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FY 2023 Hospital IPPS/LTCH PPS Final Rule

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On August 1, 2022, CMS released the final rule for the federal fiscal year ("FY") 2023 inpatient prospective payment system ("IPPS") and long-term care hospital ("LTCH") payment system, which is scheduled to be published in the Federal Register on August 10, 2022. In April 2022, just after the publication of the IPPS proposed rule, we circulated an alert summarizing certain aspects of CMS's proposals. Below is a quick summary of what CMS determined regarding each of the following topics in the final rule: 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. As discussed below, CMS decided to finalize a majority of its proposals in this final rule, but notably did not finalize its proposed limitation on counting Section 1115 waiver days in the Medicare disproportionate share hospital ("DSH") calculation. Please feel free to reach out if you have any questions about any of these issues.

A. COVID-19-RELATED REIMBURSEMENT AND REPORTING CHANGES

1. **Change in Data Used to Calculate MS-DRGs and Outlier Payments**. CMS finalized its proposal to the use of FY 2021 data for purposes of the FY 2023 IPPS and LTCH PPS rate setting but with several modifications to the usual rate-setting methodologies to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries at IPPS hospitals and LTCHs as compared to FY 2021. First, CMS finalized its proposal to calculate the FY 2023 MS-DRG and MS-LTC-DRG relative weights by initially calculating two sets of relative weights, one including and one excluding COVID-19 claims, and then averaging those two sets of relative weights to calculate the final FY 2023 relative weight values. CMS also finalized its proposal to modify the calculation of the outlier fixed-loss threshold by using charge inflation factors and cost-to-charge ratios using pre-pandemic data from March 2019 and March 2020. However, CMS modified its initial proposal by calculating two fixed-loss thresholds, one using FY 2021 claims data including COVID-19 cases and one excluding COVID-19 cases, and then averaging those two amounts to determine the final fixed-loss threshold for FY 2023. CMS stated that this revision to its proposed methodology would "better reflect a reasonable estimation of the case mix for FY 2023" and was consistent with the methodology CMS finalized for determining the MS-DRG and MS-LTC-DRG relative weights.

2. **Change in Conditions of Participation ("CoP") on Pandemic Reporting**. CMS finalized its proposal to revise the hospital and critical access hospital infection prevention and control CoP requirements to continue COVID-19-related reporting requirements commencing upon the conclusion of the current COVID-19 public health emergency ("PHE") declaration and lasting until April 30, 2024 (unless the Secretary determines an earlier end date). CMS modified its proposal to decrease the number of data categories that hospitals are required to report by removing suspected COVID-19 infections among patients and staff as well as several categories relating to COVID-19 and influenza infections among staff. CMS withdrew its proposal to establish additional data reporting requirements to address future PHEs related to epidemics and infectious diseases.

3. **Proposed Payment Adjustments for N95 Respirators Made Domestically**. In response to the comments solicited in the IPPS proposed rule, last month CMS proposed in the CY 2023 outpatient prospective payment system ("OPPS") proposed rule to make a payment adjustment under the OPPS and IPPS for the additional resource costs of domestic NIOSH-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023. Under the proposal, payments would be provided biweekly as interim lump sum payments to the hospital and would be reconciled at cost report settlement. CMS also proposes to make a downward adjustment of the OPPS of 0.01% to make the policy change budget neutral. But CMS does not propose to make the separate IPPS payment adjustment related to the costs of

acquiring domestic respirators budget neutral, explaining with respect to the IPPS approach that it seeks "[t]o further support the strategic policy goal of sustaining a level of supply resilience for NIOSH-approved surgical N95 respirators that is critical to protect the health and safety of personnel and patients in a public health emergency."

B. PERFORMANCE & DATA REPORTING PROGRAMS

1. **Hospital Readmissions Reduction Program Changes**. CMS finalized its proposal to resume using data related to pneumonia readmissions beginning in FY 2024 that was suppressed from the calculation for prior years, while excluding patients with principal or secondary COVID-19 diagnoses, for the same reasons mentioned in the proposed rule: improved coding practices, decreased COVID-19 admissions, and more data on measure specifications. CMS also finalized modifying the technical measure specifications of the six condition or procedure specific risk-standardized readmission measures to include a covariate adjustment for patient history of COVID-19 in the 12 months prior to admission. Finally, CMS stated that it would continue to consider comments on updating the Hospital Readmissions Reduction Program to incorporate provider performance for socially at-risk populations.

2. **Hospital Value-Based Purchasing Program: Suppression of Measures and Other Changes**. CMS finalized suppression of the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measure for FY 2023 due to the lingering impacts of COVID-19 and emergence of COVID-19 variants, such as the Delta variant. CMS also finalized suppression of five Hospital Acquired Infection ("HAI") measures: National Healthcare Safety Network ("NHSN") Catheter-Associated Urinary Tract Infection Outcome Measure; NHSN Central Line-Associated Bloodstream Infection Outcome Measure; American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure; NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus Bacteremia Outcome Measure; and NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection Outcome Measure. CMS stated that commenters supported suppression of these measures, as it "would ensure that hospitals are not penalized for challenges brought on by the pandemic which are not representative of the care generally provided." Additionally, CMS finalized revisions to the scoring and payment methodology for FY 2023 such that hospitals will not receive Total Performance Scores and, instead, CMS will reduce each hospital's base-operating DRG payment amount by two percent and assign a value-based incentive payment amount that matches the two percent reduction to the base operating DRG payment amount. For FY 2025, CMS finalized its proposals to update the baseline periods for certain measures, including the HCAHPS measure and the five HAI measures.

