IOWA HOSPITAL ASSOCIATION

2023 Medicare Hospital IPPS and OPPS Rules

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Introductions

Martie Ross, JD

mross@pyapc.com

Mike Nichols, CPA

mnichols@pyapc.com

PYA

pyapc.com
800.270.9629

ATLANTA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

FY 2023 IPPS Final Rule

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1. Hospital IPPS Payment Update

- **4.3% increase** in operating payment rate
  - Proposed rule = 2.6%
  - Largest rate increase in 25 years
  - Actual rate increase = 1.7% due to offsets
    - Outlier offset -1.7%
    - Disproportionate share offset -0.3%
    - Low-volume/Medicare-dependent hospital expiration -0.6%
- Capital PPS rate = $483.76
  - 2.3% increase over FY2022
- Total estimated change for Iowa hospitals = 3.2% increase over FY2022 (excluding outliers)

Iowa-Specific IPPS Payment Update (DataGen)

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2022 IPPS Payments	**$903,869,800**		**$65,570,700**		**$969,440,200**	
Provider Type Changes	($2,081,000)	-0.2%	($118,900)	-0.2%	($2,199,900)	-0.2%
Marketbasket Update (Includes Budget Neutrality)	$34,612,200	3.8%	$1,575,300	2.4%	$36,187,400	3.7%
ACA-Mandated Marketbasket Reductions	($2,617,100)	-0.3%	*Not Applicable*		($2,617,100)	-0.3%
MACRA-Mandated Coding Adjustment	$4,281,300	0.5%	*Not Applicable*		$4,281,300	0.4%
MS-DRG Weight 10% Reduction Cap Budget Neutrality	($221,000)	0.0%	($13,500)	0.0%	($234,800)	0.0%
Wage Index/GAF (Wage Data and Reclassification)	($4,523,600)	-0.5%	($534,200)	-0.8%	($5,057,200)	-0.5%
> Change in Labor Share	$10,700	0.0%	*Not Applicable*		$10,700	0.0%
Wage Index/GAF (Other Changes)	$2,140,900	0.2%	$230,300	0.4%	$2,371,100	0.2%
> Expiration of Previous 5% Stop Loss Transition Budget Neutrality	$123,400	0.0%	$11,800	0.0%	$135,200	0.0%
> Expiration of Previous 5% Stop Loss Transition Wage Index	$236,800	0.0%	$18,500	0.0%	$255,300	0.0%
> Current 5% Stop Loss Transition Wage Index	$1,864,200	0.2%	$169,400	0.3%	$2,033,600	0.2%
> Current 5% Stop Loss Transition Budget Neutrality	($282,000)	0.0%	($26,800)	0.0%	($308,500)	0.0%
> Change in Imputed Floor	$0	0.0%	$0	0.0%	$0	0.0%
> Removal of Previous Bottom Quartile Budget Neutrality	$1,727,300	0.2%	$159,100	0.2%	$1,886,500	0.2%
> Removal of Previous Bottom Quartile Wage Index	($736,600)	-0.1%	($85,100)	-0.1%	($821,500)	-0.1%
> Current Bottom Quartile Increase	$890,300	0.1%	$143,800	0.2%	$1,033,800	0.1%
> Current Bottom Quartile Budget Neutrality	($1,682,900)	-0.2%	($160,300)	-0.2%	($1,843,000)	-0.2%
Transitional DSH Year-Over-Year	$0	0.0%	$0	0.0%	$0	0.0%
DSH: UCC Payment Changes [1]	($3,709,100)	-0.4%			($3,709,100)	-0.4%
> DSH UCC Distribution Factor Change	($2,368,900)	-0.3%	*Not Applicable*		($2,368,900)	-0.2%
Change in Hospital Specific Rate	$6,613,100	0.7%			$6,613,100	0.7%
MS-DRG Updates	($2,845,500)	-0.3%	($213,800)	-0.3%	($3,059,800)	-0.3%
Quality Based Payment Adjustments [2]	$2,672,500	0.3%	$201,000	0.3%	$2,873,300	0.3%
Net Change due to Low Volume Adjustment	($3,926,800)	-0.4%	($246,200)	-0.4%	($4,173,100)	-0.4%
Estimated FFY 2023 IPPS Payments	**$934,265,700**		**$66,450,700**		**$1,000,716,400**	
Total Estimated Change FFY 2022 to FFY 2023 ¥	***$30,395,900***	***3.4%*** ▲	***$880,000***	***1.3%*** ▲	***$31,275,600***	***3.2%*** ▲

¥ The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2031. It is estimated that reduction due to sequestration for FFY 2023 IPPS-specific payments will be: $20,014,400.

