The FY 2022 Reimbursement Outlook: The Cath Lab Impact

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Healthcare is an ever-changing entity, so it is no wonder hospitals encounter difficulty in keeping current with reimbursement updates, especially amid a pandemic that’s swiftly approaching a two-year duration. Hospital leaders must continually be aware of shifting regulations, increasing scrutiny on quality outcomes, pressure to achieve greater profit margins…and the list goes on.

Corazon works hard to stay on the leading edge of payment updates and other important financial trends, and we believe it is imperative that hospitals are prepared for what’s to come, well in advance of the effective date of any changes. Understanding financial updates can help hospital and program leaders, along with the cath lab staff, to be informed of new criteria and also how changes, whether major or minor, will impact the hospital’s bottom line.

Inpatient Payment Updates

Under the Centers for Medicare and Medicaid Services (CMS) FY2022 hospital inpatient final rule, the market basket update is 2.7% for acute care hospitals; however, hospitals will only see a net increase of 2.5% in overall operating payment rates, due to adjustments. These adjustments include a 0.7% decrease to address economic productivity and a mandatory 0.5% increase required by legislation.

With the market basket updates, facilities should realize a gain in inpatient reimbursement rates over the last fiscal year. Table 1 highlights a comparison of average weighted payments from FY2021 to FY2022 for the most common inpatient cath lab procedures. All procedures realize a gain from 2.2% to 2.7%. Contradictory to years past, in FY22, CMS did not make dramatic changes to the DRG weights, which directly impacts average reimbursement. Given the pandemic’s impact on healthcare facilities throughout the country, CMS did little to disrupt the inpatient payment landscape for the coming year.

Although there were no MS-DRG numbering additions/deletions within the cardiovascular service line, there were 42 new procedure codes within cardiovascular procedures, nine of which are specific to new technology. Over half of the new technology procedures use computer-aided mechanical aspiration devices from Penumbra, Inc.

Additionally, CMS has officially removed the requirement that hospitals must report the median payor-specific negotiated rates by Medicare severity-diagnosis related group for contracted Medicare advantage plans. CMS has stated that this reversal will reduce administrative burden on hospitals, a much-welcomed relief given the strain of the extended public health emergency (PHE).

Quality Updates

In order to realize maximum inpatient reimbursement potential, hospitals must adhere to the three quality standards noted below or else receive a reduction in base inpatient payments. For hospitals with poor quality performance, the FY2022 increases in reimbursement for cath lab-based procedures will easily be overshadowed by penalties.

Corazon recommends close operational attention to these areas, as any unintentioned or unexpected payment decrease due to quality missteps can compound quickly, equating to major financial losses for the overall bottom line. Indeed, ensuring that quality standards are in place is the best means for optimizing reimbursement margins, whether for these or other important quality measures.

Readmissions

The Hospital Readmissions Reduction Program (HRRP) requires a reduction to a hospital’s base operating DRG payment to account for excess readmissions for selected applicable conditions. Data from July 2017–December 2019 for the six following conditions are used to determine potential penalties: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, and coronary artery bypass grafting. CMS normally would have assessed data through July 2020, but excluded the timeframe in which the COVID-19 PHE started. Beginning in FY23 however, CMS plans to adopt a measure suppression policy for pneumonia readmissions, and the five remaining conditions will be modified to exclude COVID-19 patients.

Value-Based Purchasing (VBP)

The estimated base operating DRG payment amount reduction for FY2022 (2% reduction) is the same amount available for value-based incentive payments. However, given the COVID-19 PHE, CMS finalized several measure suppressions, which diluted the methodology of the VBP program, leaving only measures in the clinical outcomes domain and resulting in an unfair national comparison. Therefore, CMS will not calculate a score for any one domain and instead will award to all hospitals a value-based payment amount for each discharge that is equal to the amount withheld.

Table 1. FY2022 Inpatient Reimbursement Changes.

