TOYON ASSOCIATES, INC.

Toyon University® Presents

FFY 2024 Medicare IPPS Proposed Rule

May 9, 2023

Contents

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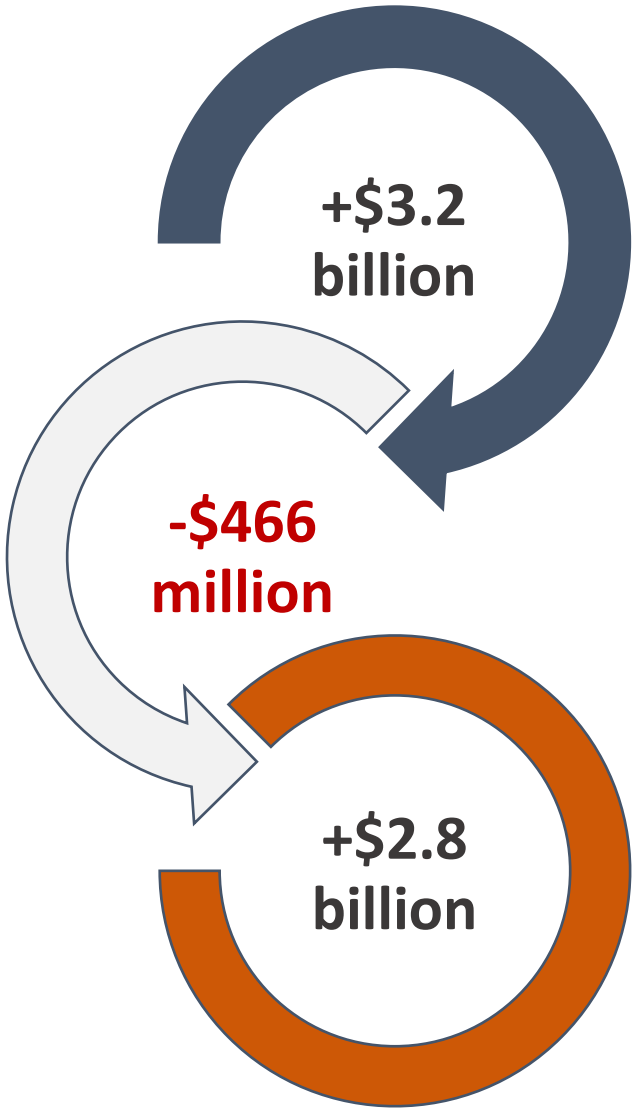
Comments to CMS

- Comments are due to CMS no later than 5 p.m. EDT on Friday June 9, 2023
- In commenting, please refer to file code CMS–1785–P
- Comments may be sent electronically at https://www.regulations.gov/ (see instructions under the ‘‘submit a comment’’ tab)
- Comments may also be submitted by mail to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1785–P, P.O. Box 8013, Baltimore, MD 21244–1850

FFY 2024 IPPS Rate Setting

National IPPS Payments



Increase to operating payments (includes -$169 million reduction to UC DSH)

Decrease in payments related to payment changes in programs for new technology

Net overall change of +$2.8 billion in IPPS payments, as compared to FFY 2023

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Payment Updates

% Impact on Medicare FFS Payments

Adjustments	FFY 2024 Proposed Rule	FFY 2023 Final Rule	Change
Market Basket	3.00%	4.10%	-1.10%
Documentation and Coding Restoration	0.00%	0.50%	-0.50%
ACA Productivity Adjustment	-0.20%	-0.30%	0.10%
Net Update	**2.80%**	**4.30%**	**-1.50%**

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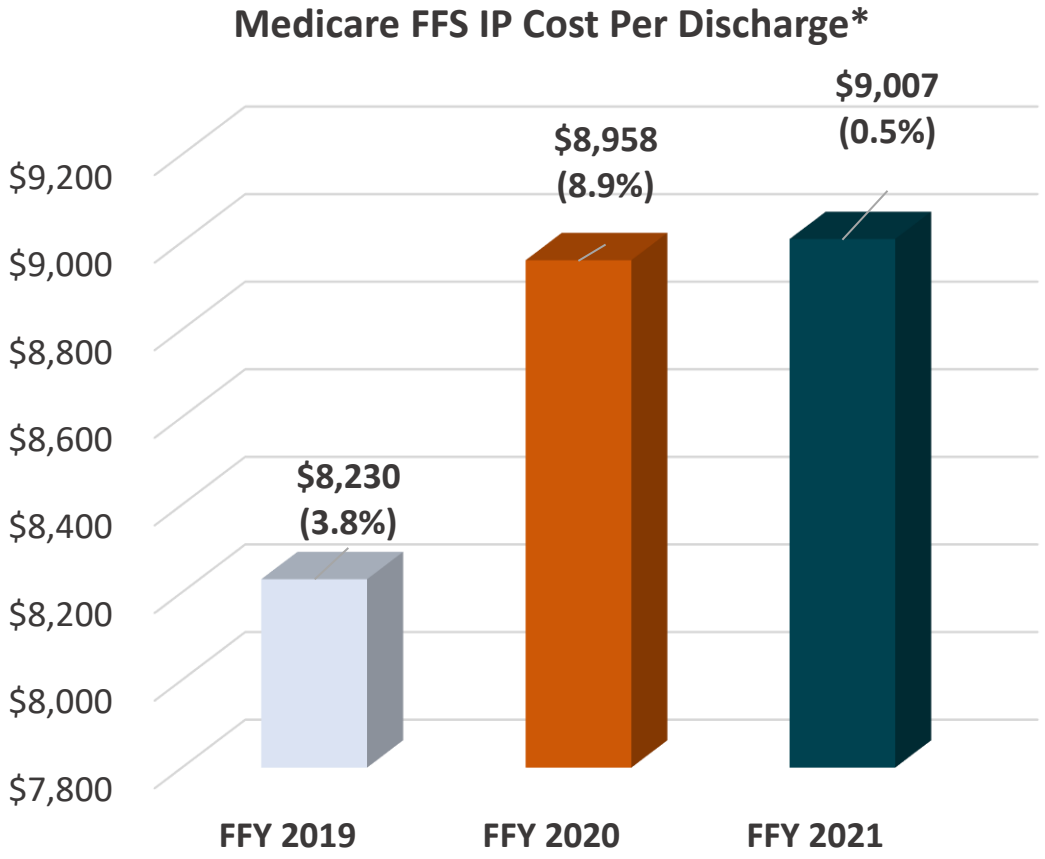
Request for Market Basket Increase



