Medicare Inpatient Prospective Payment System

Final Payment Rule Brief Provided by the Wisconsin Hospital Association

Program Year: FFY 2023

Overview and Resources

On August 1, 2022, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2023 final rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and marketbasket, the following policies were adopted in this rule:

- Utilizing FFY 2021 Medicare Provider and Review (MedPAR) and FFY 2020 Hospital Cost Report (HCRIS) data for standard calculations with modifications to account for any data that may be impacted by the COVID-19 public health emergency (PHE);
- The final rate increase amount (+0.5%) for the MACRA Coding Offset adjustment;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies including hospital eligibility for DSH payments in FFY 2023 being based on audited FFY 2018 and FFY 2019 S-10 data and a three-year average of S-10 data for FFY 2024 and beyond;
- Change the in Factor 3 calculation for Indian Health Service (IHS)/Tribal hospitals and Puerto Rico hospitals;
- Creation of a permanent 5% cap on wage index decreases;
- Creation of a permanent 10% cap on MS-DRG weight decreases;
- Updates to the Value-Based Purchasing (VBP), Readmission Reduction Program (RRP) and Hospital-Acquired Condition (HAC) programs; and
- Updates to the payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive Programs.

Program changes will be effective for discharges on or after October 1, 2022 unless otherwise noted. CMS estimates the overall impact of this final rule update to be an increase of approximately $1.4 billion in aggregate payments for acute care hospitals in FFY 2023. This estimate includes increased operating payments and decreases due to changes in new technology add-on payments; GME weighting methodology; and the expiration of the temporary changes to the low-volume payment adjustment; and capital payments.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page.

On August 10, 2022, an online version of the final rule will be available at https://www.federalregister.gov/public-inspection/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

Note: Text in italics is extracted from the August 1, 2022 Display version of the final rule.

IPPS Payment Rates

Display pages 39 – 49, 51 – 54, 299 – 314, 740 – 761, 1,018 – 1,020, 1,797 – 1,871, and 1,873 – 1,897

The table below lists the federal operating and capital rates adopted for FFY 2023 compared to the rates currently in effect for FFY 2022. These rates include all marketbasket increases and reductions as well as the application of annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the IQR Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

	Final FFY 2022	Final FFY 2023	Percent Change
Federal Operating Rate	**$6,121.65**	**$6,375.74** (proposed at $6,315.77)	**+4.15%** (proposed at +3.17%)
Federal Capital Rate	**$472.59**	**$483.76** (proposed at $480.29)	**+2.36%** (proposed at +1.63%)

The following table provides details for the finalized annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2023.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket/Capital Input Price Index update	**+4.1%** (proposed at +3.1%)		**+2.5%** (proposed at +1.7%)
ACA-Mandated Productivity Adjustment	**-0.3 percentage point (PPT)** (proposed at -0.4 PPT)		**—**
MACRA-Mandated Retrospective Documentation and Coding Adjustment	**+0.5%**	**—**	**—**
Lowest Quartile Wage Index Adjustment	**+0.01 %** (proposed at +0.02%)		**-0.02%** (proposed at -0.03%)
Wage Index Cap Policy	**-0.02%** (proposed at -0.03%)		
MS-DRG Weight Cap Policy	**-0.02%** (as proposed)		**-0.02%** (as proposed)
Annual Budget Neutrality Adjustments	**-0.13%** (proposed at -0.01%)		**-0.09%** (proposed at -0.02%)
Net Rate Update	***+4.15%*** *(proposed at +3.17%)*	***+3.63%*** *(proposed at +2.66%)*	***+2.36%*** *(proposed at +1.63%)*

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** ***(Display pages 755 – 757, 1,797 – 1,798 and 1,876)***: The IQR MB penalty imposes a 25% reduction to the full MB and the EHR Meaningful Use (MU) penalty imposed a 75% reduction to the full MB; hence the entirety of the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2023 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Marketbasket Update (4.1% MB less 0.3 PPT productivity adjustment)	**+3.8%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 4.1%)	**—**	**-1.025 PPT**	**—**	**-1.025 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 4.1%)	**—**	**—**	**-3.075 PPT**	**-3.075 PPT**
Adjusted Net Marketbasket Update (prior to other adjustments)	***+3.8%***	***+2.775%***	***+0.725%***	***-0.3%***

- **Use of FFY 2021 Data and Methodology Modifications (*Display pages 39 – 49 and 299 – 314):*** In past years, CMS has utilized the best available data sources for IPPS rate setting, including MedPAR claims data for the fiscal year that is two years prior and hospital cost repot (HCRIS) data beginning three fiscal years prior to the rate setting year (FFYs 2021 and 2020, respectively for FFY 2023). However, in the FFY 2022 IPPS final rule, CMS adopted the use of FFY 2019 data due to FFY 2020 data being significantly impacted by the COVID-19 public health emergency (PHE). Similarly, a CMS analysis has found that both the FFY 2021 MedPAR and FFY 2020 HCRIS data also contain figures that were significantly impacted by the PHE. CMS believes that, due to an expected

continued impact of COVID-19 on hospitalizations, the use of the FFY 2021 data would still be appropriate, with the following modifications:

- Modifying the calculation of the MS-DRG relative weights by averaging two sets of weights, one including COVID-19 claims and one excluding COVID-19 claims, to reduce the effect of COVID-19 cases on relative weights;
- Modifying the calculation of the fixed-loss outlier threshold based on the average of the outlier-fixed loss thresholds calculated using FFY 2021 data including and excluding COVID-19 claims; and
- Inflating the charges from the FFY 2021 MedPAR claims using a factor computed by comparing the average covered charge per case in the March 2019 MedPAR file of FFY 2018 to the average covered charge per case in the March 2020 MedPAR file of FFY 2019 to determine the outlier fixed-loss amount. CMS will also adjust the cost-to-charge ratios (CCR) from the December 2021 update of the provider specific file (PSF) by comparing the percentage change in the national average case-weighted CCR from the March 2019 PSF to that in the March 2020 PSF.

