2023 IPPS Final Rule + CMS Updates to Know

Understand the latest updates from Washington that impact your healthcare business

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What we'll cover in today's session

1. Highlights from 2023 IPPS Final Rule
2. Recommendations for providers
3. Regulatory updates, insights, and revenue cycle considerations
4. Tips and resources
5. Q&A

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2023 IPPS Final Rule Highlights

The difficult reality for hospitals + health systems

2022 is on pace to be the worst financial year since the beginning of the pandemic

-KaufmanHall, Aug 2022

Margins plummeted

Labor expenses increased

Outpatient activity down

Medicare reimbursement cuts are expected to continue

-8.6% Margin decline on Medicare services in 2020

-9% Medicare margin projected to fall in 2022

$100B Combined underpayments from Medicare and Medicaid in 2020

Source:
- KaufmanHall, Aug 2022
- AHA Fact Sheet May 2022

HIGHLIGHT #1

Annual increase tops 4%

- Acute care hospitals that report quality data and are meaningful users of EHRs will receive a **4.3-percent increase** in Medicare rates in fiscal year 2023.
- The rate reflects a hospital market basket update of 4.1 percent reduced by 0.3 percentage point for productivity, plus a 0.5 percentage point adjustment required by statute.
- This update reflects the most recent data available and is 1.1 percentage point higher than the proposed update for FY 2023.

HIGHLIGHT #2

MS-DRGs remain static

CMS **did not propose any new MS-DRGs** for FY 2023, so the number of MS-DRGs is maintained at 767 for FY 2023.

HIGHLIGHT #3

Uncompensated care payment decreases

CMS will distribute roughly **$6.8 billion** in uncompensated care payments for FY 2023, a **decrease of approximately $318 million from FY 2022**.

- For FY 2023, CMS finalized using the two most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2018 cost reports and the FY 2019 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals.
- In addition, for FY 2024 and subsequent fiscal years, CMS finalized using a three-year average of the data on uncompensated care costs from Worksheet S-10 for the three most recent fiscal years for which audited data are available.

HIGHLIGHT #4

Medicaid section 1115 demonstrations tabled

- After further consideration of the proposal relating to the treatment of section 1115 demonstration days for purposes of the DSH adjustment (87 FR 28398 through 28402), **CMS will not move forward with the current proposal**.
- They expect to revisit in future rulemaking, and CMS encourages interested parties to review any future proposal and submit comments at that time.

HIGHLIGHT #5

Proxy data disqualified for Tribal and Puerto Rican providers

- CMS is **discontinuing the use of proxy data for uncompensated care costs** in determining uncompensated care payments for Indian Health Service and Tribal hospitals and hospitals in Puerto Rico.
- The agency is also establishing a new supplemental payment to promote long-term payment stability for these hospitals.

HIGHLIGHT #6

Birthing-friendly designation

CMS finalized the **establishment of a 'birthing-friendly' hospital designation** for Fall 2023. CMS states that “Reducing maternal morbidity and mortality is a priority of the Biden-Harris Administration.”

HIGHLIGHT #7

Cap on wage index decreases

CMS will now **permanently apply a budget-neutral 5-percent cap** on any decrease to a hospital's wage index from the prior fiscal year.

HIGHLIGHT #8

GME calculation policy changes

The 2023 final rule implements a **modified policy for Direct Graduate Medical Education** (GME) full-time equivalent cap calculations.

HIGHLIGHT #9

NAHE payment rate updates

CMS finalized its proposed updates to the **Medicare Advantage nursing and allied health education ("NAHE")** payment rates and GME reduction factors.

HIGHLIGHT #10

VBP and HAC measures suppressed

For FY 2023, CMS will suppress most measures in its Hospital Value-based Purchasing Program, and all measures in its Hospital-Acquired Condition Reduction Program. As a result, **hospitals will not experience FY 2023 payment adjustments under either program**.