3. **Hospital-Acquired Conditions ("HAC") Reduction Program: Suppression of Measures**. CMS finalized its proposal 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 FY 2023, due to effects of COVID-19. Specifically, CMS will suppress the CMS PSI 90 measure and the five CDC NHSN HAI measures from the calculation of measure scores and Total HAC Scores for FY 2023. CMS will continue to publicly report measure information for all measures, including suppressed measures. CMS also finalized its proposal to update the measure specifications, including to risk-adjust for COVID-19 diagnoses.

4. **New Measures for Hospital Inpatient Quality Reporting ("IQR") Program**. CMS finalized the adoption of ten new measures for the Hospital IQR Program, including 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 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 Program Changes**. CMS finalized its proposal 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 also finalized its proposal to begin public display of four End-of-Life measures, but with modification. Public display would begin with FY 2025 data, which corresponds to data collected from July 1, 2022, through June 30, 2023, to provide hospitals with enough time to review their confidential reports. CMS also finalized beginning public display of the 30-Day Unplanned Readmissions for Cancer Patients measures beginning with FY 2024 data.

C. MEDICAL EDUCATION PAYMENTS

1. **Revisions to Graduate Medical Education ("GME") Payment Calculation for Hospitals Training Fellows Above Their Full-Time Equivalent ("FTE") Cap**. CMS finalized its proposal to adopt a new GME payment formula retroactively for cost reporting periods beginning on or after October 1, 2001, in response to 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), which struck down CMS's "proportional reduction method" on the ground that it impermissibly modified the GME weighting factors. While CMS noted that it had received many comments in support of the proposal, CMS also stated that many commenters had urged CMS to abandon its proposal to use retroactive rulemaking to implement the change. CMS rejected those comments, believing that the use of retroactive rulemaking was not inconsistent with the agency's past practice and that the use of retroactive rulemaking was permitted under the Medicare statute's limited retroactive rulemaking exceptions. First, CMS stated that the "explicit statutory requirement that the Secretary promulgate a rule governing GME reimbursement renders retroactive application here 'necessary to comply with statutory requirements.'" CMS further found that the public interest would "be served by having past payments calculated in the same way as future payments," given that those past payments were set by a regulation "that a court held inconsistent with substantive statutory requirements and the agency engage[d] in a new notice-and-comment rulemaking to implement that judicial ruling."

CMS also finalized its revisions to the GME regulation retroactively for cost reporting periods beginning on or after October 1, 2001, providing 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 reiterated that the new rule is "not a basis for reopening a CMS or contractor determination," and makes clear that even though the rule is being given retroactive effect, the agency will not reopen closed cost reports. Effectively, this means that only cost years that have been appealed or for which no NPR has been issued would likely see relief under the rule. In response to comments, CMS made several clarifying revisions to the cost report instructions and also clarified that in calculating the three-year rolling average, the hospital's weighted FTE counts for the preceding two periods would be calculated in accordance with the revised methodology and that the new methodology would apply to additional cap slots that hospitals were awarded under Section 422 of the Medicare Modernization Act.

2. **Allow Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations**. Seeking to add additional flexibility for rural training programs, CMS finalized its proposal without modification to allow certain urban and rural hospitals participating in a rural training program to enter into a "Rural Track Medicare GME Affiliation Agreement" to aggregate their rural track FTE limitations. Under prior regulations, GME affiliation agreements for urban and rural teaching hospitals that train residents in a rural track program were not permitted. Under the final rule, only urban and rural hospitals that participate in the same "separately accredited family medicine programs" with rural track FTE limitations in effect prior to October 1, 2022, will be permitted to enter into affiliation agreements. 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**. CMS finalized its proposed updates to the Medicare Advantage nursing and allied health ("NAH") payment rates and GME reduction factors. Using data from cost years ending in FYs 2018 and 2019, CMS finalized its proposal capping 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 of 1999. CMS also finalized its proposal 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 stated that rates for CY 2022 will be proposed in the FY 2024 rule, and for CY 2023 in the FY 2025 proposed rule.

D. DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. **Treatment of Medicare Part C Days in DSH calculation**. The final rule does not address the treatment of Part C days in the Medicare DSH calculation. In August 2020, CMS issued a proposed rule to retroactively adopt the same payment standard on Medicare Part C days in the DSH payment calculation underlying the invalidated rule and DSH fractions at issue in the *Allina* litigation. We still await a final rule.