- **Retrospective Coding Adjustment** ***(Display pages 51 – 54 and 1,822 – 1,823)*****:** CMS is adopting a retrospective coding adjustment of +0.5% to the federal operating rate in FFY 2023 as part of the sixth and final year of rate increases tied to the American Taxpayer Relief Act (ATRA). The initial coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by $11 billion over a 4-year period, resulting in a cumulative rate offset of approximately -3.2%.

- **Outlier Payments** ***(Display pages 48 – 49, 1,823 – 1,868, and 1,885 – 1,887)*****:** CMS continues to believe that using a methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold is a reasonable approach and would provide a better predictor for upcoming fiscal year. Therefore, for FFY 2023, CMS will incorporate total outlier reconciliation dollars from the FFY 2017 cost reports, supplemented by reconciliation reports for two hospitals made available to CMS outside of the March 2022 HCRIS extract, into the outlier model using a similar methodology to FFY 2022.

  CMS will also use the estimated per-discharge IHS/Tribal and Puerto Rico supplemental payments in the calculation of the outlier fixed-loss cost threshold, consistent with the policy of including estimated uncompensated care payments.

  Analysis done by CMS determined outlier payments at 5.12% of total IPPS payments; CMS is adopting an outlier threshold of $38,859 (proposed at $43,214) for FFY 2023, which includes a charge inflation factor which is calculated using the March 2019 MedPAR file of FFY 2018 charge data and the March 2020 MedPAR file of FFY 2019 charge data. This threshold is 25.40% higher than the current (FFY 2022) outlier threshold of $30,988.

- **Stem Cell Acquisition Budget Neutrality Factor** (***Display page 1,800***): CMS will continue to not remove the Stem Cell Acquisition budget neutrality factor and to also not apply a new factor for FFY 2023 as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider using cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

Wage Index

Display pages 545 – 640, 1,800, 1,813 – 1,820, 1,822, 1,871 – 1,872, and 1,887 – 1,890

- **Permanent Cap on Wage Index Decreases** ***(Display pages 627 – 640, 1,819 – 1,820, 1,822, and 1,888 – 1,890)*****:** In the past, CMS implemented wage index transition policies with limited duration in order to phase in significant changes to labor market areas with the intent to mitigate short-term negative impact to affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of IPPS payments, CMS will apply a 5% cap on any decrease of the FFY 2023 IPPS wage index, and all future IPPS wage indexes, compared with the previous year's final wage index. The cap will be applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPPS's prior FFY wage index is calculated with the application of the 5% cap,

the following year's wage index would not be less than 95% of the IPPS' capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. If a hospital reclassifies as rural under 42 CFR 412.103 with an effective date after this day, the policy would apply to the reclassified wage index instead.

CMS is also adopting the proposal that a new IPPS be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS would not have a wage index in the prior FFY.

This policy will be implemented in a budget neutral manner with a net budget neutrality factor of 0.99983 (proposed at 0.9997), after backing out the effects of the FFY 2022 adjustment.

- **Codes for Constituent Counties in CBSAs** ***(Display pages 550 – 552)*****:** Consistent with previous policies, CMS utilizes the Federal Information Processing Standard (FIPS) codes as designated by the Census Bureau to crosswalk a county to a CBSA for purposes of the hospital wage index. For FFY 2023, Chugach Census Area, AK (FIPS code 02063) and Copper River Census Area, AK (FIPS code 02066) will be implemented and be located in CBSA 02 (Rural Alaska). CMS notes that that there will be no impact or change for hospitals in these counties as a result of this policy.

- **Rural Floor** ***(Display pages 577 – 583, 1,800, and 1,816 – 1,818)*****:** In the FFY 2020 IPPS final rule, CMS adopted a policy where hospitals that reclassified from urban to rural had their wage data removed from the rural floor calculation to prevent inappropriate payment increases under the rural floor. This wage data was also removed from the calculation to determine the wage index for rural areas of each state. This rural floor policy and the related budget neutrality adjustment were subject to litigation (*Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*) in which it was determined that the Secretary does not have the authority to establish a rural floor lower than the rural wage index for a state. As such, CMS is finalizing the removal of that policy that began in FFY 2020.

- **Imputed Floor (Display** ***pages 583 – 588):*** The American Rescue Plan of 2021 established a minimum area wage index for hospitals in all-urban states for FFY 2022 and onward, not implemented in a budget neutral manner, to be applied after the application of the rural floor budget neutrality adjustment.

  The states that receive an imputed floor are New Jersey, Rhode Island, Delaware, Connecticut, Puerto Rico, and Washington, D.C based on the data available for the final rule. CMS includes the imputed floor adjustment in wage index tables accompanying this final rule.

