling in the PSF regarding ALL circumstances related to the wage index and is to be relied upon as the final source how to update the PSF.

For FY 2022, the following policies and updates will apply to the wage index:

- Increase the wage index values for hospitals with a wage index value below the 25th percentile wage index value across all hospitals. Refer to MAC Implementation File 1 for the FY 2022 25th percentile wage index value.

- We are continuing a wage index transition for FY 2022 **only** for hospitals that received the 5-percent cap in FY 2021 by applying a 5 percent cap on any decrease in the hospital's FY 2022 wage index compared to its wage index for FY 2021. A list of hospitals eligible for this transition will be provided to MACs in one of the tabs in the spreadsheet in the zip file labeled MAC Implementation File 5 on the FY 2022 MAC Implementation Files webpage. MACs will use the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38) to ensure these hospitals are paid correctly for FY 2022. Complete instructions for updating the PSF are included in the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications.pdf" in MAC Implementation File 5.

- For FY 2022 (discharges on or after October 1, 2021), MACs shall enter in the PSF a blank in Data Element 64 (Supplemental Wage Index Flag) and Data Element 63 (Supplemental Wage Index) for all hospitals. Pricer is not using these fields for FY 2022.

Aside from the hospitals receiving a transition wage index for FY 2022 that are listedin MAC Implementation File 5, if a MAC believes use of a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38) is necessary for FY 2022, the MAC shall seek approval from the CMS Central Office prior to entering a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38). We refer the MAC to the FY 2022 MAC Implementation File webpage and the file "Instructions to Fill Out the PSF for the Wage Index and Reclassifications" for complete details filling in the PSF regarding ALL circumstances related to the wage index.

J. Multicampus Hospitals

CMS allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a

campus or campuses in different CBSAs, the MAC adds a suffix to the CCN of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also, note that, 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). In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers. In addition, if MACs learn of additional mergers during FY 2022 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact WageIndex@cms.hhs.gov for instructions.

K. Rural Referral Centers (RRCs)

For FY 2022, in light of the COVID-19 PHE, CMS amended the regulations at §§ 412.96(c)(1), (h)(1), (i)(1) and (i)(2) with regard to the data to be used to determine whether the hospital meets the criteria for purposes for RRC classification. In accordance with these changes, to determine whether a hospital meets the CMI criterion for purposes of 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 determine whether a hospital meet the discharges 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.

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 is received by its MAC no later than September 15, 2021, in order 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 receive a low-volume hospital payment adjustment for FY 2022 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2022. Accordingly, for FY 2022, such a hospital must send written verification that is received by its MAC no later than September 15, 2021, stating that it meets the mileage criterion applicable for FY 2022. If a hospital's request for low-volume hospital status for FY 2022 is received after September 15, 2021, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2022 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

The regulations implementing the hospital payment adjustment policy are at § 412.101. For FY 2022 discharges, the Pricer will calculate the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF using the adjustment factor value in the LV Adjustment Factor field on the PSF. Therefore, if a hospital qualifies for the low-volume hospital payment adjustment for FY 2022, the MAC shall ensure the low-volume indicator field on the PSF (position 74 – temporary relief indicator) holds a value of 'Y'. For such hospitals, the MAC shall also update the LV Adjustment Factor on the PSF (positions 252 - 258) to hold the value of the low-volume hospital payment adjustment factor (determined by the formula described above). Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2021 but no longer meets the low-volume hospital definition for FY 2022, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2021, the MAC shall update the low-volume indicator field to hold a value of 'blank' and update the LV Adjustment Factor on the PSF to hold a value of 'blank'.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: https:/www.qualitynet.org/inpatient/iqr/apu. A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that will receive the quality initiative bonus. The field shall be left blank for hospitals that will receive the statutory reduction under the Hospital Inpatient Quality Reporting (IQR)

Program. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and MACs shall update the provider file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2022 under the Hospital IQR Program are found in MAC Implementation File 3 available on the FY 2022 MAC Implementation Files webpage.

