ROPES & GRAY

ALERT ▪ Health Care

April 22, 2022

CMS Publishes Federal Fiscal Year 2023 Hospital Payment Proposed Rule

Attorneys
Stephanie A. Webster
Christine Moundas
James Harold (Harry) Richards
Alex J. Talley
David O. Ault

On April 18, 2022, the Centers for Medicare & Medicaid Services ("CMS") published its annual proposed rule for the federal fiscal year ("FY") 2023 inpatient prospective payment system ("IPPS") and long-term care hospital ("LTCH") payment system. The proposed rule again includes a number of proposals related to the COVID-19 Public Health Emergency ("PHE") and its impact on hospitals. The proposed rule also features more typical content stemming from statutory changes and litigation developments related to hospital reimbursement. This Alert details key changes proposed by CMS on the following topics: A. COVID-19-related payment calculation and reporting changes, B. performance and data reporting requirements, C. medical education payments, D. disproportionate share hospital payments, E. wage index and geographic reclassification, and F. the Medicare interoperability program.

Comments on these proposals are due to CMS by June 17, 2022. 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 PAYMENT CALCULATION AND REPORTING CHANGES

1. Change in Data Used to Calculate MS-DRGs and Outlier Payments. CMS proposes to use FY 2021 data for purposes of FY 2023 Medicare rate-setting. For IPPS and LTCH PPS, HHS primarily uses two data sources, claims data and cost report data, both of which were significantly impacted by the COVID-19 PHE. Because the agency expects some Medicare beneficiaries to be hospitalized with COVID-19 in FY 2023, HHS determined that it is more appropriate to use FY 2021 data as the most recent available data during the period of the COVID-19 PHE. However, recognizing that there may be fewer COVID-19 hospitalizations in FY 2023 than in FY 2021, the agency additionally proposed modifications to its usual rate-setting methodologies to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries as compared to FY 2021. In particular, CMS proposed to modify the calculation of the FY 2023 MS-DRG and MS-LTC-DRG relative weights by initially calculating two sets of weights, one including and one excluding COVID-19 claims. CMS would then average the two sets of relative weights to calculate the proposed FY 2023 relative weights, which CMS believes would reduce the effect of COVID-19 cases on the relative weights in order to account for the expected drop in Medicare COVID-19 hospitalizations. CMS also proposed to modify the calculation of the outlier fixed-loss threshold by using charge inflation factors and cost-to-charge ratio adjustment factors calculated using pre-pandemic data from March 2019 and March 2020 as opposed to the later data that would ordinarily be used to calculate these factors. The agency believes that using older pre-pandemic data would provide a better measurement of these factors because CMS does not believe that the charge inflation that has occurred during the COVID-19 pandemic will continue. HHS is also requesting comments on the potential use of FY 2021 data without the proposed modifications for purposes of FY 2023 rate-setting.

2. Change in Conditions of Participation ("CoP") on Pandemic Reporting. CMS proposes revising the hospital and Critical Access Hospital ("CAH") infection prevention and control CoP requirements to continue COVID-19 and seasonal flu reporting requirements. CMS states that the current reporting requirements have been important in responding to the COVID-19 PHE and in considering future planning to prevent the spread of respiratory viruses and infections. CMS proposes revising the hospital infection and control CoP to continue such COVID-19 and seasonal flu reporting requirements commencing either upon the conclusion of the current COVID-19 PHE declaration or the effective date of this proposed rule, whichever is later, and lasting until April 30, 2024, unless the Secretary determines an earlier date. In addition, CMS has proposed additional reporting requirements that would require hospitals to report certain data elements to the CDC in the event of any future PHE declarations by the Secretary. CMS proposed that the

hospital provide the information specified on a daily basis, unless the Secretary specifies a lesser frequency. CMS estimates that the proposed changes to the CoP requirements for hospitals would result in additional annual cost to hospitals and CAHs of $38,204,400 for weekly reporting and $536,331,000 for daily reporting.

