HEALTHCARE REGULATORY ROUND-UP EPISODE #34

FY2023 Final Rules – Are You Ready for October 1?

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Introductions

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FY2023 Inpatient PPS

Hospital IPPS Payment Update

- Final rule includes **4.3% increase** in operating payment rate
  - Largest rate increase in 25 years
  - Proposed at 2.6%
  - Actual rate increase lower due to offsets
    - Outlier offset -1.7%
    - Disproportionate share offset -0.3%
    - Low-volume/Medicare-dependent hospital expiration -0.6%
    - Final update percentage **+1.7%**
- Capital PPS rate = $483.76
  - 2.3% increase over FY2022

Standardized Amounts Wage Index > 1.0

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)--FY 2023

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 3.8 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.725 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.775 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.3 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,310.00	$2,065.74	$4,182.32	$2,004.54	$4,267.44	$2,045.34	$4,139.76	$1,984.15

Standardized Amounts Wage Index ≤ 1.0

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2023

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 3.8 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.725 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.775 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.3 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,952.96	$2,422.78	$3,835.85	$2,351.01	$3,913.92	$2,398.86	$3,796.82	$2,327.09

MS-DRG Weight Fluctuations

- Calculation of MS-DRG weights
  - CMS calculated two sets of weights – one with and one without COVID-19 claims
  - Averaged the two weights to determine FY2023 relative weights
- Finalized 10% cap on weight decreases from prior fiscal year (impacts 27 DRGs for FY2023)

Wage Index

- Labor share remains at 67.6% for hospitals with wage index > 1
  - Statutorily at 62% for hospitals with wage index ≤ 1
- Permanent 5% cap on any reduction to hospital's wage index from prior year
  - Implemented in budget neutral manner through national adjustment to standardized amount (winners and losers)
- Will use 2019 occupational mix data

Wage Index – Low Quartile

- Low quartile
  - Maintains low wage index hospital policy despite March 2022 court decision
    - Impacts hospitals with wage index below 25th percentile (.8427)
    - Increases wage index to half the difference between otherwise applicable hospital-specific wage index value and 25th percentile for all hospitals
      - Policy applied in budget-neutral manner by adjusting standardized amounts (winners and losers)
- Rural floor calculation
  - *Citrus v. Bececca*
  - Will **include** hospitals that reclassed from urban to rural
    - Impacts about 275 hospitals

Fixed-Loss Outlier Threshold

- Final outlier threshold **$38,859** (proposed at $43,214)
  - Used 2018/2019 claims data
    - Lessens impact of the pandemic
  - Necessitated by target of paying 5.1% of IPPS funds as outlier payments
  - Current outlier threshold - $30,988

Medicare Uncompensated Care Payments

- Reduces Medicare DSH and UCC payments by approximately **$318 million** over FY2022 (vs. proposed $0.8 billion reduction)
  - Total DSH payments = $10.4 billion
  - Will use FY2018 and FY2019 Worksheet S-10 data for UCC payments for 2023
  - Will use 3-year average of most recent audited data for future years

Use of Section 1115 Waiver Days in Medicaid Fraction

- CMS again did not finalize revision of Medicaid fraction to include only those patients receiving health insurance under section 1115 waiver (not including those receiving uncompensated care)
  - Proposed for FY2022 but did not implement
  - Issue currently being litigated in several states with Medicaid uncompensated care pools
  - Will consider in future rulemaking

Direct Graduate Medical Education Cap and Count

- Calculation of full-time equivalent caps based on recent litigation *(Milton S. Hershey Medical Center, et al. v. Becerra)*
  - Modified policy to be applied prospectively (CR periods beginning after 10/1/22)
  - If weighted and unweighted FTE counts exceed FTE cap amount, weighted count will be adjusted to equal FTE Cap amount
  - If weighted count does not exceed FTE cap, direct GME reimbursement will be based on weighted cap amount
  - Weighting factor cannot be lower than the factor prescribed in statute (.5)

Direct GME Rural Track Programs

- Allows urban and rural hospital participating in same rural track program to establish Medicare GME affiliation agreement (sharing cap space through reallocation once caps for both hospitals have been established)
- Eligible urban and rural hospitals may enter into rural track Medicare GME affiliation agreements effective with July 1, 2023, academic year

