799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

**Vizient Office of Public Policy and Government Relations**

# Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

**April 21, 2023**

## Background & Summary

On April 10, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule to update the Fiscal Year (FY) 2024 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS) ("Proposed Rule") (fact sheet available here). CMS proposes to increase the inpatient payment rate for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users by 2.8 percent. Based on various policy changes and circumstances described in the Proposed Rule, CMS anticipates hospital payments will increase by $2.7 billion in FY 2024.

The Proposed Rule contains several policy proposals, including delaying implementation of the "three-way split criteria" as related to MS-DRGs until FY 2025, using more than three years of audited data for purposes of uncompensated care payments, refinements to wage index-related policy and increasing the outlier cost threshold for outlier payments. In addition, CMS proposes several policies to address health equity in various programs, including the Hospital Inpatient Quality-Reporting (IQR) Program, the Medicare Promoting Interoperability (PI) Program, the Hospital-Acquired Condition Reduction Program (HACRP), and the Hospital Value-Based Purchasing (VBP) Program. CMS also provides several requests for information, including an appropriate basis for identifying safety-net hospitals for Medicare purposes.

Comments are due **no later than 5PM on June 9, 2023**. Vizient looks forward to working with members to help inform our letter to the agency.

## Proposed IPPS Payment Rate Updates for FY 2024

After accounting for inflation and other adjustments required by law, the Proposed Rule increases IPPS operating payment rates by 2.8 percent in FY 2024 for hospitals that successfully participate in the Hospital IQR Program and are meaningful EHR users. The Proposed Rule includes an initial market-basket update of 3.0 percentage points, minus 0.2 percentage points for productivity as mandated by the Affordable Care Act (ACA). Regarding the MS-DRG Documentation and Coding Adjustment, which partially restores cuts as a result of the American Taxpayer Relief Act (ATRA), CMS proposes a 0.0 percentage point adjustment. These changes are reflected in the following table.

**Proposed IPPS Payment Rate Updates for FY 2024**

| Proposed Policy | Average Impact on Payments (Rate) |
|---|---|
| Estimated market-basket update | 3.0% |
| Productivity Adjustment* | -0.2% |
| MS-DRG Documentation and Coding Adjustment | 0.0% |
| **Estimated payment rate update for FY 2024 (before applying budget neutrality factors)** | **2.8%** |

*In the Proposed Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP). CMS notes that the data and methods are unchanged and that the agency refers to this as the productivity adjustment.

In addition, CMS proposes four applicable percentage increases applied to the standardized amount, as demonstrated in the below table. To determine the proposed applicable percentage increase, CMS adjusted the proposed market-basket rate-of-increase by considering (1) whether a hospital submits quality data; and (2) whether a hospital is a meaningful EHR user. In addition, CMS applies a 0.2 percentage point reduction for the productivity adjustment. Also, hospitals may be subject to other payment adjustments under the IPPS which are not reflected in the below table (e.g., reductions under the HRRP and the HACRP; upward and downward adjustments under the Hospital VBP Program). In the Proposed Rule, CMS also provides a table (pg. 1291) that displays changes from FY 2023 standardized amounts to the proposed FY 2024 standardized amounts.

**Proposed FY 2024 Applicable Percentage Increases for the IPPS**

| FY 2024 | 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 |
|---|---|---|---|---|
| Proposed market basket rate-of-increase | 3.0 | 3.0 | 3.0 | 3.0 |
| Proposed adjustment for not submitting quality data | 0 | 0 | -0.75 | -0.75 |
| Proposed adjustment for not being a Meaningful EHR User | 0 | -2.25 | 0 | -2.25 |
| Proposed Productivity Adjustment* | -0.2 | -0.2 | -0.2 | -0.2 |
| **Proposed applicable percentage increase applied to standardized amount** | **2.8** | **0.55** | **2.05** | **-0.2^** |

*In the Proposed Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP). CMS notes that the data and methods are unchanged and that the agency refers to this as the productivity adjustment.
^ Section 1886(b)(3)(B)(xi) of the Social Security Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

## Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

The ACA required changes, which began in 2014, regarding the way disproportionate share hospital (DSH) payments are made to hospitals. Under this payment formula, hospitals receive 25 percent of

the Medicare DSH funds that they would have received under the prior formula ("empirically justified"). The other 75 percent flows into a separate pool that is reduced relative to the number of uninsured who received care and then distributed based on the proportion of total uncompensated care each Medicare DSH provides. This pool is distributed based on three factors:

- **Factor 1:** 75 percent of the Office of the Actuary estimate of the total amount of estimated Medicare DSH payments
- **Factor 2:** Change in the national uninsured rates
- **Factor 3:** Proportion of total uncompensated care each Medicare DSH provides

CMS estimates the empirically justified Medicare DSH payments for FY 2024 to be approximately $3.405 billion. Also, for FY 2024, CMS estimates total Medicare DSH and uncompensated care payments will decrease by approximately $115 million compared to FY 2023, according to a CMS fact sheet.

The uncompensated care payments have redistributive effects, which are based on a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that are projected to be eligible to receive Medicare DSH payments. The calculated payment amount is not directly tied to a hospital's number of discharges.

To calculate Factor 1 and model the impact of this Proposed Rule, CMS describes the various data sources it utilized, including the Office of the Actuary's (OACT's) January 2023 Medicare DSH estimates (based on data from the September 2022 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2023 IPPS final rule Impact File. CMS also describes assumptions it made in estimating the Medicare DSH Expenditures for FY 2024, such as discharge and case-mix assumptions related to the impact from the COVID-19 pandemic. For FY 2024, CMS provides that Factor 1 would be approximately $10.216 billion ($13.621 billion minus $3.405 billion) and notes it will use more recent data in the FY 2024 IPPS final rule.

For Factor 2, CMS proposes to use a methodology similar to the methodology applied in rulemaking for FYs 2018-2023. To calculate Factor 2, CMS used various data sources to project the change in the national uninsured rates in both calendar year (CY) 2023 and CY 2024. CMS notes that projected rates of growth in enrollment for private health insurance and the uninsured are based largely on the OACT's models and that greater detail is available in an OACT report. Notably, OACT estimated the uninsured rate to be 9.3 percent for CY 2023 and 9.2 percent in CY 2024. Using a weighted average approach to estimate the rate of uninsurance, CMS finds Factor 2 would be 65.71 percent. The proposed FY 2024 uncompensated care amount, if equivalent to proposed Factor 1 multiplied by proposed Factor 2, equals approximately $6.713 billion.

For FY 2023, to calculate Factor 3, CMS proposes to use the three most recent years of audited cost report data (i.e., FY 2018, 2019 and 2020 cost reports). CMS further clarifies that for the Proposed Rule, the agency used reports from the December 2022 HCRIS extract, but intends to use the March 2023 update of HCRIS to calculate the final Factor 3 for the FY 2024 IPPS final rule.

CMS also proposes changes related to the per discharge amount of interim uncompensated care payments. Since FY 2014, CMS has made interim uncompensated care payments during the FY on a per discharge basis. Traditionally, CMS used a three-year average of the number of discharges for a hospital to produce an estimate of the amount of the hospital's uncompensated care payment per discharge. However, due to the COVID-19 public health emergency (PHE) potentially leading to discharge underestimations, for FY 2024, CMS proposes to exclude FY 2020 from the three-year average (CMS similarly excluded FY 2020 data in the FY 2023 IPPS final rule). For FY 2024, CMS proposes to use data from FY 2019, FY 2021, and FY 2022 to compute a 3-year average of the number of discharges in order to calculate the per discharge amount. As previously noted, the per

discharge amount is used to determine interim uncompensated care payments to projected DSH-eligible hospitals during FY 2024.

**CMS welcomes comments on the proposals noted above.** In addition, CMS provides a FY 2024 IPPS Proposed Rule Medicare DSH supplemental data file on the Proposed Rule Website.

## Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Under the IPPS, the DRG classifications and relative weights are adjusted (at least annually) to account for changes in resource consumption. Relative weight adjustments aim to reflect changes in treatment patterns, technology and other factors that may alter the relative use of hospital resources. To calculate proposed MS-DRG relative weights for FY 2024, CMS proposes to use the FY 2022 MedPAR claims file[1] and FY 2021 HCRIS dataset, which are the most recently available datasets for FY 2024 ratesetting. For FY 2024, CMS has not proposed any modifications to the agency's usual ratesetting methodologies to account for the impact of COVID-19 on the ratesetting data.

CMS proposes several updates to MS-DRGs (i.e., adding and removing MS-DRGs) as described in the Proposed Rule (pg. 57-254). Also, the proposed 19 national average cost-to-charge ratios (CCRs) for FY 2024 are provided in the Proposed Rule (pg. 269). These CCRs are used in the methodology CMS uses to determine the proposed relative weights. Table 5, as found on the Proposed Rule website, provides information on proposed MS-DRGs, relative weighting factors, and geometric and arithmetic mean lengths of stay. **CMS welcomes comments on each of the MS-DRG classifications and relative weight proposed changes.**

## Application of the Non-Complication or Comorbidity (NonCC) Subgroup Criteria to Existing MS-DRGs with a Three-Way Severity Level Split

In the Proposed Rule, CMS restates its FY 2021 IPPS final rule policy to expand the criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG to include the NonCC subgroup for a three-way severity level split. This previously finalized criteria (see table below), when applied, would result in some MS-DRGs that are currently split into three severity levels shifting to a two severity-level split. In the FY 2022 IPPS final rule, due to the volume of MS-DRG changes associated with implementing this policy and the COVID-19 PHE, CMS delayed applying the updated criteria until FY 2023 or in future rulemaking. In the FY 2023 IPPS Final Rule, CMS again delayed application of the NonCC subgroup criteria due to the COVID-19 PHE and until additional analyses could be performed to assess the impacts of the policy.