For new hospitals, A/B MACs shall enter a '1' in the PSF and provide information to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) as soon as possible so that the Hospital Inpatient VIQR SC can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the Hospital Inpatient VIQR SC the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital IQR Program reporting requirements. The MACs shall provide this information monthly to the Hospital Inpatient VIQR SC. It shall include: State Code, Medicare Accept Date, Provider Name, Contact Name and email address (if available), Provider ID number, physical address, and Telephone Number.

N. Hospital-Acquired Condition (HAC) Reduction Program

The Hospital-Acquired Condition (HAC) Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent 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 (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment adjustment applies to all Medicare fee-for-service discharges for that fiscal year.

CMS did not make the list of providers subject to the HAC Reduction Program for FY 2022 public in the final rule, because hospitals have until mid-September 2021 to notify CMS 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 publicly available on the Provider Data Catalog website in January 2022. If necessary, MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program in a Technical Direction Letter (TDL). Until CMS issues final values, contractors shall enter 'N' in the HAC Reduction Indicator field.

O. Hospital Value-Based Purchasing (VBP) Program

For FY 2022, CMS will not adjust payments for any hospital in the Hospital VBP Program. MACs shall update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'N' for every hospital. The Hospital VBP Program adjustment field (VBP Adjustment) should be null for all hospitals. Tables 16A and 16B will not be issued for FY 2022 with the FY 2022 IPPS/LTCH PPS Final Rule.

P. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2022 in the near future in Table 15 of the FY 2022 IPPS/LTCH PPS final rule (which are available via the Internet on the FY 2022 IPPS/LTCH PPS Final Rule Tables webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2022 in Table 15 are available.) Hospitals that are 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. (Note the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) field in the PSF refers to the HRRP payment adjustment factor.)

Upon receipt of this file, the MACs shall update the Hospital Readmissions Reduction Program participant (HRR Indicator) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2021 as follows:

• If a provider has an HRRP payment adjustment factor on Table 15, MACs shall input a value of '1' in the HRR Indicator field and enter the HRRP payment adjustment factor in the HRR Adjustment field.

• If a provider is not listed on Table 15, MACs shall input a value of '0' in the HRR Indicator field and leave the HRR Adjustment field blank.

Until CMS issues final values, contractors shall enter '0' in the HRR Indicator field.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

In the FY 2022 IPPS/LTCH PPS Final Rule, CMS 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. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2022. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2022, which is available via the Internet on the FY 2022 Final Rule Data Files webpage.

MACs shall enter the updated estimated per claim uncompensated care payment amounts in data element 57 in the PSF from the FY 2022 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File, as described below. The interim estimated uncompensated care payments that are paid on a per claim basis will be reconciled 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, that is, hospitals with CCNs established after October 1, 2018, that are determined 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 can be found 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, Factor 3 is multiplied by the total uncompensated care payment amount finalized in the FY 2022 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement. For FY 2022, Puerto Rico hospitals that do not have a FY 2013 report are considered new hospitals and would be subject to this new hospital policy, as well.

If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of 0.93, MACs shall contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as a new hospital for purposes of DSH uncompensated care payments. However, CMS notes, it is possible that there will be additional new hospitals during FY 2022 and therefore those would not be available to be listed on the Medicare DSH Supplemental Date File.

In the FY 2022 final rule, CMS introduced an additional trim for hospitals that were not projected DSH eligible for purposes of interim uncompensated care payments. Similar to new hospitals, the hospitals impacted by this new trim, do not have a Factor 3 listed in the FY 2022 Medicare DSH Supplemental File. If the hospital subject to the new trim, is ultimately determined DSH eligible at cost report settlement, then the MAC shall review Worksheet S-10 and 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, e.g. hospitals 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 the MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

CMS uses a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount, is divided by the hospital's historical 3-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that is used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

Under the policy finalized 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 zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year, then the MAC shall review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. Examples include, but are not limited to, the following:

1. a request showing a large projected increase in discharges during the fiscal year to support reduction of its per discharge uncompensated care payment amount.
2. a request that its per discharge uncompensated care payment amount be reduced to zero midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital.

