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May 2022

Key Takeaways from the FY 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule

Comments due June 17, 2022 by 5:00 p.m. EDT

On April 18, 2022, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule, available here.[1] The CMS fact sheet is available here. Key takeaways from the Proposed Rule are summarized below.

Key policies from the Proposed Rule include:

- Increasing operating payment rates for hospitals paid under the IPPS by 3.2% for FY 2023;
- Applying the IPPS operating market basket update of 3.1% to the per discharge limit (target amount) for IPPS-excluded hospitals;
- Increasing the outlier threshold (fixed-loss amount) by 39% to $43,214 for FY 2023;
- Revising hospital and Critical Access Hospitals (CAH) Conditions of Participation (CoPs) to extend current COVID-19 and Seasonal Influenza reporting requirements and to include new reporting requirements for future PHEs;
- Soliciting comments regarding principles for measuring healthcare quality disparities across CMS quality programs;
- Reviewing 13 applications for New Technology Add-On Payments (NTAPs) under the traditional pathway, including applications for CARVYKTI™, DARZALEX FASPRO®, and Teclistamab;
- Continuing NTAPs for two CAR T-cell therapies, ABECMA® and Tecartus™ in FY 2023;
- Maintaining assignment of non-CAR T-cell therapies and other immunotherapies, in addition to CAR T-cell therapies, to MS-DRG 18;
- Increasing the base reimbursement of MS-DRG 18 by 0.75% to approximately $248,806.48 in FY 2023;
- Continuing to exclude clinical trial claims that group to MS-DRG 18 for purposes of calculating the DRG's relative weight; and
- Using FY 2021 MedPAR claims data for FY 2023 rate setting, including MS-DRG 18 and MS-DRG 18's payment adjustor.

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Key Proposed Changes in the FY 2023 IPPS Proposed Rule

Policy Topic	Current Policy	FY 2023 Proposed Policy
Overall Payment Rate Updates		
Annual Payment Rate Update for Hospitals Paid under the IPPS	CMS made a **2.5%** update to operating payment rates in FY 2022 for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users.[2] The increase reflects the following: • 2.7% market basket rate of increase; • -0.7% productivity adjustment; and • 0.5% permanent adjustment required under section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[3]	**CMS proposes a 3.2% update to operating payment rates in FY 2023 for hospitals that successfully participate in IQR and are meaningful EHR users.[4]** The increase reflects the following: • 3.1% proposed market basket rate of increase; • -0.4% proposed productivity adjustment; and • 0.5% proposed permanent adjustment required under section 414 of MACRA.[5]
Annual Payment Rate Update for Hospitals Excluded from the IPPS	Certain IPPS-excluded hospitals receive payment for furnished inpatient hospital services on a reasonable cost basis.[6] CMS uses the percentage increase in the IPPS operating market basket to annually update the per discharge limit (the target amount) of these hospitals.[7] CMS applied the IPPS operating market basket update of **2.7%** to the per discharge	CMS continues applying the percentage increase in the IPPS operating market basket to update the per discharge limit (the target amount) of certain IPPS-excluded hospitals that receive payment for furnished inpatient hospital services on a reasonable cost basis.[9] **CMS proposes to apply the IPPS operating market basket update of 3.1% to the per discharge limit (target amount) for IPPS-excluded hospitals in FY 2023.[10]**

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	limit (target amount) for IPPS-excluded hospitals in FY 2022.[8]	
Outlier Payments		
Outlier Threshold (Fixed-loss Amount)	CMS makes payments to hospitals, in addition to basic prospective payments, for "outlier" cases with extraordinarily high costs.[11] To qualify for outlier payments, a case must have costs above a threshold (i.e., a dollar amount by which the costs of a case must exceed payments to qualify for an outlier payment).[12] CMS finalized an outlier threshold (fixed-loss amount) of **$30,988** for FY 2022.[13]	**CMS proposes an outlier threshold (fixed-loss amount) of $43,214 for FY 2023, a 39% increase from FY 2022.[14]**
Data and Quality Reporting		
Conditions of Participation (CoPs) for Hospitals and Critical Access Hospitals (CAHs)	CoPs for hospitals and CAHs require infection prevention and control programs, as well as antibiotic stewardship program organization and policies.[15] This includes tracking all infection surveillance, prevention, and control, and antibiotic use activities.[16] Through guidance and interim final rules, CMS also requires hospitals to report certain data relevant to planning, monitoring, and resource allocation during the COVID-19 PHE, including the number of patients hospitalized with COVID-19 and	**CMS proposes to revise hospital and CAH CoPs to extend the current COVID-19 and Seasonal Influenza reporting requirements until April 30, 2024.[19]** **The agency also proposes to revise hospital and CAH CoPs to include new reporting requirements for future PHEs related to a specific infectious disease or pathogen.[20]** Under these proposed requirements, hospitals and CAHs would be required to report certain relevant data to the CDC's National Health Safety Network (NHSN) or CDC-supported surveillance systems during these types of PHEs in the future.[21]