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals** ***(Display pages 589 – 595, 1,818 – 1,819, 1,822, and 1,887 – 1,890)*****:** CMS had noted that many comments from the Wage Index RFI in the FFY 2019 IPPS proposed rule reflected *"a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals."* As a result, CMS had made a variety of changes in the FFY 2020 final rule to reduce the disparity between high and low wage index hospitals.

  As adopted, this is to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. For FFY 2023, CMS will continue the policy that hospitals with a wage index value in the bottom quartile of the nation would have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals.

  CMS notes that this policy is subject to pending litigation (*Bridgeport Hospital, et al., v. Becerra)* in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered additional briefing on an appropriate remedy. This court decision involves only FFY 2020, is not final, and is subject to potential appeal.

CMS will also continue to offset these wage index increases in a budget neutral manner by applying a budget neutrality adjustment to the national standardized amount. For the FFY 2023 final rule, the value of the 25th percentile wage index is 0.8427 (proposed at 0.8401), and the net budget neutrality adjustment is 1.000117 (proposed at 1.000176) after backing out the effects of the FFY 2022 adjustment.

- **CY 2019 Occupational Mix Adjustment** ***(Display pages 571 – 576)*****:** In the FFY 2022 IPPS final rule, CMS finalized the use of the CY 2019 Occupational Mix Survey for the calculation of the FFY 2023 wage index. The final FFY 2023 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS calculated the FFY 2023 occupational mix adjusted national average hourly wage to be $47.73 (proposed at $47.71).
- **Labor-Related Share** ***(Display pages 623 – 627 and 1,871)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2023, CMS will continue to apply a labor-related share of 67.6% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.
- **Cost-of-Living Adjustment Updates** ***(Display pages 1,871 – 1,872):*** For inpatient facilities in Alaska and Hawaii, the IPPS provides a cost-of-living adjustment (COLA). The COLA is applied by multiplying the non-labor-related portion of the facility standardized amount by the applicable COLA factor. The IPPS COLA factors adopted in 2022 for Alaska and Hawaii, in effect for FFYs 2022 – 2025, are shown below:

Area	Final FFYs 2022 - 2025
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.22
City of Juneau and 80-kilometer (50-mile) radius by foot	1.22
Rest of Alaska	1.24
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

A complete list of the final wage indexes for payments in FFY 2023 is available on the CMS website at https://www.cms.gov/files/zip/fy2023-ipps-nprm-tables-2-3-4a-4b.zip.

DSH Payments

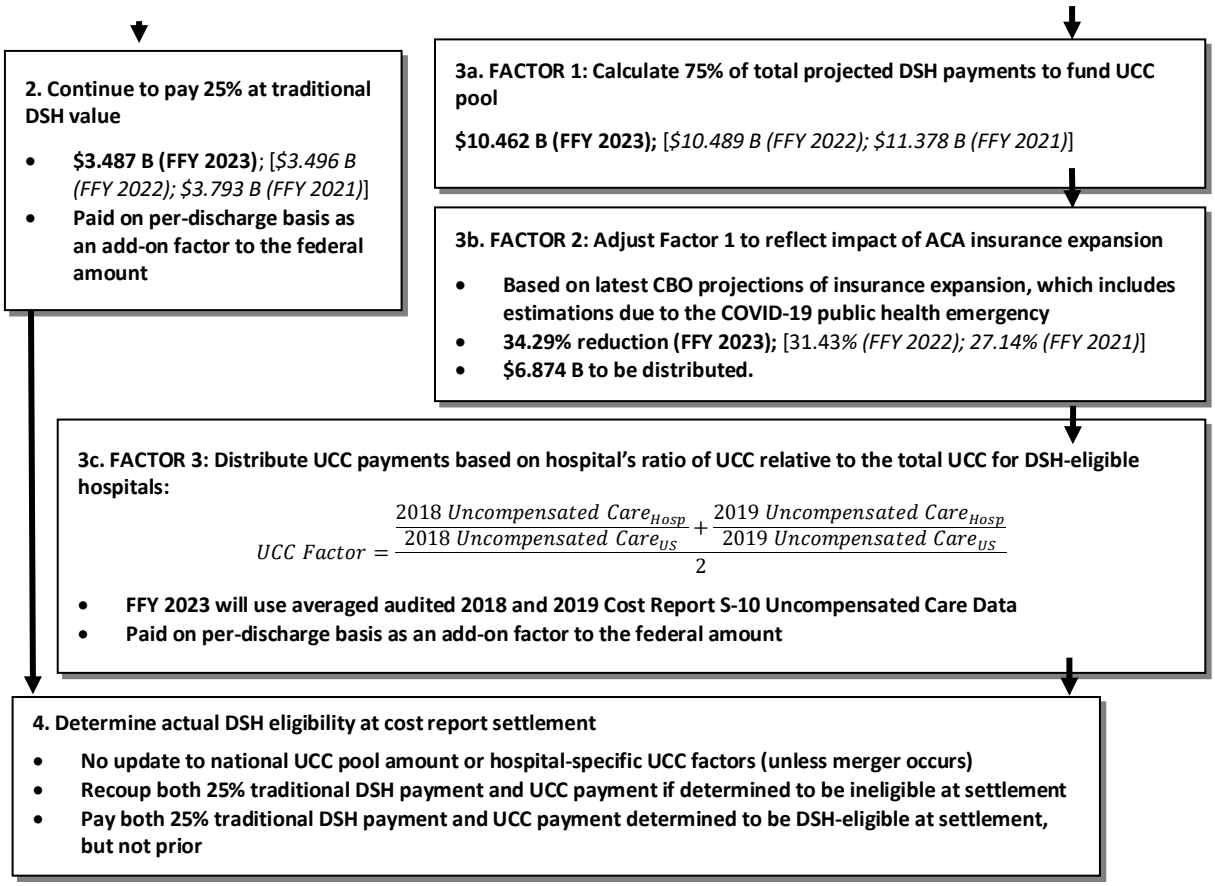
Display pages 641 – 739

The ACA mandates the implementation of Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds, referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2023** ***(Display pages 641 – 724)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program has been finalized to change from FFY 2022 to FFY 2023:

1. Project list of DSH-eligible hospitals (15% DSH percentage or more) and project total DSH payments for the nation using traditional per-discharge formula

- **$13.949 B (FFY 2023) ;** [*$13.985 B (FFY 2022); $15.171 B (FFY 2021)*]
- **Includes adjustments for inflation, utilization, and case mix changes**



The DSH dollars available to hospitals under the ACA's payment formula would decrease by $0.036 billion in FFY 2023 relative to FFY 2022 due to a decrease in the pool from projected DSH payments.

- **Eligibility for FFY 2023 DSH Payments** ***(Display pages 645 – 650)*****:** CMS is projecting that 2,368 hospitals will be eligible for DSH payments in FFY 2023 based on audited FFY 2019 and FFY 2018 S-10 data. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2023. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file is available at https://www.cms.gov/files/zip/fy2023-ipps-fr-medicare-dsh-supplemental-data-file.zip.

- **Adjustment to Factor 3 Determination** ***(Display pages 677 – 723)*****:** In consideration of comments discussed in the FFY 2022 IPPS final rule, CMS adopted the use of the two most recent years of cost report data that has been audited for a significant number of hospitals receiving substantial Medicare uncompensated care payments to calculate Factor 3 for all eligible hospitals, rather than a single year. For FFY 2023, CMS will use the average of Worksheet S–10 data from the audited FFY 2018 and audited FFY 2019 cost reports to calculate Factor 3. For FFY 2024 and onwards, CMS will utilize the most recent three years of audited cost report data to determine Factor 3. Specifically, for FFY 2024 CMS expects to use FFY 2018, FFY 2019, and FFY 2020 for this determination. Hospitals that do not have data for all three years will have their Factor 3 determined based on the average of the available data for the appropriate years. In the rare case when CMS would use a cost report that starts in one FFY and spans the entirety of the subsequent FFY, the same cost report would not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFY, the most recent prior cost report that spans some portion of that FFY will be used. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, a scaling factor will be

applied to the Factor 3 values for each of these hospitals, similarly to the scaling factor methodology used for FFYs 2018 and 2019. For each DSH-eligible hospital, this scaling factor is calculated as:

$$\frac{1}{Actual\ sum\ of\ all\ hospital\ Factor\ 3\ values}.$$

This quotient is then multiplied by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount. This process ensures that the sum of the scaled UCC payments for all hospitals is consistent with the estimate of the total amount available to make UCC payments.

For new hospitals established on or after October 1, 2019 that do not have cost report data for the most recent year of data being used in the Factor 3 calculation, CMS will continue the policy established in FFY 2020 that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but would not receive interim UCC payments. Factor 3 for new hospitals will use a denominator based solely on UCC costs from cost reports for the most recent year for which audits have been conducted. The resulting Factor 3 would then have a scaling factor applied to it. This modification will also apply to newly merged hospitals with data based on the surviving hospital's CMS Certification Number (CCN). If the hospital's cost reporting period is less than 12 months, the data from the newly merged hospital's cost report will be annualized.

CMS will continue the trimming methodology adopted in the FFY 2021 IPPS final rule with modification for the use of multiple years of cost report data. If unaudited UCC costs for FFY 2018 or FFY 2019 are greater than 50% of total operating costs for that FFY, then a ratio of UCC costs to the hospital's total operating costs for the other year will be applied to the total operating costs of the aberrant year. Additionally, for hospitals that have not had their FFY 2018 and/or FFY 2019 cost reports audited, CMS will continue the policy adopted in FFY 2021 for an alternative trimming methodology using a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs, and a dollar threshold that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible, including Indian Health Service (IHS), Tribal, and Puerto Rico hospitals. Specifically, cases where a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care to total UCC costs is greater than 60%, CMS would exclude the hospital from the prospective Factor 3 calculation. For hospitals subject to this alternate trim and determined to be DSH-eligible at cost report settlement, CMS will continue to apply its policy where those hospitals' UCC payments would be calculated after their MACs have reviewed the UCC information reported on worksheet S-10, subject to the previously mentioned scaling factor.

CMS will use a hospital's three-year average discharge number to estimate their interim uncompensated care payment per discharge for FFY 2024 and subsequent years. As in past years, interim payments made using this value will be reconciled at cost report settlement to equal the uncompensated care pool distribution amount that will be published with accompanying final rule.

For FY 2023, hospitals will have 15 business days from the date of public display of the FFY 2023 IPPS final rule to review and submit comments on the accuracy of these files published along with the final rule. Comments regarding issues that are specific to data and supplemental data files for this final rule can be submitted to Section3133DSH@cms.hhs.gov. Any changes to distribution amounts will be posted on the CMS website prior to October 1, 2022.