*Data per Healthcare Cost Report Information System (HCRIS)

Recommended Comment to CMS

Request add-on to market basket increase greater than 3.0%

- MedPAC recommends a one percent increase to the FFY 2024 market basket (i.e., from 3% to 4%).
- MedPAC's March 2023 Report to Congress states CMS's market basket updates in prior years are understated.
  - For instance, the FFY 2022 hospital price increase was 3% higher than the market basket applied by CMS.
- Recognition of the inflation in healthcare expenses, rising insurance premiums and investments to ensure continued access to quality care in provider communities is needed in the market basket update.
  - Hospital costs have increased 4.4% on average over the past three years.
  - The most notable increase is 8.9% from FFY 2019 to FFY 2020.

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Standard Rates

2.80% Full Update Quality Reporting and Meaningful EHR User		
Labor | Non-Labor	**FFY 2024 PR**	**FFY 2023 FR**
Wage Index > 1.0000		
Labor (67.6%)	$4,410.86	$4,310.00
Non-Labor (32.4%)	$2,114.08	$2,065.74
Wage Index < = 1.0000		
Labor (62.0%)	$4,045.46	$3,952.96
Non-Labor (38.0%)	$2,479.48	$2,422.78

2.05% Reduced Update Meaningful Health User, but Not for Quality Data		
Labor | Non-Labor	**FFY 2024 PR**	**FFY 2023 FR**
Wage Index > 1.0000		
Labor (67.6%)	$4,378.68	$4,267.44
Non-Labor (32.4%)	$2,098.66	$2,045.34
Wage Index < = 1.0000		
Labor (62.0%)	$4,015.95	$3,913.92
Non-Labor (38.0%)	$2,461.39	$2,398.86

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Standard Rates

0.55% Reduced Update Quality Data, but not as Meaningful EHR User		
Labor/Non-Labor	**FFY 2024 PR**	**FFY 2023 FR**
Wage Index > 1.0000		
Labor (67.6%)	$4,314.32	$4,182.32
Non-Labor (32.4%)	$2,067.81	$2,004.54
Wage Index < = 1.0000		
Labor (62.0%)	$3,956.92	$3,835.85
Non-Labor (38.0%)	$2,425.21	$2,351.01

-0.20% Reduced Update Not as Meaningful Health User or for Quality Data		
Labor/Non-Labor	**FFY 2024 PR**	**FFY 2023 FR**
Wage Index > 1.0000		
Labor (67.6%)	$4,282.14	$4,139.76
Non-Labor (32.4%)	$2,052.39	$1,984.15
Wage Index < = 1.0000		
Labor (62.0%)	$3,927.41	$3,796.82
Non-Labor (38.0%)	$2,407.12	$2,327.09

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Other Key Standard Rates

Description	FFY 2024 Proposed Rule	FFY 2023 Final Rule
National UC DSH Funding	$6,801,695,884	$6,970,733,471
Sequestration Adjustment	-2.00%	-2.00%
Capital Rate	$505.54	$483.76
Fixed Loss Outlier Threshold	$40,732.00	$38,859.00

Long Term Care Hospital (LTCH) Rates:

LTCH Full Update	$47,948.15	$46,432.77
LTCH Reduced Update	$47,016.21	$45,538.11

MS-DRG Weights – Top 25 Increases

MS-DRG	MS-DRG Title	FFY 24 Proposed	FFY 23 Final	Variance
017	AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC	6.16	4.37	40.91%
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN..	26.60	18.98	40.13%
886	BEHAVIORAL AND DEVELOPMENTAL DISORDERS	1.67	1.37	22.04%
117	INTRAOCULAR PROCEDURES WITHOUT CC/MCC	1.21	0.99	21.57%
883	DISORDERS OF PERSONALITY AND IMPULSE CONTROL	1.89	1.61	16.78%
592	SKIN ULCERS WITH MCC	2.07	1.78	16.13%
876	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	3.71	3.20	16.05%
849	RADIOTHERAPY	2.69	2.34	15.18%
507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITH CC/MCC	2.13	1.85	14.74%
533	FRACTURES OF FEMUR WITH MCC	1.63	1.43	14.18%
297	CARDIAC ARREST, UNEXPLAINED WITH CC	0.72	0.64	13.85%
425	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITHOUT CC/MCC	1.62	1.43	13.43%
820	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH MCC	6.01	5.32	13.00%
090	CONCUSSION WITHOUT CC/MCC	0.93	0.82	12.76%
814	RETICULOENDOTHELIAL AND IMMUNITY DISORDERS WITH MCC	2.11	1.88	12.23%
727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM WITH MCC	1.61	1.44	12.22%
598	MALIGNANT BREAST DISORDERS WITH CC	1.20	1.07	11.93%
697	URETHRAL STRICTURE	1.11	0.99	11.84%
855	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITHOUT CC/MCC	1.71	1.53	11.76%
922	OTHER INJURY, POISONING AND TOXIC EFFECT DIAGNOSES WITH MCC	1.74	1.56	11.60%
113	ORBITAL PROCEDURES WITH CC/MCC	2.50	2.25	11.52%
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL…	1.10	0.99	11.37%
928	FULL THICKNESS BURN WITH SKIN GRAFT OR INHALATION INJURY WITH CC/MCC	6.89	6.19	11.24%
884	ORGANIC DISTURBANCES AND INTELLECTUAL DISABILITY	1.74	1.57	10.93%
019	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS	7.89	7.13	10.62%

