Policy Update

CMS Releases FY 2024 IPPS Proposed Update

Summary

On April 10, 2023, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) proposed update, along with proposed policy and regulation changes. The proposed rule would update Medicare payment policies and quality reporting programs relevant for inpatient hospitals, and would build on key agency priorities, including advancing health equity and improving the safety and quality of care.

The proposed rule is available here. A CMS factsheet on the proposed rule is available here. The proposed rule is scheduled to be published in the *Federal Register* on May 1, 2023, and comments are due on June 9, 2023.

CMS simultaneously posted proposed updates to the Long-Term Care Hospital (LTCH) Prospective Payment System; that proposed rule is not summarized here.

Key Takeaways

- CMS proposes an increase of 2.8% in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) program and are meaningful electronic health record (EHR) users. This reflects a projected FY 2024 hospital market basket percentage increase of 3.0%, reduced by a 0.2 percentage point productivity adjustment.
- CMS proposes to distribute roughly $6.87 billion in uncompensated care payments for FY 2024, a decrease of approximately $161 million from FY 2023, using the three most recent years of audited Worksheet S-10 data.
- CMS proposes to treat hospitals that undergo urban-to-rural reclassification as rural for all wage index calculation purposes. These changes would cause disturbances in the wage index that would affect all hospitals. CMS also proposes to continue the low wage index hospital policy that supplements wage index values for hospitals with a wage index value below the 25th percentile, notwithstanding several federal district court cases that have ruled this policy unlawful.
- With respect to quality reporting program changes, CMS proposes to make health equity adjustments in the Hospital Value-Based Purchasing Program and requests comments on how to further address geriatric care, including the future establishment of a geriatric hospital designation.
- For FY 2024, CMS proposes to return to its pre-pandemic practice of using the most recent available data to calculate Medicare Severity Diagnosis-Related Group (MS-DRG) relative weights. CMS proposes to continue delay of the non-complication or comorbidity (NonCC) subgroup criteria for FY 2024 and seeks feedback from stakeholders to inform application of the criteria for FY 2025 rulemaking.
- CMS proposes to treat rural emergency hospitals (REHs) similarly to critical access hospitals (CAHs) for purposes of determining graduate medical education (GME) payments.
- Advancing health equity is a major theme throughout the proposed rule. CMS proposes to increase the severity of the designation of homelessness from NonCC to complication or comorbidity as an indicator of increased resource utilization, which may result in higher payment for certain hospital stays. CMS also proposes to provide incentives to hospitals in the Hospital Value-Based Purchasing Program to perform well on existing measures, and to those that care for high proportions of individuals dually insured by Medicare and Medicaid.
- CMS proposes to revise the criteria that applicants must meet in order to apply for new technology add-

on payments (NTAP).
- CMS solicits feedback on several requests for information (RFIs), including RFIs focusing on safety net hospitals, health equity and the long-term care hospital quality reporting program.

Standardized Amount

Key Takeaway: CMS proposes an increase of 2.8% for hospitals that successfully participate in CMS reporting programs.

The standardized amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies various other statutorily mandated or inspired adjustments. The 2.8% increase to the standardized amount reflects a 3.0% market basket update, less a 0.2% productivity adjustment.

The standardized amount is subject to multiple other budget neutrality adjustments and varies based on an individual hospital's participation in the IQR and EHR programs. Hospitals that fail to submit quality data are subject to a -0.75 percentage point adjustment, and hospitals that fail to be meaningful EHR users are subject to a -2.25 percentage point adjustment. The proposed FY 2024 standardized amount for hospitals that successfully participate in both programs is $6,524.94.

The proposed FY 2024 standardized amounts, shown in the table below, are the sum of the labor-related and non-labor-related shares without adjustment for geographic factors. The labor-related share reflects the proportion of the federal base payment that is adjusted by a hospital's wage index.