<table>
<thead>
<tr>
<th>MS-DRGs</th>
<th>Description</th>
<th>FY22 Average CMS Payment</th>
<th>% Change FY21-FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Cardiology</td>
<td>Diagnostic Cath</td>
<td>$10,667</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>286-287</td>
<td>PCI with DES</td>
<td>$15,908</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>246-247</td>
<td>PCI without DES</td>
<td>$16,154</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>248-249</td>
<td>PCI without Stent</td>
<td>$13,586</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>250-251</td>
<td>TAVR</td>
<td>$40,831</td>
<td>+ 2.2%</td>
</tr>
<tr>
<td>Vascular</td>
<td>Carotid Stent</td>
<td>$15,254</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>034-036</td>
<td>Peripheral Vascular</td>
<td>$18,818</td>
<td>+ 2.7%</td>
</tr>
<tr>
<td>Electrophysiology</td>
<td>Ablation</td>
<td>$22,475</td>
<td>+ 2.6%</td>
</tr>
<tr>
<td>273, 274</td>
<td>ICD System</td>
<td>$42,190</td>
<td>+ 2.2%</td>
</tr>
<tr>
<td>222-227</td>
<td>Pacemaker System</td>
<td>$18,490</td>
<td>+ 2.7%</td>
</tr>
</tbody>
</table>

FY = fiscal year; CMS = Centers for Medicare and Medicaid Services; MS-DRG = Medicare Severity-Diagnosis Related Group; PCI = percutaneous coronary intervention; DES = drug-eluting stent; TAVR = transcatheter aortic valve replacement; ICD = implantable cardioverter defibrillator
amount of $109,500 per hospital and a maximum total penalty amount of $2,007,500.

**Inpatient-Only List**

The inpatient-only (IPO) list is a catalog of services that, due to their medical complexity, must be performed in the inpatient setting in order to receive Medicare payment. In the CY21 outpatient final rule, CMS eliminated the IPO list over a three-year period, removing 298 services in the first phase of the elimination, most of which were musculoskeletal procedures. The complete removal of all 1,700 procedures is planned by CY24. For CY22, CMS has proposed halting this effort and adding the 298 procedures back onto the IPO list. Furthermore, CMS is proposing a means to clarify how future procedures would be removed.

**Ambulatory Surgical Center (ASC) Covered Procedure List**

The covered procedure list (CPL) is a list of procedures that are eligible for payment under Medicare when furnished in an ASC. In the CY21 final rule, CMS added 267 surgical procedures to the CPL using a new methodology. However, in the proposed CY22 rule, CMS is reverting back to the longstanding patient safety criteria methodology and removing 258 of the 267 procedures.

While the removal of these procedures does affect ASCs, the most common cardiovascular procedures remain on the CPL, including diagnostic cath, PCI without Stent, PCI with Stent with angioplasty (single branch), most peripheral vascular intervention (PVI) procedures, and most implantable cardioverter defibrillator (ICD) and pacemaker procedures. For all of these procedures, an average payment increase of 3% is expected.

**Conclusion**

The final rulings go into effect October 1, 2021 for the inpatient payment system and January 1, 2022 for the outpatient payment system. Based on this summary, Corazon recommends all hospitals pay close attention to the financial and quality performance of the cardiovascular service line and the cath lab in particular. It is within these key areas that the bottom line can be most impacted, either favorably or unfavorably, when payment methodology is misunderstood or misapplied.

Though many of the FY2022 changes are positive, Corazon strongly believes that all organizations must prepare for the future by allocating appropriate resources, scheduling necessary training, and keeping clinical and financial teams apprised of required policy and/or procedure changes. This effort is necessary to proactively tackle any issues that may arise and ultimately will protect the profit margin of the cardiovascular specialty, also a necessity in these uncertain times.

For a summary chart outlining these changes, please reach out to Corazon and request our DRG Cheatsheet.

**Bibliography**


**Kristin Truesdell, Vice President**

Kristin Truesdell is a Vice President at Corazon, Inc., offering strategic program development for the cardiovascular, neuro, and orthopedic specialties. Corazon provides a full continuum of consulting, accreditation, recruitment, and interim management services for hospitals, health systems, and practices of all sizes across the country and in Canada.

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