[1] CMS also notes that for the Proposed Rule, the agency's initial MS-DRG analysis was based on ICD-10 claims data from the September 2022 update of the FY 2022 MedPAR file, which contains hospital bills received from October 1, 2021, through September 30, 2022.

| Criteria | 3-way split (MCC vs. CC vs. NonCC) | 2-way split MCC vs. (CC + NonCC) | 2-way split (MCC+CC) vs. NonCC |
|---|---|---|---|
| Step 1: 500+ cases in the MCC/CC/NonCC group | 500+ cases for MCC group; AND 500+ cases for CC group; AND 500+ cases for NonCC group | 500+ cases for MCC group; AND 500+ cases for (CC+NonCC) group | 500+ cases for (MCC+CC) group; AND 500+ cases for NonCC group |
| Step 2: 5%+ of the patients are in the MCC/CC/NonCC group | 5%+ cases for MCC group; AND 5%+ cases for CC group; AND 5%+ cases for NonCC group | 5%+ cases for MCC group; AND 5%+ cases for (CC+NonCC) group | 5%+ cases for (MCC+CC) group; AND 5%+ cases for NonCC group |
| Step 3: 20%+ difference in the average cost between groups | 20%+ difference in average cost between MCC group and CC group; AND 20%+ difference in average cost between CC group and NonCC group | 20%+ difference in average cost between MCC group and (CC+NonCC) group | 20%+ difference in average cost between (MCC+CC) group and NonCC group |
| Step 4: $2,000+ difference in average cost between subgroups | $2,000+ difference in average cost between MCC group and CC group; AND $2,000+ difference in average cost between CC group and NonCC group | $2,000+ difference in average cost between MCC group and (CC+NonCC) group | $2,000+ difference in average cost between (MCC+CC) group and NonCC group |
| Step 5: The $R^2$ of the split groups is greater than or equal to 3 | $R^2 > 3$ for the three-way split within the base MS-DRG | $R^2 > 3$ for the two-way split (MCC vs (CC+NonCC)) within the base MS-DRG | $R^2 > 3$ for the two-way split ((MCC+CC) vs NonCC) within the base MS-DRG |

In the agency's analysis of MS-DRG classification requests for FY 2024, CMS applied the criteria, as described in the above table, to each of the MCC, CC, and NonCC subgroups. Tables 6P.10a-6P.10f, as found on the Proposed Rule website, detail the potential changes with application of the NonCC subgroup criteria. For example, Table 6P.10b lists the 135 MS-DRGs that would potentially be subject to deletion with application of the NonCC Subgroup Criteria and lists the 86 MS-DRGs that would potentially be created. In addition, Table 6P.10d provides the data analysis of all 49 base MS-DRGs anticipated to change based on the application of the three-way severity level split.

CMS is also making available additional files reflecting the application of the NonCC subgroup criteria that are related to the proposed MS-DRG changes (e.g., support files for alternate analysis with application of the NonCC subgroup criteria on the Proposed Rule website).

CMS indicates it is making this information available to inform comments regarding the application of the NonCC subgroup criteria for FY 2025 rulemaking. **Also, CMS makes clear that it proposes**

**to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2024, but seeks comment as it develops the FY 2025 proposed rule.**

## Comprehensive CC/MCC Analysis

In the FY 2008 IPPS final rule, CMS provided a process for subdividing diagnosis codes into three different levels of CC severity (i.e., MCC, CC or NonCC). In the FY 2021 IPPS final rule, given significant diagnosis code changes had occurred since 2008, CMS indicated it would continue plans for a comprehensive CC/MCC analysis, using a combination of claims data analysis and application of nine guiding principles (as provided in the FY 2021 IPPS final rule). As part of this plan for a comprehensive CC/MCC analysis, in the FY 2022 IPPS final rule, CMS finalized a new edit within the Medicare Code Editor (MCE) for "unspecified" codes, effective with discharges on and after April 1, 2022. In the FY 2023 IPPS Final Rule, the agency did not believe it was appropriate to propose to change the designation of any ICD-10-CM diagnosis codes to provide time to adjust to the new edit which became effective for discharges on or after April 1, 2022. **In the Proposed Rule, CMS continues to seek feedback regarding the guiding principles, as well as other possible ways the agency can incorporate meaningful indicators of clinical severity.**

In the FY 2023 IPPS proposed rule, CMS sought comment on how the reporting of diagnosis codes in categories Z55-Z65 (persons with health hazards related to socioeconomic and psychosocial circumstances) might improve the agency's ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRGs. CMS reiterated that Z59.00 (and its subcategories Z59.01 and Z59.02) are more frequently reported codes that describe social determinants of health. In the Proposed Rule, after performing an analysis and considering the nine previously finalized guiding principles, CMS proposes to change the severity level designation for diagnosis codes Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness) from NonCC to CC for FY 2024. **CMS seeks feedback and notes it is interested in receiving feedback on how it might support documentation and reporting of the diagnosis codes describing social and economic circumstances in support of efforts to advance health equity.**

## Relative Weight Calculation for MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies)

In the FY 2021 IPPS final rule, CMS created MS-DRG 018 for cases that include procedures describing CAR T-cell therapies, including those cases participating in a clinical trial. As finalized, clinical trial cases and expanded use cases are identified by using a $373,000 proxy for standardized drug claims (less than this proxy would mean the claim was a clinical trial).

CMS now questions the need to apply this proxy to identify the clinical trial and expanded use claims. Instead, to calculate the relative weight for MS-DRG 018 for FY 2024, CMS proposes that only those claims that group to MS-DRG 018 that (1) contain ICD-10-CM diagnosis code Z00.6[2] and do not include payer-only code "ZC" or (2) contain condition code "ZB" (or, for subsequent fiscal years, condition code "90") would be excluded from the calculation of the average cost for MS-DRG 018. **CMS seeks comment on these proposals.**

[2] Diagnosis code *Z*00.6: Encounter for examination for normal comparison and control in clinical research program

## Proposed Add-On Payments for New Services and Technologies for FY 2024

Under the IPPS, a service or technology may be considered for a new technology add-on payment (NTAP) if: (1) the medical service or technology is new ("newness" criterion); (2) the medical service or technology is costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate ("cost" criterion); and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies ("substantial clinical improvement" criterion). In addition, certain transformative new devices and antimicrobial products may qualify under an alternative NTAP pathway.

The NTAP payment mechanism is based on the cost to hospitals for the new medical service or technology. CMS does not include capital costs in the add-on payments for a new medical service or technology or make new technology add-on payments under the IPPS for capital-related costs. CMS also reiterates that add-on payments for new medical services or technologies are not subjected to budget neutrality. Overall, CMS estimates a decrease of $466 million from changes in the NTAPs.

Table II.P.-01 (pg. 292 of the Proposed Rule) provides a list of 10 technologies for which CMS proposes to continue NTAPs because the three-year NTAP anniversary date will occur on or after April 1, 2024. Table II.P.02 (pg. 296 of the Proposed Rule) lists the 15 technologies for which CMS proposes to discontinue NTAPs because the three-year NTAP anniversary date will occur prior to April 1, 2024. Estimates for NTAPs proposed to continue for FY 2024 are available in a table (pg. 1409) in the Proposed Rule.

Under the traditional pathway for NTAP applications, CMS indicates that it received 27 applications for NTAPs for FY 2024. However, 8 applications were withdrawn prior to the issuance of the Proposed Rule. In the Proposed Rule, CMS addresses the 19 remaining applications but notes that it has not yet determined whether these 19 technologies will meet the criteria for NTAPs for FY 2024. Under the alternative NTAP pathways, CMS received 27 applications for FY 2024, but 7 applications were withdrawn before the Proposed Rule was released. CMS addresses the remaining applications in the Proposed Rule (pg. 503 - 581) and proposed to approve 19 alternative pathway applications submitted for the FY 2024 NTAP; CMS does not propose to approve one application because it indicates the applicant has not provided adequate cost analysis.

## Evaluation of Eligibility Criteria for New Medical Service or Technology Applications

In the FY 2009 IPPS final rule, CMS codified its practice of evaluating the eligibility criteria for new medical service or technology add-on payment applications. CMS first determines whether a medical service or technology meets the newness criterion, and if so, then CMS determines whether the technology meets the cost threshold and represents a substantial clinical improvement over existing medical services or technologies. In the FY 2021 IPPS final rule, CMS clarifies the various type of FDA approvals, clearances, and classifications that it considers under the NTAP policy. Among those clarifications, CMS provided that new technologies must receive FDA marketing authorization (such as pre-market approval (PMA); 510(k) clearance; the granting of a De Novo classification request, or approval of a New Drug Application (NDA)) by July 1 of the year prior to the beginning of the fiscal year for which the application is being considered.

