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# CMS Publishes 2022 Hospital IPPS/LTCH PPS Proposed Rule

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On April 27, 2021, CMS published its annual proposed rule for the federal fiscal year 2022 inpatient prospective payment system ("IPPS") and long-term care hospital ("LTCH") payment system. As the world continues to face the challenges of the COVID-19 pandemic, and with the Biden Administration making the public health emergency and vaccination efforts top priorities, it comes as no surprise that the proposed rule includes a significant number of proposals related to COVID-19. But the proposed rule also features more typical content stemming from statutory changes and litigation developments related to hospital reimbursement. This Alert details some key changes proposed by CMS on the following topics: A. COVID-19-related reimbursement and reporting, B. indirect and direct graduate medical education, C. disproportionate share hospital payments, D. bad debt, E. wage index and geographic reclassification, F. organ acquisition, and G. negotiated Medicare Advantage rate reporting and associated rate setting.

*Comments on these proposals are due to CMS by June 28, 2021.* We recommend you consider submitting comments on any provision potentially affecting your organization. Please feel free to reach out to your Ropes & Gray advisor with any questions about these proposals.

## A. COVID-19-RELATED REIMBURSEMENT AND REPORTING

1. **Extension of New COVID-19 Treatments Add-On Payment.** CMS proposes to extend the expiration date of its New COVID-19 Treatments Add-On Payment ("NCTAP") from the declared end of the public health emergency until the end of the federal fiscal year in which the public health emergency is officially ended. Under the NCTAP, CMS pays hospitals the lesser of (1) 65 percent of the operating outlier threshold for the claim, or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment for certain cases that use a drug or biological product currently authorized for emergency use or approved for treating COVID-19. Originally this add-on payment was only for discharges occurring on November 2, 2020 through the end of the public health emergency. CMS states that to balance its goals of (1) mitigating financial disincentives for hospitals to use new COVID-19 treatments, (2) minimizing any disruption in payments for the use of such treatments following the end of the COVID-19 public health emergency, and (3) avoiding redundant supplemental payments, CMS proposes a two-pronged approach: To address the first two goals, CMS plans to extend the NCTAP for eligible products that are not approved for any new technology add-on payments through the end of the fiscal year in which the public health emergency ends; for example, if the emergency ends on December 31, 2021, discharges would be eligible for the NCTAP through September 30, 2022. To address the third goal, CMS plans to discontinue the NCTAP for discharges on or after October 1, 2021 for any product that is approved for new technology add-on payments beginning fiscal year 2022 (i.e., October 1, 2021).

2. **Inclusion of COVID-19 Vaccination Rates among Health Care Personnel in Hospital Inpatient Quality Reporting Program.** CMS proposes to implement a new performance measure assessing COVID-19 vaccination rates among a hospital's Health Care Personnel ("HCP") in non-long-term care facilities in the Hospital Inpatient Quality Reporting ("IQR") Program. CMS believes that the measure is necessary in light of (1) CDC guidance that health care settings pose a high risk of COVID-19 exposure and transmission, (2) the need to incentivize and track HCP vaccination in acute care facilities, and (3) the value in providing patients, especially those at high-risk for developing serious complications from COVID-19, with valuable data to guide their selection of treatment facilities. Under the proposal, providers would report their ratio of vaccinations with the denominator being the number of HCP eligible to work at least one day in the health care facility (excluding individuals with contraindications to COVID-19 vaccines) and the numerator being the cumulative number of



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HCP eligible to work in the facility for at least one day during the submission period who received a completed vaccination course against COVID-19 or a repeated interval if revaccination is recommended. Given the time-sensitive nature of the public health emergency, CMS proposes an abbreviated reporting period for the FY 2023 IQR year that would require vaccination data from October 1, 2021, to December 31, 2021. In subsequent years, CMS proposes quarterly reporting deadlines.