MS-DRG Weights – 32 DRGs Held Harmless at 10.00% Reduction from FFY 2023

MS-DRG	MS-DRG Title	FFY 24 Proposed	FFY 23 Final	Variance
022	INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITHOUT…	3.92	4.36	-10.00%
136	SINUS AND MASTOID PROCEDURES WITHOUT CC/MCC	1.04	1.16	-10.00%
159	DENTAL AND ORAL DISEASES WITHOUT CC/MCC	0.67	0.75	-10.00%
290	ACUTE AND SUBACUTE ENDOCARDITIS WITHOUT CC/MCC	1.09	1.21	-10.00%
295	DEEP VEIN THROMBOPHLEBITIS WITHOUT CC/MCC	0.80	0.89	-10.00%
332	RECTAL RESECTION WITH MCC	3.65	4.06	-10.00%
411	CHOLECYSTECTOMY WITH C.D.E. WITH MCC	3.04	3.38	-10.00%
412	CHOLECYSTECTOMY WITH C.D.E. WITH CC	2.07	2.30	-10.00%
424	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITH CC	2.13	2.37	-10.00%
509	ARTHROSCOPY	1.37	1.52	-10.00%
547	CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	0.82	0.91	-10.00%
550	SEPTIC ARTHRITIS WITHOUT CC/MCC	0.94	1.05	-10.00%
582	MASTECTOMY FOR MALIGNANCY WITH CC/MCC	1.74	1.93	-10.00%
599	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	0.67	0.75	-10.00%
601	NON-MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	0.63	0.70	-10.00%
672	URETHRAL PROCEDURES WITHOUT CC/MCC	0.94	1.04	-10.00%
688	KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	0.78	0.87	-10.00%
709	PENIS PROCEDURES WITH CC/MCC	2.17	2.41	-10.00%
710	PENIS PROCEDURES WITHOUT CC/MCC	1.30	1.44	-10.00%
783	CESAREAN SECTION WITH STERILIZATION WITH MCC	1.74	1.93	-10.00%
798	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC	0.84	0.93	-10.00%
802	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITH MCC	3.43	3.81	-10.00%
817	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH MCC	2.82	3.13	-10.00%
818	OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH CC	1.43	1.59	-10.00%
826	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WITH MAJOR O.R…	4.63	5.14	-10.00%
831	OTHER ANTEPARTUM DIAGNOSES WITHOUT O.R. PROCEDURES WITH MCC	1.08	1.19	-10.00%
836	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	1.41	1.57	-10.00%
837	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR WITH HIGH DOSE…	4.84	5.38	-10.00%
838	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH CC OR HIGH DOSE…	2.00	2.22	-10.00%
848	CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	0.84	0.93	-10.00%
949	AFTERCARE WITH CC/MCC	1.07	1.19	-10.00%
970	HIV WITH EXTENSIVE O.R. PROCEDURES WITHOUT MCC	2.78	3.09	-10.00%

Quality-Based Reimbursement

Value Based Purchasing (VBP)*			Hospital Acquired Condition (HAC) Reduction Program		Hospital Readmissions Reduction Program (HRRP)
Returns in FFY 2024 after being suppressed in FFY 2023	Proxy VBPs are in Table 16A of the Proposed Rule, but will be updated with more current data after the Final Rule (Table 16B)	FFY 2026 modifications (based on 2024 activity) focused on quality performance for Medicare-Medicaid beneficiaries	Returns in FFY 2024 after being suppressed in FFY 2023	Hospitals in the lowest quartile on select measures receive the one-percent payment reduction to IPPS payments	No proposed changes for FFY 2024

***All IPPS hospitals are subject to a 2 percent contribution to the VBP pool, which is estimated to be $1.7bn for FFY 2024**

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Medicare Dependent Hospital (MDH) Status

Section 4102 of the 2023 extends the MDH program through FFY 2024

If a MDH canceled a rural reclassification effective on or after 10/1/22, then the provider must again request to be reclassified as rural and reapply for MDH classification

Low Volume Adjustment (LVA)*

Section 4101 of the 2023 CAA criteria (1 of 2):

- More than 15 road miles from another subsection (d) hospital

Section 4101 of the 2023 CAA criteria (2 of 2):

- Less than 3,800 total discharges on most recent cost report
- Hospitals with less than 500 total discharges receive the maximum 25% adjustment

***Hospitals have until September 1, 2023, to request low volume status for FFY 2024.**

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Medicare Disproportionate Share (DSH)

Uncompensated Care (UC)