Beginning with the NTAP applications for FY 2025, CMS proposes to require applicants to have a complete and active FDA market authorization request at the time of NTAP application submission, and to provide to CMS documentation of FDA acceptance or filing.

Also, CMS proposes that, beginning with FY 2025 applications, an NTAP applicant must have received FDA approval or clearance by May 1 (rather than July 1) of the year prior to the beginning

of the FY for which the application is being considered. CMS clarifies this timeline would not apply for an application that is submitted under the alternative pathway for certain antimicrobial products.

**CMS seeks comment on the proposal to modify the NTAP application eligibility requirements for technologies that are not already FDA market-authorized to require such applicants to have a complete and active FDA market authorization request at the time of new technology add-on payment application submission, to provide documentation of FDA acceptance or filing to CMS at the time of application submission, and to move the FDA marketing authorization deadline from July 1 to May 1, beginning with applications for FY 2025.**

## New COVID-19 Treatments Add-On Payment

In response to the COVID-19 PHE, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) under the IPPS for certain COVID-19 cases. CMS provided this policy to mitigate potential financial disincentives for hospitals to provide these new treatments, and to minimize any potential payment disruption immediately following the end of the PHE. While CMS initially indicated the NCTAP would last until the end of the PHE, in the FY 2022 IPPS final rule, the agency extended the NCTAP through the end of the FY in which the PHE ends for all eligible products. CMS also previously finalized a policy to reduce the NCTAP for an eligible case by the amount of any NTAP (if applicable).

In the Proposed Rule, CMS notes that if the PHE ends in May 2023, as planned by the Department of Health and Human Services (HHS), then discharges involving eligible products would continue to be eligible for the NCTAP through September 30, 2023. The NCTAP will expire at the end of FY 2023 and no NCTAP would be made beginning in FY 2024 (i.e., for discharges on or after October 1, 2023). More information about the NCTAP is available on a CMS website.

## Outlier Payments

Costs incurred by a hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount.

For FY 2024, generally, CMS proposes to use the same methodology from FY 2020 to incorporate an estimate of outlier reconciliation in the FY 2024 outlier fixed-loss cost threshold. Also, CMS proposes to continue to aim to pay 5.1 percent of aggregate payments under IPPS as outlier payments. Although in the FY 2023 IPPS final rule, CMS made modifications to its methodology for calculating the FY 2023 outlier threshold due to COVID-19, for FY 2024, generally, CMS is not proposing to continue such changes. CMS ultimately proposes an outlier fixed-loss cost threshold for FY 2024 to be $40,732, an increase from FY 2023 which was $38,859.

## Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires that the HHS Secretary adjust the standardized amounts for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. The wage index reflects data from the Medicare Cost Report and the Hospital Wage Index Occupational Mix Survey. The wage index must be updated annually, and any updates or adjustments must be budget neutral – meaning the overall, aggregate payment to hospitals cannot change. CMS provides wage index tables (tables 2, 3, and 4B) on the Proposed Rule website.

The proposed FY 2024 wage index values are based on Medicare cost report data for cost reporting periods beginning October 1, 2019 and until October 1, 2020 (FY 2020).[3] CMS reiterates its ongoing practice for the wage index to generally use the most current data and information available, which is usually data that is upwards of four years old. In the Proposed Rule, CMS indicates it considered the best available data for purposes of the wage index, particularly given the potential impact of COVID-19. Based on the agency's analysis of the FY 2020 wage data compared to prior data periods, CMS found the following:

- Approximately 85 percent of hospitals had an increase in their average hourly wage from FY 2019 to FY 2020, compared to a range of 76-77 percent of hospitals for the most recent 3 year periods.[4]
- Approximately 81 percent of all core based statistical area (CBSA) average hourly wages increased from FY 2019 to FY 2020, compared to a range of 73-75 percent of all CBSAs for the most recent 3 year periods.
- Approximately 36 percent of all urban areas have an increased in their area wage index from FY 2019 to FY 2020, compared to a range of 41-43 percent of all urban areas for the most recent 3 year periods.
- Approximately 2.8 percent of all rural areas have an increase in their wage index from FY 2019 to FY 2020, compared to a range of 4-6 percent of all rural areas for the most recent 3 year periods.
- The unadjusted national average hourly wage increased by a range of 2.4-2.8 percent per year from FY 2016 to FY 2019. For FY 2020, the unadjusted national average hourly wave increased by 5.3 percent from FY 2019.

The agency states that it is not readily apparent whether any changes due to the COVID-19 PHE impacted the wages paid by individual hospitals. In addition, CMS notes that even if COVID-19 did differentially impact individual hospitals, it is not clear how to isolate those changes from other changes that might have occurred during this same time. Because the agency finds no other substantive issues with the data, it proposes to use the FY 2020 wage data for FY 2024. **CMS invites comment on this proposal.**

## Proposed Occupational Mix Adjustment to the FY 2024 Wage Index

CMS uses an occupational mix adjustment to control for the effects of hospitals' choices to employ different combinations of staff to provide care services on the wage index. For the FY 2024 wage index, CMS used Worksheet S-3 wage data of 3103 hospitals and occupational mix surveys of 3007 hospitals. CMS notes it had a "response" rate of 97 percent and will apply proxy data for hospitals that did not reply, for new hospitals, and for hospitals that submitted erroneous or aberrant data, as done in prior years. To compute the FY 2024 occupational mix adjustment, CMS is not proposing any changes to the methodology and plans on applying the occupational mix adjustment to 100 percent of the FY 2024 wage index. In applying this methodology, the proposed FY 2024 occupational mix adjusted national average hourly wage is $50.27, compared to $47.73 in FY 2023. A table comparing the FY 2024 proposed occupational mix adjusted wage indexes to the proposed unadjusted wage indexes by CBSA is found in the Proposed Rule (pg. 612). For example, the table indicates that 55.6 percent of urban areas and 55.3 percent of rural areas have a wage index that is increasing.

[3] For wage index purposes, CMS notes that these cost reports will be referred to as "FY 2020 cost report," the FY 2020 wage data," or the "FY 2020 data."
[4] These periods are FY 2016 to FY 2017, FY 2017 to 2018, and FY 2018 to 2019.

CMS indicates that a new measurement of occupational mix is required for FY 2025. The new CY 2022 survey that received OMB approval in January 2023 (the survey is available here) will be used as a basis for the new measure of occupational mix in FY 2025. While not the subject of rulemaking in the Proposed Rule, CMS indicates that hospitals are required to submit their completed 2022 surveys to their Medicare Administrative Contractors (MACs) by June 30, 2023.

## Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment

### Rural Floor Policy

The "rural floor" policy provides that area wage indexes applied to any hospital that is located in an urban area of state cannot be lower than the area wage index for hospitals in rural areas in that state. In addition, CMS applies a national budget neutrality adjustment when implementing the rural floor policy. Based on the FY 2024 wage index used in the Proposed Rule, CMS estimated that 596 hospitals would receive the rural floor adjustment in FY 2024.

Under current regulations (i.e., § 412.103), a hospital that is in an urban area may apply to CMS for reclassification as rural if certain requirements are met. Hospitals that convert, for purposes of the Proposed Rule, are known as § 412.103 hospitals. In recent years, CMS's wage index and floor policies involving the treatment of hospitals reclassified from urban to rural under § 412.103 have been the subject of litigation. As provided in the Proposed Rule, courts have found that CMS's policies that do not treat § 412.103 hospitals the same as geographically rural hospitals are unlawful. As a result of such decisions, CMS finalized a policy in the FY 2023 IPPS final rule that calculates the rural floor as it was calculated before FY 2020. Specifically, CMS finalized policy to include the wage data of § 412.103 hospitals that have no Medicare Geographic Classification Review Board (MGCRB) reclassification in the calculation of the rural floor, and to include the wage data of such hospitals in the calculation of "the wage index for rural areas in the State in which the county is located." Also, in the FY 2023 IPPS final rule, CMS indicated that it would apply the same policy as it did prior to the FY 2023 IPPS final rule for calculating the rural floor (the rural wage index sets the rural floor). In this Proposed Rule, CMS systematically addresses the comments and rulings impacting the rural wage index. CMS indicates it now believes that an interpretation that the statutory text "shall treat the [§ 412.103 hospitals] as being located in the rural area" instructs CMS to treat § 412.103 hospitals the same as geographically rural hospitals for the wage index calculation. In addition, CMS notes, "many hospitals eligible for § 412.103 reclassifications have paired that reclassification with a MGCRB wage index reclassification to escalate their wage index beyond what would be otherwise available to them under the law".

Based on the previously noted interpretation, which the agency acknowledges can lead to significant financial consequences because hospitals have used both §412.103 and MGCRB to reclassify, resulting in their wage index increasing beyond what would traditionally be available. CMS proposes several changes. First, that § 412.103 hospitals reclassifying from urban to rural will be included in the calculation of the rural wage index.[5] Second, CMS is proposing to exclude "dual reclass" hospitals, which are hospitals that seek to classify both as § 412.103 and Medicare Geographic Classification Review Board[6] reclassifications, from the calculation of the rural wage index. Two tables in the Proposed Rule (pg. 623) contrast the current and proposed calculation of the rural wage index policy.