- **Supplemental Payment for IHS/Tribal and Puerto Rico Hospitals** ***(Display pages 724 – 738):*** Unlike in prior years, CMS will utilize Worksheet S-10 for the calculation of Factor 3 for IHS, Tribal, and Puerto Rico hospitals rather than determining Factor 3 amounts for these providers by utilizing the FFY 2013 data for Medicaid days combined with the most recent update of the SSI days. CMS is concerned that this FFY 2013 data is no longer a good proxy for the cost that these hospitals incur by treating the uninsured due to its age. CMS will use audited FFY 2018 and FFY 2019 cost reports to calculate Factor 3, which is the same as all other hospitals.

In order to mitigate the impact of these calculation changes in determining Factor 3 for IHS/Tribal and Puerto Rico hospitals, CMS will establish a permanent supplemental payment for these hospitals. This payment will be calculated using each hospital's FFY 2022 UCC payments (or estimated UCC payments if not DSH eligible) as a base and then adjusted by one plus the percent change in the total UCC pool amount between the applicable year and FFY 2022. For hospitals not projected to be DSH eligible in FFY 2022, CMS will use the uncompensated care payment that the hospital would receive if the hospital were to be eligible. For FFY 2023, each eligible hospital's FFY 2022 UCC amount would be multiplied by 0.956 to reflect the -4.4% (proposed at -9.1%) change in UCC from FFY 2022 to FFY 2023.

If the base year amount is equal to or lower than the hospital's UCC payment for the current FFY then the hospital will not receive a supplemental payment. CMS is also aligning the eligibility and payment processes for the supplemental payment with the process used to make UCC payments, which includes the process changes for FFY 2023 and FFY 2024 and onwards, as well as reconciliation at cost report settlement as determined by the MAC.

Counting Days Associated with Section 1115 Demonstration Projects in the Medicaid Fraction ***(Display page 739):***
Due to a number of court decisions regarding the inclusion of certain patient days in the numerator of the Medicaid fraction when calculating a hospitals disproportionate patient percentage, CMS had proposed that for a section 1115 demonstration patient day to be included in the numerator, that patient must be eligible for essential health benefits (EHB) under an approved state Medicaid plan (section 1115 demonstration itself or insurance purchased with the use of premium assistance equal to at least 90% of the cost of the health insurance provided by a section 1115 demonstration) that includes coverage for EHBs on that day or directly receives EHBs on that day under an authorized waiver. Due to the number and nature of the comments received, CMS is not moving forward with this proposal but expects to revisit the topic in future rulemaking.

GME Payments

Display pages 785 – 831

In response to the May 17, 2021 court decision in *Milton S. Hershey Medical Center, et al. v. Becerra,* regarding CMS's proportional reduction methodology applied to the weighted GME FTE count when the weighted FTE count exceeded the FTE cap, CMS finalized to retroactively implement a modified policy applicable to all teaching hospitals, effective for cost reporting periods beginning on-or-after October 1, 2001. This policy will also be prospectively paid for cost report periods beginning on or after October 1, 2022. This policy will address situations for applying the FTE cap when a hospital's weighted FTE count is greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their initial residency period (IRP) to an amount less than 0.5.

In the FFY 2023 IPPS proposed rule, CMS stated that under the aforementioned policy *"…in the instance where a hospital's unweighted allopathic and osteopathic FTE count exceeds its FTE cap, we propose to add a step to also compare the total weighted allopathic and osteopathic FTE count to the FTE cap. If the total weighted allopathic and osteopathic FTE count is equal to or less than the FTE cap, then no adjustments would be made to the respective primary care & OB/GYN weighted FTE counts or the other weighted FTE counts. If the total weighted allopathic and osteopathic FTE count exceeds the FTE cap, then we would adjust the respective primary care & OB/GYN weighted FTE counts or the other weighted FTE counts to make the total weighted FTE count equal the FTE cap, as follows:*

((primary care & OB/GYN weighted FTEs/total weighted FTEs) x FTE cap)) +
((other weighted FTEs/ total weighted FTEs) x FTE cap)).

The sum would be the current year total allowable weighted FTE count, which would be reported on Worksheet E-4, line 9, column 3.

More specific to the Medicare cost report, we propose to revise the instructions to Worksheet E-4, line 9 to state: If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, of this line.

Otherwise, if the total weighted FTE count from line 8, column 3 is greater than the amount on line 5, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) x FTE cap)). Enter in column 2 the result of ((other weighted FTEs/ total weighted FTEs) x FTE cap)). Enter in column 3 the sum of ((primary care & OBGYN weighted FTEs/total weighted FTEs) x FTE cap)) + ((other weighted FTEs/ total weighted FTEs) x FTE cap)).”

Furthermore, CMS will modify the cost report instructions for Worksheet E-4, lines 12 and 13 respectively to state that *“…effective for cost reporting periods beginning on or after October 1, 2001, if subject to the cap in the prior year or penultimate year respectively, if the prior/penultimate year total weighted FTE count from line 8, column 3 is greater than the amount on line 5 from the prior/penultimate year, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) x FTE cap)). Enter in column 2 the result of ((other weighted FTEs/total weighted FTEs) x FTE cap)) plus the amount on line 10, column 2.”*

The table on Display page 815 shows the Nursing and Allied Health (NAH) Education Programs Medicare Advantage add-on rates for CY 2020 and CY 2021 as well as the data sources used to calculate each pool.