3. **Data Suppression Measures in Response to COVID-19: Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program and Hospital-Acquired Conditions Program.** In response to the COVID-19 public health emergency, CMS proposes adjustments to its Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program and Hospital-Acquired Conditions Programs. Stating that "[i]t is not [CMS's] intention to penalize hospitals for performance on measures that are affected significantly by global events like the COVID-19 [public health emergency]," CMS proposes measures to suppress the use of data elements that might be adversely affected by the COVID-19 pandemic. For Hospital Readmissions, CMS proposes to exclude data related to pneumonia readmissions from the calculation for FY 2023 (because of the likely association between pneumonia and COVID-19), and adjusting the five remaining readmission measures to exclude COVID-19-diagnosed patients from the readmission rate calculation. For Hospital Value-Based Purchasing, CMS proposes to suppress data on the following measures: Hospital Consumer Assessment of Healthcare Providers and Systems; Medicare Spending Per Beneficiary Hospital; Five Healthcare-Associated Infection Safety Measures; and the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure. CMS also proposes to suppress all measures in the Person and Community Engagement, Safety, and Efficiency and Cost Reduction Domains for the FY 2022 program year, after determining that COVID-19 has affected those measures significantly. For Hospital-Acquired Conditions, CMS proposes to suppress the use of third- and fourth-quarter data from calendar year 2020 for certain measures: the CMS Patient Safety and Adverse Events measure, and CDC acquired condition measures. The rule notes that in the first two quarters of 2020, this data was reported but was suppressed and not used to assess or penalize hospitals. In lieu of using these data measures for calendar year 2020, CMS proposes alternate time periods that it feels will provide a reliable basis for 2022 and 2023 scoring.

For all three programs, CMS stresses the need for flexibility in response to the COVID-19 public health emergency. CMS also clarifies its invocation of the "Extraordinary Circumstances Exception" in compiling data for the Hospital Readmissions Reduction and Hospital Acquired Conditions Programs, emphasizing that, for the latter, an approved exception "does not exempt hospitals from payment reductions under the [Hospital-Acquired Conditions] Reduction Program."

## B. INDIRECT AND DIRECT GRADUATE MEDICAL EDUCATION

The proposed rule includes three proposals implementing provisions of the Consolidated Appropriations Act of 2021 ("CAA")[1] relating to payments to hospitals for direct graduate medical education ("GME") and indirect medical education ("IME") costs as well as a fourth proposal requiring support in the Intern and Resident Information System ("IRIS") report for resident counts in the cost report.

1. **Proposed New GME and IME Resident Slots.** Section 126 of the CAA requires the distribution of an additional 1,000 new Medicare-funded medical residency positions to train physicians. Beginning in FY 2023, CMS proposes to distribute 200 new slots per year (for both GME and IME) to hospitals that fall within at least one of four categories: (1) hospitals located in rural areas or treated as being in rural areas; (2) hospitals that are training residents in excess of their FTE caps; (3) hospitals located in states with new medical schools and/or

[1] The CAA amends Section 1886(h) of the Social Security Act to (1) permit Medicare funding for new residency positions, (2) allow qualified hospitals to apply for an increase on their resident limits or per resident amounts, and (3) create greater flexibility in the Rural Training Track ("RTT") funding. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, §§ 126, 127, 131, 134 Stat. 1182, 2967-71, 2974-77 (2020).



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additional locations and branch campuses; and (4) hospitals that have campuses or provider-based facilities located in areas designated as Health Professional Shortage Areas ("HPSAs"). Although the statute provides that a hospital may not receive more than 25 additional resident FTEs, CMS expects that demand for these positions will be high and proposes that each hospital receive no more than 1.0 FTE per year. CMS proposes to distribute the additional slots to qualifying hospitals with priority given to programs that serve underserved populations within population HPSAs, with programs serving areas with higher HPSA scores receiving higher prioritization. As an alternative, CMS is also considering a simpler prioritization approach for FY 2023, under which CMS would distribute 200 additional residency positions for FY 2023 among hospitals that qualify under one or more of Categories (1)-(4), with higher priority given to applications from hospitals that qualify in more categories.

2. **Proposed Changes to Rural Training Track ("RTT") Program.** CMS proposes to implement section 127 of the CAA, which provides more flexibility for rural and urban hospitals to partner to address the need for additional physicians in rural areas. CMS proposes four major changes to the rural training track ("RTT") program. First, CMS proposes that each time an urban hospital and rural hospital establish an RTT program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes, both the urban and rural hospitals may receive a "rural track FTE limitation" (*i.e.*, an RTT cap). Second, CMS proposes that urban hospitals that have existing RTT caps can receive RTT cap adjustments for additional RTT programs that the hospital establishes (and the rural hospitals associated with those programs would also receive RTT cap increases). Third, CMS proposes to remove the requirement that RTT programs be separately accredited, and would now provide that, as long as the program in its entirety is accredited by the ACGME, it may qualify as an RTT and both urban and/or rural hospitals will receive RTT caps. Finally, CMS proposes that during the 5-year cap growth window for RTTs, the residents participating in the RTT would not be included in a hospital's 3-year rolling average calculation.