	Hospital Submitted Quality Data and Is a Meaningful EHR User	Hospital Submitted Quality Data and Is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User
FY 2024 Proposed Standardized Amount	$6,524.94	$6,382.13	$6,477.34	$6,334.53
Percent Change	2.8%	0.55%	2.05%	-0.2%

Medicare Severity Diagnosis-Related Group Updates

New Deadline and Intake System for MS-DRG Change Requests

Key Takeaway: As previously finalized, beginning with FY 2024, all change requests must be submitted via a new electronic application intake system by October 20 of each year.

CMS is required by statute to adjust the DRG classifications and relative weights at least annually to reflect changes in treatment patterns, technology and any other factors that may change the relative use of hospital resources. Providers and other stakeholders can submit MS-DRG change requests for CMS to consider in the annual rate setting process.

As discussed in the FY 2023 IPPS/LTCH proposed and final rules, CMS has updated the deadline and process for requesting MS-DRG changes. Beginning with FY 2024, CMS's deadline to request changes to MS-DRGs is October 20 of each year. CMS also changed the process for submitting requested changes. Beginning with FY 2024, MS-DRG classification change requests must be submitted via a new electronic application intake system, the Medicare Electronic Application Request Information System™ (MEARIS™). Requests sent via email will no longer be considered.

Data and Methodology Change for Rate Setting

Key Takeaway: For FY 2024, CMS proposes to return to its historical practice of using the most recent available data to calculate MS-DRG relative weights.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS relies on claims data captured in the MedPAR file and cost report data captured in the Healthcare Cost Report Information System file. CMS uses the most recent data available at the time of rulemaking, which normally captures claims from discharges that occurred for the two FYs prior to the FY addressed in the rulemaking. In recent years, CMS has modified the data and methodology for determining MS-DRG relative weights to account for changes in utilization for certain types of services during the COVID-19 public health emergency (PHE). For example, for FY 2022 CMS used FY 2019 MedPAR data rather than FY 2020 MedPAR data; for FY 2023, CMS returned to its historical practice of using the most recent available data, including FY 2021 MedPAR claims, but calculated relative weights based on an average of two sets of relative weights, one including and one excluding COVID-19 claims.

For the FY 2024 rate setting, CMS proposes to return to its historical practice of using the most recent available data, including the FY 2022 MedPAR claims and the FY 2021 cost reports, to calculate MS-DRG relative weights. CMS does not propose any further major methodological changes for the purposes of setting MS-DRG relative weights for FY 2024.

Refinement of MS-DRG Classification

Key Takeaway: CMS proposes to continue delay of the NonCC subgroup criteria for FY 2024 and seeks feedback from stakeholders to inform application of the criteria for FY 2025 rulemaking.

Current MS-DRGs provide up to three levels of severity for a particular condition based on the presence of a complication or comorbidity or a major complication or comorbidity. In FY 2021, CMS finalized a proposal to apply expanded three-way severity split criteria. CMS believes that applying these criteria would better reflect resource stratification and avoid low volume counts for the NonCC level MS-DRGs. In FY 2022 and 2023, CMS finalized a delay in implementing this proposal due to the COVID-19 PHE.

In response to prior public comments, for FY 2024 CMS will make available additional analyses reflecting application of the criteria in connection with the proposed FY 2024 MS-DRG changes for public review and comment. This feedback will inform application of the NonCC subgroup criteria for FY 2025 rulemaking. CMS proposes to continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2024. CMS is also interested in hearing from stakeholders about the experiences of large urban hospitals, rural hospitals and other hospital types, and will take these comments into consideration for development of the FY 2025 proposed rule.

New Technology Add-On Payments

NTAP Policy Proposals for FY 2024

Key Takeaway: CMS proposes to revise the criteria that applicants must meet in order to apply for NTAP.