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	Acute Respiratory Illness (e.g., Seasonal Influenza Virus).[17] These reporting requirements will expire when the COVID-19 PHE declaration ends.[18]	
Measuring Healthcare Quality Disparities in CMS Quality Programs	CMS included a request for information (RFI) titled "Closing the Health Equity Gap in CMS Hospital Quality Programs" and stakeholder responses in the FY 2022 IPPS Final Rule.[22] This RFI described potential expansions of the CMS disparity methods and requested public comments regarding: • Future potential stratification of quality measure results by race and ethnicity; • Improving demographic data collection; and • Potential creation of a hospital equity score to synthesize results across multiple social risk factors.[23]	**CMS includes a request for information titled "Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs."[24]** CMS requests stakeholder input as the agency continues to consider advancing the use of measurement and stratification (i.e., calculating measure results for specific groups or subpopulations of patients) as tools to address healthcare disparities and advance healthcare equity.[25] CMS requests comments regarding: • Potential approaches for measuring healthcare disparities through measure stratification; • Considerations that could inform the selection of healthcare quality measures to prioritize for stratification; • Types of social risk factor and demographic data that could be used in stratifying measures for healthcare disparity measurement; • Strategies for identifying meaningful differences in performance when measure results are stratified; and • Considerations for determining how quality programs will report measure results stratified by social risk factors and demographic variables to healthcare providers and reporting strategies that could hold healthcare providers accountable for identified disparities.[26]

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New Technology Add On Payments (NTAPs)		
FY 2023 Applications for New Technology Add On Payments (NTAPs)	To qualify for an NTAP under the traditional pathway, a service or technology must: (1) substantially improve, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; (2) be sufficiently new; and (3) not be reimbursed adequately in the existing DRG system.[27] If approved, the maximum NTAP would be the lesser of: (1) 65% of the average cost of the technology; or (2) 65% of the costs in excess of the MS-DRG payment.[28]	CMS applies its existing criteria for evaluating a new technology's eligibility for the add-on payments and maximum NTAP amount for FY 2023.[29] In the Proposed Rule, the agency reviews a total of 13 applications for NTAPs under the traditional pathway, including:[30] • **CARVYKTI™**: A CAR T-cell therapy for the treatment of patients with multiple myeloma;[31] • **DARZALEX FASPRO®**: A combination of daratumumab and hyaluronidase for the treatment of light chain (AL) amyloidosis;[32] and • **Teclistamab**: A bispecific antibody (bsAb) for the treatment of relapsed or refractory multiple myeloma.[33] CMS outlines observations regarding CARVYKTI™, DARZALEX FASPRO®, and Teclistamab and considers applicable NTAP requirements for substantial clinical improvement, newness, and cost.[34] The agency requests certain additional information and solicits public comments.
NTAP Continuations for CAR T-cell Therapies	In the FY 2022 IPPS Final Rule, CMS concluded that two CAR T-cell therapies, ABECMA® and Tecartus™, met NTAP requirements for substantial clinical improvement, newness, and cost.[35]	**CMS proposes to continue NTAPs for ABECMA® and Tecartus™ for FY 2023, finding that both would still be considered new for purposes of NTAPs.[36]**
Chimeric Antigen Receptor (CAR) T-Cell Therapy Reimbursement		
Medicare Severity Diagnosis Related Group (MS-DRG) 18 – "Chimeric Antigen Receptor (CAR) T-cell and	For FY 2022, CMS expanded MS-DRG 18 to reflect the inclusion of cases involving non-CAR T-cell therapies and other immunotherapies, in addition to CAR T-cell therapies.[37]	**CMS proposes to maintain the inclusion of cases involving non-CAR T-cell therapies and other immunotherapies, in addition to CAR T-cell therapies, in MS-DRG 18.[39]** The agency highlights that FY 2021 MedPAR data analysis for MS-DRG 18 procedure codes showed a wide range in the volume of cases (from 4 cases to 435 cases), average length of stay (11.3 days to 20.3 days), and