In addition, CMS will create “Rural Track Medicare GME Affiliation Agreements” which would allow an urban and rural hospital to aggregate their respective IME and GME rural track FTE limitations to share those cap slots and facilitate cross-training of residents. This would also allow additional cap slots that establish rural training tracks. Eligible hospitals may enter into this agreement effective for the July 1, 2023 academic year. This policy will only to apply to programs that are separately accredited and in family medicine with the following two requirements, which will be reassessed in future rulemaking:

- *“…the responsible representatives of each urban and rural hospital entering into the Rural Track Medicare GME Affiliation Agreement must attest in that written agreement that each participating hospital’s FTE counts and rural track FTE limitations in the agreement do not reflect FTE residents nor FTE caps associated with programs other than the rural track program.”* and
- *“…to only allow urban and rural hospitals to participate in Rural Track Medicare GME Affiliated Groups if they are separately accredited 1-2 family medicine programs that have rural track FTE limitations in place prior to October 1, 2022….”*

New definitions and requirements associated with this affiliation agreement can be found on Display pages 829 - 830.

The Indirect Medical Education adjustment factor will remain at 1.35 for FFY 2023.

Updates to the MS-DRGs

Display pages 50 – 544, 832 – 836, 1,809 – 1,813, 1,822, and 1,890 – 1,893

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. For IPPS rate-setting, CMS typically uses the MedPAR claims data file that contains claims from discharges 2 years prior to the fiscal year that is the subject of rulemaking. For Hospital Cost Report data, CMS traditionally uses the dataset containing cost reports beginning 3 years prior to the fiscal year under study. As stated earlier, CMS believes utilization patterns reflected in the FFY 2021 IPPS claims data were impacted by the COVID-19 PHE and therefore CMS will modify the calculation of the MS-DRG relative weights by averaging two sets of weights, one including COVID-19 claims and one excluding COVID-19 claims.

The total number of payable DRGs would be held constant at 765, with 75.2% of DRG weights changing by less than +/- 5%, 6.93% changing by +/- 10% or more, and 4.1% that are affected by the relative weight cap on reductions. The five MS-DRGs with the greatest year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	Final FFY 2022 Weight	Final FFY 2023 Weight	Percent Change

MS-DRG 817: OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH MCC	2.3068	3.1298	35.68%
MS-DRG 933: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	2.2629	3.0330	34.03%
MS-DRG 836: ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	1.1735	1.5688	33.69%
MS-DRG 688: KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	0.6858	0.8664	26.33%
MS-DRG 969: HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC	5.8519	7.2476	23.85%

When CMS reviews claims data, they apply several criteria to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within an MS-DRG is needed, a subgroup must meet all five criteria in order to warrant being created.

Beginning in FFY 2021, CMS expanded the criteria to also include Non-CC subgroups with the belief that this would better reflect resource stratification and promote stability of MS-DRG relative weights by avoiding low volume counts for the Non-CC level MS-DRGs. In the FFY 2022 proposed rule, CMS found that applying this criteria to all MS-DRGs would cause major changes in the list of MS-DRGs. These updates would have also had an impact on relative weights and payments rates for FFY 2022. Due to the PHE and concerns about the impact that implementing this many MS-DRG changes at one time, CMS adopted a delay of the application of the Non-CC subgroup criteria for these MS-DRGs until FFY 2023.

In the FFY 2023 proposed rule, CMS analyzed how applying the Non-CC criteria to the eligible MS-DRGS would affect the MS-DRG structure for FFY 2023. Their findings showed that 123 MS-DRGs (41 MS-DRGs multiplied by 3 severity levels) would be deleted and 75 new DRGs would be created. These updates would also impact the payment rates for the particular types of cases. Due to the ongoing PHE, CMS continues to have concerns about the impact that the number of MS-DRG changes would have and finalized not to apply the non-CC subgroup criteria to these 123 MS-DRGs that would otherwise be subject to the criteria. CMS intends to address the application of the Non-CC subgroup criteria to eligible MS-DRGs in future rulemaking.

Beginning in FFY 2024, CMS is changing the deadline to request changes to the MS-DRGs to October 20th of each year to allow additional time for review. Any requested updates would be submitted using the Medicare Electronic Application Request Information System (MEARIS), which CMS is in the process of implementing.

The full list of the final FFY 2023 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2023-ipps-fr-table-5.zip. For comparison purposes, the FFY 2022 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2022-ipps-fr-table-5-fy-2022-ms-drgs-relative-weighting-factors-and-geometric-and-arithmetic-mean.zip.

- **Cap for Relative Weight Reductions** ***(Display pages 304 – 314, 1,809 – 1,813, and 1,822)*****:** In previous rulemaking, CMS adopted policies which limited significant declines in MS-DRG relative weights from one federal fiscal year to the next, with special consideration going towards lower volume MS-DRGs.

  In an effort to address concerns from commenters and to mitigate financial impacts due to significant fluctuations, beginning FFY 2023, CMS is adopting a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year. This would be implemented in a budget neutral manner. As such, CMS will apply a budget neutrality adjustment of 0.999764 (proposed at 0.999765) to the standardized amount for all hospitals. This cap would only apply to a given MS-DRG if it retains its MS-DRG number from the prior year and would not apply to the relative weight for any new or renumbered MS-DRGs for the year. CMS has released a supplemental file along with this final rule showing how MS-DRG

weights are calculated, including the weight prior to the application of this cap, which can be found on the IPPS final rule home page.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapies** ***(Display pages 69 – 78, 291 – 299, and 832 – 836)*****:** In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 [Chimeric Antigen Receptor (CAR) T-cell Immunotherapy]. As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign these procedure codes to the most appropriate MS-DRG. For FFY 2023, CMS will continue to apply an adjustment for cases that would apply to MS-DRG 018 using the same methodology adopted for FFY 2021.