Historically, CMS has stated that in order to qualify for NTAP, an applicant must have approval or clearance from the US Food and Drug Administration (FDA) by July 1 of the year prior to the beginning of the FY for which the application is being considered (*i.e.*, FDA approval or clearance by July 1, 2023, for FY 2024 NTAP applications). In recent FYs, CMS has seen a substantial increase in the number of NTAP applications: 17 in FY 2020, 24 in FY 2021, 38 in FY 2022, 37 in FY 2023 and 54 in FY 2024. CMS notes a significant number of these applicants have submitted NTAP applications that "lack critical information that is needed to evaluate whether the technology meets the eligibility criteria." This absence of critical information is attributed in part to applicants not yet having submitted evaluation requests to FDA.

To address this concern, CMS proposes two changes for eligibility to apply for NTAP:

- Applicants whose technology has not yet received FDA approval or clearance must have completed submission to the FDA, and that application must be in active status. Applicants must submit documentation to demonstrate the completed submission as part of their application.
- Devices or drugs under consideration for NTAP must receive FDA approval or clearance by May 1 prior to the start of the FY for which the applicant is applying. This proposal would change the deadline from July 1 to May 1, shortening the timeframe by two months for applicants.

The second policy proposal would not apply to drugs that apply through the alternative pathway for qualified infectious disease products (QIDP). Such drugs would still be eligible for conditional approval provided that they receive FDA approval or clearance by July 1 in the FY for which they are applying for NTAP.

If finalized, these policies would become effective for FY 2025.

No Extension for Technologies with Expiring NTAP Period

Key Takeaway: CMS does not propose an extension for technologies whose NTAP period is scheduled to expire at the end of FY 2023, and proposes to end new COVID-19 technology add-on payments (NCTAP) at the end of FY 2023.

NTAP designation normally includes the first two to three years that a product is on the market, after which CMS reasons that the costs of the new technology are captured in the MS-DRG weights. CMS evaluates the eligibility of new technologies for this additional payment annually based on their newness date (typically defined as the date of market entry). Under current policy, CMS only extends add-on payments for an additional year if the three-year anniversary of the newness date occurs in the latter half of the upcoming FY.

As previously noted, CMS proposes to use FY 2022 MedPAR data for the FY 2024 rate setting process for IPPS. Because the FY 2022 MedPAR data is likely to fully reflect the costs of new technologies with expiring NTAP periods, CMS does not propose a one-time NTAP extension for these technologies (as the agency did earlier in the COVID-19 PHE). If finalized as proposed, this policy would apply to 15 technologies (see Table II.P.-02). Eleven existing devices and drugs would remain eligible for NTAP in FY 2024 (see Table II.P.-01).

In the FY 2023 rulemaking cycle, CMS finalized a policy to end NCTAP at the end of the FY following the conclusion of the COVID-19 PHE. CMS proposes to end NCTAP as of September 30, 2023, if the Secretary of Health and Human Services ends the PHE in May 2023 as expected.

NTAP Applications for FY 2024

Key Takeaway: CMS reviewed an increased number of NTAP applications in this rule and published applications online.

In the proposed rule, CMS discusses 39 NTAP applications. Excluding the applications withdrawn prior to publication of the proposed rule, 19 devices and drugs applied through the traditional pathway and 20 went through the alternative pathways (17 devices with breakthrough or pending breakthrough status, and three products designated as QIDP). The number of FY 2024 NTAP applications reviewed represents a 50% increase over applications reviewed for FY 2023, even with the 15 withdrawn applications.

Consistent with its efforts to increase transparency, in the FY 2023 rulemaking cycle CMS finalized a policy to publicly post NTAP applications online starting with FY 2024 cycle. CMS posted applications and supporting documentation for this cycle online at https://mearis.cms.gov/public/publications/ntap. These postings exclude certain cost information, selected volume information, and any information that the applicant noted as confidential or proprietary. The agency did not post any applications withdrawn prior to the publication of the FY 2024 proposed rule. Even with this additional information accessible to stakeholders, CMS still discusses any outstanding concerns or issues with the application, albeit in a more succinct manner, in the proposed rule.