&

Empirical Method

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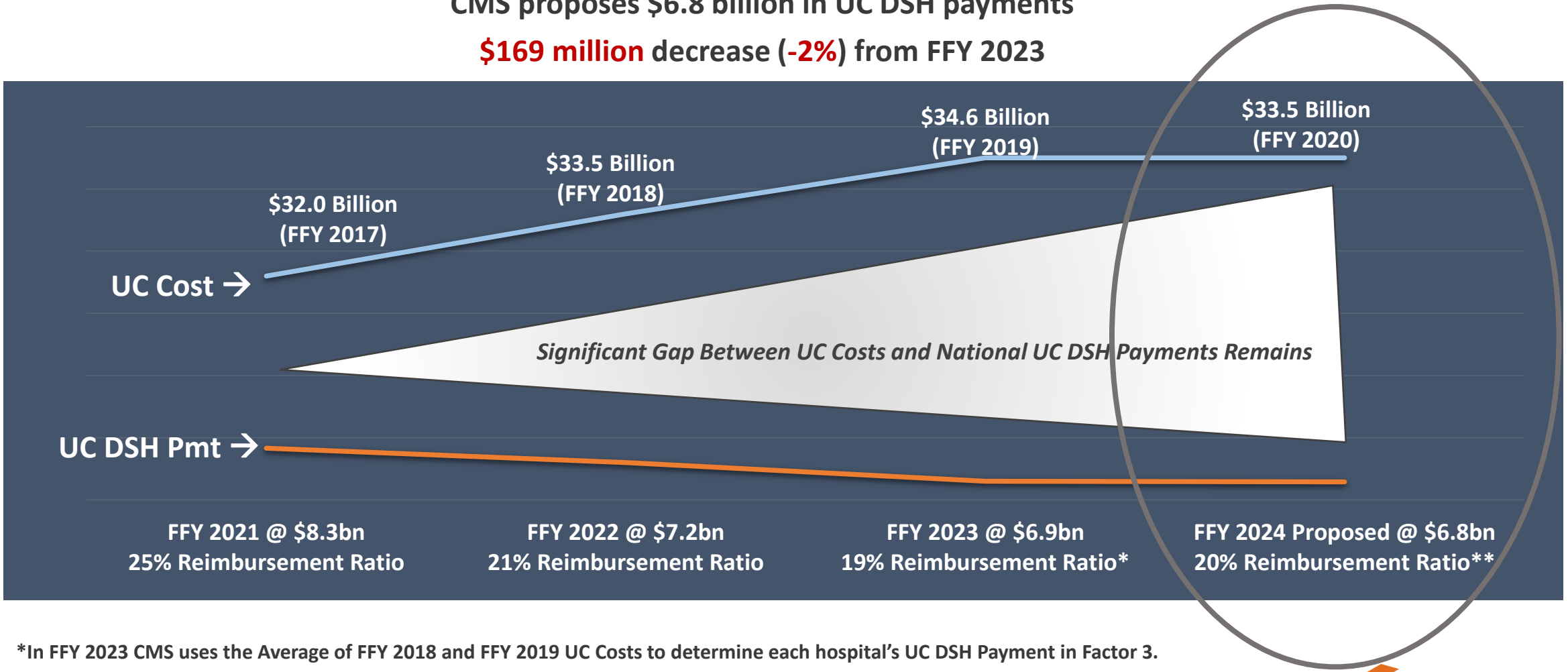
Uncompensated Care DSH

CMS proposes $6.8 billion in UC DSH payments

$169 million decrease (-2%) from FFY 2023



*In FFY 2023 CMS uses the Average of FFY 2018 and FFY 2019 UC Costs to determine each hospital's UC DSH Payment in Factor 3.

**In FFY 2024, CMS proposes to use the average of FFY 2018, 2019 and 2020 UC Costs to determine each hospital's UC DSH Payment in Factor 3.

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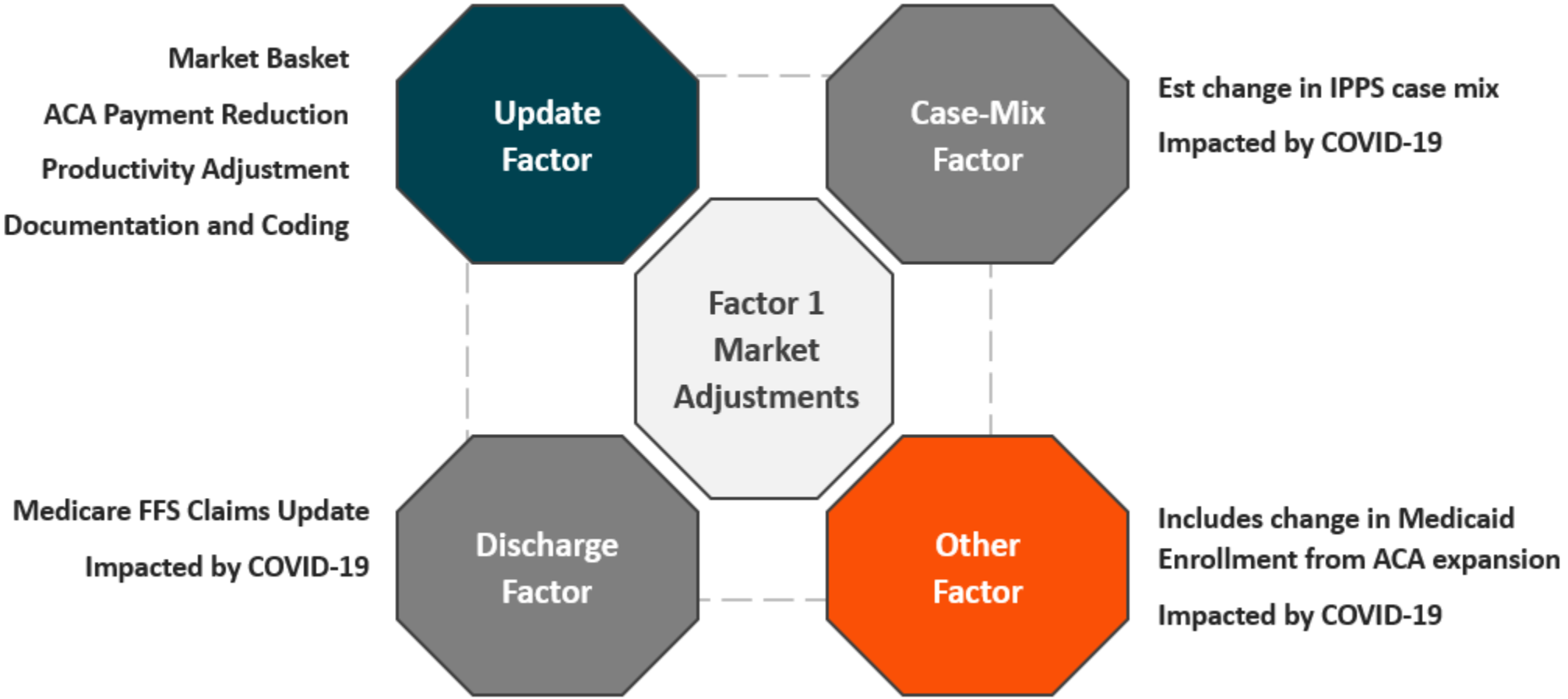
Uncompensated Care DSH