Other Adjustments: Low Volume Adjustment

- Low volume adjustment reverts to pre-2011 criteria, absent Congressional action:
  - Less than 200 total discharges (including Medicare and non-Medicare)
  - Located more than 25 miles from the nearest “subsection (d)” hospital (PPS acute care)
- Payment adjustment = 25% of the hospital’s total PPS payment
- Hospital qualifying for LVA in 2022 may continue to receive LVA if both discharge and mileage requirements are met
- Hospitals requesting LVA adjustment must apply to the MAC prior to September 1, 2022, to receive the benefit for the full fiscal year

Other Adjustments: Medicare Dependent Hospitals

- Limited to small rural hospitals:
  - Less than 100 available beds
  - Medicare utilization based on days or discharges exceed 60% in last 2/3 settled cost reports
  - Payment adjustment equals 75% of difference between PPS operating payments and adjusted hospital specific amount
- Scheduled to expire September 30, 2022
  - *Historically MDH provision has been extended prior to previous scheduled eliminations*

Hospital Inpatient Quality Reporting Program

Name	Voluntary Reporting	Mandatory Reporting	Payment Determination
Hospital Commitment to Health Equity	N/A	CY 2023	FFY 2025
Screening for Social Drivers of Health	CY 2023	CY 2024	FFY 2026
Screen Positive Rate for Social Drivers of Health	CY 2023	CY 2024	FFY 2026
Cesarean Birth eCQM	CY 2023	CY 2024	FFY 2026
Severe Obstetric Complications eCQM	CY 2023	CY 2024	FFY 2026
Hospital-Harm—Opioid-Related Adverse Events eCQM	N/A	CY 2024	FFY 2026
Global Malnutrition Composite Score eCQM	N/A	CY 2024	FFY 2026
Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure Following Elective Primary Total Hip/Knee Arthroplasty	1/1/23 to 6/20/23; 7/1/23 to 6/30/24	7/1/2024 to 6/30/2025	FFY2028
Medicare Spending Per Beneficiary - Hospital	N/A		FFY 2024
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip/Knee Arthroplasty	N/A		FFY 2024

Hospital Commitment To Health Equity - Attestation

Domain	Elements
Equity is a Strategic Priority	Our hospital strategic plan – (A) Identifies priority populations who currently experience health disparities (B) Identifies healthcare equity goals and discrete action steps to achieving these goals (C) Outlines specific resources which have been dedicated to achieving our equity goals (D) Describes our approach for engaging key stakeholders
Data Collection	(A) Our hospital collects demographic information, including self-reported race and ethnicity and/or SDOH on the majority of patients (B) Our hospital has staff training in culturally sensitive collection of demographic and/or SDOH information (C) Our hospital inputs demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified EHR technology.
Data Analysis	Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards
Quality Improvement	Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities
Leadership Engagement	(A) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our hospital senior leadership (including executives and trustees) annually reviews key performance indicators stratified by demographic and/or social factors.

Screening for Health-Related Social Needs (HRSNs)

- Report percentage of all patients age 18+ at time of admission screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
  - Use self-selected screening tool (e.g., AHC Health-Related Social Needs Screening Tool)
    - Reference to Social Interventions Research and Evaluation Network (https://sirenetwork.ucsf.edu/tools/evidence-library)
- Separately report positive screening rate for each of 5 domains

Global Malnutrition Composite Score eCQM

- For each hospital inpatient age 65+
  - Screening for malnutrition risk at admission
  - Completing nutrition assessment for patients who screened for risk of malnutrition
  - Appropriate documentation of malnutrition diagnosis in patient's medical record if indicated by assessment findings
  - Development of nutrition care plan for malnourished patients including recommended treatment plan

Promoting Interoperability

2022

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 Points
	Bonus: Query of PDMP	10 points (*bonus*)*
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
	-OR-	
	Health Information Exchange Bi-Directional Exchange*	40 points*
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report the following four measures: * • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting	10 points
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (*bonus*)*

Notes: The Security Risk Analysis measure, SAFER Guides measure, and attestations required by section 106(b)(2)(B) of MACRA are required, but will not be scored. Electronic clinical quality measures (eCQM) measures are required, but will not be scored.