3. **Proposal to Calculate New FTE Caps and Per Resident Amounts for Certain Hospitals with Low FTE Caps and Per Resident Amounts.** CMS proposes to implement section 131 of the CAA, which provides an opportunity for hospitals that previously established low or zero per resident amounts or low resident FTE caps to establish new per resident amounts and FTE caps. Eligible hospitals fall into two categories: 1) those whose per resident amount and/or resident caps were set based on less than 1.0 FTE in a cost reporting period beginning before October 1, 1997 ("Category A"), and 2) those whose per resident amounts and/or resident caps were established based on training less than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997 and before December 27, 2020 ("Category B"). CMS proposes that eligible hospitals would have a new per resident amount established if they train at least 1.0 FTE (for Category A) or more than 3.0 FTEs (for Category B) in a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025. CMS emphasizes that to establish a new per resident amount, the hospital need not necessarily be training residents in a new program. Hospitals in Categories A and B would be eligible for an FTE cap adjustment if the hospital "begins training" at least 1.0 FTE (for Category A) or 3.0 FTEs (for Category B) in a program year beginning on or after December 27, 2020 and before December 26, 2025. Unlike the establishment of the per resident amount, however, CMS proposes that in the case of an FTE cap adjustment, the hospital must first begin training FTE residents in a *new* residency program during that time frame.

4. **Proposed Requirements for IRIS Report Supporting Cost Report.** CMS further proposes to amend 42 C.F.R. § 413.24(f)(5)(i) to state that the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the hospital's cost report, or the cost report will be rejected for lack of supporting documentation.

## C. DISPROPORTIONATE SHARE HOSPITAL PAYMENT

As is typically the case, CMS devotes a signification portion of its annual proposed rule to the Disproportionate Share Hospital ("DSH") payment calculation. The proposed rule is silent on the ongoing ramifications of the *Allina* litigation


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and does not address the treatment of Medicare Part C days in the DSH payment calculation. It is possible, however, that the final IPPS rule could address those topics following the proposed rule in August 2020. CMS's FFY 2022 DSH proposals are as follows:

1. **DSH – Change in Policy on Section 1115 Waiver Days in Medicaid Fraction.** CMS proposes to revise the DSH regulation to further limit the inclusion in the Medicaid fraction of the DSH calculation of inpatient days for patients who are made eligible for Medicaid through a Section 1115 expansion waiver. Specifically, CMS proposes to include those days in the DSH calculation only if the patient directly receives inpatient hospital insurance coverage on that day under a waiver authorized under Section 1115. CMS's stated reason for this change is to exclude from the DSH calculation patient days 1) where hospitals receive payment from an uncompensated care pool under a Section 1115 waiver, and 2) for patients who receive premium assistance (financial assistance that can be used to purchase health insurance from a private entity) under a Section 1115 waiver. CMS claims authority under the Deficit Reduction Act of 2005 to include in the DSH calculation only those patients in expansion projects who receive benefits that are comparable to traditional Medicaid benefits. That statute provides that the Secretary may include in the DSH calculation patient days for patients who "are regarded" as Medicaid eligible because they receive benefits under an approved waiver/demonstration project.[2] The agency then attempts to distinguish Section 1115 waiver programs that provide premium assistance from traditional Medicaid by noting that the insurance purchased with premium assistance does not guarantee the scope of benefits available under traditional Medicaid, and claiming that individuals receiving premium assistance under an expansion waiver may be significantly wealthier than traditional Medicaid beneficiaries. Similarly, the agency also attempts to distinguish Section 1115 waiver projects funded through uncompensated care pools because those projects do not provide inpatient health coverage directly to patients or make payments on behalf of specific covered individuals. CMS states that it proposes this revision in response to a series of court cases that concluded that Section 1115 waiver days must be included in the DSH calculation under the current regulation. *See HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020).
2. **DSH – Continued Reduction in Uncompensated Care Payments.** Since 2014, CMS has used three factors to determine the amount of uncompensated care payments to hospitals. These factors represent CMS's estimate of 75 percent of the amount of Medicare DSH payments that would have been paid under the pre-2014 system, an adjustment to that amount to account for changes in the national uninsured rate, and each eligible hospital's estimated uncompensated care amounts relative to total uncompensated care for all eligible hospitals. CMS proposes to pay a total of $7.627 billion in DSH uncompensated care payments to hospitals, marking a significant decrease from the $8.290 billion in payments for 2021 and the $8.350 billion in payments for 2020. The agency started with a baseline of DSH payments made in 2018, and then used largely the same assumptions and estimates as prior years, to arrive at an estimated figure of DSH amounts that would be paid in 2022 (so called Factor 1). In a change from prior years, CMS now estimates that per capita spending for Medicaid beneficiaries who enrolled due to Medicaid expansion is 78 percent of the per capita spending for pre-expansion Medicaid beneficiaries, whereas previously the agency estimated these individuals cost 50 percent as much due to their better health. Similar to the prior two years, Factor 2 would use the same data from the CMS actuary to estimate that the ratio of the nationwide uninsured fell from 14 percent to 10.1 percent between 2013 and 2022, which by statute further reduced the pool of available funds to the proposed amount of $7.627 billion. The calculation for distributing the pool (Factor 3) would be based solely on the charity care figures from hospitals' FY 2018 cost report Worksheet S-10s. The agency used a February 19, 2021 HCRIS extract for the Worksheet S-10 data for the proposed rule, and proposes to use a March 2021 extract in the final rule calculations. Hospitals