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

Note: no Iowa hospital has wage index >1.0

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

Note: all Iowa Hospitals have wage index < 1.0

2. 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
  - Budget neutrality adjustment
    - 0.999764 for operating rates
    - 0.9998 for capital rates

3. Wage Index

- Labor share remains at 67.6% for hospitals with wage index > 1
  - Statutorily at 62% for hospitals with wage index ≤ 1 (i.e., all Iowa hospitals)
- 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
- Impact of all wage index changes on Iowa hospitals = slight decrease of $304,000

Iowa Hospitals Wage Index Value

Table 3- WAGE INDEX TABLE BY CBSA - FY 2023 (CONTAINS THE FOLLOWING DATA: AVERAGE HOURLY WAGE, WAGE INDEXES AND THE GAF. ALSO INCLUDES WAGE INDEXES PRIOR TO APPLICATION OF THE FRONTIER WAGE INDEX AND/OR RURAL FLOOR AS WELL AS AN INDICATOR FOR CBSAs ELIGIBLE FOR THE FRONTIER AND/OR RURAL FLOOR WAGE INDEX)- FY 2023 FINAL RULE											
CBSA	Area Name	State	State Code	Wage Index	GAF	Reclassified Wage Index	Reclassified GAF	Eligible for Rural Floor Wage Index	[3]Pre-Frontier and/or Pre-Rural Floor and/or Pre-Imputed Floor Wage Index	Reclassified Wage Index Eligible for Rural Floor Wage Index	[3]Reclassified Wage Index Pre-Frontier and/or Pre-Rural Floor
16	IOWA	IA	16	0.7843	0.8467						
11180	Ames, IA	IA	16	0.8633	0.9042	0.8633	0.9042				
16300	Cedar Rapids, IA	IA	16	0.8539	0.8975	0.8414	0.8885				
19340	Davenport-Moline-Rock Island, IA-IL	IA	16	0.7843	0.8467	0.7843	0.8467	Y	0.7752	Y	0.7752
19780	Des Moines-West Des Moines, IA	IA	16	0.8585	0.9008	0.8585	0.9008				
20220	Dubuque, IA	IA	16	0.8261	0.8774						
26980	Iowa City, IA	IA	16	0.9248	0.9479	0.8678	0.9075				
36540	Omaha-Council Bluffs, NE-IA	IA	16	0.9628	0.9744	0.9628	0.9744				
43580	Sioux City, IA-NE-SD	IA	16	0.8269	0.8780						
47940	Waterloo-Cedar Falls, IA	IA	16	0.8086	0.8646						

25th percentile wage index value across all hospitals			0.8427
IOWA	IA	16	0.7843
Differnce			0.0584
50% of difference			0.0292
REVISED Rural Iowa Wage Index			**0.8135**

Wage Index – Low Quartile & Rural Floor Calculation

- 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. Becerra*
  - Will **include** hospitals that reclassed from urban to rural
    - Impacts about 275 hospitals

4. 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

FY2023 Oultier Threshhold	38,859	
FY2022 Outlier Threshhold	30,988	
Threshhold Increase	7,871	
Statewide CCR	Urban	Rural
Iowa	0.251	0.325
Marginal Cost Increase	31,359	24,218

5. Medicare Uncompensated Care Payments

- Nationally, 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
- Total estimated impact for Iowa hospitals = $4,079,000 decrease from FY2022 (based on hospitals projected to receive UCC payments)