  As providers do not typically pay for the cost of a drug for clinical trials, CMS is finalizing an adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018, similarly to FFYs 2021 and 2022. The adjustment of 0.21 (proposed at 0.20) will be applied to the payment amount for clinical trial cases that would both group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6, contain standardized drug charges of less than $373,000 or when there is expanded access use of immunotherapy. As in the past, CMS would not apply this payment adjustment to cases where a CAR T-cell therapy product is purchased but the case involves a clinical trial of a different product as well as where there is expanded us of immunotherapy.

- **New Technology** ***(Display pages 318 – 544)***: CMS states that numerous new medical services or technologies are eligible for add-on payments outside the PPS. Table II.F.-02 on Display page 355 shows the 11 technologies that will have their add-on payment discontinued for FFY 2023 since their 3-year anniversary date will occur before April 1, 2023. Table II.F.-01 on Display pages 349 – 350 shows the 15 technologies that will continue to receive add-on payments for FFY 2023.

  Due to the circumstances around FFY 2022 rate setting and the COVID-19 PHE, CMS adopted a one-time exception to continue add-on payments for certain technologies approved for payment in FFY 2021, but would otherwise be discontinued in FFY 2022, due to the technologies no longer being considered new. CMS is discontinuing add-on payments for these technologies as they are no longer considered "new" and data in the FFY 2021 MedPAR fully reflects their costs. Table II.F.-03 on Display page 360 shows these 13 technologies.

  CMS will implement four new technology add-on payments under the traditional pathway, and six under alternative pathways (with one, DefenCath™ requiring FDA marketing authorization by July 1, 2023 to remain eligible).

  To identify administration of therapeutic agents approved to receive the new technology add-on payment, CMS proposed to transition to the use of National Drug Codes (NDC), rather than ICD-10-PCS Section X codes. Based on comments received, this proposal was not finalized and CMS will reassess this policy proposal in future rulemaking.

  Beginning in the FFY 2024 new technology add-on payment cycle, CMS will post online the application and certain materials received from the applicants. This would also include any information acquired subsequent to the application submission but not cost, volume, any submitted materials that the applicant does not have the right to make public, or any confidential information identified as such by the applicant. All relevant materials would be publically posted at the time of proposed rule and no sooner, excluding any applications withdrawn prior to the publication of the proposed rule.

  CMS previously established the New COVID-19 Treatments Add-on Payment (NCTAP) to increase the current IPPS payment amount for drugs and biologicals authorized for emergency use for the treatment of COVID-19 in the inpatient setting. Specifically, beginning for discharges on or after November 2, 2020 through the end of the PHE, hospitals will be paid the lesser of 65% of the operating outlier threshold for the claim or 65% of the amount by which the cost of the case exceed the standard DRG payment, including the relative weight Coronavirus Aid, Relief, and Economic Security Act adjustment.

In the FFY 2022 IPPS final rule, CMS finalized that discharges which qualify for NCTAP shall remain eligible for the add-on for the remainder of the fiscal year following the end of the PHE in order to minimize payment disruption. The extension of NCTAP was also adopted for eligible products that are not otherwise approved for new technology add-on through the end of the fiscal year in which the PHE ends. Further information about NCTAP can be found at https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap.

- **Request for Information – Social Determinants of Health (SDOH) Diagnosis Codes *(Display pages 219 – 236)*:** CMS requested information on the following topics that pertain to the 96 diagnosis codes relating to SDOH (Z codes found in categories Z55 – Z65) to gauge whether or not a proposal to change severity level designations of these codes in future rulemaking would be appropriate:
    - *"How the reporting of certain Z codes – and if so, which Z codes - may improve our ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs?*
    - *Whether CMS should require the reporting of certain Z codes – and if so, which ones – to be reported on hospital inpatient claims to strengthen data analysis?*
    - *The additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries.*
    - *Whether codes in category Z59 (Homelessness) have been underreported and if so, why? In particular, we are interested in hearing the perspectives of large urban hospitals, rural hospitals, and other hospital types in regard to their experience. We also seek comments on how factors such as hospital size and type might impact a hospital's ability to develop standardized consistent protocols to better screen, document and report homelessness."*

  Additionally, CMS invited comment on *"ways the MS-DRG classification can be useful in addressing the challenges of defining and collecting accurate and standardized self-identified socioeconomic information for the purposes of reporting, measure stratification, and other data collection efforts."*

  Comments on these topics can be found on Display pages 230 – 236.

- **Possible Mechanisms to Address Rare Diseases and Conditions Represented by Low Volumes within the MS-DRG Structure *(Display pages 274 – 282):*** CMS solicited public comment on how *"…the reporting of certain diagnosis codes may improve our ability to recognize severity of illness, complexity of service, and utilization of resources under the MS-DRGs, as well as feedback on mechanisms to improve the reliability and validity of the coded data as part of an ongoing effort across CMS to evaluate and develop policies to reduce health disparities."* Specifically, CMS sought comment on the potential issues related to patient access for beneficiary population that are diagnosed with rare diseases and conditions, which are represented by low volumes in claim data.

  Comments on these topics can be found on Display pages 281 – 283.