[2] The Deficit Reduction Act of 2005, Pub. L. No. 109-171, §5002(a), 120 Stat. 4, 31 (2006), states that, in determining a hospital's count of Medicaid patient days, the Secretary "may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI."


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identifying any errors with their Factor 3 data have a deadline of June 28, 2021 to notify the agency by sending an email to the following account: Section3133DSH@cms.hhs.gov.

CMS's DSH-related proposals have also been affected by the COVID-19 public health emergency. For FY 2022, CMS proposes to modify the calculation of the per discharge interim payments from the normal three-year average of discharge data to just two years (FYs 2018 and 2019) omitting FY 2020 "due to the decrease in discharges due to the pandemic."

## D. BAD DEBT

**Requirement that State Medicaid Agencies Accept Enrollment of Medicare Suppliers/Providers.** In a proposal that will have ramifications on Medicare bad debt reporting and appeals, CMS proposes new requirements on state Medicaid agencies. These state agencies are required by statute to process Medicare claims for dually-eligible beneficiaries to determine Medicare cost-sharing liability. Despite this requirement, CMS states that some states have resisted this obligation by not adjudicating cost-sharing claims and not issuing remittance advices for Medicare bad debt purposes for provider types that are not explicitly included in the Medicaid state plan. CMS proposes to require state Medicaid programs to accept enrollment of all Medicare providers and suppliers—regardless of the state's own Medicaid plan—if the provider or supplier meets all federal Medicaid requirements. The state would be required to enroll these additional provider types only for purposes of the submission, adjudication of cost-sharing claims, and the issuance of a Medicaid remittance advice. CMS proposes that states must be in compliance with this requirement in time to process claims on or after January 1, 2023, and will consider enforcement penalties for noncompliance in future rulemaking. CMS states that it believes that this change would help reduce Medicare bad debt appeals and litigation costs.

## E. WAGE INDEX AND GEOGRAPHIC RECLASSIFICATION

1. **Reinstatement of the Imputed Rural Floor Wage Index for All-Urban States.** As required by the American Rescue Plan Act enacted into law earlier this year, CMS proposes to permanently reinstate the imputed rural floor wage index calculation for hospitals located in all-urban States (i.e. States without designated rural areas).[3] For FYs 2005-2018, CMS had a policy of calculating an imputed rural floor for all-urban States whereby it compared the average wage index for all-urban States to each other and applied that ratio to the State's own highest wage index value to calculate an imputed rural floor. CMS ceased this calculation for FYs 2019-2021, instead calculating wage indices for those all-urban hospitals without the use of a rural floor. Effective with discharges on or after October 1, 2021, CMS is required by the American Rescue Plan Act to reinstate the previous imputed rural floor methodology for all-urban States, and this rate cannot be less than the imputed rural floor CMS calculated for that State in FY 2018. The new statute also specifies that this adjustment shall not be applied in a budget neutral manner, so the increase to the wage index for these all-urban States will not be offset by a decrease to the standardized amount or wage index starting point. CMS expects the following States and jurisdiction to be all-urban for FY 2022: Connecticut, Delaware, New Jersey, Rhode Island, and Washington D.C.