	Proposed FFY 2024	Final FFY 2023	Final FFY 2022
Factor 1 (Empirical DSH Estimates Not Accounting for ACA Implementation)			
Base Year Empirical DSH (Before Factor 1 Update)	$13,257,000,000	$13,814,000,000	$13,882,000,000
Factor 1 Updates	**$364,387,093**	**$134,974,706**	**$102,752,729**
Projected DSH Payments	**$13,621,387,093**	**$13,948,974,706**	**$13,984,752,729**
75% of Available UC DSH Funds	75.00%	75.00%	75.00%
Gross Uncompensated Care Pool (Factor 1)	**$10,216,040,320**	**$10,461,731,029**	**$10,488,564,547**
Factor 2 (Reduction for Change in Uninsured Population)			
Uninsured Population Reduction (Factor 2)	**65.71%**	**65.71%**	**68.57%**
National UC DSH Funding			
Adjusted UC DSH Funding	$6,712,960,094	$6,874,403,459	$7,192,008,710
Supplemental UC DSH Funding	$88,735,790	$96,330,012	$0
Total UC DSH Funding	**$6,801,695,884**	**$6,970,733,471**	**$7,192,008,710**
Change from Prior Year ($)	**($169,037,587)**	**($221,275,239)**	**($1,098,005,811)**
Change from Prior Year (%)	**-2.42%**	**-3.08%**	**-13.24%**

Uncompensated Care DSH



Uncompensated Care DSH

Suggested Comments to CMS on Factor 1 Changes

If adopted, recommendations could increase the UC DSH Fund by $1 billion

DSH hospitals would receive 23% of UC Cost as compared to proposed 20% of UC Cost

Update Factor (Market Basket)

- Update 2022 by 3.0 percentage points (per MedPAC finding that hospitals incurred prices 3 percentage points higher than CMS's 2022 market basket)
- Implement MedPAC recommendation of 1% increase to CMS's FFY 2024 Market Basket

Source: MedPAC's March 2023 Report to Congress

Medicare Discharge Factor

- Use of higher Medicare projections
- March 2023 Medicare Trustee Report* estimates higher projections than the FFY 2024 IPPS Proposed Rule

*Admissions Incidence (pg. 121)

Uncompensated Care DSH

FFY 2020 DSH: $13.3bn

Projected FFY 2024 DSH: $13.6bn

	A	B	C	D	E	F= B*C*D*E		
FFY	**Base Pmts (bns)**	**Update**	**Discharges**	**Case-Mix**	**Other**	**Factor 1 Total**	**Updated Pmts (bns)**	**Key**
2020	$13.3							
2021		1.0290	0.9400	1.0290	0.9850	0.9804	$13.0	
2022		1.0250	0.9430	0.9970	1.0011	0.9647	$12.4	
2023		1.0430	0.9750	1.0050	1.0484	1.0715	$13.4	
2024		1.0280	0.9760	1.0050	1.0055	1.0139	**$13.6**	A
75% of Expenditure							**$10.2**	**B = A*.75**
Factor 2							**65.7%**	**C**
UC DSH Pool							**$6.7**	**D = B*C**

Uncompensated Care DSH

Factor 1 with Changes (Based on Suggested Comments)

FFY 2020 DSH: $13.3bn

Updated Projected FFY 2024 DSH: $15.6bn

	A	B	C	D	E	F= B*C*D*E	
FFY	**Base Pmts (bns)**	**Update**	**Discharges**	**Case-Mix**	**Other**	**Factor 1 Total**	**Updated Pmts (bns)**	**Key**
2020	$13.3							
2021		1.0290	0.9400	1.0290	0.9850	0.9804	$13.0	
2022		1.0550	0.9760	0.9970	1.0011	1.0277	$13.4	
2023		1.0430	1.0230	1.0050	1.0484	1.1242	$15.0	
2024		1.0380	0.9930	1.0050	1.0055	1.0416	**$15.6**	E
75% of Expenditure							**$11.7**	**F = E*.75**
Factor 2							**65.7%**	**G**
UC DSH Pool							**$7.7**	**H = F*G**
Change as Compared to FFY 2024 Proposed							**$1.0**	

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Uncompensated Care DSH

Suggested Comments to CMS on Factor 2 Changes

Measurement of Change in Uninsured Since ACA

- **Recognize recent data on anticipated decreases in Medicaid enrollment as an increase to the uninsured population** (i.e., due to the expiration of the continuous enrollment provision in the Families First Coronavirus Response Act).
  - Naturally Occurring Retirement Community (NORC) projects 3.8 million people will lose Medicaid coverage and become uninsured due to the sunsetting provisions of the FFCRA.
  - In the Factor 1 estimate, CMS decreases the projected DSH expenditure based on an expected decrease of 11% to the Medicaid population in FFY 2024 (due to beneficiaries losing coverage after the conclusion of the COVID-19 Public Health Emergency).
  - It is recommended CMS applied recent projections of declining Medicare enrollment to increase the Factor 2 adjustment.