[5] In FY 2023 IPPS/LTCH PPS CMS finalized the inclusion of these hospitals' data in the calculation of the rural floor calculation only.
[6] The MGCRB makes determinations on geographic reclassification requests of hospitals that are receiving payment under IPPS but wish to reclassify to a higher wage area for purposes of receiving a higher payment rate. This could be urban to another urban area, rural to urban, or urban to rural.

In addition, CMS proposes several modifications related the rural wage index given the agency's proposed interpretation regarding § 412.103 hospitals and "dual reclass" hospitals. For example, beginning with FY 2024, CMS proposes modifications related to its regulatory hold harmless policy for situations where hospitals reclassify into a state's rural area to mitigate negative impacts to rural hospitals. **CMS seeks comment on whether there are any remaining policies that CMS should reexamine in light of the proposed reinterpretation of the statute.**

### "Imputed Floor" Policy

From FYs 2005–2018, CMS utilized an imputed floor policy for hospitals in all-urban states, and it was considered as a factor in the national budget neutrality adjustment. Section 9831 of the American Rescue Plan Act (ARPA) requires that for discharges occurring on or after October 1, 2021, the area wage index applicable to any hospital in an all-urban state may not be less than the minimum area wage index for the fiscal year for hospitals in that State established using the methodology that was in effect for FY 2018.

Unlike the imputed floor policy that was in effect from FYs 2005–2018, the ARPA provided that the imputed floor wage index shall not be applied in a budget neutral manner. In the FY 2022 IPPS final rule, CMS adopted the ARPA requirements to implement the "imputed floor" policy. For FY 2024, CMS proposes to continue to apply the FY 2022 "imputed floor" policy. Based on available data for the Proposed Rule, CMS indicates that hospitals in the following states would be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2024: Connecticut, Delaware, Washington, D.C., New Jersey, and Rhode Island.

### State Frontier Floor Policy

The ACA requires that the wage index for hospitals in low density states (known as the Frontier Floor Wage Index) cannot be below 1.0000. In the Proposed Rule, CMS indicates 43 hospitals would receive the Frontier Floor adjustment so their FY 2024 wage index would be 1.0000. These hospitals are in Montana, North Dakota, South Dakota, and Wyoming. Although Nevada meets the definition of a frontier state, all hospitals in Nevada currently receive a wage index value greater than 1.0000.

### Low Wage Index Hospital Policy

In the FY 2022 IPPS final rule, CMS finalized a policy that provides certain low wage index hospitals with the opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index. CMS achieved this by temporarily increasing the wage index values for certain hospitals with low wage indexes and providing an adjustment to the standardized amount for all hospitals so that the policy was budget neutral.[7] For FY 2024, CMS proposes to continue the low wage hospital index policy for hospitals whose wage index values are in the bottom quartile.

In the Proposed Rule, CMS notes that the low wage index hospital policy and related budget neutrality adjustment are the subject of litigation (*Bridgeport Hospital, et al., v. Becerra*, No. 1:20-cv-01574 (D.D.C.)). On March 2, 2022, the District Court found that the Secretary did not have authority to adopt the low wage index policy and ordered an additional briefing on the appropriate remedy. In the Proposed Rule, CMS indicates it has appealed the court's decision but does not provide additional information regarding the status of the litigation. CMS indicates it may "decide to take a different approach" depending on the development in the court proceedings.

[7] Under the FY 2020 policy, CMS increases the wage index for each hospital by half the difference between the otherwise applicable final wage index value for a year for the hospital and the 25th percentile wage index value for that year across all hospitals.

Based on the data for the Proposed Rule and CMS's proposal to continue to apply the low wage index hospital policy as done in FY 2020-2022 (i.e., as a uniform budget neutrality factor applied to the standardized amount), the FY 2024 proposed 25th percentile wage index value across all hospitals is 0.8615.

## Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees

Beginning in FY 2005, CMS provided a process to make an "out-migration adjustment" to the hospital wage index based on commuting patterns of hospital employees. For FY 2024, CMS indicates the out-migration adjustment will continue to be based on the data derived from the custom tabulation of the American Community Survey utilizing 2008 – 2012 (5-year) microdata. CMS notes that in the future, it may consider using the next Census or other available data, as appropriate. Table 2 associated with the Proposed Rule includes the proposed out-migration adjustment for the FY 2024 wage index and Table 4A provides a list of counties eligible for the out-migration adjustment, and the number of years adjustments will be in effect.

## Proposed Labor-Related Share for the FY 2024 Wage Index

The labor-related share is used to determine the proportion of the base payment rate to which the area wage index should be applied and includes a cost category if such costs are labor intensive and vary with the local market. CMS notes that in the FY 2022 IPPS Final Rule, the agency rebased and revised the hospital market basket. In the Proposed Rule, CMS does not provide any further changes to the labor-related share. For FY 2024, for all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are less than or equal to 1.000, CMS proposes to apply the wage index to a labor related share of 62 percent of the national standardized amount. For all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.000, for FY 2024, CMS proposes to apply the wage index to a proposed labor-related share of 67.6 percent of the national standardized amount.

## Proposed Payment Adjustment for Low-Volume Hospitals

Beginning in FY 2005, an additional payment to each qualifying low-volume hospital (LVH) under the IPPS was made (referred to as the LVH adjustment). The LVH adjustment is based on total per discharge payments (e.g., capital, DSH, IME and outlier payments). Additional changes to temporarily expand eligibility for the LVH adjustment were provided in the ACA and subsequent legislation (e.g., hospitals had to have fewer than 1,600 discharges for individuals entitled to Medicare Part A and be located within 15 miles of other hospitals). The Bipartisan Budget Act of 2018 (Pub. L. 115–123) later modified the definition of an LVH and the methodology for calculating the payment adjustment for FYs 2019 through 2022. In addition, the law provided that the adjustment would apply only for discharges occurring in FYs 2019-2022. However, the Consolidated Appropriations Act (CAA), 2023 (passed in December 2022) retroactively modified these requirements to October 1, 2022 and extended the provisions from FY 2019-2022 through FYs 2023 and 2024. The law provides that the temporary definition will revert to the previous requirements in FY 2025.[8]

In the Proposed Rule, CMS indicates that consistent with Section 4101 of the CAA, 2023, the methodology for calculating the payment adjustment for low-volume hospitals will be consistent with

[8] The previous requirements were that a hospital is located more than 25 road miles from another similar hospital and that has less than 800 discharges during the fiscal year.

the methodology from FYs 2019-2022. To qualify, a hospital must have fewer than 3,800 total discharges and be located more than 15 road miles from the nearest IPPS hospital. The applicable percentage increase is based on a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for low-volume hospitals with 500 or fewer discharges to a 0 percent additional payment for low-volume hospitals with more than 3,800 discharges. These amendments were extended through September 30, 2024.[9] CMS clarifies that a hospital that qualified for the LVH determination for FY 2023 may continue to receive the payment for FY 2024 without reapplying if it continues to meet both the discharge and mileage criteria stated above.

## Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program

Medicare-Dependent Hospital (MDH) designations are available to hospitals that have a disproportionately high Medicare patient mix. The MDH program was originally set to expire on September 30, 2022. However, laws enacted in 2022 restored the program retroactive to October 1, 2022. CMS now proposes to restore all applicable regulations to the program.

Given different laws extended the MDH program with varying timelines, some hospitals needed to be reinstated into the program, as noted in the Proposed Rule. CMS also indicates that it believes that there are no hospitals that were not properly reinstated to the program but provides that if a hospital is unsure of its MDH status, it should contact its Medicare Administrative Contractor (MAC). Further, CMS clarifies that any hospital that also applied for sole community hospital (SCH) classification or cancelled its rural reclassification in anticipation of the termination of the MDH program will receive a notice from its MAC detailing its status in light of the program extension.

## Indirect and Direct Graduate Medical Education

Payments to hospitals for the direct costs of an approved graduate medical education (GME) program are based on a methodology that determines a hospital-specific base-period per resident amount (PRA). In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of FTE residents working in all areas of the hospital complex (and non-provider sites, when applicable), and the hospital's Medicare share of total inpatient days.

In addition, under IPPS, there is an indirect medical education (IME) adjustment for hospitals that have residents in an approved GME program. The hospital's IME adjustment applied to the DRG payments is calculated based on the ratio of the hospital's number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital to the number of inpatient hospital beds. The calculation of both direct GME payment and the IME payment adjustment is affected by the number of FTE residents that a hospital is permitted to count. Consistent with prior policy, for discharges occurring during FY 2024, the IME formula multiplier is 1.35. CMS estimates application of the multiplier results in an increase in the IPPS payment amount of 5.5 percent for every approximately 10 percent increase in the hospital's resident-to-bed ratio.