- CMS will publicly report the FY 2023 results of the HAC Reduction Program's patient safety indicator measure.
- CMS also adopted ten new measures for the Inpatient Quality Reporting program, including three health equity-related measures and two perinatal electronic clinical quality measures.
- CMS will increase the IQR program's electronic clinical quality measures (eCQM) reporting requirements from four to six measures beginning with the calendar year 2024 reporting period.

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Recommendations for Providers

Tips to chart your own course for financial success

- Partner with experts trusted in the industry
- Ensure you’re maximizing your DRG savings
- Stay compliant with coding and billing updates
- Collaborate across RCM departments and ensure systems, people and processes are aligned

Payer rules are changing constantly.
How are you keeping up?

What is your star rating?

Medicare Cost Report

Why this matters

- Proposed changes to MBD and DSH files will be required with future filings for cost reports after Oct 1, 2022
- Additional data may need to be collected soon to complete these for the FFY 2023 cost report

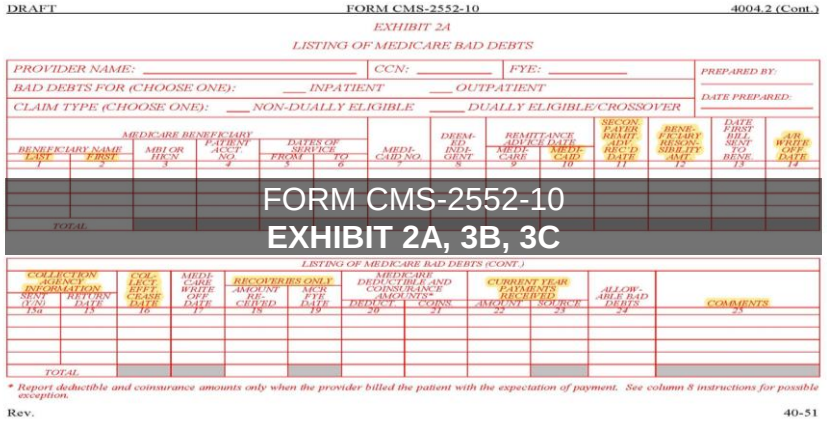
DRAFT FORM CMS-2552-10 4004.2 (Cont.)

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____ CCN: _____ FYE: _____

PREPARED BY:

BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT

DATE PREPARED:

CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ___ DUALLY ELIGIBLE/CROSSOVER

MEDICARE BENEFICIARY													
BENEFICIARY NAME LAST 1	FIRST 2	MBI OR HICN 3	PATIENT ACCT NO. 4	DATES OF SERVICE FROM 5	TO 6	MEDI-CAID NO. 7	DEEM-ED IND-IGENT 8	REMITTANCE ADVICE DATE MEDI-CARE 9	MEDI-CAID 10	SECON-DAYER REMIT. ADV. REC'D DATE 11	BENE-FICIARY RESPON-SIBILITY AMT. 12	DATE PROST BILL SENT TO BENE. 13	A/R WRITE OFF DATE 14
TOTAL													

FORM CMS-2552-10
EXHIBIT 2A, 3B, 3C

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION SENT (Y/N) 15a	RETURN DATE 15b	COL-LECT. EFFT. CEASE DATE 16	MEDI-CARE WRITE OFF DATE 17	RECOVERIES ONLY AMOUNT RE-CEIVED 18	MCR FYE DATE 19	MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS* DEDUCT 20	COINS 21	CURRENT YEAR PAYMENTS RECEIVED AMOUNT 22	SOURCE 23	ALLOW-ABLE BAD DEBTS 24	COMMENTS 25
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

Rev. 40-51

Proposed changes to Medicare Bad Debt, S10 and DSH Files

On June 22, 2022, (CMS) issued a Federal Register notice pertaining to the CMS-2552-10 Hospital and Health Care Complex Cost Report and included proposed changes to Medicare Cost Reporting instructions.

Source:https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2552-10

Have you run a revenue analysis to ensure you're maximizing reimbursement?