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Uncompensated Care Funding

Factor 3
Each DSH Hospital's Proportion of UC DSH Funding

CMS Proposes to use the **average UC cost from FFY 2018, FFY 2019 and FFY 2020 to determine Factor 3.**

- If necessary, Toyon recommends providers request amended cost reports and/or re-openings for any material UC cost changes applicable to prospective data used for UC DSH payments.
  - FFY 2025 UC DSH will use 2019, 2020 and 2021 UC cost data.
- CMS states any changes to prior year UC costs (i.e., from 2018, 2019 and/or 2020) needed to be submitted earlier this year so that the data was available in the March 2023 HCRIS update.

Toyon recommends providers comment to CMS requesting a clear S-10 revision timeline and process, like wage index.

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Uncompensated Care Funding

Verification of Worksheet S-10 UC cost (Factor 3)

- Providers have until **July 30th** to notify CMS for issues related to mergers and/or to report potential upload discrepancies due to MAC mishandling of Worksheet S-10 data during the report submission process (i.e., not reflecting audit results due to MAC mishandling or most recent report differs from previously accepted amended report due to MAC mishandling).
- Please see CMS's filed entitled "FY 2024 IPPS Proposed Rule Medicare DSH Supplemental Data File" (ZIP file) at CMS's FFY 2024 Proposed Rule website.
- Providers may contact CMS at Section3133DSH@cms.hhs.gov to request corrections.

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Empirical DSH

Section 1115 Demonstration Days

Proposed in the February 28, 2023 Federal Register

Current State

- Patients ‘‘regarded as’’ eligible for medical assistance under an approved State Medicaid plan*
- Patient days for which hospitals have received payment from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration
- Patient days for patients who received premium assistance under a section 1115 demonstration

*Deficit Reduction Act (DRA), 1886(d)(5)(F)(vi) of the Social Security Act

*CFR §412.106(b)(4)

Proposed For FFY 2024
(Discharges on/after 10/1/2023)

Patients regarded as ‘‘eligible for medical assistance under a State plan approved under title XIX’’, patients who:

1) Receive health insurance authorized by a section 1115 demonstration; or
2) Buy health insurance with premium assistance provided to them under a section 1115 demonstration, where State expenditures to provide the health insurance or premium assistance is matched with funds from title XIX (Medicaid)

Section 1115 demonstration days are allowable whereby a patient is not entitled to Medicare Part A benefits, and:

1) Their health insurance covers inpatient hospital services; or
2) Premium assistance covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services

CMS Proposes to exclude patient days for which hospitals have received payment from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration

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Empirical DSH

Section 1115 Demonstration Days

Proposed in the February 28, 2023 Federal Register

CMS notes the following seven states whereby patient days would qualify in the DSH calculation (as these states provide benefits that are 100% of the premium cost to the patients):

States with Allowable 1115 Demonstration Days (Discharges on/after 10/1/2023)	1. Arkansas
	2. Massachusetts
	3. Oklahoma
	4. Rhode Island
	5. Tennessee
	6. Utah
	7. Vermont

Empirical DSH

Capital DSH for Rural Reclassified Hospitals

CMS proposes DSH hospitals reclassified as rural under 42 CFR § 412.103 will be eligible to receive capital DSH payments

This proposal is effective for discharges on or after October 1, 2023 (FFY 2024)

Toyon estimates 578 rural reclassified hospitals will receive $170 million in capital DSH payments in FFY 2024 as result of this change

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Safety-Net Hospital Request for Information

Safety-Net Hospital Request for Information

Medicare Safety Net Index (MSNI)

1. Medicare Low-Income Subsidy (LIS) Enrollment Ratio: Medicare dual Eligible +Part D LIS*) / Total Medicare IP Discharges
2. Ratio of Uncompensated Care Costs to Total Operating Revenue
3. Medicare Share of Total Inpatient Days

MedPAC Recommends

1. Transition empirical DSH and UC DSH through the MSNI
2. Add $2 billion to the MSNI pool
3. Reimburse providers through scaled IPPS and OPPS percentage add-on amounts and corresponding amounts for MA population

Sources:

MedPAC Report to Congress March 2023

MedPAC Report to Congress June 2022

***Part D (Prescription Coverage) = Income below 150 percent of the federal poverty level**

Safety-Net Hospital Request for Information

TABLE 3-8 Simulated effect of redistributing current DSH and UC payments under the MSNI and adding $1 billion to the FFS MSNI pool by type of hospital, 2019

Hospital characteristic	Mean MSNI percentage add-on to FFS Medicare payments*	Aggregate percentage change in:		Percentile effect on all-payer total margins in percentage points**			
		FFS Medicare revenue	All-payer total revenue	5th	25th	75th	95th
All IPPS hospitals	10.4%	0.5%	0.1%	-1.7%	-0.4%	1.7%	4.6%
Government (*n* = 349)	14.0	-1.5	-0.6	-2.6	-0.5	1.6	4.6
For profit (*n* = 592)	11.6	2.3	0.8	-1.7	0.0	2.4	5.7
Nonprofit (*n* = 1,663)	9.2	0.5	0.2	-1.6	-0.4	1.4	4.2
Rural (*n* = 611)	13.7	3.3	1.1	-0.4	0.0	2.6	5.7
Urban (*n* = 1,990)	9.3	0.2	0.1	-2.0	-0.6	1.4	4.2
Teaching (*n* = 1,568)	10.1	0.1	0.0	-2.3	-0.6	1.4	4.0
Nonteaching (*n* = 1,033)	10.5	1.3	0.4	-1.4	0.0	1.8	5.1
MA share of stays							
< 25% (*n* = 1,308)	9.7	0.7	0.2	-1.2	0.0	1.4	5.0
25% to 50% (*n* = 949)	10.2	0.5	0.2	-1.7	-0.4	1.9	4.3
> 50% (*n* = 347)	12.5	-0.3	-0.1	-3.1	-1.0	1.6	4.4