### Calculation of Prior Year IME Resident to Bed Ration When There is a Medicare GME Affiliation Agreement

CMS states that it has been asked by teaching hospitals to clarify how to use the cost report to determine whether the provider "increased its current year FTE cap" and that the provider increased its "current year FTE count" due to affiliation. In the Proposed Rule (pg. 750-753), CMS clarifies the

[9] This legislation was passed after the FY 2023 IPPS final rule was released.

process. The agency proposes to add clarifying text to the instructions on Form CMS-2552-10 Worksheet E, Part A, line 20 to more clearly indicate how these calculations are performed.

## Training in New Rural Emergency Hospital (REH) Facility Type

When CMS finalized the REH facility Conditions of Participation (CoPs) in the CY 2023 OPPS/ASC final rule, the agency received requests to designated REHs as GME eligible facilities similar to the GME designation for Critical Access Hospitals (CAHs). CMS also states that because some CAHs may want to convert to a REH, it understands the importance of making GME payments available to this new provider type. Further, CMS notes that making REHs GME eligible facilities would provide more training opportunities in rural communities.

As a result, CMS proposes to treat REHs in a manner similar to CAHs for purposes of determining GME payments. Under this proposal, REHs would have the option to be treated as either non-provider sites, allowing another hospital to incur the costs of the resident training at the REH for Medicare payment purposes, or to incur the cost of the resident training and be reimbursed by Medicare at 100 percent of the allowable costs.

## Reasonable Cost Payment for Nursing and Allied Health Education Programs

Medicare has historically paid providers for Medicare's share of the costs that providers incur in connection with approved education activities, such as approved nursing and allied health (NAH) education programs. The costs of these programs are excluded from the definition of "inpatient hospital operating costs" and are not included in the calculation of payment rates for hospitals or hospital units paid under the IPPS, the Inpatient Rehabilitation Facility PPS, or the Inpatient Psychiatric Facility PPS. Section 541 of the Balanced Budget Refinement Act (BBRA) of 1999 provides for additional payments to hospitals for costs of NAH programs associated with services to MA enrollees but limits total spending to no more than $60 million in any calendar year.

Section 4143 of the CAA, 2023 states that this $60 million payment cap will not apply for CYs 2010-2019 because the agency used a formula that did not correctly account for each hospital's MA patient load.

CMS aims to implement Sec. 4143 of the CAA, 2023 in the Proposed Rule by providing a method for Medicare Administrative Contractors (MACs) to make appropriate adjustments given the removal of the $60 million payment cap. As a result, some providers may be eligible for additional payments

## Hospital Readmissions Reduction Program (HRRP)

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. The 21st Century Cures Act requires comparing peer groups of hospitals with respect to the number of their Medicare-Medicaid dual-eligible beneficiaries (dual-eligibles) in determining the extent of excess readmissions. The HRRP currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery. **CMS does not propose any changes to the HRRP in the Proposed Rule.**

## Hospital Value-Based Purchasing (VBP) Program

The ACA established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person

and Community Engagement. Typically, the applicable incentive payment percent is required by statute (e.g., 2 percent). In the Proposed Rule, CMS proposes changes to measures, changes to administration of the HCAHPS Survey, as well as a new Health Equity Adjustment bonus for hospitals.

## Proposal to Codify the Current Hospital VBP Program Measure Removal Factors

In the FY 2019 IPPS/LTCH PPS final rule, CMS finalized eight measure removal factors for the Hospital VBP Program. CMS proposes to codify these factors, as it has done with other programs. Similarly, CMS proposes to codify the same measure removal factors for the Hospital IQR Program Measure Removal Factors as discussed below. **CMS seeks comment on this proposal.**

## Proposed Substantive Measure Modifications

CMS proposes to make substantive measure modifications to the Medicare Spending per Beneficiary (MSPB) hospital measure as well as the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure. These proposals are made in conjunction with proposals to remove the measures from the Hospital IQR Program in the coordinating years. For more information on the use of these measures in the Hospital IQR Program, please see information below.[10]

### Proposed Substantive Measure Updates to the Medicare Spending per Beneficiary (MSPB)—Hospital Measure (CBE #2158) Beginning with the FY 2028 Program Year (PY)

CMS proposes to adopt substantive measure updates to the MSPB Hospital Measure beginning with the FY 2028 PY. This includes three refinements that are intended to ensure a more comprehensive assessment of hospital performance including: an update to allow readmissions to trigger new episodes to account for episodes and costs currently not included in the measure but are within the hospital's reasonable influence;[11] a new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to episode start date; and an updated MSPB amount calculation. These changes were endorsed by the consensus-based entity in the fall 2020 measure cycle and finalized for use in the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule. **CMS invites comment on this proposal.**

### Proposed Substantive Measure Updates to the Hospital-Level RSCR Following Elective Primary THA and/or TKA (CBE #1550) Measure Beginning with the FY 2030 PY

CMS proposes to adopt substantive measure updates to the THA/TKA Complication measure beginning with the FY 2030 PY. This update is the inclusion of index admission diagnoses and in-hospital comorbidity data from Medicare Part A claims, as finalized for use in the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule.

[10] Measures in the Hospital VBP Program must be publicly reported for one year prior to the beginning of the performance period. As stated in the FY 2023 IPPS/LTCH PPS final rule, these measures were adopted into the Hospital IQR Program with the intention to propose the updated measure into the Hospital VBP Program after the required year of public reporting in the Hospital IQR Program.

[11] This measure was re-evaluated by the consensus-based entity (CBE) in the Fall 2020 cycle. The proposal to allow a readmission occurring in the 30-day post-discharge period of an episode to initiate new episodes of care was created to increase the number of episodes for which a provider can be scored and align the incentives of the measure during readmissions. The CBE believes this would further incentivizes providers to continuously provide more efficient and high-quality care to patients. For more information on this, please visit the MSPB measure website.

## Proposed New Measure Beginning with the FY 2026 PY: Severe Sepsis and Septic Shock: Management Bundle (CBE #0050)

CMS proposes to adopt the Severe Sepsis and Septic Shock: Management Bundle measure in the Hospital VBP Program under the Safety Domain beginning with the FY 2026 PY. According to CMS, this measure supports the efficient, effective, and timely delivery of high-quality sepsis care. Since its adoption into the Hospital IQR Program in FY 2017, CMS indicates performance rates have increased with every *Care Compare* refresh, until progress was interrupted by the COVID-19 pandemic. Based on this data, CMS believes that additional incentives will support continued improvement in measure performance. CMS has previously made technical adjustments to the measure since its inclusion in the Hospital IQR Program and is proposing to adopt the updated measure into the Hospital VBP Program. **CMS invites comment on this proposal.**

## Proposed Updates to the Data Collection and Submission Requirements for the HCAHPS Survey Measure Beginning with the FY 2027 PY

CMS proposes to make the same updates to the form and manner of the administration of the HCAHPS Survey in the Hospital VBP Program as it does in the Hospital IQR Program. As discussed below, these include changes to the modes of survey administration, an extended data collection period, a limit to the number of supplemental items on the survey, and the requirement that Spanish-language translations are provided to all patients who indicate a preference for Spanish-language materials. **CMS invites comment on this proposal.**

## Previously Adopted and Newly Proposed Baseline and Performance Periods

The table below outlines previously adopted and newly proposed baseline performance periods for the FY 2026 PY. Also, Tables V.K.-05-07 of the Proposed Rule (p. 794) provide previously established and newly estimated performance standards for the FY 2025 – FY 2029 PYs.

| Measure | Baseline Period for FY 2026 PY | Performance Period for the FY 2026 PY |
|---|---|---|
| Person and Community Engagement Domain | | |
| HCAHPS | 1/1/2022 – 12/31/2022 | 1/1/2024 – 12/31/2024 |
| Clinical Outcomes Domain | | |
| Mortality measures (MORT-30-AMI, MORT-30-HF, MORT-30-COPD, MORT-30-CABG, MORT-30-PN (updated cohort)) | 1/1/2016 – 6/30/2019 | 7/1/2021 – 6/30/2024 |
| COMP-HIP-KNEE | 1/1/2016 – 3/31/2019 | 4/1/2021 – 3/31/2024 |
| Safety Domain | | |
| NHSN measures (CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, CDI, MRSA Bacteremia) | 12/1/2022 – 12/31/2022 | 1/1/2024 – 12/31/2024 |
| SEP-1* | 1/1/2022 – 12/31/2022 | 1/1/2024 – 12/31/2024 |
| Efficient and Cost Reduction Domain | | |
| Medicare Spending Per Beneficiary (MSPB) | 1/1/2022 – 12/31/2022 | 1/1/2024 – 12/31/2024 |

*CMS proposes to adopt the Severe Sepsis and Septic Shock: Management Bundle measure beginning with the FY 2026 PY.

## Proposed Change to the Scoring Methodology – Health Equity Adjustment

To further improve health equity, CMS proposes to add the Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS) beginning with the FY 2026 PY. CMS proposes that the HEA Bonus Points would be calculated using a methodology that incorporates a hospital's performance across all four domains for the PY and its proportion of patients with dual-

eligibility status (DES). CMS indicates it created the HEA bonus points to reward hospitals that serve greater percentages of underserved populations and have higher quality performance. CMS proposes to use DES to identify underserved populations because the DES data is readily available and already used in the Hospital Readmissions Reduction Program (HRRP).