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Other Immunotherapies"	CMS added 16 new ICD-10-PCS codes for these therapies to MS-DRG 18.[38]	average costs ($157,950 to $310,561) for the administration of CAR T-cell therapies in MS-DRG 018.[40] CMS indicates it intends to explore potential refinements and evaluate further modifications to MS-DRG 18 based on additional claims data as it becomes available.[41]
MS-DRG 18 Base Reimbursement	MS-DRG 18 pays a base reimbursement of approximately **$246,954.95** in FY 2022.[42]	MS-DRG 18 would pay a base reimbursement of approximately **$248,806.48** in FY 2023, an increase of 0.75% from FY 2022.[43]
MS-DRG 18 Relative Weight, Payment Adjustment for Clinical Trial Cases, and Expanded Access Use of Immunotherapy	CMS excludes clinical trial claims that group to MS-DRG 18 for purposes of calculating the DRG's relative weight so the DRG's relative weight accurately reflects the cost of CAR T-cell therapies.[44] CMS applies its payment adjustment methodology for clinical trial cases under MS-DRG 18, given the exclusion from the DRG's relative weight.[45] CMS applies an adjustor of **0.17** to the applicable clinical trial cases.[46] When a CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, CMS includes the claim when calculating the average cost for MS–DRG 18 because the CAR T-cell therapy is not the product subject to the clinical trial.[47] The payment adjustment is not applied in calculating the payment for the case.[48]	CMS proposes to continue excluding clinical trial claims that group to MS-DRG 18 for purposes of calculating the DRG's relative weight so the DRG's relative weight accurately reflects the cost of CAR T-cell therapies.[51] CMS also proposes to maintain its payment adjustment methodology for clinical trial cases under MS-DRG 18, given the exclusion from the DRG's relative weight.[52] **CMS proposes to apply an adjustor of 0.20 to the applicable clinical trial cases.[53]** When a CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, CMS would continue to include the claim when calculating the average cost for MS–DRG 18 because the CAR T-cell therapy is not the product subject to the clinical trial.[54] The payment adjustment would not be applied in calculating the payment for the case.[55] CMS would continue excluding expanded access use of immunotherapy when calculating the average cost for MS–DRG 18.[56] The payment adjustment would continue to be applied when calculating the payment of these cases.

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	CMS excludes expanded access use of immunotherapy when calculating the average cost for MS–DRG 18.[49] The payment adjustment is applied when calculating the payment of these cases.[50]	
Claims Data for MS-DRG 18 Rate Setting	CMS uses Medicare Provider Analysis and Review (MedPAR) data for rate setting purposes, which contains fully coded diagnostic and procedure data for all Medicare inpatient hospital bills for discharges in a fiscal year.[57] CMS used FY 2019 MedPAR claims data for FY 2022 rate setting (previously used for the FY 2021 Final Rule), including MS-DRG 18 and MS-DRG 18's payment adjustor, to approximate expected FY 2022 inpatient hospital utilization.[58] CMS explained that FY 2020 MedPAR claims data captures changes in inpatient hospital utilization driven by the COVID-19 public health emergency and that the use of FY 2019 MedPAR claims data would better approximate expected FY 2022 inpatient hospital utilization.[59]	**CMS proposes to use FY 2021 MedPAR claims data for FY 2023 rate setting, including MS-DRG 18 and MS-DRG 18's payment adjustor.**[60] The agency notes this is consistent with the agency's historic practice of using the most recent available data for rate setting.[61] **However, CMS proposes to calculate the FY 2023 MS-DRG relative weights by calculating two sets of weights (one including COVID-19 claims and one excluding COVID-19 claims in the FY 2021 MedPAR claims data) and then averaging the two sets of relative weights together.**[62] CMS explains that this averaging is intended to reduce, but not eliminate entirely, the effect of COVID-19 cases on relative weight calculation, reflecting the agency's estimation of the case mix for FY 2023.[63] CMS requests comment on an alternative approach using the FY 2021 claims data without averaging.[64] MS-DRG 18 would pay a base reimbursement of approximately **$248,806.48** under the proposed approach with averaging and approximately **$247,013.58** under the alternative approach without averaging.[65] CMS additionally proposes to apply a permanent 10% cap on the reduction in a MS-DRG's relative weight in a given year for payment stability and predictability.[66]