3. Potential Payment Adjustment for N95 Respirators Made Domestically. CMS requests comments on the appropriateness of an IPPS and Outpatient Prospective Payment System ("OPPS") payment adjustment for N95 respirators that are wholly domestically made. Wholly domestically made NIOSH-approved surgical N95 respirators, while critical to pandemic preparedness and protecting health care workers and patients, can result in additional costs for hospitals as they are generally more expensive than foreign-made masks. CMS is considering a payment adjustment to apply to 2023 and potentially subsequent years. There are two possible frameworks for a payment adjustment on which CMS seeks feedback. Under the first approach, CMS would provide biweekly interim lump-sum payments to hospitals that would be reconciled at cost report settlement. Alternatively, CMS could develop a claims-based approach wherein Medicare could establish an MS-DRG add-on payment that could be applied to each applicable Medicare IPPS discharge (or an Ambulatory Payment Classification ("APC") add-on payment for each non-telehealth OPPS service).

B. PERFORMANCE & DATA REPORTING PROGRAMS

1. Hospital Readmissions Reduction Program. CMS is proposing multiple adjustments to the Hospital Readmissions Reduction Program. CMS proposes to resume use of data related to pneumonia readmissions that was suppressed from the calculation for prior years, while excluding patients with principal or secondary COVID-19 diagnoses, because of improved coding practices, decreased COVID-19 admissions, and more data on measure specifications. Beginning with the FY 2023 program year, CMS is proposing to modify technical measure specifications for the six readmission measures to adjust for patients with a history of COVID-19 in the 12 months prior to the admission in recognition of "COVID-19['s] long lasting effects for some patients which could affect a patient's risk factors for readmittance." Additionally, CMS is seeking comment on updating the Hospital Readmissions Reduction Program to incorporate provider performance for socially at-risk populations.

2. Hospital Value-Based Purchasing (VBP) Program: Suppression of Measures and New Proposals. CMS is proposing various changes including suppressing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and five Hospital Acquired Infection (HAI) measures for the FY 2023 Program year due to the lingering impacts of COVID-19 on patients: National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure; NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure; American College of Surgeons - Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure; NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure; and NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure. CMS also proposes to revise the scoring and payment methodology for the FY 2023 program year such that hospitals will not receive Total Performance Scores (TPSs), and instead, CMS will award each hospital a payment incentive multiplier that results in a value-based incentive payment that is equal to the amount withheld for the fiscal year. Further, CMS proposes technical updates to the measures in the Clinical Outcomes Domain. For the FY 2025 program year, CMS is proposing to update the baseline periods for certain measures.

3. Hospital-Acquired Conditions (HAC) Reduction Program: Suppression of Measures and Data Collection. CMS is proposing to suppress certain measures from the calculation of measure scores and the Total HAC Score, thereby not penalizing any hospital under the HAC Reduction Program for the FY 2023 program year, due to effects of COVID-19. CMS is proposing to update the measure specifications, including to risk-adjust for COVID-19 diagnoses. CMS requests information from stakeholders on the potential adoption of two digital NHSN measures and on overarching principles for measuring health care quality disparities across CMS Quality Programs. Additionally, CMS is updating the NHSN CDC Hospital Acquired Infection data submission requirements for newly opened hospitals and clarifying the removal of the no-mapped location policy.

ATTORNEY ADVERTISING

4. New Measures for Hospital Inpatient Quality Reporting (IQR) Program. CMS is proposing the adoption of 10 new measures for the Hospital Inpatient Quality Reporting (IQR) Program, in order to "assess clinical processes, patient safety and adverse events, patient experiences with care, care coordination, and clinical outcomes, as well as cost of care." The measures include: Hospital Commitment to Health Equity; Screening for Social Drivers of Health; Screen Positive Rate for Social Drivers of Health; and Four electronic clinical quality measures (eCQM) that measure Cesarean Birth, Severe Obstetric Complications, Opioid-Related Adverse Events, and Global Malnutrition. Additional measures include malnutrition, patient-reported outcomes performance measure following total hip or total knee arthroplasty, and Medicare spending per beneficiary. The measures begin with voluntary reporting periods followed by mandatory reporting periods.

5. PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Changes. CMS seeks to adopt and codify a patient safety exception for the measure removal policy to align with the measure removal policies adopted in other programs such as the Hospital IQR Program. CMS is also proposing to begin public display of the End-of-Life (EOL) measures beginning with the FY 2024 program year data, and to begin public display of the 30-Day Unplanned Readmissions for Cancer Patients measures beginning with the FY 2024 program year data. Additionally, CMS seeks comment on a potential future proposal to adopt two NHSN infection measures, "because cancer patients are often immunosuppressed and therefore more vulnerable to healthcare-associated infections."