The HEA bonus points would be calculated by multiplying the measure performance scaler by the underserved multiplier. The measure performance scaler would be assigned based on a hospital's performance in the four VBP domains. A hospital would receive 4, 2, or 0 points for top third, middle third, or bottom third, respectively, of performance on each domain. CMS would then multiply the underserved multiplier[12] by the performance scaler to determine the number of HEA bonus points. The HEA bonus points would be added to the total weighted domain scores to determine the Total Performance Score. Tables V.K.-14 and -15 in the Proposed Rule (p. 813-817) illustrate these calculations.

Alternatively, CMS requests feedback on using the Area Deprivation Index (ADI) score of 85 or greater, and/or enrollment in the Low-Income Subsidy (LIS) program as additional indicators for the HEA bonus points. CMS states that living in an area with an ADI score of 85 or above is shown to be a predictor of 30-day readmission rates, lower rates of cancer survival, and other negative outcomes. CMS proposes to use the ADI score in conjunction with DES to capture the socioeconomic factors that impact a patient's access to care both at the individual and neighborhood level. CMS expresses concern that the ADI is updated infrequently and has not been studied in the Hospital VBP program, but that the agency hopes to use it in the future to align with programs such as the Shared Savings Program, where the ADI is already in use.

CMS also states that the proportion of patients that receive LIS under the Medicare Part D prescription drug program may capture a more consistent group of low-income patients, as the criteria for LIS are standard across the states while DES varies. However, CMS notes that LIS is limited only to the U.S. states and some beneficiaries who qualify for LIS are not automatically enrolled, and as a result, those individuals who do not enroll may not be included in the LIS population. CMS believes including LIS with DES would be the best way to reduce variability across the states but indicates it will not include LIS with DES at this time because LIS is not available in the U.S. territories.

**CMS seeks comment on these proposals. Specifically, CMS seeks input on the scoring methodology as well as on expanding indicators for the underserved multiplier in the future.**

### Proposal to Modify the Total Performance Score (TPS) Maximum

The current TPS definition is a numeric score ranging from 0 to 100. CMS proposes to modify the numeric range to 0 to 110, based on its projection of the top possible score for the HEA bonus points. This change would begin in the FY 2026 performance period.

## Request for Information (RFI) on Potential Additional Changes to the Hospital VBP Program That Would Address Health Equity

CMS seeks comment on ways to address health disparities through the Hospital VBP Program. Specifically, CMS seeks input on using other variables and indicators (such as the ADI or LIS) in conjunction with DES to identify populations that have been disadvantaged or underserved; whether they should use a quintile system for scoring the HEA instead of thirds; whether future HEA bonus

[12] As provided in the Proposed Rule, the underserved multiplied is defined as the logistic function applied to the proportion of inpatient stays for patients with DES during the calendar year two years before the applicable PY divided by the total number of inpatient Medicare stays (inpatient Medicare stays includes both fee-for-service and MA stays).

points should only focus on a hospital's quality performance in the focus population (i.e., DES); whether CMS should use a linear scoring function instead of the proposed logistic exchange function; and whether there are other approaches the Hospital VBP Program could propose to adopt to address health disparities. **CMS seeks public feedback on these questions.**[13]

## Hospital-Acquired Conditions (HAC) Reduction Program

The ACA established the HAC Reduction Program (HACRP) to reduce the incidence of HACs by requiring hospitals to report on a set of measures (CMS PSI 90 and CDC NHSN HAI measures). Hospitals in the worst performing quartile (25 percent) would receive a one percent payment reduction. A hospital's Total HAC Score and its ranking in comparison to other hospitals in any given year will depend on several different factors. CMS proposes changes to the validation process for FY 2025 and updates related to targeting criteria for hospitals granted an extraordinary circumstances exception (ECE).

### Validation Reconsideration Beginning with FY 2025 PY

CMS proposes to add a validation reconsideration process to the HAC Reduction Program, which will give hospitals the opportunity to request reconsideration of their final validation scores before the scores are used in the HAC Reduction Program scoring calculations. This proposed process will align with the data validation process used in the Hospital IQR Program reconsideration process. Hospitals requesting reconsideration would submit a request and supporting materials within 30 days of the initial validation process and would be limited to information already submitted during the initial validation process. After the reconsideration process is complete, CMS will re-calculate a hospital's confidence interval based on the results of the reconsideration and determine whether the hospital passed or failed the validation requirements for the HAC Reduction Program. CMS is not proposing a reconsideration process for any other program requirements, only data validation. **CMS invites comment on this proposal.**

### Proposal to Update the Targeting Criteria for Hospitals Granted an Extraordinary Circumstances Exception (ECE)

CMS proposes to update the targeting criteria for validation of hospitals granted an ECE in the HAC Reduction Program, as also proposed in the Hospital IQR Program. This would include targeting criteria to include any hospital with a two-tailed confidence interval that is less than 75 percent and that received an ECE for one or more quarters for the data period validated. If finalized, the proposal would align the HAC Reduction Program and the Hospital IQR Program's targeting criteria for validation selection with the Hospital Outpatient Quality Reporting (OQR) Program's criteria. More information is provided in the Hospital IQR Program section of the proposed rule. **CMS invites comment on this proposal.**

### RFI: Advancing Patient Safety in the HAC Reduction Program

As part of the ongoing effort to evaluate and strengthen the HAC Reduction Program, **CMS seeks input on the addition of new program measures**, specifically on patient safety focused electronic clinical quality measures (eCQMs) to promote further alignment across quality reporting and value-based purchasing programs. CMS also seeks feedback on adopting eCQMs that are used in the

[13] For a full list of questions, see the Proposed Rule, p. 825-827.

Hospital IQR Program, including the patient safety related eCQMs added in previous years, and the three eCQMs CMS proposes to add in FY 2024.[14]

**CMS also invites comment on future measures and how the HAC Reduction Program can promote patient safety. Specifically, CMS invites comment on measures to address emerging high priority patient harm events and healthcare-associated infections (HAIs), measures to address equity gaps in harm events, weighing and scoring methods to better assess hospital performance and improve equity, and how the HAC Reduction Program can encourage patient safety while also prioritizing equitable care.**

## Hospital Inpatient Quality Reporting (IQR) Program

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. To receive the full payment increase, hospitals must report data on measures selected by the Secretary for each fiscal year.

In the Proposed Rule, CMS proposes to adopt three new measures (as provided in the table below), modify three current measures, and remove three current quality measures. CMS proposes to modify the hybrid hospital-wide all-cause risk standardized mortality measure and the hybrid hospital-wide all-cause readmission measures beginning with the FY 2027 payment determination. CMS also proposes to modify the COVID-19 Vaccination among Healthcare Personnel (HCP) measure beginning in the Q4 CY 2023 reporting period/FY 2025 payment determination. CMS proposes to remove two measures from the IQR program in conjunction with the proposal to adopt the measures in the Hospital Value-Based Purchasing Program,[15] as well as to remove the elective delivery prior to 39 weeks gestation measure. Table IX.C.02 of the Proposed Rule (pg. 966-968) provides a list of measures of the previously finalized and newly proposed Hospital IQR Program measure set for the FY 2025 payment determination. Similar tables for the FYs 2026-2028 payment determinations are also provided in the Proposed Rule (pg. 968-974).

CMS also proposes to codify its process for removing measures from the IQR program. **CMS seeks comment on these proposals.**

[14] These measures include: Hospital Harm—Opioid-Related Adverse Events eCQM (added in the FY 2023 IPPS/LTCH PPS final rule); Hospital Harm-Severe Hypoglycemia eCQM (added in the FY 2022 IPPS/LTCH PPS final rule); Hospital Harm-Severe Hyperglycemia eCQM (added in the FY 2022 IPPS/LTCH PPS final rule); Hospital Harm-Acute Kidney Injury eCQM (proposed in FY 2024 IPPS/LTCH PPS rule); Hospital Harm-Pressure Injury eCQM (proposed in FY 2024 IPPS/LTCH PPS rule); and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults eCQM (proposed in FY 2024 IPPS/LTCH PPS rule).

[15] The measures include the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty and the Medicare spending per beneficiary (MSPB) hospital measure.

| Measure | | Proposed Changes | Timeline (starting with most imminent changes) |
|---|---|---|---|
| **Changed measures** | HCP COVID-19 Vaccination* | Align the measure with CDC's definition of "up-to-date" vaccination | Beginning with the Q4 CY 2023 reporting period/FY 2025 payment determination |
| | Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure** | Include MA admissions in the calculation of this measure | Beginning with the FY 2027 payment determination |
| | Hybrid Hospital-Wide All-Cause Readmission Measure** | Include MA admissions in the calculation of this measure | Beginning with the FY 2027 payment determination |
| **New Measures** | Hospital Harm – Pressure Injury eCQM | N/A | Inclusion in the measure set beginning with the CY 2025 reporting period/FY 2027 payment determination |
| | Hospital-Harm—Acute Kidney Injury eCQM | N/A | Inclusion in the measure set beginning with the CY 2025 reporting period/FY 2027 payment determination |
| | Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM | N/A | Inclusion in the measure set beginning with the CY 2025 reporting period/FY2027 payment determination |
| **Existing measures being removed** | Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01) | CMS will permanently remove this measure from the Hospital IQR Program | Remove beginning with the CY 2024 reporting period/FY 2026 payment determination |
| | Medicare Spending Per Beneficiary (MSPB) Hospital measure*** | CMS will remove this measure from the Hospital IQR Program and add it to the Hospital VBP Program in the corresponding payment year | Remove beginning in the FY 2028 payment determination |
| | Hospital-level risk standardized complication rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) measure*** | CMS will remove this measure from the Hospital IQR Program and add it to the Hospital VBP Program in the corresponding payment year | Remove beginning in the FY 2030 payment determination |

*CMS proposes to modify this measure to align with CDC guidance on COVID-19 vaccination.
**CMS proposes to modify these measures to include MA beneficiaries in addition to FFS beneficiaries.
***The removal of these measures will only happen if these policies are finalized for addition to the Hospital VBP Program.

