HEALTHCARE REGULATORY ROUND-UP - Episode #47

FY2024 Hospital Inpatient Proposed Rule + Medicare Advantage Final Rules

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Introductions

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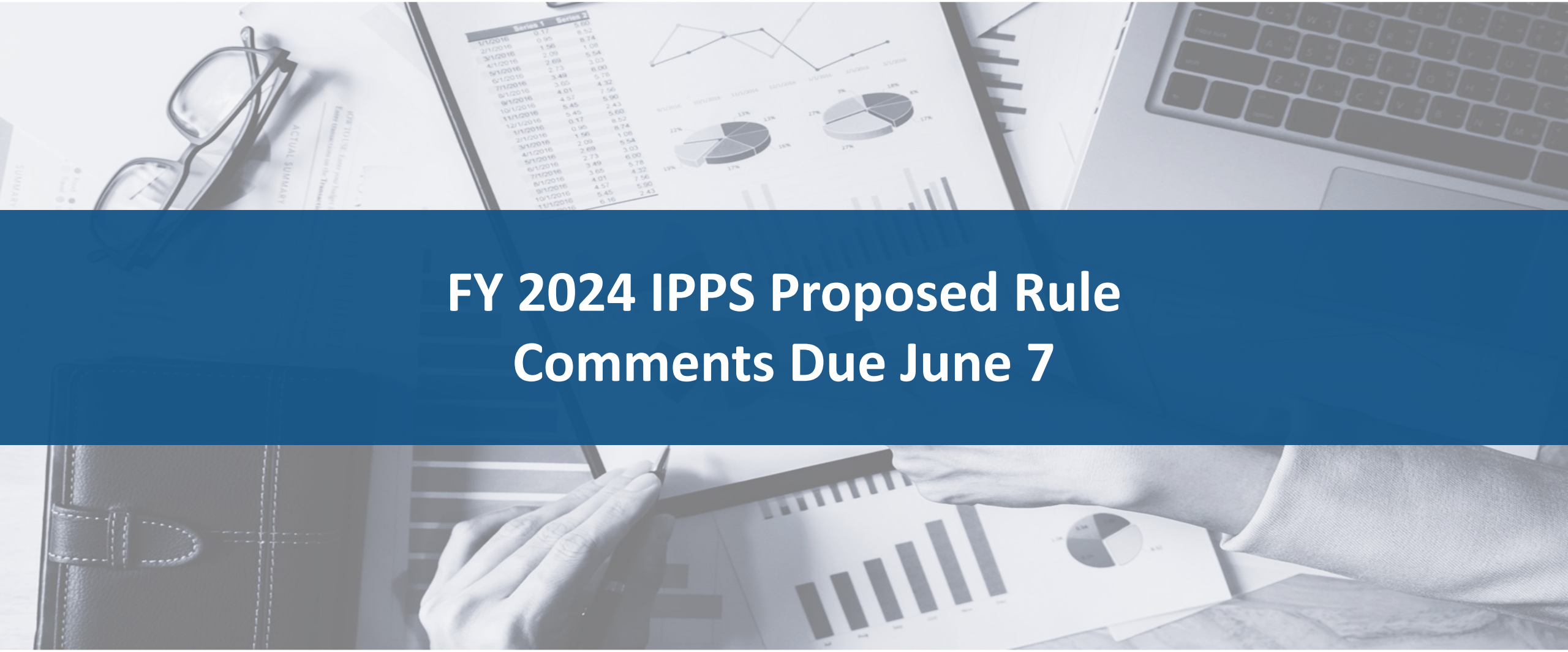