Cost Criterion for NTAP

Key Takeaway: CMS proposes to use FY 2022 MedPAR data to establish proposed FY 2025 threshold values.

One criterion that CMS uses to assess whether a new technology qualifies for NTAP is whether the charges for the technology meet or exceed certain threshold amounts. Historically, CMS has evaluated this cost criterion using threshold amounts established in the prior year's final rule. In this proposed rule, as finalized in the FY 2021 IPPS final rule, CMS proposes to use the proposed threshold amounts for the upcoming FY for any proposed new MS-DRGs to evaluate whether the technology meets the cost criterion.

CMS proposes no changes to the other criteria it considers when evaluating a new technology's eligibility for the add-on payments (*i.e.*, newness and substantial clinical improvement).

Quality Data Reporting Requirements

Hospital Quality Reporting Program Changes

Key Takeaway: CMS proposes to make health equity adjustments and seeks feedback on future efforts to address geriatric care.

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital IQR Program, Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition (HAC) Reduction Program, Medicare and Medicaid Promoting Interoperability Programs, and Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. These programs feature a mix of performance-based financial rewards and penalties as well as the public release of quality data.

In this proposed rule, CMS proposes to make health equity adjustments in the HVBP by providing incentives to hospitals to perform well on existing measures and to hospitals that care for high proportions of underserved individuals, as defined by dual Medicare-Medicaid eligibility status. CMS also requests comments on how to further address geriatric care in CMS's quality reporting programs, including the potential adoption of new geriatric structural measures, and on the potential future establishment of a geriatric hospital designation. The following chart outlines specific proposed changes to each of the quality programs in more detail.

Hospital IQR Program

Hospitals are required to report data on measures to receive the full annual percentage increase for IPPS services that would otherwise apply.

Proposals

- Adopt three new quality measures (pressure injury, acute kidney injury and excessive radiation dose/inadequate image quality for diagnostic computed tomography), remove three existing quality measures (risk-standardized complication rate total hip/knee arthroplasty measure, Medicare spending per beneficiary measure, elective delivery measure) and modify three current quality measures (hybrid hospital wide all cause readmission/risk standardized mortality measures, COVID-19 Vaccination among Healthcare Personnel (HCP) (see below)).
- Modify the COVID-19 Vaccination Coverage among HCP measure beginning with Q4 calendar year (CY) 2023 reporting period/FY 2025 payment determination.
    - The measure **currently** is defined as the percentage of HCP who receive a complete COVID-19 vaccination course.
    - Numerator:
        - Cumulative number of HCP eligible to work in the hospital or facility for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2.
    - Denominator:
        - Number of HCP eligible to work in the healthcare facility for at least one day during the reporting period, excluding persons with contraindications to SARS-CoV-2 vaccination.
    - This rule **proposes** to replace the term "complete vaccination course" with the term "up to date" for recommended COVID-19 vaccines.
        - "Up to date" would be defined by the CDC guidance as of the first day of the applicable reporting quarter, which can be found here.
        - The rule proposes that the numerator would specify the timeframes within which an HCP is considered "up to date" with recommended COVID-19 vaccines.
        - These proposals also apply to the **LTCH Quality Reporting Program** (QRP) and the **PCHQR Program.** Note, the rule does not address the separate condition of participation related to COVID-19 vaccines.

Requesting Comment

- The agency requests comment on the potential future inclusion of geriatric measures and a potential public-facing geriatric hospital designation. This designation could be similar to the Birthing-Friendly designation that was finalized in the FY 2023 IPPS/LTCH PPS final rule, but using geriatric structural measures.

Hospital Readmissions Reduction Program

HRRP reduces payments to hospitals with excess readmissions of selected applicable conditions.

Proposals

- There are no proposed changes to this program.
- All previously finalized policies under this program will continue to apply.

Hospital Value-Based Purchasing Program

The HVBP Program withholds participating hospitals' Medicare payments by 2% and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.