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CAR T-Cell Therapy Reimbursement Summary Chart						
Payment Components	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023 (Proposed)**
DRG Base Reimbursement	No Specific CMS Assigned MS-DRG[67]	$40K (Autologous Bone Marrow Transplant MS-DRG 16)[68]	$43K (Autologous Bone Marrow Transplant MS-DRG 16)[69]	$239K (CAR-T MS-DRG 18)[70]	$247K (CAR-T and Other Immunotherapies MS-DRG 18)[71]	$249K (CAR-T and Other Immunotherapies MS-DRG 18)[72]
Maximum NTAP Amount	No NTAP[73]	50% of 373K, or $186.5K for Kymriah™ and Yescarta™[74]	65% of $373K or $242.5K for Kymriah™ and Yescarta™[75]	NTAPs for Kymriah™ and Yescarta™ Discontinued[76]	65% of $419.5K or $272.7K for ABECMA®[77] 65% of $399K or $259.4K for Tecartus™[78]	65% of $419.5K or $272.7K for ABECMA®[79] 65% of $399K or $259.4K for Tecartus™[80] NTAP Application for CARVYKTI™, a New CAR-T Therapy, Under CMS Review[81]

Commenting on the Proposed Rule

- The deadline for submitting comments is **5:00 p.m. EDT on June 17, 2022.** Commenters must refer to file code CMS-1771-P when commenting on the Proposed Rule. Interested stakeholders can submit comments electronically by visiting Regulations.gov. Alternatively, comments can be submitted by mail to the following addresses:

Regular Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-1850

Express or Overnight Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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[1] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates, Proposed Rule, 87 Fed. Reg. 28,108 (May 10, 2022), *available at* https://www.govinfo.gov/content/pkg/FR-2022-05-10/pdf/2022-08268.pdf [hereinafter "IPPS Proposed Rule"].

[2] CMS, Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F) (Aug. 2, 2021), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0; CMS, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates, 86 Fed. Reg. 44,774, 45,579 (Aug. 13, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf [hereinafter "FY 2022 IPPS Final Rule"].

[3] *Id.*; FY 2022 IPPS Final Rule at 45,533.

[4] CMS, Fact Sheet: FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P (Apr. 18, 2022), https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps; IPPS Proposed Rule at 28,708.

[5] *Id.*; IPPS Proposed Rule at 28,663.

[6] FY 2022 IPPS Final Rule at 45,321.

[7] *Id.* at 45,321-22.

[8] *Id.* at 45,322.

[9] IPPS Proposed Rule at 28,459.

[10] *Id.*

[11] CMS, Outlier Payments; Background (Dec. 1, 2021), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.

[12] *Id.*

[13] FY 2022 IPPS Final Rule at 45,554.

[14] IPPS Proposed Rule at 28,669.

[15] 42 C.F.R. § 482.42; *id.* § 485.640.

[16] *Id.*

[17] IPPS Proposed Rule at 28,619.

[18] *Id.*

[19] *Id.* at 28,619-20.

[20] *Id.* at 28,620

[21] *Id.*

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[22] FY 2022 IPPS Final Rule at 45,349-60.

[23] *Id.* at 45,349, 45356.

[24] IPPS Proposed Rule at 28,479.

[25] *Id.* at 28,480.

[26] *Id.*

[27] *See* 42 C.F.R. § 412.87(b)(1)–(3).

[28] 42 C.F.R. § 412.88(a)(2)(ii).

[29] IPPS Proposed Rule at 28,204-07.

[30] *Id.* at 28,218.

[31] *Id.*

[32] *Id.* at 28,225.

[33] *Id.* at 28,283.

[34] *Id.* at 28,218-35, 28,283-87.