Iowa Hospitals Uncompensated Care Payments

					UCC Payments			UCC Costs	
State Code	State	Medicare CCN	Provider Name	CN FY22	FY23 FR	FR Variance	2018 UCC (Annualized)	2019 UCC (Annualized)	UCC Varinace
16	Iowa	160082	Unitypoint Health - Des Moines Iowa Methodist Medi	$ 2,161,717	$ 2,130,224	$ (31,493)	10,132,514	10,912,681	780,167
16	Iowa	160058	University Of Iowa Hospital & Clinics	$ 5,098,024	$ 4,584,665	$ (513,359)	23,895,729	21,330,612	(2,565,117)
16	Iowa	160057	Great River Medical Center	$ 1,308,644	$ -	$ (1,308,644)	6,133,944	7,390,098	1,256,154
16	Iowa	160045	St Lukes Hospital	$ 1,090,600	$ 1,016,462	$ (74,137)	5,111,916	4,921,151	(190,765)
16	Iowa	160146	St Lukes Regional Medical Center	$ 973,782	$ 856,993	$ (116,789)	4,564,364	3,886,482	(677,882)
16	Iowa	160047	Methodist Jennie Edmundson	$ 554,338	$ 615,724	$ 61,385	2,598,324	3,495,229	896,905
16	Iowa	160028	Chi Health Mercy Council Bluffs	$ 1,189,624	$ 1,114,033	$ (75,591)	5,576,069	5,420,934	(155,135)
16	Iowa	160029	Mercy Hospital	$ 537,384	$ 531,178	$ (6,206)	2,518,854	2,729,079	210,225
16	Iowa	160117	Finley Hospital	$ 452,590	$ 414,079	$ (38,511)	2,121,402	1,964,545	(156,857)
16	Iowa	160001	Unitypoint Health - Marshalltown	$ 795,564	$ -	$ (795,564)	3,729,009	1,786,438	(1,942,571)
16	Iowa	160110	Allen Hospital	$ 855,985	$ 770,105	$ (85,880)	4,012,218	3,584,689	(427,529)
16	Iowa	160122	Fort Madison Community Hospital	$ 148,319	$ -	$ (148,319)	695,207	-	(695,207)
16	Iowa	160069	Mercyone Dubuque Medical Center	$ 458,541	$ 422,875	$ (35,666)	2,149,297	2,023,994	(125,303)
16	Iowa	160104	Trinity Bettendorf	$ 463,137	$ 428,279	$ (34,858)	2,170,841	2,055,974	(114,867)
16	Iowa	160112	Spencer Municipal Hospital	$ 280,970	$ 227,480	$ (53,490)	1,316,979	922,828	(394,151)
16	Iowa	160083	Mercyone Des Moines Medical Center	$ 3,170,419	$ 2,946,104	$ (224,315)	14,860,554	14,217,768	(642,786)
16	Iowa	160079	Mercy Medical Center - Cedar Rapids	$ 2,955,901	$ 2,443,276	$ (512,624)	13,855,055	10,211,134	(3,643,921)
16	Iowa	160033	Genesis Medical Center-Davenport	$ 1,507,137	$ 1,496,528	$ (10,609)	7,064,332	7,722,103	657,771
16	Iowa	160153	Mercyone Siouxland Medical Center	$ 1,798,267	$ 1,690,361	$ (107,906)	8,428,932	8,258,224	(170,708)
16	Iowa	160067	Mercyone Waterloo Medical Center	$ 1,953,879	$ 1,506,262	$ (447,616)	9,158,324	5,658,494	(3,499,830)
16	Iowa	160101	Broadlawns Medical Center	$ 2,178,794	$ 2,080,953	$ (97,841)	10,212,560	10,335,773	123,213
16	Iowa	160064	Mercyone North Iowa Medical Center	$ 785,739	$ 832,875	$ 47,137	3,682,956	4,554,252	871,296
16		160008	Keokuk Area Hospital		$ -	$ -			
16		160030	Mary Greeley Medical Center		$ 530,913	$ 530,913			
				$ 30,719,352	$ 26,639,371	($4,079,982)	143,989,380	133,382,481	(10,606,899)
			Ratio of Cost to Payment	21.33%	19.97%	38.47%			