Proposals

- Adopt substantive measure modifications to two existing measures:
  - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CBE #1550) beginning with the FY 2030 program year.
  - Medicare spending per beneficiary (MSPB) (CBE #2158) beginning with the FY 2028 program year. Changes would include allowing readmissions to trigger new episodes. With these changes, CMS proposes to remove this measure from the Hospital IQR program for FY 2028 payment determination.
- Add technical changes to the administration of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
  - Change the scoring policy to include a health equity scoring adjustment and modify the Total Performance Score (TPS) maximum to be 110, resulting in numeric score range of 0 to 110.
- Adopt the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the FY 2026 program year.
- Adopt a health equity scoring change for rewarding excellent care in underserved populations.
- Codify the eight measure removal factors as well as the policies for updating measure specifications and retaining measures.

Requesting Comment

- CMS requests feedback on additional health equity changes to the Hospital Value-Based Purchasing (VBP) Program scoring methodology for future consideration.

Hospital Acquired Condition Reduction Program

Hospitals report on a set of measures on hospital-acquired conditions. Hospitals with scores in the worst performing quartile are subject to a 1% payment reduction.

Proposals

- Establish a validation reconsideration process for hospitals that failed to meet data validation requirements. This process would begin with the FY 2025 program year and affect CY 2022 discharges.
  - CMS intends for the HAC Reduction Program's proposed reconsideration processes to be similar to the reconsideration processes of the Hospital IQR Program.
- Modify the targeting criteria for data validation to include hospitals that received an extraordinary circumstances exception during the data periods validated beginning with the FY 2023 program year, affecting the CY 2024 discharges.

Requesting Comment

- CMS requests comment on potential future measures that would advance patient safety and reduce health disparities.
- CMS requests feedback on the potential adoption of several patient safety related electronic clinical quality measures (eCQMs) that are currently used in the Hospital IQR Program.

PPS-Exempt Cancer Hospital Quality Reporting Program

The Affordable Care Act (ACA) established this quality reporting program for PPS-exempt cancer hospitals.

Proposals

- Add four new measures, of which three are health equity focused (facility commitment to health equity, screening for drivers of health, screen positive rate for social drivers of health) and one is the patient preference focused measure (documentation of goals of care discussions among cancer patients).
- Adopt a modified version of the COVID-19 Vaccination Coverage among HCP measure beginning with the FY 2025 program year (as described above).
- Publicly report the Surgical Treatment Complications for Localized Prostate Cancer measure beginning with data from FY 2025 program year.
- Modify data submission and reporting requirements for the HCAHPS Survey measure beginning with the FY 2027 program year.
    - The proposal includes additions to modes of survey administration (and one removal), extension of the data collection period, removal of the prohibition of proxy respondents, requirement to use official translations of the HCAHPS Survey, and a limit on the number of supplemental HCAHPS Survey items.

Medicare Promoting Interoperability Program

The Medicare and Medicaid EHR Incentive Programs are now known as the Promoting Interoperability Program.

Proposals

- Adopt three new eCQMs beginning with the CY 2025 reporting period (pressure injury, acute kidney injury, and excessive radiation dose/inadequate image quality for diagnostic computed tomography).
- Maintain for an additional year the definition of "EHR reporting period" as a minimum of any continuous 180-day period.

Long-Term Care Hospital Quality Reporting Program Changes

Key Takeaway: CMS proposes to increase the current 80% data threshold to 90%.

The LTCH QRP is a pay-for-reporting program. LTCHs that do not meet reporting requirements are subject to a 2 percentage point reduction in their annual payment update. Beginning with the FY 2026 quality reporting period, CMS proposes to increase the data completion threshold so that LTCHs must report 100% of the required quality measure data and standardized patient assessment data collected on at least 90% of the assessments they submit through the CMS designated submission system, an increase from the current 80% requirement. CMS also proposes to adopt the COVID-19 Vaccine Percent of Patients/Residents Who Are Up to Date (Patient/Resident level COVID-19 Vaccine) measure and to update the COVID-19 Vaccination Coverage among HCP measure, in alignment with the Hospital IQR and PCHQR Programs.