Free historical analysis to uncover potential missed net revenue:

- Medicare DSH
- Medicare Bad Debt
- S-10
- DRG-V assessment

***Expert tip**: take a longitudinal look at your Medicare reimbursement*

Historical Analysis of Uncompensated Care and Impact of Worksheet S-10				
Top US Hospital Pre Use of the S-10				
	Pre Worksheet S-10		Worksheet S-10 Transition	
	2016 Actual	2017 Actual	2018 Actual	2019 Actual
Total Uncompensated Care Pool	$6,406,145,534	$6,054,458,493	$6,766,695,163	$8,272,872,447
Change from previous year		-5.49%	11.76%	22.26%
System's Share - Factor 3 per PUF File	0.742133%	0.750951%	0.545960%	0.330698%
System's Share - Factor 3 as Whole #	742.13	750.95	545.96	330.70
Change from previous year		1.19%	-27.30%	-39.43%
System's UCC Payment	$47,542,127	$44,887,948	$36,943,417	$27,358,255
Dollar Change from previous year		($2,654,180)	($7,944,531)	($9,585,161)
Per Cent Chan				

Medicare Bad Debt (MBD) Revnue Opportunity - Cloudmed Historical Analysis				
	Conservative	Typical	Aggressive	Increase to
	1.00%	2.00%	3.00%	State Avg
	CLOUDMED MBD Projected Value Add Range*			
	$ 188,679	$ 377,359	$ 566,038	$ 1,097,517
	$ 396,548	$ 793,096	$ 1,189,644	$ 2,060,040
	$ 300,679	$ 601,357	$ 902,036	$ 1,236,305
	$ 319,998	$ 639,997	$ 959,995	$ 1,729,355
	$ 357,698	$ 715,396	$ 1,073,094	$ 2,185,477
	$ 475,011	$ 950,022	$ 1,425,032	$ 3,151,518
	$ 517,238	$ 1,034,476	$ 1,551,714	$ 3,093,207
	$ 2,555,851	**$ 5,111,703**	**$ 7,667,554**	**$ 14,553,419**

Hospital Fiscal Year End	E Parts A&B Ded and Coins	MBD Claimed	% D&C Claimed	% D&C State Avg	Crossover Claimed	% Crossover Claimed	% Crossover State Avg	% Crossover of D&C Claimed
12/31/2015	29,027,591	418,180	1.44%	7.26%	0	0.00%	4.09%	0.00%
128/31/2016	61,007,407	1,469,336	2.41%	7.60%	14,625	0.02%	4.67%	1.00%
12/31/2017	46,258,252	1,494,880	3.23%	7.34%	0	0.00%	4.57%	0.00%
12/31/2018	49,230,531	1,356,384	2.76%	8.16%	7,172	0.01%	4.79%	0.53%
12/31/2019	55,030,480	1,248,820	2.27%	8.38%	8,064	0.01%	4.52%	0.65%
12/31/2020	73,078,588	826,726	1.13%	7.77%	21,602	0.03%	3.80%	2.61%
12/31/2021	79,575,066	1,742,042	2.19%	8.17%	53,277	0.07%	3.16%	3.06%

IPPS FINAL RULE UPDATES

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Regulatory Updates, Insights, and Revenue Cycle Considerations

Proposed and Final Rule Insights from (IPPS, OPPS, MPFS)

RIS presented by NAHRI Revenue Integrity Symposium

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Several RFIs

(informs future rule making)

Proposed vs Finalized IPPS Outlier Threshold

($38K Finalized vs $43K Proposed)

No new MS-DRGs this year but....

(change is in the air)

PCS vs NDC criteria for NTAP

(Proposed - Not Finalized)

Transition of NCD edits to the MACs

(Proposed - Not Finalized)

Unspecified DX code Edit

(Took effect April 2022 and will remain)

CC 90 vs Remarks for reporting no-cost CAR-T therapies

(IPPS Finalized)

Skin Substitutes Rebrand

("Wound Care Management Products" - MPFS Proposal)

Claiming Stem Cell Acquisition Costs

(Worksheet D-6 still pending)

Part A Deductible for CY 2023 is $1,600

(Finalized)

340B OPPS CY 2023 Proposed Rule

Summary

- Effective Jan 1, 2023, CMS "fully anticipates" all OPPS drugs will again be paid at ASP + 6%
- CMS has proposed to offset the increase with a –4% adjustment to OPPS
- As the 2018 OPPS increase was only +3.2%, OP payments would be reduced by -0.8% below baseline
- In the OPPS Proposed Rule, CMS sought public comment on how to reconcile 2018 - 2022

How will CMS repay hospitals for 340B cuts?