DHS vs. UCC Cost Pool Payments: Trend

Year	DSH Pool	UCC Pool at 75%	% W/O Insurance	UCC Factor 2	UCC Amount	$ Variance to PY	% Change
2014	$ 12,772,000,000	$ 9,579,000,000	17.00%	94.30%	$ 9,032,997,000	$ -	0.00%
2015	$ 13,383,462,196	$ 10,037,596,647	13.75%	76.19%	$ 7,647,644,885	$ (1,385,352,115)	-15.34%
2016	$ 13,411,096,528	$ 10,058,322,396	11.50%	63.69%	$ 6,406,145,534	$ (1,241,499,351)	-16.23%
2017	$ 14,396,635,710	$ 10,797,476,783	10.00%	55.36%	$ 5,977,483,147	$ (428,662,387)	-6.69%
2018	$ 15,552,939,524	$ 11,664,704,643	8.15%	58.01%	$ 6,766,695,165	$ 789,212,018	13.20%
2019	$ 16,339,055,838	$ 12,254,291,879	9.48%	67.51%	$ 8,272,872,447	$ 1,506,177,283	22.26%
2020	$ 16,583,455,657	$ 12,437,591,743	9.40%	67.14%	$ 8,350,599,096	$ 77,726,649	0.94%
2021	$ 15,170,673,476	$ 11,378,005,107	10.20%	72.86%	$ 8,290,014,521	$ (60,584,575)	-0.73%
2022	$ 13,984,752,729	$ 10,488,564,547	9.60%	68.57%	$ 7,192,008,710	$ (1,098,005,811)	-13.24%
2023	$ 13,948,974,705	$ 10,461,731,029	9.30%	65.71%	$ 6,874,403,459	$ (317,605,251)	-4.42%
	$ 145,543,046,364	$ 109,157,284,773	10.84%	68.93%	$ 74,810,863,964	$ (2,158,593,541)	
		75.00% Average			68.53% Cumulative Decline		
Shortfall of Pool Distribution compred to 75%					$ (34,346,420,809)		

ROI on UCC

Data Year	Pool Year	Reported UCC	UCC Pool	ROI
2014	2018	$31,598,052,056	$ 6,766,695,165	21.41%
2015	2019	$30,210,112,106	$ 8,272,872,447	27.38%
2016	2020	$29,616,638,717	$ 8,350,599,096	28.20%
2017	2021	$31,966,377,083	$ 8,290,014,521	25.93%
2018	2022	$33,387,796,552	$ 7,192,008,710	21.54%
2019	2023	$34,460,436,451	$ 6,874,403,459	19.95%
		$ 191,239,412,965	$ 45,746,593,398	24.07%
				Average

6. Direct Graduate Medical Education Cap & Count

- Calculation of full-time equivalent caps based on recent litigation in *Milton S. Hershey Medical Center 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 (0.5)

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

7. 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

8. 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.

9. 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

Value-Based Payments: Iowa Impact (DataGen)

	FFY 2022	FFY 2023	Impact
Base Operating Dollars Subject to VBP and RRP	$787,275,800	$812,885,900	
Value Based Purchasing Program Impact	$0	$0	$0
Readmissions Reduction Program Impact	($1,828,000)	($1,881,400)	($53,400)
HAC Program Impact (on IPPS Total Revenue)	($2,926,700)	$0	$2,926,700
Net Impact of Quality Programs	($4,754,700)	($1,881,400)	$2,873,300

FY 23 VBP and HAC factors are suppressed due to COVID-19 PHE

10. 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)

11. 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…."

12. Inpatient Rehabilitation Facility PPS

- Payments to increase 3.2 percent
- Outlier threshold = $12,536 (currently $9,491)
- Permanent cap on wage index decreases
- No change in labor-related share – stays at 72.9 percent
- Total estimated change for Iowa rehab facilities = 1.9% increase over FY2022
- 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

Iowa Inpatient Rehabilitation Facility PPS (DataGen)

Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) FFY 2023 Final Rule Analysis

Estimated Change in Medicare Payments

Federal Fiscal Year (FFY) 2022 Final Rule Compared to FFY 2023 Final Rule

Iowa

Impact Analysis	Dollar Impact	Percent Change
Estimated 2022 IRF PPS Payments	*$74,329,600*	
Marketbasket Update	$3,121,700	4.2%
ACA-Mandated Marketbasket Reduction	($222,800)	-0.3%
Wage Index and Case-Mix Budget Neutrality (including all other BN)	($148,200)	-0.2%
Wage Index and Labor-Related Share	($1,317,500)	-1.8%
> Wage Index 5% Reduction Cap	$80,900	0.1%
Change in Rural Adjustment	$0	0.0%
Case-Mix Group (CMG) Updates	($44,400)	-0.1%
Estimated 2023 IRF PPS Payments	*$75,718,400*	
Total Estimated Change from FFY 2022 to FFY 2023	***$1,388,800***	***1.9%***

The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2031. It is estimated that sequestration will reduce FFY 2023 IRF-specific payments by: $1,514,400.