Wage Index

Key Takeaway: CMS proposes to relent to years of challenges to its implementation of urban-to-rural reclassification rules. The resulting changes would cause disturbances in the wage index that would affect all hospitals.

Medicare payments to hospitals (and various other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (*e.g.*, the perceived cost of labor is higher in New

York City than in rural Oklahoma). CMS updates the wage index annually based on hospital cost report data and other inputs and policies.

Urban-to-Rural Reclassifications

In 1999, Congress created an opportunity for hospitals physically located in urban areas to be treated for Medicare payment purposes as if they are located in rural areas. Many urban hospitals have taken advantage of this opportunity to qualify for certain payment programs and enhancements available only to rural hospitals, or to improve their applicable wage index. From the very beginning, CMS took steps to limit and occasionally discourage uses of this reclassification opportunity, and over the years several hospitals have successfully sued CMS for allegedly arbitrarily restricting access. In light of these many years of litigation, CMS now proposes to treat hospitals undergoing urban-to-rural reclassification (under 42 C.F.R. § 412.103) "the same as geographically rural hospitals for the wage index calculation." If finalized, this change would substantially alter how CMS calculates the wage index in ways that would affect all hospitals, not just those that seek urban-to-rural reclassification. Because the wage index is applied in a budget-neutral manner, this could result in payment increases or decreases, depending on how an individual hospital is situated.

Elsewhere in the proposed rule, CMS concedes to another adverse litigation outcome (*Toledo Hospital v. Becerra*) and proposes that, effective for discharges occurring on or after October 1, 2023, hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital disproportionate share hospital (DSH) payments.

Low Wage Index Hospital Policy

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile and stated that it intended this policy to be effective for at least four years. Affected hospitals had their wage index value increased by half the difference between the otherwise applicable wage index value for a given hospital and the 25th percentile wage index value across all hospitals. CMS achieved budget neutrality for this change by adjusting (*i.e.*, reducing) the standardized amount applied across all IPPS hospitals.

This FY 2020 low wage index hospital policy and the related budget neutrality adjustment have been challenged in federal court in two instances, and in both cases (*Bridgeport Hospital, et al. v. Becerra* and *Kaweah Delta Health Care District, et al. v. Becerra*) the district courts found that CMS lacked the authority to adopt the low wage index hospital policy. The US Department of Health and Human Services (HHS) has appealed the *Bridgeport* case and is expected to appeal the *Kaweah Delta* case as well. For FY 2023, CMS decided to continue the low wage index policy pending resolution of these ongoing judicial proceedings.

For FY 2024, CMS again proposes to continue the low wage index hospital policy and the related budget neutrality adjustment. CMS likely will have to revisit this policy soon, perhaps as early as the final rule, if HHS is unable to reverse the lower court decisions on appeal.

Disproportionate Share Hospital Payment/Uncompensated Care Payment

Uncompensated Care Payment

Key Takeaway: CMS proposes to distribute roughly $6.87 billion in uncompensated care payments (UCP) for FY 2024, a decrease of approximately $161 million from FY 2023, using the three most recent years of audited Worksheet S-10 data.

Starting from FY 2014, CMS has distributed a prospective amount of UCP to Medicare DSH hospitals based on their relative share of uncompensated care nationally. As required by statute, the UCP pool amount is equal to 75% of total amount of estimated Medicare DSH payments, adjusted for the change in the rate of uninsured individuals. For FY 2024, CMS proposes to distribute approximately $6.87 billion in UCP. This would be a decrease of approximately $161 million from CMS's estimate of the UCP to be distributed in FY 2023.