## Quality Program Proposal to Adopt the Up-to-Date COVID-19 Vaccination Among Healthcare Personnel Measure

The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure is a process measure developed by CDC to track COVID-19 vaccination coverage in healthcare settings. The

measure was originally finalized in the FY 2022 IPPS final rule.[16] When the measure was originally finalized, it focused on the primary series of COVID-19 vaccines that were on the market at the time. As guidance on vaccines evolves, CMS proposes to update the language of the measure to reflect changing guidance on the vaccines. CMS proposes to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition. CMS also proposes updating the numerator to specify the time frames within which HCP are considered up to date with recommended COVID-19 vaccines,[17] beginning with quarter 4 of the 2023 reporting period/FY 2025 payment determination. CMS is also proposing public reporting of the modified version of the COVID-19 vaccination measure would begin with the October 2024 *Care Compare* refresh, or as soon as is technically feasible. The data submission process would not change. **CMS invites comment on this proposal.**

## Potential Future Inclusion of Two Geriatric Care Measures and Publicly-Reported Geriatric Care Designation

As the population ages, patients present to hospitals with more complex medical, behavioral, and psychosocial needs, which CMS indicates the current IQR measures do not accurately measure. **CMS requests comment on the potential future inclusion of the Geriatric Hospital measure and the Geriatric Surgical measure.** These measures are attestation-based structural measures that would be added to the Hospital IQR program to assess geriatric care across various domains to improve patient care.[18] Hospitals would answer yes or no to a variety of questions over seven domains of geriatric patient care. To receive a domain score, a hospital would need to answer yes to all questions within that domain, and the number of completed domains would be divided by seven (the number of total possible domains) for a score. As noted in the Proposed Rule, in a December 2022 meeting, the Measure Advisory Partnership (MAP) conditionally supported these two measures for rulemaking, but shared concerns about the reliability of attestation-based measures as well as whether there was too much overlap between the Medical and Surgical measures. **CMS seeks comment on the potential future inclusion of these measures in the Hospital IQR Program.**

**CMS also seeks comment on a geriatric care hospital designation**, similar to the Birthing-Friendly designation finalized in the FY 2023 IPPS/LTCH PPS final rule. Specifically, CMS seeks information on barriers and challenges hospitals face in treating the geriatric population, as well as best practices and feedback on how family caregivers can be integrated into care delivery. Additional information can be found in the Proposed Rule (pg. 987-988).

## Proposed Changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure

The HCAHPS Survey is the first national, standardized, publicly reported survey of a patient's hospital experience. The HCAHPS Survey is administered to a random sample of adults who receive medical, surgical, or maternity care, and is not restricted to Medicare beneficiaries. Hospitals are required to survey patients throughout each month of the year and submit data four times a year. Scores are published on *Care Compare*. CMS proposes several changes to the administration of the HCAHPS Survey beginning in CY 2025.[19]

---

[16] This change will apply to all quality programs including Hospital IQR, LTCHQR, and PPS-Exempt Cancer HQR programs. However, this discussion primarily focuses on the change to the Hospital IQR Program.
[17] The definitions will be updated at the beginning of the applicable reporting quarter. For Q4 of CY 2022, HCP are considered up to date if they meet one of the following criteria: (1) individuals who received an updated bivalent booster dose; or (2)(a) individuals who received their last booster dose less than two months ago; or (2b) individuals who completed their primary series less than two months ago.
[18] For more information see Table IX.C.06 on p. 982 of the proposed rule.
[19] CMS proposes the same changes for the HCAHPS Survey in the Hospital VBP Program and Hospital IQR Program.

### Proposed Addition of Three New Modes of Survey Implementation

Currently, hospitals can administer the HCAHPS survey through three modes of survey administration – Mail Only, Phone Only, and Mail-Phone modes. CMS proposes to add three additional methods of survey administration – Web-Mail, Web-Phone, and Web-Mail-Phone modes – to the allowable modes of survey administration. **CMS seeks comment on this proposal.**

### Proposed Removal of Proxy Respondents to the HCAHPS Survey

HCAHPS protocols ask that only the patient respond to the survey, not a proxy respondent. However, CMS found that proxy response occurs despite this instruction, and that inclusion of proxy responses does not impact HCAHPS measure scores. Therefore, CMS proposes to remove the requirement that only the patient may respond to the survey, allowing a patient's proxy to respond to surveys beginning with January 2025 discharges. **CMS seeks comment on this proposal.**

### Proposed Extension of the Data Collection Period

HCAHPS surveys are sent during the first 42 days following discharge. When CMS extended the response period to 49 days, it found that patients who traditionally do not respond to HCAHPS surveys in the first 42 days responded during days 43-49, especially those in vulnerable and underrepresented populations. CMS proposes to extend the data collection period from 42 to 49 days. **CMS seeks comment on this proposal.**

### Proposed Limit on the Number of Supplemental HCAHPS Survey Items

The HCAHPS survey captures 29 standardized questions, however, hospitals are allowed to include supplemental items on to the survey. CMS states that this allowance leads to a decline in response rates. The MA & Prescription Drug Plan CAHPS Survey limits the number of supplemental items allowed on the survey to 12. CMS proposes to limit the supplemental items on the HCAHPS Surveys to 12 items. **CMS seeks comment on this proposal, as well as comments proposing other limits lower than 12.**

### Proposed Requirements to Use Official Spanish Translation for Spanish Language-Preferring Patients

The HCAHPS Survey is available to be translated in eight languages other than English. However, hospitals are not currently required to use these translations. CMS notes that Spanish language-preferring patients constitute approximately 4 percent of HCAHPS survey respondents. CMS proposes to require hospitals to collect information about the language that the patient speaks while in the hospital, and that the official CMS Spanish translation of the HCAHPS Survey be administered to all patients who prefer Spanish, beginning with January 2025 discharges. **CMS seeks comment on this proposal, as well as suggestions for additional translations beyond what is already available.**

### Proposed Removal of Two Administration Methods

CMS proposes to remove two HCAHPS administration methods that are no longer used by hospitals. The Interactive Voice Response (IVR) survey mode has not been used by any hospital since 2016. CMS proposes to discontinue this mode of survey administration beginning with discharges in January 2025, which also coincides with the addition of the web-based options for survey administration (see above).

Additionally, the option for a hospital to administer the HCAHPS Survey for multiple sites (known as "Hospitals Administering HCAHPS for Multiple Sites") has not been used by any hospitals since 2019. This change would give hospitals two options for HCAHPS survey administration: either contracting with an approved HCAHPS vendor, or self-administration of the HCAHPS Survey. CMS proposes to remove this option beginning with discharges in January 2025.

### Requestion for Information on Potential Addition of Patients with a Primary Psychiatric Diagnosis to the HCAHPS Survey Measure

The HCAHPS Survey was designed for patients in the medical, surgical, and maternity service lines of short-term, acute care hospitals. **CMS seeks information on the potential inclusion of patients with a primary psychiatric diagnosis who are admitted to short-term, acute care hospitals in the HCAHPS survey.** Specifically, CMS requests public comment on whether all patients in the psychiatric service line[20] or particular sub-groups should be included, whether the current content of the HCAHPS Survey is appropriate for these patients, and whether the current HCAHPS measure implementation procedures may face legal barriers or risks when applied to patients with primary psychiatric diagnoses.

## Validation of Hospital IQR Program Data

In the FY 2021 IPPS/LTCH PPS final rule, CMS adopted a policy to combine the validation processes for eCQMs and chart-abstracted measures. Under the aligned validation process, a hospital could be selected for both validation of eCQMs and chart-abstracted measures. CMS proposes adding a new criterion for the targeting criteria used to select additional hospitals for validation, beginning with validations of CY 2024 reporting period data for the FY 2027 payment determination. This criterion would include "[a]ny hospital with a two-tailed confidence interval that is less than 75 percent, and that had less than four quarters of data due to receiving an [extraordinary circumstances exception] for one or more quarters." CMS states that this would align targeting criteria across the Hospital IQR and OQR programs.[21] **CMS invites comment on this proposal.**

## Medicare Promoting Interoperability Program

In 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals, eligible hospitals, and CAHs to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology (CEHRT). In recent years, the Medicare and Medicaid EHR Incentive Programs have evolved and are now known as the Medicare Promoting Interoperability (PI) Program".

Under the Medicare PI Program, downward payment adjustments are applied to eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods. For FY 2024, CMS proposes several updates to the PI program, including extending the continuous EHR reporting period and adding three new eCQMs.