2. **Change in Policy on Section 1115 Waiver Days in Medicaid Fraction**. CMS declined to finalize its proposals related to Section 1115 waiver days. The proposal would have made three changes limiting the inclusion of Section 1115 waiver days in the DSH calculation: 1) it would have excluded patient days where hospitals receive payment for services furnished to inpatients from an uncompensated care pool under a Section 1115 waiver; 2) it would have allowed hospitals to count patients who receive premium assistance under a section 1115 waiver but only if the assistance was equal to or greater than 90% of the cost of the health insurance; and 3) it would have changed 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. In the final rule, CMS stated that "[d]ue to the number and nature of the comments that we received on our proposal," it decided "not to move forward with the current proposal" but "expect[s] to revisit the treatment of section 1115 demonstration days for purposes of the DSH adjustment in future rulemaking."

3. **Continued Reduction in Uncompensated Care Payments**. The general process for deriving estimates and making calculations was finalized, but there were several changes in the actual figures from the proposed to final rule:

- CMS increased Factor 1 from $9.949 billion in the proposed rule to $10.461 billion in the final rule. (As in the proposed rule, the agency used essentially the same assumptions and estimates used in prior years to arrive at a DSH amount for 2022. But CMS relied upon the Office of the Actuary June 2022 Medicare DSH estimates in this final rule, rather than the January 2022 estimates that it relied upon in the proposed rule.) While the final Factor 1 is approximately $500 million higher than the proposal, it is still $27 million less than the final Factor 1 for FY 2022.

- For Factor 2, CMS proposed to use 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). CMS finalized the uninsured rate at 9.2% in Factor 2. (CMS also finalized a proposed technical change in 42 C.F.R. § 412.106(g)(1)(ii), after receiving no comments in response, to reflect the statutory methodology for determining Factor 2 for FYs 2018 onward because the regulation is currently limited "inadvertently" to FYs 2014 through 2017.)

- As a result, the overall pool of DSH uncompensated care funds increased from $6.538 billion to $6.874 billion between the proposed and final rules, but still decreased by over $300 million from the $7.192 billion total pool in FY 2022.

- 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 finalized its proposals to use FY 2018 Worksheet S-10 data from FY 2018 and 2019 cost reports for Factor 3 for FY 2023 and to start using the three most recent years of audited Worksheet S-10 data starting in FY 2024. CMS also used as proposed the March 31, 2022, HCRIS update to calculate Factor 3 for the current year.

4. **Supplemental Payment for Indian Health Service and Tribal Hospitals and Puerto Rico Hospitals for FY 2023 and Subsequent Fiscal Years**. CMS finalized its proposal to discontinue using low-income insured days to determine Factor 3 for IHS and Tribal hospitals and hospitals located in Puerto Rico. Instead, CMS will calculate Factor 3 for these hospitals solely based on Worksheet S-10 data. CMS also finalized without modification its proposal to provide such hospitals with a supplemental payment calculated as the difference between the uncompensated care payments they received using Worksheet S-10 for Factor 3 and the adjusted base year amounts. Because total uncompensated care DSH payments decreased by 4.4% between FY 2022 and FY 2023, CMS states that it will calculate an affected hospital's base year amount for FY 2023 by multiplying the hospital's FY 2022 uncompensated care amount by 0.956.

E. WAGE INDEX AND GEOGRAPHIC RECLASSIFICATION

1. **Continuation of the Low Wage Index Hospital Policy**. CMS finalized its proposal to continue the current low wage index hospital policy initially adopted for FY 2020. Under that policy, CMS states that it 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, CMS increased the 25th percentile from 0.8401 to 0.8427 based on updated data. CMS again acknowledged the Court's decision in *Bridgeport Hospital v. Becerra*, No. 20-cv-1574, 2022 WL 612658 (D.D.C. Mar. 2, 2022), finding that the agency did not have the statutory authority to adopt this policy, but similarly explained that the decision only addresses the FY 2020 rule and may still be appealed. This decision is discussed in detail in another alert. CMS did not address, however, the Court's subsequent remand of the matter to the agency without instructions. *See* Order, *Bridgeport Hospital v. Becerra*, No. 20-cv-1574 (D.D.C. July 27, 2022). The parties have 60 days (i.e., until September 25, 2022) to appeal.

2. **Permanent 5% Cap on Wage Index Decreases**. CMS finalized without modification its proposed permanent 5% cap on all wage index decreases each year, regardless of the circumstances causing the decline. The cap will be applied in a budget-neutral manner through a national adjustment to the standardized amount every year. CMS added a new paragraph at 42 C.F.R. § 412.64(h)(7) to reflect this change.

3. **No Reclassification for Rural Campus of Multi-Campus Hospital Reclassified from Urban to Rural**. CMS finalized without modification its proposed amendment to 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 finalized 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 technology. The finalized changes to the PI Program largely mirror CMS's proposed changes in the proposed rule. Among other things, the changes (1) alter reporting requirements and the methodology for determining PI Program scores; (2) change the manner in which PI Program objectives and measures are published from their current location in the federal regulations to instead being addressed in the annual rulemaking preamble language or references by CMS to third-party measure 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.