Note: DSH (disproportionate share hospital), UC (uncompensated care), MSNI (Medicare Safety-Net Index), FFS (fee-for-service), IPPS (inpatient prospective payment systems), MA (Medicare Advantage). The table presents unweighted mean values comparing payments that occurred in 2019 with what payments would have been under an MSNI distribution of safety-net dollars. Data include all IPPS hospitals in the United States (excluding territories) with more than 200 discharges and complete cost report data in 2019. The 5th and 95th percentiles on the right-hand side of the table illustrate that 5 percent had a reduction equal to or larger than the 5th percentile and 5 percent had an increase equal to or larger than the 95th percentile in our 2019 simulation.
*Add-on adjustments are applied to inpatient and outpatient payments excluding Part B drugs.
**Estimates of change in total margins assume that MA plans shift payment rates to equal the shift in FFS payment rates and that the ratio of MA to FFS volume can be estimated using the ratio of MA discharges to FFS discharges.

Source: MedPAC analysis of cost report and claims data.

MSNI Payment Simulation

MedPAC Report to Congress (March 2023)

TOYON ASSOCIATES, INC.

Safety-Net Hospital Request for Information

#	Question
1	How should safety-net hospitals be identified or defined?
2	What factors should not be considered when identifying or defining a safety-net hospital and why?
3	What are the different types of safety-net hospitals?
4	What are the main challenges facing safety-net hospitals?
5	What are particular challenges facing rural safety-net hospitals?
6	What new approaches or modifications to existing approaches should be implemented or considered to address these challenges, either for safety-net hospitals in general, or for specific types of safety-net hospitals, including rural safety-net hospitals?
7	How helpful is it to have multiple types or definitions of safety-net hospitals that may be used for different purposes or to help address specific challenges?
8	For Medicare purposes, would these new or modified approaches require new statutory authority, or could they be accomplished using existing statutory authority? If existing statutory authority, please identify the existing statutory authority.
9	Are there specific payment approaches either as previously described or otherwise to consider for rural safety-net hospitals, including acute care hospitals and CAHs, to address challenges?

Safety-Net Hospital Request for Information

#	Question
10	For any new or modified approaches, how can specific hospitals be identified as safety-net hospitals, or a type of safety-net hospital, using existing data sources? Are there new data sources that should be developed to better identify these hospitals?
11	Is MedPAC's SNI an appropriate basis for identifying safety-net hospitals for Medicare purposes? How might it be improved? Should there be a threshold for identifying safety net hospitals using the SNI?
12	Should an area-level index, such as the ADI*, be part of an appropriate basis for identifying safety-net hospitals? Would it be appropriate to adapt the risk-factors based scores used in the Shared Savings Program to the identification of safety-net hospitals? How might it be adapted?
13	Are there social determinants data collected by hospitals that could be used to inform an approach to identify safety net hospitals? Are there HHS or CMS policies that could support that data collection?
14	What challenges do safety-net hospitals face around investments in information technology infrastructure? What are ways that HHS policy could advance more robust investments in infrastructure for safety net hospitals? How could any potential payment adjustments be determined?
15	Should safety-net hospitals' reporting burden and compensation be different than other hospitals? If so, how?
16	What are the patient demographics at safety-net hospitals? What challenges do patients of safety net hospitals face before and after receiving care at the hospital?
17	Given Administration efforts to reduce the patient burden of medical debt, are there ways to develop payment approaches for safety net hospitals that would also support hospital patients that need financial assistance?

***Per the Assistant Secretary for Planning and Evaluation (ASPE) - The Area Deprivation Index (ADI) or the Social Deprivation Index (SDI) are the best available choices when selecting an index for addressing health related social needs or social determinants of health.**