The US District Court has yet to decide how CMS will remedy these claims. AHA is pushing HHS to ensure that not only should hospitals receive timely repayment for unlawful cuts to payment rates, but also that budget neutrality should not be applied to remedy the reimbursement cuts. "***Hospitals should not have to pay for the agency's mistakes***." – AHA

- RevCycleIntelligence, July 2022

Source: https://revcycleintelligence.com/news/aha-calls-for-timely-repayment-to-340b-hospitals-after-unlawful-cuts

340B Program Updates

BREAKING NEWS!

UPDATE

[Judge rules HHS must halt unlawful cuts to certain 340B hospitals for 2022]

- On 9/28/2022, the US District Court ruled that CMS must **immediately** start paying 340B drugs at ASP + 6%
- On 10/17/22, CMS issued the following update:

Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period

On September 28, 2022, the United States District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs in the Calendar Year 2022 Outpatient Prospective Payment System (OPPS) final rule with respect to their prospective application. The Court ruled:

- CMS can't apply the average sales price (ASP) minus 22.5% drug payment rate for these drugs for the rest of the year
- As a result, CMS will revert to paying the default rate (generally ASP plus 6%) under Medicare statute for 340B-acquired drugs

CMS is uploading revised OPPS drug files that will apply the default rate (generally ASP plus 6%) to 340B-acquired drugs for the rest of the year. CMS also will reprocess claims our contractors paid on or after September 28, 2022, using the default rate (generally ASP plus 6%).

- In the last week, messaging from the MACs has changed
- Things are developing hourly concerning how/if the MACs will adjust CY 2022 dates of service…stay tuned!

Source: https://revcycleintelligence.com/news/aha-calls-for-timely-repayment-to-340b-hospitals-after-unlawful-cuts

Drug Waste and Modifier "JZ"

Why this matters

- Since 2017, modifier "JW" reporting for drug wastage has been required on all separately payable, single dose drugs administered in the outpatient setting.
- This change could represent significant administrative burden for outpatient providers, with no positive payment impact.
- Hospitals should anticipate an increase in drug waste audits
- Review your CDM edits, charging practices, and drug waste documentation now to ensure compliance with current "JW" reporting and preparedness for "JZ"

CMS Proposes New Modifier for Reporting No Drug Waste

Section 90004 of the Infrastructure Investment and Jobs Act requires manufacturers to refund CMS for drug wastage exceeding 10% of the vial size. CMS doesn't trust that modifier "JW" is being reported consistently by hospitals, and has therefore proposed adding a new modifier, “JZ” to attest when there is no drug wastage.

2023 MPFS Proposed Rule; Would also apply to hospitals

Facet Joint Injections x Prior Authorizations

Why this matters

- CMS justified an earlier start date due to provider familiarity with Prior Auth (PA) protocol
- Hospitals should begin planning for this now as documentation requirements could pose a challenge
- Prior Auth is a Condition of Payment – no appeal rights
- Review the PA Operational Guide for documentation requirements, timelines, and how to achieve and maintain exemption status

CMS Plans to Add Facet Joint Injections to Prior Auth List

CMS has proposed adding Facet Joint Interventions to its list of services requiring Prior Authorization starting March 1, 2023. This decision is based on increased (over)utilization in the last 10 years and OIG findings on improper payments to physicians. Physicians are not subject to prior authorization requirements as a condition of payment.