2. **Changes to Timing of Cancellations of Urban to Rural Reclassifications.** CMS proposes to make two changes to the timing of a hospital's request to cancel a previously granted reclassification from urban to rural that would have the effect of locking a hospital into its rural status for a longer period of time. First, CMS proposes that requests to cancel rural reclassifications be submitted to the CMS Regional Office no earlier than one calendar day after the date when reclassification became effective. Second, CMS proposes to replace the existing rule, which provides that cancellation of reclassification be requested 120 days prior to the end of the fiscal year and take effect at the beginning of the next fiscal year, with a requirement that cancellation requests

[3] The American Rescue Plan Act amends Section 1886(d)(3)(E) of the Social Security Act by adding a floor on the area wage index for hospitals in all urban states, stating, "For discharges occurring on or after October 1, 2021, the area wage index applicable under this subparagraph to any hospital in an all-urban State . . . may not be less than the minimum area wage index for the fiscal year for hospitals in that State." American Rescue Plan Act, Pub. L. No. 117-2, § 9831(a)(2), 135 Stat. 4 (2021).



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instead become effective in the fiscal year that begins in the calendar year after the calendar year in which the request is submitted. CMS states this change is needed because the agency has seen a pattern of hospitals timing their reclassification applications in a manner that allows the hospitals to receive the State's rural wage index (which is effective the date of application), but also allows the hospitals to exclude their own wage data (which would have lowered the state rural wage index). CMS noted these hospitals would then cancel their rural reclassifications prior to the next fiscal year and before their wage data could be used to bring down the State's rural wage index.

3. **Change to MGCRB Application Process for Hospitals Reclassified as Rural.** In a separate interim final rule released in conjunction with this proposed rule, CMS made a change to the average hourly wage data to which a hospital reclassified as rural compares its own data in an application to the Medicare Geographic Classification Review Board ("MGCRB") for reclassification to a different geographical area. Previously, CMS's policy was that a hospital that had opted to reclassify from urban to rural was required to compare its wage index to that of the urban area in which it was actually physically located in order to meet the requirement that its wages are at least 106 percent of those in its current geographic area, as opposed to using the State-wide rural area wage data. In 2020, the United States District Court for the District of Columbia issued a decision holding that CMS's previous policy violated the Medicare Act, and held that hospitals that previously were reclassified as rural must be compared to the wage data of the State's rural area when making a further reclassification application to the MGCRB. *See Bates County Memorial Hospital v. Azar*, 464 F. Supp. 3d 43 (D.D.C. 2020). CMS made this change to its regulations via a separate interim final rule that waived the notice and comment period and 30-day delay effective date, stating it was in the public interest to implement the *Bates* decision quickly and in advance of any further MGCRB applications.

## F. ORGAN ACQUISITION

CMS proposes a number of changes to the regulations governing organ acquisition reimbursement. CMS claims that some of these changes "codify into the Medicare regulations some longstanding Medicare organ acquisition payment policies," that had previously been found in the Provider Reimbursement Manual, while others "codify some new organ acquisition payment policies," in response to statutory directives under the Medicare Modernization Act of 2003 and the 21st Century Cures Act.[4]

1. **Proposed New Regulatory Definitions Concerning Organ Acquisition Payment.** According to CMS, to ensure consistent terminology, the agency proposes to add a definition section to the regulations at 42 C.F.R. § 413.400, which will include definitions for the terms *organ, Organ Procurement Organization, Hospital-Based Organ Procurement Organization, transplant hospital, transplant program, freestanding, histocompatibility laboratory, and standard acquisition charge*. CMS says that some of these definitions, such as the proposed definition for "organ," will "mitigate potential stakeholder confusion."