C. MEDICAL EDUCATION PAYMENTS

1. Revisions to Graduate Medical Education ("GME") Payment Calculation for Hospitals Training Fellows above Their Full-Time Equivalent ("FTE") Cap. In response the U.S. District Court for the District of Columbia's decision in *Milton S. Hershey Medical Center v. Becerra*, No. 19-cv-2680, 2021 WL 1966572 (D.D.C. May 17, 2021), in which the Court struck down CMS's methodology for calculating direct GME payments to teaching hospitals on the grounds that CMS's regulation impermissibly modified the weighting factors, CMS proposes to adopt a new GME payment formula retroactively for cost reporting periods beginning on or after October 1, 2001. The hospitals in *Hershey* argued that CMS's earlier payment methodology, which CMS refers to as its "proportional reduction method," improperly reduced GME payments for hospitals that trained fellows beyond their initial residency period ("IRP") and that were also over their FTE cap. For example, if a hospital had a GME FTE cap of 100, trained 90 FTE residents within their IRP weighted at 1.0 and 20 additional fellows beyond their IRP weighted at 0.5, its total weighted FTE count would be further reduced using the following formula: (100 FTE cap / 110 current year unweighted FTE count) x 100 FTE current year weighted count = 90.91 FTEs. Under these circumstances, hospitals over their FTE cap who train fellows would not be able to take advantage of their full FTE caps. The Court in *Hershey* invalidated this methodology, and CMS now proposes a new methodology that would amend the GME regulation to provide that, if the hospital's unweighted number of FTE residents exceeds its FTE cap, and the hospital's number of weighted FTE residents also exceeds the FTE cap, then the hospital's respective primary care and obstetrics- and gynecology-weighted FTE counts and other weighted FTE counts would be adjusted to make the total weighted FTE count equal the FTE cap. CMS proposes to make this change effective retroactively for cost reporting periods beginning on or after October 1, 2001. CMS states that following the *Hershey* decision, the agency "has no promulgated rule governing" GME payments and that retroactive rulemaking is necessary in order to comply with the statutory requirement to make rules governing the computation of FTEs and is also in the public interest because it will permit interested stakeholders to comment on the proposal and allow the agency to have the benefit of those comments in adopting its final rule.

2. Allow Medicare GME Affiliation Agreements within Certain Rural Track FTE Limitations. Under existing regulations, CMS permits teaching hospitals to enter into "Medicare GME affiliation agreements" through which teaching hospitals can aggregate their FTE resident caps. CMS's current regulations, however, do not permit GME affiliation agreements for urban and rural teaching hospitals that train residents in a rural track program. CMS proposes to allow certain urban and rural hospitals participating in a rural training program to enter what CMS refers to as a "Rural Track Medicare GME Affiliation Agreement" to aggregate their rural track FTE limitations. Under the proposal, only urban and rural hospitals that participate in the same "separately accredited 1-2 family medicine rural track program"

ATTORNEY ADVERTISING

would be eligible to enter an affiliation agreement. Residents in a "1-2" program receive their first year of training in a core family medicine program, and their second and third year of training at another site, which may or may not be rural. In addition, only rural and urban hospitals that have rural track FTE limitations in effect prior to October 1, 2022 will be permitted to enter into affiliation agreements, and the affiliation agreements would be effective with the July 1, 2023 academic year.

3. Revisions to Medicare Advantage Nursing and Allied Health Payment Rates and GME Reduction Factors. In a 2000 rulemaking, CMS indicated that it would propose updates to the Medicare Advantage nursing and allied health ("NAH") payment rates and GME reduction factors through the annual IPPS rulemakings, but for prior years, CMS updated those rates through a series of transmittals, most recently an August 2021 transmittal that updated the rates through CY 2019. In the proposed rule, CMS stated that for CY 2020 forward, these rates will be proposed in the annual IPPS rulemakings. Using data from cost years ending in FY 2018 and 2019, CMS proposed to cap the pool of funds available for NAH Medicare Advantage payments for calendar years (CYs) 2020 and 2021 at the $60 million cap imposed by the Balanced Budget Refinement Act (BBRA) of 1999. CMS also proposed to reduce Medicare Advantage GME payments to hospitals by 3.71% for CY 2020 and 3.22% for CY 2021 to fund the NAH Medicare Advantage payment pool. CMS indicated that it will propose rates for CY 2022 in the FY 2024 IPPS proposed rule, and for CY 2023 in the FY 2025 IPPS proposed rule.