[35] FY 2022 IPPS Final Rule at 45,028-35, 45,090-104.

[36] IPPS Proposed Rule at 28,213.

[37] FY 2022 IPPS Final Rule at 44,806.

[38] *Id.* at 44,799-44,800, 44,806.

[39] IPPS Proposed Rule at 28,129-30.

[40] *Id.* at 28,131.

[41] *Id.*

[42] *See* CMS, FY 2022 IPPS Final Rule Tables Correction Notice tbls. 1A, 1D, 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Tables (last visited May 24, 2022).

[43] *See* CMS, IPPS Proposed Rule tbls. 1A, 1D, 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page#Tables (last visited April 19, 2022).

[44] FY 2022 IPPS Final Rule at 44,964-65.

[45] *Id.* at 45,320; *see* 42 C.F.R. § 412.85(c); *id.* § 412.312.

[46] FY 2022 IPPS Final Rule at 44,964-65.

[47] *Id.* at 45,319-20.

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[48] *Id.* at 45,320.

[49] *Id.* at 45,319-20.

[50] *Id.* at 45,320.

[51] IPPS Proposed Rule at 28,199-200.

[52] *Id.* at 28,417.

[53] *Id.* at 28,200.

[54] *Id.* at 28,417.

[55] *Id.*

[56] *Id.*

[57] FY 2022 IPPS Final Rule at 44,789.

[58] *Id.* at 44,793; CMS, Fact Sheet; Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)(Aug. 2, 2021), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0.

[59] CMS, Fact Sheet; Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)(Aug. 2, 2021), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0.

[60] IPPS Proposed Rule at 28,200, 28,417; *see* CMS, IPPS Proposed Rule tbl. 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page#Tables (last visited May 24, 2022).

[61] CMS, Fact Sheet; FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P (Apr. 18, 2022), https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps.

[62] IPPS Proposed Rule at 28,200.

[63] *Id.*

[64] *Id.* at 28,125.

[65] *See* CMS, 2023 Proposed Rule Alternative Considered Budget Neutrality Factors, Adjustments, Standardized Amounts, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page#Tables (last visited May 24, 2022); *see also* CMS, IPPS Proposed Rule Alternatives Considered MS-DRG Weights, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page#Alternative (last visited May 24, 2022).

[66] IPPS Proposed Rule at 28,201-02.

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[67] Letter from Am. Soc'y for Blood and Marrow Transplantation to the CMS, CMS Payment Models for Chimeric Antigen Receptor T Cell (CAR-T) Therapy at 7 (Sept. 6, 2017), https://higherlogicdownload.s3.amazonaws.com/ASBMT/UploadedImages/6cfeff77-6acc-46fe-8d3d-db9dddebe47a/ASBMT_Letter_CMS_CAR_T_9_6_17_Final.pdf.

[68] *See* CMS, FY 2019 IPPS Final Rule: Correction Notice Tables tbls. 1A, 1D, 5, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables (last visited May 24, 2022).

[69] *See* CMS, FY 2020 IPPS Final Rule: Correction Notice Tables tbls. 1A, 1D, 5, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Tables (last visited May 24, 2022).

[70] *See* CMS, FY 2021 IPPS Final Rule tbls. IA, ID, 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page#Tables (last visited May 24, 2022).

[71] *See* CMS, FY 2022 IPPS Final Rule: Correction Notice Tables tbls. 1A, 1D, 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Tables (last visited May 24, 2022).

[72] *See* CMS, IPPS Proposed Rule tbls. 1A, 1D, 5, https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page#Tables (last visited May 24, 2022).

[73] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates, 82 Fed. Reg. 37,990, 38,115 (Aug. 14, 2017).

[74] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Final Rule, 83 Fed. Reg. 41,144, 41,299 (Aug. 17, 2018).

[75] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Final Rule, 84 Fed. Reg. 42,044, 42,187 (Aug. 16, 2019).

[76] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates, 85 Fed. Reg. 58,432, 58,611 (Sept. 18, 2020).

[77] *See* FY 2022 IPPS Final Rule at 45,035.

[78] *See id* at 45,104.

[79] *See* IPPS Proposed Rule at 28,213.

[80] *See id.*

[81] *See id.* at 28,218-28,225.

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