13. Inpatient Psychiatric Facility PPS

- Payments to increase by 2.5 percent
- Increase in labor-related share from 77.2 percent to 77.4 percent
- Outlier threshold = $24,630 (currently $16,040)
- Permanent cap on wage index decreases
- Total estimated change for Iowa inpatient psychiatric facilities = 2.2% increase over FY2022

Iowa Inpatient Psychiatric Facility PPS

Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) FFY 2023 Final Rule Analysis

Estimated Change in Medicare Payments

Federal Fiscal Year (FFY) 2022 Final Rule Correction Notice Compared to FFY 2023 Final Rule

Iowa

Impact Analysis	Dollar Impact	Percent Change
Estimated FFY 2022 IPF PPS Payments	*$19,610,900*	
Marketbasket Update	$803,900	4.1%
ACA-Mandated Marketbasket Reductions	($58,700)	-0.3%
Wage Index Budget Neutrality (includes all other budget neutrality)	$26,400	0.1%
5% Wage Index Cap Budget Neutrality	($2,100)	0.0%
Wage Index and Labor Share	($336,700)	-1.7%
> Wage Index 5% Reduction Cap	$0	0.0%
Estimated FFY 2023 IPF PPS Payments	*$20,043,700*	
Total Estimated Change from FFY 2022 to FFY 2023	***$432,800***	***2.2%***

The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2031. It is estimated that sequestration will reduce FFY 2023 IPF-specific payments by: $400,800.

Source: DataGen

CY 2023 OPPS Proposed Rule

1. OPPS and ASC payment rate updates
2. Payment for 340B drugs
3. Changes to the Inpatient Only List
4. Additional services requiring prior authorization
5. Clinic visits provided in rural sole community hospitals
6. Rural Emergency Hospital Program

1. OPPS and ASC Payment Rate Updates

- Proposed 2.7% rate increase
  - Update based on market basket increase of 3.1% and -0.4% productivity reduction
  - Uses claims data from CY2021; June 2020 HCRIS cost report data
  - IPPS proposed 2.6% increase; final rule = 4.3%
  - Hospitals failing to meet quality reporting requirements subject to additional 2% reduction to OPPS conversion factor
- Proposed OPPS conversion factor = $86.79 (currently $84.18)
- Proposed ASC conversion factor = $51.32 (currently $49.91)

2. Payment for 340B Drugs

- Impact of Supreme Court ruling in *American Hospital Association v. Becerra*
  - Cannot vary payment rates for drugs/biologicals among groups of hospitals without first surveying acquisition costs
  - Decision focused on CYs 2018 and 2019
- Proposed rule at OMB when Court's ruling issued
  - CMS noted that final rule would reflect decision of the Court
    - ASP + 6 percent
    - When will CMS use findings from 2020 survey of acquisition costs??
    - Impact on base rate due to budget neutrality??
      - Paying 340B drugs at same level as other separately payable drugs "will have an effect on the payment rates for other items and services due to the budget-neutral nature" of the system

3. Changes to the Inpatient Only List

- IOL represents medically complex/invasive services and not appropriate as an outpatient service
- Removal of 10 maxillofacial procedures
- Addition of 8 services to IOL, including –
  - Total disc arthroplasty
  - Implantation of absorbable mesh or other prothesis for delayed closure due to soft tissue infection or trauma
  - Certain repairs of anterior abdominal hernias (4) and parastomal hernias (2)
- Adds lymph node biopsy to ASC covered procedure list

4. Prior Authorization

- Proposes to add facet joint interventions
  - Would be effective on or after March 1, 2023
- Current services requiring prior authorization –
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation
  - Cervical fusion with disc removal
  - Implanted spinal neurostimulators

5. Clinic Visits in Rural SCHs

- Current policy uses MPFS to determine rates for clinic visits at off-campus provider-based departments
  - PFS-equivalent determined as 40% of OPPS rate
- Proposes to exempt rural sole community hospitals from the site-neutral clinic visit reduction
  - Services would be paid at full OPPS rate
- Solicited comments on applicability to other rural hospitals, e.g., under 100 beds

6. Rural Emergency Hospital Program

- New category of Medicare payment authorized by Consolidated Appropriations Act, 2021
- Facility furnishes emergency services and observation care + other outpatient services; no inpatient services (other than distinct part unit SNF)
- Eligibility limited to facilities operating as CAHs or rural PPS hospitals with 50 beds or fewer as of 12/27/20

Implementing Regulations

- REH Conditions of Participation Proposed Rule
- OPPS Proposed Rule
  - Quality reporting program
  - Payment policies
  - Enrollment
  - Stark Law exceptions