D. DISPROPORTIONATE SHARE HOSPITAL PAYMENT

As always, CMS proposes significant changes to the Disproportionate Share Hospital ("DSH") payment calculation. The proposed rule is again silent on the ongoing ramifications of the *Allina* litigation 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 2023 DSH proposals are as follows:

1. Policy Change Restricting Inclusion of Section 1115 Waiver Days in Medicaid Fraction for Future Years. After previously proposing but not finalizing a policy change in the FY 2022 rule, CMS again 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. In this year's proposal, CMS proposes to make three changes related to the inclusion of these days in the DSH calculation. First, as it did in FY 2022, CMS is again proposing to specifically exclude patient days where hospitals receive payment for services furnished to inpatients from an uncompensated care pool under a Section 1115 waiver, claiming that such waiver programs do not provide inpatient health coverage directly to patients or make payments on behalf of specific covered individuals. Second, in contrast to FY 2022, CMS has concluded that patients who receive premium assistance (financial assistance that can be used to purchase health insurance from a private entity) under a Section 1115 waiver can be included in the Medicaid fraction provided the assistance is equal to or greater than 90% of the cost of the health insurance. The agency states it chose 90% of the cost of premium assistance as the standard because the agency believes that level of benefit is similar to the "benefits received by individuals who are eligible for Title XIX programs." Third, CMS proposes to change the existing requirement that the patient receive "inpatient hospital benefits" under the waiver to be included in the DSH calculation to instead require that the patient receive "essential health benefits" as required of Alternative Benefit Plans and defined in 42 C.F.R. § 440.347. The stated rationale for changing the standard of services is to make it easier for providers and CMS contractors to distinguish between waivers that can be included and those that cannot, such as uncompensated care pools. CMS claims authority under the Deficit Reduction Act of 2005 to make these changes and 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.[1] The proposed rule provides these changes will be effective for discharges on or after October 1, 2022. CMS does not commit to responding to comments submitted in response to their similar FY 2022 proposal, so we encourage interested parties to submit new comments on this year's rule.

ATTORNEY ADVERTISING

2. Continued Significant Reduction in Uncompensated Care Payments. Since FY 2014, CMS has been required by statute (42 U.S.C. § 1395ww(r)) to use three factors to determine the amount of uncompensated care payments to hospitals. These factors represent CMS's estimate of 75% 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 $6.538 billion in DSH uncompensated care payments to hospitals, marking a significant decrease (9.1%) from the $7.192 billion in payments for 2022 and the $8.290 billion in payments for 2021 due in large part to a decline in the estimated uninsured rate for FYs 2022 and 2023. The agency started with a baseline of DSH payments made in 2018, and then used essentially 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). Largely consistent with last year, CMS assumes that new Medicaid enrollees under expansions are healthier than the traditional Medicaid recipients and, in turn, estimates that per capita spending for Medicaid beneficiaries who enrolled due to Medicaid expansion is 80% of the per capita spending for Medicaid beneficiaries who enrolled before the Medicaid expansion. CMS also claims to account for the impact of COVID-19 on hospital caseloads in this estimate of Factor 1. Factor 2 uses the same data from the CMS actuary to estimate that the ratio of the nationwide uninsured fell from 14% to an average of 9.2% in 2022 and 2023 (down from 9.6% in FY 2022), which by statute further reduced the pool of available funds to the proposed amount of $6.538 billion. In response to comments over the last few years that using a single year of data to calculate Factor 3 (distribution of the pool) could lead to variations in payments, CMS has proposed to instead use an average of the uncompensated care figures from hospitals' audited FYs 2018 and 2019 cost report Worksheet S-10s. In addition, the agency noted it expected to move to using an average of three years of data for calculation of Factor 3 in the FY 2024 rule. The agency used a December 2021 HCRIS extract for the Worksheet S-10 data for the proposed rule, and proposes to use a March 2022 extract in the final rule calculations. Hospitals identifying any errors with their Factor 3 data have a deadline of June 17, 2022 to notify the agency by sending an email to the following account: Section3133DSH@cms.hhs.gov.