The MAC shall evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the beginning of the Federal fiscal year and/or with midyear request when the 3-year average of discharges is lower than hospital's projected FY 2022 discharges. If following review of the request and the supporting documentation, 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 requested by the hospital or another amount determined by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request does not change how the total uncompensated care payment amount shall be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the fiscal year are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

R. Outlier Payments

IPPS Statewide Average CCRs

Tables 8A and 8B contain the FY 2022 Statewide average operating and capital Cost-to-Charge ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2022 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.84(i)(3)(iv)(C), for FY 2022, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18).

2. Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §412.8(b). For FY 2022 operating CCR and capital CCR trim values, refer to MAC Implementation File 1 available on the FY 2022 MAC Implementation Files webpage.
3. Hospitals for whom the MAC obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2.1 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all hospitals, 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 Clinical Trial and Expanded Access Use Immunotherapy Cases in MS-DRG 018

CMS makes an adjustment to the payment amount for clinical trial and expanded access use immunotherapy cases that group to MS-DRG 018. For FY 2022, under this payment adjustment, payment for such discharges will be adjusted by adjusting the MS-DRG weighting factor by a factor of 0.17.

Under this policy, a payment adjustment will be applied to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there is expanded access use of immunotherapy. However, when the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment will not be applied in calculating the payment for the case.

To notify the MAC of a case where there was expanded access use of CAR T-cell therapy or other immunotherapy products, the provider may enter a Billing Note NTE02 “Expand Acc Use” on the electronic claim 837I or a remark “Expand Acc Use” on a paper claim, and MACs shall add payer-only condition code “ZB” so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other immunotherapy 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), the provider 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, and MACs shall add payer-only condition code “ZC” so that the Pricer will not apply the payment adjustment in calculating the payment for the case.

LTCH PPS FY 2022 Update

A. FY 2022 LTCH PPS Rates and Factors

The FY 2022 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2022 Final Rule Tables webpage. Other FY 2022 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2022 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated 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 LTCHs to be notified of their “Discharge Payment Percentage” (DPP), which is the ratio (expressed as a percentage) of the LTCHs’ FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs’ total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon settlement of the cost report. MACs may use the form letter available on the Internet at

https:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage. CMS notes business requirements (BRs) 11361.11 and 11361.11.1 continue to apply.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act. CMS notes BRs 11616.11, 11616.11.1. 11616.11.2 and 11616.11.3 continue to apply, subject to the provisions of Section 3711(b)(1) of the CARES Act for the duration of the COVID-19 public health emergency period. (Refer to Change Request 11742 for additional implementation on information on section 3711(b)(1) of the CARES Act.)

C. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2022, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality-reporting data in accordance with the LTCHQR Program for that year. MACs will receive more information under separate cover.

D. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2021, or effective with cost reporting periods that begin on or after October 1, 2021, or upon receipt of an as-filed (tentatively) settled cost report.

LTCH Statewide Average CCRs

Table 8C contains the FY 2022 Statewide average LTCH total Cost-to-Charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2022 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2022, Statewide average CCRs are used in the following instances:

New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18).

1. LTCHs with a total CCR in excess of the applicable maximum CCR threshold (that is, 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 available on the FY 2022 MAC Implementation Files webpage.
2. Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

LTCH Labor Market Areas and Wage Indexes

For FY 2021, the Supplemental Wage Index Flag field (data element 64) and the Supplemental Wage Index field (data element 63) in the PSF were utilized by Pricer to apply a 5 percent cap on decreases in an LTCH's LTCH PPS wage index. This policy has expired. Therefore, for FY 2022, MACs shall ensure the Supplemental Wage Index Flag field (data element 64) and the Supplemental Wage Index field (data element 63) in the PSF are blank for all LTCHs.

If a MAC believes that an LTCH is being assigned an incorrect IPPS wage index, please contact LTCHPPS@cms.hhs.gov for further instructions on utilizing the supplemental wage fields to override the incorrect value.

E. Cost of Living Adjustment (COLA) under the LTCH PPS

We have updated the COLAs for FY 2022. The COLAs effective for discharges occurring on or after October 1, 2021 can be found in the FY 2022 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2022 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2022.)