REH Payment Policies

- REH services reimbursed at 105% OPPS rate
  - Co-payment based on standard rate
  - Includes services furnished in REHs' off-campus provider-based departments
  - Utilize OPPS claims processing system with REH-specific payment flag; but REH claims not used for OPPS rate setting purposes
  - CMS interprets section 1834(x)(1) to define "REH services" as those services reimbursed under OPPS
    - "We are soliciting comments on whether CMS should adopt a narrower definition of REH services…"
- Payment for non-REH services
  - Clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography paid at applicable fee schedule rate (no 5% increase)

REH Facility Payment - Calculation

- CY 2019 total estimated CAH spending = $12,083,666,636
  - Include copayments
  - Use claims data (CMS = $450M more than cost report data; 42 more CAHs included in claims data than cost report data)
- CY 2019 total estimated PPS payments for CAHs: $7,679,358,171
  - Model PPS payments by processing CAH claims through IPPS, IRF-PPS, IPF-PPS, OPPS, and SNF-PPS* (rejected MedPAC's recommendation to adjust for "missing" primary diagnoses)
  - Calculate/estimate supplemental payments for new technology, outlier claims, clotting factor, IME, DSH, UCC, and low-volume hospitals (but not value-based purchasing adjustments)
- Difference of $4,404,308,465 divided by 1,368 (number of CAHs enrolled in Medicare in CY 2019) = **$3,219,528** (or $268,294 per month)
- For subsequent years, increase by hospital market basked percentage increase

REH Facility Payment - Potential Issues

- Under-count 2019 CAH payments
  - Did not include payments for professional services under Method II
  - Did not include cost-based ambulance payments
- Issues relating to payment adjustments for quality reporting/promoting interoperability, low-volume hospitals, DHS/UCP, IME
- Inconsistent numbers for estimated PPS payments
  - Page 44786: "Total Projected Amount of Medicare Spending for CAHs if Paid Prospectively in CY 2019: $7.68 billion"
  - Page 44780: "Total estimated prospective payment for CAHs in CY 2019 with copayments: $7,033,248,418"
  - $472,298 difference in annual facility payment
- Include 6 CAHs that closed in 2019 in total count of CAHs (no adjustment)

REH Benefit Calculation PPS Hospital ≤ 50 Beds

- Inpatient
  - Compare REH Facility Payment to inpatient PPS reimbursement foregone
    - Basic IPPS amounts and outliers
    - Payment adjustments (IME, DSH, UCC)
    - Special payment designations (MDH, LVA, etc.)
- Outpatient
  - 5% increase only applied to OPPS services

REH Benefit Calculation Critical Access Hospital

- Inpatient
  - Compare REH Facility Payment to inpatient cost reimbursement foregone
  - Apply facility payment to cover overhead costs
  - Evaluate potential overhead that could be eliminated without inpatient services
  - Level of routine nursing services required to maintain observation and swing bed services
- Outpatient
  - Compare current cost reimbursement to 105% of OPPS services
  - Impact on patient coinsurance (20% of billed charges vs. individual APC specific coinsurance)
  - Ancillary services contribution analysis (what services remain viable without any inpatient volume?)
  - Infrastructure required to properly bill and analyze payments under APC methodology
- Swing Beds
  - Compare cost reimbursement to SNF PPS Patient Driven Payment Model (PDPM)
  - Costs associated with establishing definitive SNF unit vs. “variable” swing-beds

REH Enrollment Process

- What we know
  - Submit change of information application (as opposed to initial enrollment application)
  - MAC screening for entities with lowest level of risk
  - Billing privileges effective on date of survey completion
  - Not required to provide Medicare Outpatient Observation Notice
- Transition process
  - Continue to receive payment as CAH/PPS hospital up until REH billing privileges effective?

REH Stark Law Exceptions

- REHs do not provide hospital services but do provide other designated health services
- Expand hospital-specific compensation arrangements to include REHs
- Propose new REH ownership exception (vs. reliance on rural provider exception)
  - Ownership interest in entire REH (vs. specific department)
  - Ownership not directly or indirectly conditioned on referrals or other business generated
  - Physicians not offered more favorable terms
  - Restrictions on financing and guarantees
  - Distributions proportional to ownership interest
  - No guaranteed additional investment opportunities or other opportunities on more favorable terms

How can we HELP?

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