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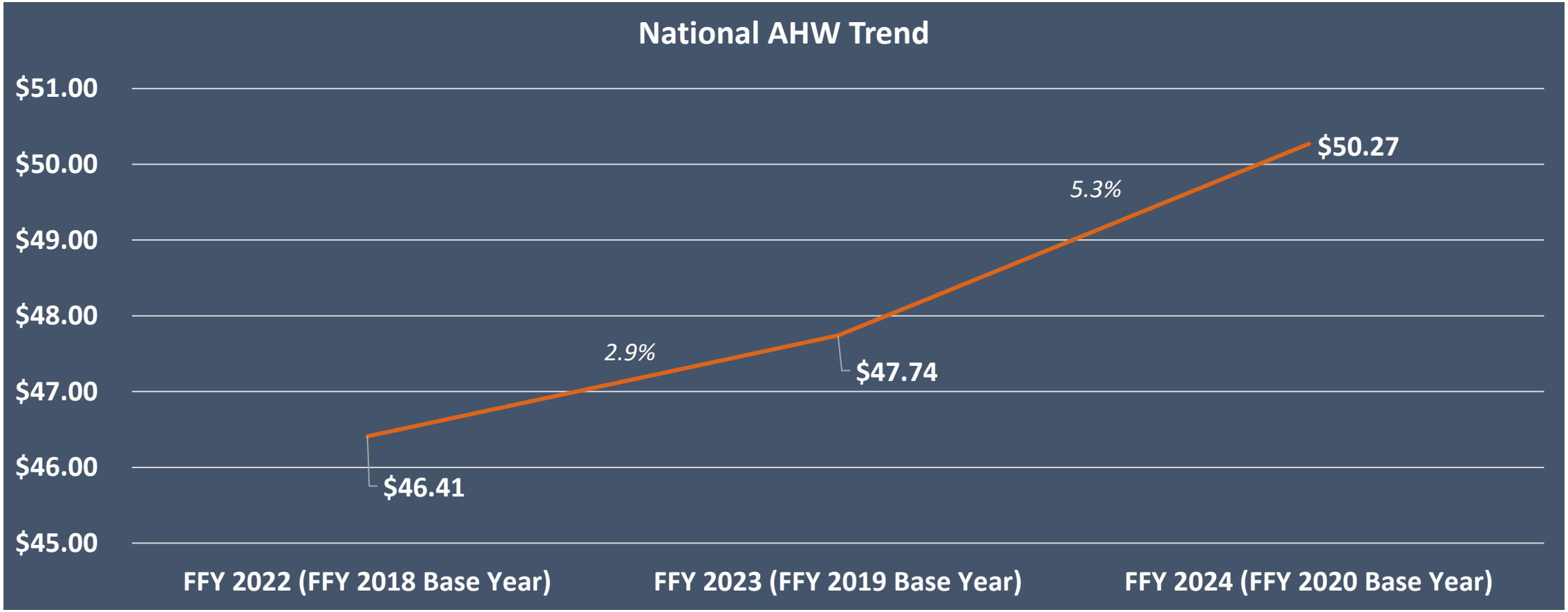
Wage Index Update

Wage Index Update



Proposed Wage Index Policy Changes

5% Cap

Permanent cap "to smooth year-to-year decreases in hospitals' wage indexes" regardless of circumstances causing a hospital's decline

State Rural Floor

Proposed inclusion of urban-to-rural reclassified hospitals (§412.103) when determining a state's rural floor wage index

High-Low Adjustment

Continues policy to reduce wage index high-to-low disparities by increasing the values for low wage index hospitals below the 25th percentile (or a WIF of 0.8615 in FFY 2024)

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Rural Floor Hypothetical Illustration

Hospitals	AHW	% of CBSA	412.103 Rural Reclassification	MGCRB Reclassification
Provider 1	$55.56	27.00%		
Provider 2	$57.14	22.00%		
Provider 3	$50.00	16.00%		
Provider 4	$57.14	33.00%	Yes	Yes*
Provider 5	$58.33	2.00%	Yes	Yes*

Rural Floor Wage Index is Higher of A or B

A. Rural Floor Wage Index: No 412.103 Reclassifications:

Total AHW *(Providers 1, 2, 3)*	**$54.55**
National AHW	**$50.27**
Wage Index no 412.103 Hospitals	**1.0850**

B. Rural Floor Wage Index: Including 412.103 Reclassifications:

Total AHW *(Providers 1, 2, 3, 4 and 5)*	**$55.44**
National AHW	**$50.27**
Wage Index with 412.103 Hospitals	**1.1028**

***If provider was not reclassified to another CBSA (MGCRB reclassification), then provider would be included in the rural floor wage index calculation under both Scenarios A and B.**

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Wage Index Update – Important Dates

June 10, 2023

Rural Redesignation Lock-In Date

June 15, 2023

Medicare Geographic Classification Review Board (MGCRB) Terminations and Withdraws*

***Reclassified hospitals are not eligible to receive an out-migration factor adjustment, so hospitals that are expected to receive a rural floor wage index (imputed or Statewide rural floor) should consider reclassification withdrawal to secure an outmigration adjustment.**

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Graduate Medical Education

Increased Medicare Advantage Allied Health Funding Calendar Years 2010 – 2019

Calendar Year	Revised MA Allied Health Pool Section 4143 CAA, 2023	Funding Increase (Compared to $60M)	Funding Increase %
2010	$62,997,033	$2,997,033	5.00%
2011	$66,438,422	$6,438,422	10.73%
2012	$76,035,672	$16,035,672	26.73%
2013	$84,753,118	$24,753,118	41.26%
2014	$93,598,893	$33,598,893	56.00%
2015	$102,448,386	$42,448,386	70.75%
2016	$110,412,962	$50,412,962	84.02%
2017	$119,165,456	$59,165,456	98.61%
2018	$130,335,289	$70,335,289	117.23%
2019	$140,589,366	$80,589,366	134.32%

Requirements for Providers with Allied Health

1) Cost report is within the three-year reopening period as of 12/29/2022*; and

2) Allied Health program(s) were in operation as of 12/29/2022

*Transmittal 11904 - Implementation of Consolidated Appropriations Act (CAA) of 2023, Section 4143: Waiver of Cap on Annual Payments for Nursing and Allied Health Education Payments

No impact to the percent reduction to MA GME funding

Graduated Medical Education

GME Affiliation Agreements Prior Year IME Resident Count Clarification

Add the lower of the following to the prior year cost report's "current year allowable FTEs" (E Part A Line 12) -

A) Difference between the CY three-year average FTE count (E part A Line 15) and the PY allowable FTE count (prior year cost report E Part A Line 12)

B) The FTE cap increase per the affiliation agreement (difference of CY and PY cost report "adjustment (increase or decrease) to the FTE count" on E part A Line 8)

Rural Emergency Hospital (REH) Teaching Costs

REHs may opt to be a non-provider site and include FTE residents training at the REH in its direct GME and IME FTE counts for Medicare payment purposes.

TOYON ASSOCIATES, INC.

Thank you

Please see an estimate of your hospital's FFY 2024 IPPS Payments here on Toyon's website

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