2023 OPPS Proposed Rule (Not Yet Finalized)

New Tech: Cell and Gene Therapy

Why this matters

- Innovative, costly and unlike anything we've ever seen
- Complicated evolution of applicable codes, billing requirements, and payment structure (NTAP vs New DRG)
- Medicare has applied an unprecedented rate-setting methodology for CAR-T, but that could change
- There is a strong pipeline of new Cell and Gene Therapy products entering the market ($$$)
- Hospital charging practices matter more than ever for future rate-setting!

Charging towards the next generation of CAR-T

On the heels of an FDA go-ahead for gene therapy Zynteglo, bluebird bio has won an FDA-accelerated approval for Skysona for the rare neurological disorder cerebral adrenoleukodystrophy (CALD). The company is charging **$3 million** per treatment with Skysona, higher than Zynteglo's $2.8 million, making it the priciest therapy in the world.

- Fierce Pharma Sept '22

https://www.fiercepharma.com/pharma/3m-gene-therapy-bluebird-breaks-own-record-fda-approval-skysona

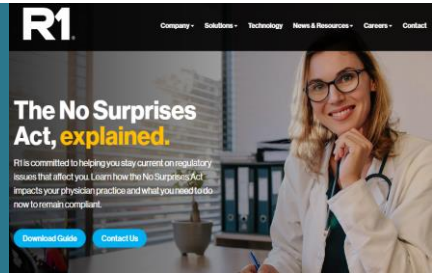
No Surprises Act (NSA)

Why this matters

- Billions of dollars at stake for payers and providers depending on how arbitrator rules
- Providers won the argument that proposed rule prevented meaningful negotiation and tipped in favor of payers
- Ensure you have workplan ready on how you'll meet and fight for the requirements of the rule

Check out R1's No Surprises Act Resource Center

Link Here



NSA arbitration process gets an update

Arbitrators need to consider all permissible information in order to settle out-of-network disputes between providers and payers, and determine the appropriate out-of-network rate to be reimbursed

- Fierce Healthcare, Aug 2022

Source: https://www.fiercehealthcare.com/providers/biden-admin-releases-final-surprise-billing-rule-updates-arbitration-process-after-legal

Inflation Reduction Act (IRA)

Why this matters

- Providers realize better reimbursement as patients continue to remain on ACA plans
- CMS to negotiate drug prices directly with drug manufacturers (Top 10 under Part D in 2026; Top 15 under Part B in 2028)
- Despite positive steps, hospitals still need more financial support given impacts of pandemic

IRA signed into law → positive implications for healthcare

The bill funds marketplace health insurance premium subsidies and expands Medicare prescription drug benefits, including a cap on the cost of insulin and other Part D reforms to reduce healthcare costs

-HealthcareDive, Aug 2022

Source: https://www.healthcaredive.com/news/biden-signs-inflation-reduction-act-aca-subsidies-payers-hospitals/629865/

Medicare Advantage x Prior Authorizations

Why this matters

- Reduces administrative burden on RCM teams with faster, real-time decisions on prior auth requests that routinely get approved
- Enrollment in MA program on track to reach nearly 70% of Medicare population by 2030 (HealthAffairs)
- Vote could take place this year (strong bipartisan support in Senate)
- Success of this ruling could eventually cascade down to commercial plans

House passes law to streamline authorizations for MA patients

The Improving Seniors' Timely Access to Care Act aims to modernize antiquated prior authorization processes, making it easier and faster for seniors to get medical care.

- Modern Healthcare, Sep 2022

Source:https://www.medicaleconomics.com/view/house-passes-reform-to-medicare-advantage-prior-authorizations

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Tips and Resources

Resources to support you

We have a new IPPS Resource page!

For more detailed IPPS Memo

https://www.cloudmed.com/ipps-resource-center/

Other recommended IPPS links

CMS.gov | Web Pricer Inpatient PPS

https://webpricer.cms.gov/#/provider-directory/ipps

FY 2023 IPPS Final Rule Home Page
https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page

Watch for more from our government experts

IPPS Webinar FAQ Guide (Oct)
MAPAM Conference (Massachusetts) (Oct 24)
OPPS Final Rule Memo (Nov)
Medicare Cost Report webinar (HANYS) (Q4)
340B Insider webinar (Q4)

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Q&A

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