## EHR Reporting Periods

CMS proposes to define the EHR reporting period in CY 2025 to include a minimum of any continuous 180-day period within CY 2025 for participating eligible hospitals and CAHs, as it is defined for CY 2024. Additionally, CMS proposes to align the reporting and performance periods for participating eligible hospitals and eligible hospitals who have not yet demonstrated that they are meaningful EHR users. Currently, for participating hospitals, the EHR reporting period occurs 2 years before the payment adjustment year. For hospitals demonstrating meaningful use for the first time, the EHR reporting period occurs 1 year before the payment adjustment. CMS proposes to

---

[20] CMS designates MS-DRG codes 876 (Major Procedure with Principal Diagnosis of Mental Illness), 880 (Acute Adjustment Reaction and Psychosocial Disfunction), 881 (Depressive Neuroses), 882 (Neuroses Except Depressive), 883 (Disorders of Personality and Impulse Control), 884 (Organic Disturbances and Intellectual Disability), 885 (Psychoses), 886 (Behavioral and Developmental Disorders), 887 (Other Mental Disorder Diagnoses), 894 (Alcohol/Drug Abuse or Dependence, Left AMA) and 895-897 (Alcohol/Drug Abuse or Dependence) as the relevant diagnosis codes for defining this population.

[21] CMS proposes a similar policy for the HACRP, as discussed above.

remove the requirement to attest to meaningful use by October 1 of the prior year to the payment adjustment year for eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year, beginning with the EHR reporting period in CY 2025.

If finalized, beginning in the CY 2025 reporting period, eligible hospitals and CAHs would submit data during the 2 months following the close of the CY in which the EHR reporting period occurs, or a later date specified by CMS, for a payment adjustment in FY 2027. Eligible hospitals that have not demonstrated they are meaningful EHR users in a prior year would attest during the submission period that occurs during the 2 months following the close of the CY in which the EHR reporting period occurs, or by a later date specified by CMS, also for a payment adjustment in FY 2027. This proposed change would align the submission dates for participating and non-participating hospitals. **CMS invites comment on this proposal.**

### Safety Assurance Factors for EHR Resilience (SAFER) Guides

In the FY 2022 IPPS/LTCH PPS final rule, CMS adopted the SAFER Guides measure under the Protect Patient Health Information Objective beginning with the EHR reporting period in CY 2022. Eligible hospitals are required to attest to whether or not they have conducted an annual self-assessment using all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs, with one yes/no attestation statement. Although this attestation has been required since the CY 2022 EHR reporting period, both answers are acceptable without penalty.

CMS proposes to modify the requirements for the SAFER Guides measure for the EHR reporting period in CY 2024 to require an attestation of “yes.” An attestation of “no” would result in the eligible hospital or CAH not meeting the measure and not satisfying the definition of a meaningful EHR user and would subject the hospital to a downward payment adjustment. **CMS invites comment on this proposal.**

### Proposed Changes to Clinical Quality Measures in Alignment with the Hospital IQR Program

CMS proposes to align the eCQM reporting requirements for the Medicare PI Program with the requirements under the Hospital IQR Program when feasible. Accordingly, CMS proposes to add the three proposed Hospital IQR Program eCQM measures to the Medicare PI Program for CY 2025: the Hospital Harm – Pressure Injury eCQM; the Hospital Harm – Acute Kidney Injury eCQM; and the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Level – Inpatient) eCQM. CMS also proposes that, if this proposal is finalized, these measures would be available for eligible hospitals and CAHs to select as one of their three self-selected eCQMs for the CY 2025 reporting period and subsequent years. **CMS invites comment on this proposal.**

### Overall Hospital Quality Star Ratings

In the Proposed Rule, CMS references the CY 2021 OPPS/ASC final rule where the agency finalized a methodology to calculate the Overall Hospital Quality Star Ratings, but does not propose any modifications.

### Rural Community Hospital Demonstration Program

The Rural Community Hospital Demonstration Program, which was established in 2003, and was extended by the Consolidated Appropriations Act, 2021 (CAA 2021) for an additional five years, pays rural community hospitals under a reasonable cost-based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. In the Proposed Rule, CMS summarizes the status of the demonstration program, and the ongoing

methodologies for implementation and budget neutrality. Based on the agency's analysis, the budget neutrality factor for FY 2024 is 0.999619.

## Special Requirements for Rural Emergency Hospitals

Also in the CAA, 2021, Congress established a new Medicare provider type: Rural Emergency Hospitals (REHs). REHs will furnish emergency department and observation care and may provide other specified outpatient medical and health services under certain circumstances. CMS finalized policies related to the REHs in the CY 2023 OPPS/ASC final rule. In January 2023, CMS released additional requirements and guidance for facilities enrolling as REHs. CMS proposes to codify these additional requirements from the January guidance and has provided a proposed Information Collection Requirement (ICR) in the Proposed Rule. Specifically, a hospital seeking enrollment as an REH must include an action plan containing: (1) a plan for initiating REH services; (2) a detailed transition plan that lists the specific services that the provider will retain, modify, add, and discontinue as an REH; (3) a detailed description of other outpatient medical and health services that it intends to furnish on an outpatient basis as an REH; and (4) information regarding how the provider intends to use the additional facility payment including a description of the services that the additional facility payment would be supporting. **CMS seeks comment on this proposal.**

CMS also proposes to update certain definitions in the survey and certification of regulations to include REHs in several sections of the code relevant to providers.

## Physician Self-Referral Law: Physician-Owned Hospitals

The physician self-referral law prohibits physicians from making referrals for certain health services payable by Medicare to an entity with which he or she has a financial relationship, with some exceptions, such as the rural provider and whole hospital exceptions. In the Proposed Rule, CMS notes that it may grant exceptions to permit expansion of facility capacity of physician owned hospitals. Hospitals may apply if applicable, or if they are a "high Medicaid facility." The process for applying for an expansion was finalized in the CY 2012 OPPS final rule however CMS proposes to clarify these regulations.

In the Proposed Rule, CMS clarifies its position regarding expansion requests. More specifically, CMS indicates that "meeting the criteria for an applicable hospital or high Medicaid facility merely makes a hospital eligible to request an expansion exception, but it does not guarantee approval of such a request." CMS proposes several regulatory changes to clarify this position. For example, the agency outlines regulatory changes to clarify that the expansion exception process is separate from the requirements a hospital must satisfy under the rural provider and whole hospital exceptions.

CMS also proposes to reinstate program integrity restrictions that were removed in the CY 2021 outpatient prospective payment system (OPPS) final rule.

## RFI: Safety Net Hospitals

As part of CMS's efforts to address health equity and support underserved communities, the agency is seeking input on how it can support safety-net providers and ensure care is accessible to those who need it. CMS defines safety-net providers as "health care providers that furnish a substantial share of services to uninsured and low-income patients." In the June 2022 Medicare Payment Advisory Commission's (MedPAC) Report to Congress, MedPAC expressed concerns about the financial position of safety-net hospitals. Although the Medicare statute supports safety-net hospitals

through Disproportionate Share Hospital (DSH)[22] payments and uncompensated care payments, MedPAC raised concerns about whether these payments were appropriately targeting safety-net hospitals. **CMS is seeking public input on two potential approaches to targeting safety-net providers, as well as general information on safety-net providers that the agency should consider when designing programs.**

In its March 2023 Report to Congress, MedPAC proposed using a tool called the Medicare Safety-Net Index (SNI) to identify safety-net providers and hospitals. The SNI is calculated as the sum of: (1) the share of a hospital's Medicare volume associated with low-income beneficiaries; (2) the share of its revenue spent on uncompensated care; and (3) an indicator of how dependent the hospital is on Medicare. **CMS seeks input on the calculation of the SNI as well as its utility in appropriately identifying safety-net hospitals.**

CMS also seeks input on a second approach to identifying safety-net hospitals through use of area-level indices. Based on a report commissioned by the Assistant Secretary for Planning and Evaluation (ASPE), CMS believes that an area-level index might be useful in helping identify beneficiary populations that are underserved. Specifically, CMS is assessing whether the Area Deprivation Index (ADI) would be an appropriate tool to use, as it is already the basis of certain Medicare Shared Savings Program (MSSP) policies.[23]

CMS also seeks general input on safety-net hospitals including challenges, potential approaches to help, best ways to identify or define safety-net hospitals, challenges specific to rural safety-net providers, and whether there are social determinants data that could be used to inform an approach to identify safety net hospitals.[24]

## What's Next?

CMS is anticipated to publish the final IPPS regulation around August 1, 2023, with the changes being effective at the beginning of the federal fiscal year (October 1, 2023). The comment period closes on June 9, 2023.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern, AVP Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.

[22] Currently, there are both Medicare DSH and Medicaid DSH payments. The MedPAC report and recommendation apply only to Medicare DSH related issues.
[23] *See* CMS, Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule - Medicare Shared Savings Program, available at: https://www.cms.gov/files/document/mssp-fact-sheet-cy-2023-pfs-final-rule.pdf, last accessed, April 16, 2023.
[24] For a full list of questions, see the Proposed Rule p. 1188-1190.