FY 2024 IPPS Proposed Rule
Comments Due June 7

Payment Rates

- Operating rate increase of 2.8%
  - 3% market basket rate of increase (i.e., measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) minus 0.2% multi-factor productivity adjustment;
    - Based on FY22 claims data and FY21 cost report data with no COVID-19-related adjustments
    - No plus 0.5% coding and documentation adjustment (FY18 – FY23)
    - Compare to FY23: Proposed Rule = 3.2% increase; Final Rule = 4.3% increase
  - Other adjustments
    - Hospitals ≠ meet Promoting Interoperability Program requirements in FY22 = 0.55% update)
    - Hospitals ≠ meet Inpatient Quality Reporting Program requirements in FY22 = 2.05% update)
    - Hospitals that met neither program's requirements in FY22 = negative 0.2% update
  - Proposed rule used data from Q3 2022; final rule will likely use data from Q1 2023
  - National standardized amount for FY24 = $6,524.94, a 2.3% increase over FY23 ($6,375.74)
- Capital rate increase from current $483.76 to $505.54
- Increase outlier threshold from $38,859 to $40,732

MS-DRG Classifications and Relative Weights

- Add 15 new MS-DRGs and delete 16 existing MS-DRGs
  - Most fall under MDC 05 – Diseases and Disorders of the Circulatory System
    - Consolidation of some existing MS-DRGs
- Will use single year data to set weights with no COVID-19 modifications
- Modifications result in several new MS-DRGs becoming subject to Post-Acute Transfer Policy

Severity Level Designation – Z Codes for Homelessness

- For FY24, change severity level designation from non-complication or comorbidity (NonCC) to complication or comorbidity (CC)
  - Based on available data, homelessness results in higher costs; will re-evaluate as additional data becomes available
  - Example – simple pneumonia and pleurisy
    - DRG 195 (NonCC) – 0.6224
    - DRG 194 (CC) – 0.8190
- "[W]e also continue to be interested in receiving feedback on how we might otherwise foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each health care encounter and improve the reliability and validity of the coded data including in support of efforts to advance health equity."

NCTAP and NTAP

- New COVID-19 Treatments Add-Payment (NCTAP)
  - Add-on payment expires at the end of FY2023; no payment for discharges on or after 10/1/23
- New Technology Add-on Payments (NTAP)
  - NTAP applicants would be required to have complete and active FDA market authorization request at time of NTAP application submission; move FDA approval deadline from July 1 to May 1
    - Due to increase in number and complexity of applications (including AI-enabled devices)
  - Assessed 39 applications in the proposed rule; continues payment for 11 existing technologies and discontinues 15 for those no longer considered new

Medicare DSH and UCC

- Current Medicare DSH formula –
  - DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)
- Proposed rule updates DSH pool to reflect percent of uninsured
  - Dollars distributed based on proportion of total uncompensated care each Medicare DSH hospital provides
  - Will use 3-year average from Worksheet S-10 of the Medicare cost report (FYs 2018, 2019, 2020)
- Capital DSH
  - Proposes that hospitals reclassified as rural under Sec. 412.103 would not be considered rural for purposes of capital DSH, **effective for discharges on or after 10/1/23**

The Real DSH Cut: $8B cut in *Medicaid* DSH payments in FY24 and 3 years thereafter

Low Wage Index Hospital

- Maintains low wage index hospital policy through FY2024 despite March 2022 court decision in *Bridgeport Hospital v. Becerra*
  - DC District Court found in favor of hospitals, but CMS has appealed that decision
- Benefits hospitals with wage index below 25th percentile (0.8615)
  - 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 Wage Index Calculation Methodology

- Treat reclassified rural hospitals same as those that are geographically rural for purposes of rural wage index
  - Would include data from hospitals that reclassified from urban to rural in calculating rural wage index
    - In FY23, these hospitals were included in calculating rural floor *but not* rural wage index
  - Would likely increase the wage index of many rural hospitals
- Exclude hospitals with both Sec. 412.103 and MGCRB reclassifications from the calculation of the rural wage index ("dual reclass" hospitals)

Inpatient Quality Reporting (IQR) Program

25% reduction of Market Basket Increase

Additions
(beginning with CY25 reporting period)

- Hospital Harm-Pressure Injury eCQM
- Hospital Harm-Acute Kidney Injury eCQM
- Excessive Radiation Dose/Inadequate Image Quality for Adult Diagnostic CTs