2023

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP*	10 points*	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points*	Required (eligible hospital or CAHs choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points*	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points*	
	-OR-		
	Enabling Exchange under TEFCA*	30 points*	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points*	Required
Public Health and Clinical Data Exchange	Report the following five measures:* • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Reporting*	25 points*	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (*bonus*)	Optional

Notes: The Security Risk Analysis measure, SAFER Guides measure, and attestations required by section 106(b)(2)(B) of MACRA are required, but will not be scored. eCQM measures are required, but will not be scored.

Value-Based Payments

- Hospital Readmission Reduction Program
  - For FY 2024, discontinue suppression of pneumonia readmission measure
  - Beginning in FY 2023 -
    - Exclude patients with COVID-19 diagnosis from pneumonia measure
    - Include covariate adjustment for patient history of COVID-19 within one year for all measures
- Hospital Value-Based Purchasing Program
  - For FY 2023, all hospitals receive incentive payment equal to 2% withhold
- Hospital Acquired Condition Reduction Program
  - No hospital penalized for FY 2023
  - Measure updates for FY 2024

Birthing-Friendly Hospital Designation

- To be awarded (i.e., posting on Care Compare website) to hospitals that answer "Yes" to both questions in *Maternal Morbidity Structural Measure* beginning in Fall 2023
  - Currently participating in structured state or national Perinatal Quality Improvement Collaborative?
  - Implementing patient safety practices or bundles as part of these initiatives?
- "[W]e intend to propose a more robust set of metrics for awarding the designation that may include other maternal health-related measures that may be finalized for the Hospital IQR Program measure set in the future" (e.g., Cesarean Birth and Severe Obstetric Complications)

Infection Control CoPs

- Finalized post-PHE COVID-19 and seasonal influenza reporting requirements through 4/30/24 (unless Secretary discontinues earlier)
  - Deleted reporting requirements for suspected COVID–19 infections among patients and staff, confirmed COVID–19 and influenza infections among staff, COVID–19 and influenza deaths among staff, and confirmed co-morbid influenza and COVID–19 infections among staff
- Did **not** finalize proposal to require hospitals to report during any future PHE (local, state, or national) specified data elements with frequency specified by Secretary
  - "CMS believes that additional consideration is necessary to establish a longer-term solution for data collection and reporting that ensures the ongoing preparedness of the entire health care system in the event of another PHE…. We also believe that continued collaboration among government and interested parties would be beneficial to standardize and streamline data reporting to the extent possible thereby reducing burden on facilities…."

Other FY2023 Final Rules

Inpatient Rehabilitation Facility PPS

- Payments to increase 3.2 percent
- Outlier threshold = $12,536 (currently $9,491)
- Permanent cap on wage index decreases
- Displaced medical residents
  - Allows an IRF to receive temporary adjustment to FTE cap to reflect residents added as result of closure of another IRF training program
- Expansion of quality data reporting to include all patients, regardless of payer

Inpatient Psychiatric Facility PPS

- Payments to increase by 2.5 percent
- Outlier threshold = $24,630 (currently $16,040)
- Permanent cap on wage index decreases

Hospice Payment Rate Update

- Payments to increase 3.8 percent
- Aggregate cap = $32,486.92 (currently $31,297.61)

Skilled Nursing Facility PPS

- Payments to increase 2.7% (vs. proposed 4.6% reduction)
  - 1.5 percentage point market basket forecast error adjustment
  - Recalibration of Patient Drive Payment Model parity adjustment factor with two-year phase-in period (2.3% reduction in FY 2023 and FY 2024)
- Permanent cap on wage index decreases
- SNF Quality Reporting Program
  - Add influenza vaccination coverage among healthcare personnel measure in FY24
  - Change compliance date for certain SNF QRP reporting requirements from October 1st of the year that is at least two full fiscal years after end of COVID-19 PHE to October 1, 2023
- SNF value-based purchasing
  - No FY2023 payment measure (performance on SNF all-cause readmission measure still reported
  - New measures
    - FY 2026 program year: SNF HAI Requiring Hospitalization and Total Nursing Hours per Resident Day measures
    - FY 2027 program year: Discharge to Community - Post Acute Care measure

Long-Term Acute Care Hospital PPS

- Payments to increase 2.4 percent
  - Revised standard federal payment rate = $46,432.77

Our Next Health Care Regulatory Round-Up:

Physician Compensation and the Three Rs of Rural Markets—Reality, Recruiting, Regulatory Considerations

September 7, 2022

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services