For FY 2024, CMS proposes to update estimates of the three factors used to determine UCP. CMS proposes

to continue to use uninsured estimates produced by the Office of the Actuary as part of the development of the National Health Expenditure Accounts in conjunction with more recently available data in the calculation of Factor 2. CMS would use the three most recent years of audited data on uncompensated care costs from Worksheet S-10 of the FY 2018, FY 2019 and FY 2020 cost reports to calculate Factor 3 in the UCP methodology for all eligible hospitals. Also for FY 2024, CMS proposes to follow the same overall methodological approach that the agency used to calculate Factor 3 for FY 2023.

As finalized in the FY 2023 final rule, CMS continues to discontinue the use of low-income insured days as a proxy for uncompensated care in determining UCP for Indian Health Service and Tribal hospitals, and hospitals located in Puerto Rico. To mitigate the significant financial disruption for these hospitals, CMS uses a separate supplemental payment for Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico.

Graduate Medical Education

Key Takeaway: CMS proposes to treat REHs similarly to CAHs for purposes of determining GME payments.

CMS proposes a clarification of the process for calculating the indirect medical education resident-to-bed ratio in circumstances where there is a change in a hospital's full-time equivalent (FTE) residents due to participation in a GME affiliation agreement under which the hospital shares FTE cap slots with another hospital. CMS proposes to clarify the specific Medicare cost report data used in the calculation. CMS believes that there will be no financial impact associated with this clarification.

CMS proposes to treat REHs in a manner similar to CAHs for purposes of determining GME payments. REHs would have the option either to be treated as "non-provider" sites, such that another hospital could report the FTEs of residents training at the REH for Medicare payment purposes, or to incur the costs of the resident training and be reimbursed by Medicare at 100% of the allowable costs. This change would likely be favorable to rural communities and REHs, as it would provide for continued training of residents in rural areas for converting CAHs and would offer the opportunity for additional rural training of residents that might not otherwise be viable without the proposed new rules.

Special Rural Designations

Key Takeaway: CMS proposes to restore the Medicare-Dependent Hospital (MDH) and Low Volume Adjustment Programs pursuant to legislation enacted in late 2022, and to make a small but beneficial change concerning the effective date of sole community hospital (SCH) status.

Medicare-Dependent Hospital and Low Volume Adjustment Programs

The MDH designation is available to hospitals that have a disproportionately high Medicare patient mix. Qualifying hospitals are eligible for higher IPPS payments. The low-volume adjustment is available to rural hospitals with very low inpatient volumes. Qualifying hospitals receive enhanced payments that increase as volumes decrease. Both programs expired at the end of FY 2022, but legislation enacted in late 2022 restored both programs retroactive to October 1, 2022. CMS now proposes to restore all applicable regulations for both programs.

Hospitals that were classified as MDHs as of September 30, 2022, generally continue to be classified as MDHs as of October 1, 2022, with no need to reapply for MDH classification. Hospitals that qualified for the low-volume hospital payment adjustment for FY 2023 may continue to receive a low-volume hospital payment adjustment for FY 2024 without reapplying if they continue to meet both the discharge and mileage criteria. The hospital's request for low-volume adjustments can include a verification statement that it continues to meet the mileage criterion applicable for FY 2023.

Sole Community Hospitals

SCHs are hospitals that by definition are the sole source of inpatient hospital services in a community. Hospitals typically qualify for SCH designation by being a certain distance or drive-time from other hospitals.

CMS proposes a small but potentially beneficial change relevant to hospitals that may be eligible for SCH status following a merger: CMS proposes to revise current regulations such that, where a hospital's SCH approval is dependent on its merger with another nearby hospital, and the hospital meets the other SCH classification requirements, the SCH classification and payment adjustment would be effective as of the effective date of the approved merger if the Medicare Administrative Contractor receives the complete application within 90 days of CMS's written notification to the hospital of the approval of the merger. If finalized, this change would expedite acquisition of SCH status for hospitals in this circumstance.

Physician-Owned Hospitals

Key Takeaway: CMS proposes technical changes governing expansion opportunities for grandfathered physician-owned hospitals.