Adjustments

- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (impacting FY27 payment determination)
- Hybrid Hospital-Wide All-Cause Readmission measure (impacting FY27 payment determination)
- COVID-19 Vaccination Among Healthcare Personnel – replace "complete vaccination course" with "up-to-date" (beginning with Q4 CY23 reporting period)

Removals

- Hospital-Level Risk-Standardized Complication Rate Following Elective THA/TKA (beginning with 4/1/25 to 3/1/28 reporting period)
- Medicare Spending Per Beneficiary - Hospital Measure (beginning with CY26 reporting period)
- Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (beginning with CY24 reporting period)

Changes to Data Submission

- HCAHPS Survey Measure (beginning with January 2025 discharges)
- Targeting criteria for hospital validation for extraordinary circumstances exceptions

For FY24, 95 hospitals will be penalized for failure to meet IQR requirements in FY22

Promoting Interoperability (PI) Program

75% Reduction to Market Basket Update

- Define CY25 EHR reporting period
- Beginning with CY24 EHR reporting period, require eligible hospitals/CAHs to attest "yes" to having conducted annual self-assessment of all nine Safety Assurance Factors for EHR Resilience (SAFER) Guides
- Beginning with CY25 reporting period, adopt three new eCQMs for eligible hospitals/CAHs to select as one of three self-selected eCQMs

For FY24, 164 hospitals will be penalized for failure to meet PI requirements in FY22

Hospital Readmission Reduction Program (HRRP)

Up to 3% Reduction in DRG Payments

- Compare rates of 30-day risk standardized unplanned readmissions among hospitals with similar proportion of dual-eligible beneficiaries
- No proposed changes to conditions/procedures (pneumonia, AMI, HF, elective THA/TKA, COPD, CABG)
- No proposed changes to methodology for calculating readmission rates, imposing penalties
- CMS estimates 2,910 PPS hospitals (84.12%) will be penalized in FY24 based on FY22 performance

Hospital Value-Based Purchasing (VBP) Program

2% Withhold Re-Distributed to Top Performers ($1.7B in FY24 based on FY22 performance)

- Beginning with FY26 program year –
  - Adopt Severe Sepsis and Septic Shock: Management Bundle Measure (with CY24 as initial performance period)
  - Add Health Equity Adjustment (HEA) bonus points to Total Performance Score based on program performance and proportion of dual-eligible patients served
    - Similar to adjustment applied in Medicare Shared Savings Program
- RFI on additional program changes to address health equity
- Other modifications impacting later program years

All hospitals	50.18%
Location	
Urban	45.59%
Rural	66.73%
Bed size	
Bed size< 100	47.71%
Bed size 100 – 499	51.72%
Bed size 500+	46.76%
Safety net status	
Safety net hospitals	86.88%
Non-safety net	41.54%

Hospital Acquired Condition (HAC) Reduction Program

1% Penalty for Hospitals Ranked in Worst Performing Quartile

- Rankings to be calculated and penalties to be imposed in FY24
- No proposed changes to measures
  - Patient Safety and Adverse Events Composite (CMS PSI 90) (claims-based)
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)
- Requesting comment on future measures to advance patient safety and reduce health disparities
- Establish validation reconsideration process similar to IQR reconsideration process (beginning in FY25 impacting CY22 discharges)
- Modify targeting criteria for data validation to include hospitals that received an Extraordinary Circumstances Exception (beginning in FY27 impacting CY24 discharges)

RFI – Safety Net Hospitals

- "We are interested in public feedback on the challenges faced by safety-net hospitals, and potential approaches to help safety-net hospitals meet those challenges"
  - How should safety net hospitals be identified and categorized for policy purposes?
    - MedPAC's Safety-Net Index
    - Utilization of area-level indices
  - Specific challenges facing rural safety net hospitals?
  - Challenges around IT investments?
  - New approaches or modifications to existing approaches to address identified challenges?
  - Should safety-net hospitals' reporting burden and compensation be different than other hospitals?
  - What challenges do safety net hospitals' patients face before and after receiving hospital care?
  - Ways to develop payment approaches for safety net hospitals that would also support patients needing financial assistance?

