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).

Table 1. FY2022 Inpatient Reimbursement Changes.

MS-DRGs	Description	FY22 Average CMS Payment	% Change FY21-FY22
Interventional Cardiology			
286-287	Diagnostic Cath	$10,667	+ 2.7%
246-247	PCI with DES	$15,908	+ 2.7%
248-249	PCI without DES	$16,154	+ 2.7%
250-251	PCI without Stent	$13,586	+ 2.7%
266-267	TAVR	$40,831	+ 2.2%
Vascular			
034-036	Carotid Stent	$15,254	+ 2.7%
252-254	Peripheral Vascular	$18,818	+ 2.7%
Electrophysiology			
273, 274	Ablation	$22,475	+ 2.6%
222-227	ICD System	$42,190	+ 2.2%
242-244	Pacemaker System	$18,490	+ 2.7%

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

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 unintended 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 2. c-APCs for Endovascular Procedures.

c-APC	Description	Procedures	CY2021 CMS Payment	CY2022 CMS Proposed Payment	% Change CY21-CY22
c-APC 5191	Level 1 Endovascular Procedures	Dx Cath	$2,899	$2,976	+ 2.7%
c-APC 5192	Level 2 Endovascular Procedures	PCI & PVI	$4,957	$5,086	+ 2.6%
c-APC 5193	Level 3 Endovascular Procedures	PCI & PVI	$10,043	$10,309	+ 2.6%
c-APC 5194	Level 4 Endovascular Procedures	PCI & PVI	$16,064	$16,484	+ 2.6%

c-APC = comprehensive Ambulatory Payment Classification; CY = calendar year; CMS = Centers for Medicare and Medicaid Services; Dx = diagnostic; PCI = percutaneous coronary intervention; PVI = percutaneous vascular intervention

Hospital-Acquired Conditions (HAC)

As part of the Affordable Care Act, a 1% reduction in payment is made to hospitals whose ranking is in the lowest performing quartile. Similar to the HRRP and VBP programs, CMS will be suppressing measures under the HAC as well. Of note, CMS has renamed the Hospital Compare website (the location where individual hospital HAC scores could be found) to Care Compare.

Outpatient Payment Updates

Since the majority of cath lab procedures are now paid as outpatients, reimbursement for this population must be critically reviewed. The **proposed** rule released by CMS in July 2021 includes proposals that align with several key goals, notably which include (1) an overall increase of hospital-based outpatient payments by 2.3%, (2) several changes to the price transparency rule, (3) revisions to the inpatient-only list, and (4) drastic modifications to the ambulatory surgery center (ASC) covered procedure list (CPL).

Similar to the final inpatient ruling, it appears CMS will do little to disrupt outpatient reimbursement as well. Table 2 illustrates the payment difference for endovascular procedures, which include Diagnostic Cath, PCI, and Peripheral Interventions.

When evaluating the financial performance of the cath lab, Corazon recommends reviewing inpatient and outpatient procedures separately, since the reimbursement significantly differs even though the intra-procedural costs are relatively the same. This approach will help to monitor and manage patients differently, depending on setting of care, in order to appropriately maximize profitability.

Price Transparency

On January 1, 2021, the hospital price transparency rule became effective, but CMS has proposed several modifications in the CY22 proposed rule that are designed to increase compliance and reduce hospital burden. One specific change includes adjustments to the civil monetary penalty (CMP) for hospital non-compliance, which is currently $300 per day. In the proposed rule, the CMP of $300 per day would only apply to hospitals with a bed count of 30 or less, while hospitals with greater than 30 beds would receive a penalty of $10 per bed per day, not to exceed a maximum daily dollar amount of $5,500. This equates to a minimum total penalty 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.

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