The ACA amended physician self-referral proscriptions to effectively bar new physician-owned hospitals and to limit growth of existing facilities that were grandfathered by the ACA. The ACA permitted existing physician-owned hospitals to expand operating and procedure room or bed capacity subject to strict limits and onerous procedures.

CMS now proposes to revise and clarify several criteria and processes applicable to physician-owned hospital requests to expand, most of which likely would further limit capacity expansions.

Requests for Information

Potential Additional Changes to the Hospital VBP Program That Would Address Health Equity

CMS requests public feedback and comment on proposed and potential future changes to the Hospital VBP Program scoring methodology that aim to address health equity by rewarding excellent care in underserved populations beginning with the FY 2026 program year. CMS proposes methodological changes, including modifying the Total Performance Score (TPS) such that the TPS numeric score range would be 0 to 110 in order to afford even top-performing hospitals the opportunity to receive the additional health equity bonus points under the proposed health equity scoring change. CMS's questions include the following:

- Should the agency consider using any of the variables detailed in the proposed rule, area deprivation index of greater than or equal to 85, and Medicare Part D low income subsidy, in combination with or instead of dual eligibility status?
- Should the agency consider other thresholds for scoring, such as a quintile-based scoring approach whereby hospitals are awarded measure performance scaler points based on five levels of performance rather than three?
- Should the agency use a linear scoring function or actual scoring for calculating the underserved multiplier instead of the proposed logistic exchange function?
- Are there other approaches that the Hospital VBP Program could propose to adopt in order to effectively address healthcare disparities and advance health equity?

Safety Net Hospitals

CMS seeks public feedback on determining an appropriate basis for identifying safety-net hospitals for Medicare purposes. CMS would like input on the possibility of using the Safety-Net Index (SNI) developed by MedPAC or an area-level index. The SNI is calculated as the sum of the following:

- The share of the hospital's Medicare volume associated with low-income beneficiaries
- The share of its revenue spent on uncompensated care
- An indicator of how dependent the hospital is on Medicare

Area-level indices, such as the Area Deprivation Index and the Social Deprivation Index, aim to measure social disadvantage across geographic neighborhoods. This approach would ideally allow CMS to prioritize communities for funding and other assistance to improve social determinants of health, such as affordable housing, availability of food stores and transportation infrastructure.

CMS is interested in public feedback on appropriate ways to identify safety-net hospitals and potential approaches to help safety-net hospitals address the unique challenges they face. The RFI includes about 20 question prompts, which are summarized below:

- Who are the patients at safety-net hospitals, and what challenges do they face?
- What are the main challenges facing safety-net hospitals? Describe ways that HHS policy could address these challenges and how potential payments would be determined.
- What factors should and should not be considered in identifying a safety-net hospital (*e.g.*, rural location, social determinants data, proportion of uncompensated care), and why? Should there be different types of safety-net hospitals?
- Is MedPAC's SNI or an area-level index an appropriate way to identify Medicare safety-net hospitals? How might either approach be improved?
- Should safety-net hospitals be responsible for different reporting and compensation requirements than other hospitals?

Principles for Selecting and Prioritizing LTCH QRP Measures and Concepts Under Consideration for Future Years

CMS seeks public feedback related to the LTCH QRP. The first RFI section discusses a general framework or set of principles that CMS could use to identify future LTCH QRP measures. The second section draws from an environmental scan conducted to identify measurement gaps in the current LTCH QRP, and measures or measure concepts that could be used to fill these gaps. The final section solicits public comment on the principles for selecting measures for the LTCH QRP, identified measurement gaps, and measures that are available for immediate use or that may be adapted or developed for use in the LTCH QRP.

For more information, contact Deborah Godes, Rachel Hollander, Emily Cook, Kayla Holgash, Marie Knoll, Kristen O'Brien, Priyadharshini Rathakrishnan, Erica Stocker, Katie Waldo or Eric Zimmerman.