Other Issues – Addressed and Not Addressed

- Long-Term Care Hospital (LTCH) proposed update
  - Proposed rate increase of 2.9%, but payments expected to decrease overall due to 4.7% *decrease* in high-cost outlier payments
    - Outlier threshold would increase to $94,378 (currently $38,518) to maintain statutory 7.975% high-cost outlier pool
  - Changes to LTCH Quality Reporting Program
- GME payments for Rural Emergency Hospitals
- Changes in process for physician-owned hospitals to receive exception from expansion prohibition
- Changes to PPS-Exempt Cancer Hospital Quality Reporting Program
- No proposed changes to Conditions of Participation
- End of the PHE?

Remember to Submit Comments

- Comments due June 9
  - https://www.regulations.gov (CMS-1785-P)
  - Comment on what's good and what's not

Medicare Advantage

February 2023 RADV Final Rule

- RADV (Risk Adjustment Data Validation) CMS' audit program to detect plan overpayments from inclusion of unsupported diagnosis codes
  - CMS audits ~ 5% of plan contracts each year; selects random sample of enrollees; plan must produce medical records to support listed diagnoses
  - Only when medical records "comply with all CMS data and documentation requirements, . . . described in current agency policy documents, including the Medicare Managed Care Manual," do they properly support a reported diagnosis for MA documentation purposes
- Beginning with Plan Year 2018, CMS will extrapolate results across all plan enrollees
  - Anticipate audits starting in 2025
  - Extrapolation methodology to focus on contracts identified as high risk of overpayment through statistical modeling and/or data analytics (no specifics)
  - Will not apply a fee-for-service adjustment
- Provider impact?
  - MA plans' efforts to prevent and/or claw back any repayments?
  - CMS policing providers' diagnosis coding accuracy?

2024 Rate Announcement

- 3.32% payment increase for MA plans ($13.8 billion)
  - CMS had proposed 1.1% payment increase in January
- 3-year phase-in of 2024 risk adjustment model
  - While 2020 model maps 13.3% of all ICD-10s to one of 86 payment condition categories (HCCs), 2024 model maps only 10.5% of ICD-10 codes to 115 payment HCCs
  - CMS re-built HCCs from ground up, reviewing each ICD-10 to determine most appropriate groupings and weightings based on clinical considerations and ability to predict Medicare costs
  - CMS had proposed full implementation for 2024, but now will phase in 1/3 in 2024 and 2/3 in 2025
- CMS' use of 2024 risk adjustment model in alternative payment models?

April 2023 Final Rule

1. Prior authorization/utilization management
2. Health equity
3. Behavioral health
4. Plan marketing restrictions

NOTE: CMS *did not* finalize proposed changes to regulations governing providers' obligation to report and return Medicare overpayments (replace 'reasonable diligence' with 'knowing' and 'knowingly'); will be subject of later rulemaking

Prior Authorization/Utilization Management

- Based on data from MA plans representing 87% of enrollment, in 2021 –
  - 35M+ PA requests were submitted to MA plans on behalf of MA enrollees
  - Volume varied across plans, ranging from 0.3 requests per Kaiser Permanente enrollee to 2.9 requests per Anthem enrollee (average = 1.5 requests per enrollee)
  - 2M+ PA requests were fully or partially denied by MA plans
  - Only 11% of PA denials were appealed
  - 82% of appeals resulted in fully or partially overturning initial PA denial

https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

Substantive Requirements

- Must comply with NCDs, LCDs, and general coverage and benefit conditions in traditional Medicare statutes and regulations
  - Including coverage criteria for inpatient, IRF, and SNF admissions and HHA services
  - Specifically, admissions for surgeries on inpatient only list and admissions meeting two midnight benchmark (but not the two-midnight presumption applied for medical review purposes)
- If (and only if) coverage criteria not fully defined by above, may establish internal coverage criteria
  - Must be based on current evidence in widely used treatment guidelines or clinical literature
  - Must be publicly accessible (including summary of evidence)
  - Plan must demonstrate additional criteria provide clinical benefits highly likely to outweigh any harm, including delayed or decreased access to care