2. **Proposed Codification of Organ Acquisition Cost Elements.** CMS further proposes to codify in the regulation the 12 elements that it considers to be costs of acquiring organs, with additional provisions to address costs that are specific to kidney acquisition. These elements include concepts such as donor and beneficiary evaluation, costs associated with excising organs (for both live and cadaveric donors), organ transportation costs, and costs of organs acquired from other hospitals. CMS also proposes to codify provisions relating to standard acquisition costs for both transplant hospitals/Hospital Based Organ Procurement Organizations and Independent Organ Procurement Organizations, including living and cadaveric donor acquisition charges. CMS further proposes to codify its policy on costs for outpatient and laboratory services, services provided to living kidney donors,

[4] The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 requires Medicare to pay for pancreatic islet cell investigational transplants for Medicare beneficiaries in clinical trials. Pub. L. 108-173, § 733, 117 Stat. 2066, 2352 (2003). The 21st Century Cures Act expands Medicare coverage for organ acquisition costs associated with kidney transplants. Pub. L. No. 114-255, § 17006, 130 Stat. 1033, 1334 (2016).


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services provided to transplant recipients, and the use of pancreata for pancreatic islet cell transplants. Finally, in a separate section of the proposed rule, CMS requests comments on potential revision to its policy on surgeon fees for cadaveric donor organ excisions, but notes that any rulemaking on this topic would provide for separate notice and public comment.

3. **Organ Acquisition Costs and Medicare's Share.** CMS then proposes a number of adjustments to its calculation of Medicare's share of organ acquisition costs and the method by which organs are counted. Citing a heightened ability of the agency and transplant programs to track the location and disposition of organs, CMS proposes changing its policy to identify the recipient of transplanted organs and to determine whether that individual is a Medicare beneficiary. CMS said that this would result in Medicare more accurately paying for its share of organ acquisition costs. CMS accordingly proposes a number of changes to organ procurement organization reporting requirements that breaks the current "total usable organs" into ten subcategories that more accurately explain various situations that may occur, for example, "organs transplanted into non-Medicare beneficiaries." CMS also proposes new regulations to address Medicare's share of the acquisition cost for attempted organ procurement where no organ is retrieved or the organ is discarded. In a later section of the rule, CMS further proposes clarifications to its policies on organ acquisition charges for kidney-paired exchanges, donor hospital charges to organ procurement organizations, and a number of technical corrections and conforming changes to the regulations to implement all of the above proposals.
4. **Proposals Related to Medicare as a Secondary Payer.** CMS next proposes a number of measures to address organ acquisition costs and Medicare organ count when Medicare is the secondary payer, setting forth the general principle that if a Medicare beneficiary has a primary health insurer other than Medicare and that primary health insurer has primary liability for the transplant and organ acquisition costs, the Medicare Program may share liability for organ acquisition costs as a secondary payer in certain instances. CMS explains that this proposal would require a transplant hospital to bill its Medicare contractor to compare the total costs of the transplant (including the transplant DRG amount and organ acquisition cost) to the amount received from the primary payer. If the amount received from the primary payer were greater than the DRG and organ acquisition cost, there would be no Medicare liability on the procedure.

## G. NEGOTIATED MA RATE REPORTING AND RATE SETTING

**Repeal of Requirement to Report Negotiated Rates with Medicare Advantage Organizations and Repeal of Associated Rate-Setting Methodology.** Citing the burden to hospitals and the agency's "further consideration" of hospital contract arrangements with Medicare Advantage plans, CMS proposes to repeal the provision adopted in last year's final IPPS rule requiring that hospitals report on their cost reports the median payer-specific negotiated charges that the hospital has negotiated with all of its MA organization payers, by MS-DRG, for cost reporting periods ending on or after January 1, 2021. As CMS would no longer collect this payer-specific data from hospitals under this proposal, the agency also proposes to repeal the market-based MS-DRG relative weight methodology that was adopted effective for FY 2024 using that payer-specific data. Instead, it proposes to continue using the existing cost-based methodology for calculating the MS-DRG relative weights for FY 2024 and subsequent years. CMS invites comment on alternative approaches or data sources that the agency could use for this Medicare rate setting. Note that the proposed rule does not propose to alter the separate requirement that providers publish their negotiated rates in their facilities and on their websites.



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