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. 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 percent.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12373.1	The Medicare contractor shall install copybooks as needed to pay claims with the FY 2022 IPPS Pricer for discharges on or after October 1, 2021.					X				
12373.2	The Medicare contractor shall install copybooks as needed to pay claims with the FY 2022 LTCH Pricer for discharges on or after October 1, 2021.					X				
12373.3	The Medicare contractor shall install and edit claims with the MCE version 39.0 and Grouper version 39.0 software with the implementation of the FY 2022 October quarterly release.					X				
12373.4	The Medicare contractor shall establish yearly recurring hours to allow for updates to the list of ICD-10-CM diagnosis codes that are exempt from reporting Present on Admission (POA).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The list of ICD-10-CM diagnosis codes exempt from reporting POA are displayed on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html.									
12373.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
12373.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR prior to the implementation of the FY 2022 IPPS and LTCH Pricers.	X								
12373.6.1	Medicare contractors shall follow the instructions in the policy section and on the FY 2022 MAC Implementation File webpage to update the PSF and ensure that the CBSA is assigned properly for all IPPS providers. **NOTE**: MACs shall follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2022; or any change of hospital status during FY 2022.	X								
12373.6.2	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no IPPS provider has an operating CCR or a capital CCR in the PSF that is in excess of the FY 2022 applicable IPPS CCR ceilings. Additionally, use of an operating and/or capital CCR of 0.0 requires approval from the CMS Central Office.	X								
12373.6.3	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no LTCH has a total CCR in the PSF that is in excess of the FY 2022 total CCR ceiling. Additionally, use of a total CCR of 0.0 requires approval from the CMS Central Office.	X								
12373.7	Medicare contractors shall be aware that a hospital may request a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	fiscal year, as described in the policy section.									
12373.7.1	Medicare contractors shall evaluate the request for reducing the per discharge uncompensated payment amount and the supporting documentation, and update the PSF if applicable, as described in the policy section.	X								
12373.7.2	Medicare contractors shall review Worksheet S-10 for new hospitals and hospitals subject to the new trim, if the hospital(s) is determined DSH eligible at cost report settlement. Additionally, if such a hospital is determined to be DSH eligible, Medicare contractors shall calculate a Factor 3 based on the Worksheet S-10 from the hospital's FY 2022 cost report.	X								
12373.8	Medicare contractors shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.	X								
12373.9	Medicare contractors shall be aware of any manual updates included within this CR.	X								
12373.10	The CWF shall update edit and IUR 7272 and 7800 as necessary for the post-acute DRGs listed in Table 5 of the IPPS Final Rule when changes are made. **NOTE**: No new MS-DRGs were added to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy listed in Table 5 in the FY 2022 IPPS Final Rule.								X	
12373.11	Unless otherwise instructed by CMS, MACs shall seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).	X								
12373.12	For FY 2022 (discharges on or after October 1, 2021), for hospitals paid under the IPPS, MACs shall enter in the PSF a blank in Data Element 64 (Supplemental Wage Index Flag) and Data Element 63 (Supplemental Wage Index) for all hospitals.	X								
12373.13	For hospitals paid under the IPPS, MACs shall update the COLA in Data Element 22 (COLA) of the PSF for	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	hospitals located in Alaska and Hawaii based on the updated COLAs in MAC Implementation File 1. For hospitals paid under the LTCH PPS, MACs shall update the COLA in Data Element 22 (COLA) of the PSF for hospitals located in Alaska and Hawaii based on the updated COLAs in MAC Implementation File 2.									
12373.14	MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction) in the PSF if the hospital is subject to a reduction due to NOT being an EHR meaningful user.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12373.15	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Michele Hudson, 410-786-5490 or michele.hudson@cms.hhs.gov , Pamela Brown, 410-786-3940 or Pamela.Brown@cms.hhs.gov , Michael Treitel, 410-786-4552 or michael.treitel@cms.hhs.gov , Yvette Rivas, 410-786-1160 or Yvette.Rivas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0