Substantive Requirements

- Must establish Utilization Management Committee led by Medical Director to review PA policies annually
- PA approval must remain valid for as long as medically necessary to avoid disruptions in care; must provide minimum 90-day transition period when enrollee undergoing treatment changes coverage

NOTE: Procedural requirements (e.g., turn-around time on PA requests) addressed in separate proposed rule published in December 2022

Health Equity

- Star Rating Health Equity Index
  - Summarizes plan's performance among beneficiaries with specified social risk factors (SRFs) across multiple measures into single score
  - Replaces current reward factor for consistently high performance (biggest driver of Quality Bonus Payments)
  - Initial SRFs = beneficiaries who (1) receive low-income subsidy, (2) are dual eligible, (3) who are disabled
  - Initial calculation based on 2024 and 2025 data and applied to 2027 Star Ratings
- Other health equity-related plan requirements
  - Ensure services provided in culturally competent manner to expanded list of populations
  - Include in provider directories providers' cultural and linguistic capabilities (including languages offered by provider or skilled medical interpreter)
  - Identify and offer digital health education to enrollees with low digital health literacy
  - Incorporate activities to reduce disparities in health and health care into overall QI program

Behavioral Health

- For primary care and behavioral health services, plan must ensure wait times do not exceed –
  - Emergency/urgent – immediately
  - Requiring medical attention – 7 business days
  - Routine and preventive care – 30 business days
- Requires plans to demonstrate network adequacy for clinical psychology and clinical social work (time/distance and minimum ratios + telehealth credit)
  - In addition to psychiatry and inpatient psychiatric facility services
- Clarifies ‘emergency medical condition’ includes both physical and behavioral health conditions
  - No prior authorization, ‘medical necessity’ based on ‘prudent layperson’ standard

Plan Marketing Restrictions

- 22 new requirements relating to marketing and enrollment activities
- Based on CMS monitoring activities and complaints received from plans and beneficiaries
- Apply to 2024 plan year and thereafter

We are finalizing several changes to strengthen beneficiary protections and improve MA and Part D marketing. These include notifying enrollees annually, in writing, of the ability to opt out of plan business contacts from their plan; requiring agents to explain the effect of an enrollee's enrollment choice on their current coverage; clarifying that the contact is unsolicited unless an appointment at the beneficiary's home was previously scheduled; prohibiting marketing of benefits in a service area where those benefits are not available, unless unavoidable due to use of local or regional media; prohibiting the marketing of savings available based on a comparison of typical expenses borne by uninsured individuals; requiring TPMOs to list or mention all of the MA organization or Part D sponsors that they represent in marketing materials; requiring plans and sponsors to have an oversight plan that monitors agent/broker activities and reports non-compliance to CMS; adding SHIPs to the TPMO disclaimer; adding the number of organizations and products a TPMO represents to the TPMO disclaimer; placing limits around the use of the Medicare name, logo, and Medicare card; prohibiting the use of superlatives unless the material provides documentation to support the statement; prohibiting the collection of SOA cards at educational events; prohibiting a marketing event to follow an educational event with 12 hours at the same location; clarifying the requirement to record calls between TPMOs and beneficiaries includes virtual connections such as Zoom and Facetime; limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that the enrollee first asked for information; and requiring 48 hours between a Scope of Appointment and an agent meeting with a beneficiary, with exceptions for beneficiary-initiated walk-ins and the end of a valid enrollment period.

Our Next Healthcare Regulatory Round-Ups:

May 10 - No Surprises Act Update

May 24 – HIPAA Update