3. Proposed Supplemental Payment for Indian Health Service and Tribal Hospitals and Puerto Rico Hospitals for FY 2023 and Subsequent Fiscal Years. CMS proposes and seeks comment on a new supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico in light of its proposal to discontinue using low-income insured days for determining Factor 3 for these hospitals. As in prior rules, CMS highlights that hospitals in these areas report far less charity care on Worksheet S-10 compared to other hospitals due to unique health care delivery and financing in these areas. Because CMS estimates that its proposal to use Worksheet S-10 data for these hospitals would reduce their payments by 90 to 100%, it is proposing to create a new supplemental payment just for these hospitals to offset that expected decrease in uncompensated care payments. These hospitals' supplemental payment would be calculated as the difference between the uncompensated care payments they received using Worksheet S-10 for Factor 3 and the adjusted base year amounts, which in this proposed rule would be their FY 2022 uncompensated care payments reduced by 9.1%. If for some reason such a hospital's Factor 3 amount was greater than the adjusted base year amount, the hospital would not receive the supplemental payment.

E. WAGE INDEX AND GEOGRAPHIC RECLASSIFICATION

1. Continuation of the Low Wage Index Hospital Policy Despite Court Loss. CMS proposes to continue the current low wage index hospital policy initially adopted for FY 2020. Under the policy, CMS intends to reduce the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values in the lower 25th percentile, doing so in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. For FY 2023, the 25th percentile is proposed to be 0.8401. CMS notes that the policy is the subject of litigation in *Bridgeport Hospital v. Becerra*, No. 20-cv-1574, 2022 WL 612658 (D.D.C. Mar. 2, 2022), in which the Court on March 2, 2022 found the agency did not have the statutory authority to adopt this policy. CMS notes this decision only addresses the FY 2020 rule and that it may still be appealed, but states that it may decide to take a different approach in the final rule, depending on public comments and the developments in the court proceedings.

2. Permanent 5% Cap on Wage Index Decreases. CMS proposes to implement a permanent 5% cap on all wage index decreases each year, regardless of the circumstances causing the decline. While historically CMS has put in temporary caps on wage index decreases when there are changes in policy or geographic definitions due to census changes, CMS states that it seeks to make the cap on decreases permanent policy to increase the predictability of IPPS payments for hospitals and to mitigate instability and significant negative impacts to hospitals resulting from changes to the wage index. CMS proposes to implement the cap policy in a budget neutral manner by reducing the standardized amount. The agency predicts the impact on the budget neutrality factor applied to the standardized amount associated with the proposed cap would be minimal because it does not anticipate a large number of hospitals facing 5% decreases of wage index amounts, and the impact would be spread to hospitals across the country.

3. No Reclassification for Rural Campus of Multi-Campus Hospital Reclassified from Urban to Rural. CMS proposes to revise the regulations governing urban hospitals with multiple campuses seeking to reclassify as rural. Currently, the regulations indicate that the reclassification policies apply to the entire hospital (that is, the main campus and all its remote locations). CMS explains that under the statute, however, rural reclassification is available only to a hospital that is located in an urban area and satisfies the criteria specified in the statute. Given that some urban hospitals operate remote locations in both urban and rural areas, CMS seeks to amend its regulation to provide that rural reclassification under 42 C.F.R. § 412.103 applies only to the main campus and any remote locations located in an urban area, and not remote locations in rural areas.

F. MEDICARE INTEROPERABILITY

CMS proposes several changes to the Promoting Interoperability Program ("PI Program"), which was established pursuant to the Health Information Technology for Economic and Clinical Health Act of 2009 to encourage hospitals and critical access hospitals (collectively, "PI Participating Hospitals") to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health records ("EHR") technology ("CEHRT"). If finalized, the changes would, effective for the 2023 EHR reporting period, (1) alter reporting requirements and the methodology for determining PI Program scores through changes to the Electronic Prescribing, Health Information Exchange, and Provider to Patient Exchange measures, (2) change the manner in which PI Program objectives and measures are published from their current location in the federal regulations to instead addressing in the annual rulemaking preamble language or references by CMS to third-party stewards involved with the programs, and (3) lead to PI Participating Hospitals' aggregate PI Program scores being made publicly available for the first time with the stated benefit of allowing customers to identify high-performing hospitals.

1. 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."

This alert should not be construed as legal advice or a legal opinion on any specific facts or circumstances. This alert is not intended to create, and receipt of it does not constitute, a lawyer-client relationship. The contents are intended for general informational purposes only, and you are urged to consult your attorney concerning any particular situation and any specific legal question you may have. © 2022 Ropes & Gray LLP

ATTORNEY ADVERTISING