Low-Volume Hospital Adjustment

Display pages 767 – 779

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Bipartisan Budget Act of 2018 had extended the relaxed low volume adjustment criteria (>15-road miles/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 total discharges (rather than 1,600 Medicare discharges). The current payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

In FFY 2023 and subsequent years, the criteria for the low-volume hospital adjustment will return to the more restrictive levels. In order to receive a low-volume adjustment subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status for FFY 2023, consistent with historical practice, a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for FFY 2023. The MAC must receive a written request by September 1, 2022 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2022. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2022 may continue to receive the adjustment for FFY 2023 without reapplying if it meets both the adopted criteria.

RRC Status

Display pages 761 – 766

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of 3 optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The final FFY 2023 minimum case-mix and discharge values are available on the pages listed above.

Medicare-Dependent, Small Rural Hospital (MDH) Program

Display pages 780 – 785

Beginning October 1, 2022, the MDH program will no longer be in effect as the statute was not authorized beyond September 30, 2022. All hospitals that previously qualified for MDH will be paid based on the IPPS Federal rate unless they are approved for sole community hospital (SCH) status. Previous policies adopted by CMS allow for an effective date of an approved SCH status to follow the expiration date of the MDH program, as long as the MDH applies for SCH status at least 30 days before the expiration of the MDH program (September 1, 2022) and specifically requests the SCH status to be effective October 1, 2022. Accepted applications filed after September 1, 2022 would subject to the usual effective date for SCH classification.

Condition of Participation (CoP) Requirements for Hospitals and CAHs to Report Data Elements to Address Any Future Pandemics and Epidemics

Display pages 1,697 – 1,715

In an effort to create a more flexible regulatory frame work for any future pandemic or epidemic, CMS will revise the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements to after the COVID-19 PHE ends, but no earlier than October 1, 2022. CMS adopted, with modification, COVID-19 and Seasonal Influenza reporting standards to require that, beginning at the conclusion of the current COVID-19 PHE declaration and continuing until April 30, 2024, a hospital or CAH must electronically report information about COVID-19 or Seasonal Influenza in a standardized format.

CMS is not finalizing their proposal that when a PHE is declared, hospitals and CAHs will be required to report various categories of data elements to the Center for Disease Control and Prevention's National Healthcare Safety Network (NHSN).

Quality-Based Payment Adjustments

Display pages 837 – 1,006 and 1,462 – 1,479

For FFY 2023, IPPS payments to hospitals will only be adjusted for quality performance under the Readmissions Reduction Program (RRP). Detail on the FFY 2023 programs and payment adjustment factors are below (future program year changes are addressed in the next section of this brief).

In the August 2020 COVID-19 interim final rule with comment period (IFC), CMS updated the extraordinary circumstances exception policy in response to the PHE so that no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the any of the three quality programs.

- **VBP Adjustment *(Display pages 879 – 946)*:** Similar to FFY 2022, due to the impact of the COVID-19 PHE, CMS is adopting the following:
    - Omit all measures in the Person and Community Engagement and Safety domains for FFY 2023 (MORT-30-PN was already finalized to be excluded from Clinical Outcomes for FFY 2023);
    - Special scoring and payment rule for FFY 2023 that calculates measure rates for all measures, but only achievement/improvement/domain scores for the Efficiency and Clinical Outcomes domain. These scores are solely for information purposes as all hospitals will be given a value-based incentive payment amount that leaves base operating DRG payments unchanged for FFY 2023.

  Beginning with the FFY 2023 program, CMS will include a covariate adjustment for patients with a clinical history of COVID-19 in the 12 months prior to the index admission for all mortality measures. CMS also adopted the exclusion of patients with a primary or secondary COVID-19 diagnosis from the measure numerators and denominators for all clinical outcomes conditions beginning with the FFY 2023 program.

  CMS recognizes that this has an implication on the Merit-based Incentive Payment System (MIPS) program since under the facility-based measurement option, clinicians eligible for facility-based measurement may have their MIPS quality and cost performance category scores based on the Total Performance Score of the applicable hospital from the Hospital VBP Program. Clinicians who would normally be assessed through facility-based measurement would need to identify another method of participating for the CY 2022 performance period/CY 2024 payment year or submit an application for reweighting a performance category or categories, if applicable.

  As described, CMS is suppressing measures for the FFY 2023 VBP program. Therefore CMS will not adjust hospital payments for the program year nor post Tables 16A or 16B.

  Details and information on the program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

- **RRP *(Display pages 837 – 878)***: The FFY 2023 RRP will evaluate hospitals on 5 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). In the FFY 2022 final rule, CMS adopted the suppression of the pneumonia (PN) measure for the FFY 2023 due to the impact of the COVID-19 pandemic.

  The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

  Due to COVID-19 impacts, the FFY 2023 RRP will only use data from July 1, 2018 – December 31, 2019 and July 1, 2020 – June 30, 2021 for calculations.

  CMS will exclude patients with a primary or secondary COVID-19 diagnosis from the measure numerators and denominators for all RRP conditions beginning with the FFY 2023 program. Also beginning with the FFY 2023 program, CMS will include a covariate adjustment for patients with a clinical history of COVID-19 in the 12 months prior to the index admission for all RRP measures.

Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare FFS and Medicare Advantage patients during the same 3-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

The data applicable to the FFY 2023 RRP program is still being reviewed and corrected by hospitals, and therefore CMS have not yet post factors for the FFY 2023 program in Table 15. CMS expects to release the final FFY 2023 RRP factors in the fall of 2022.

Details and information on the RRP currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hrrp.

- **HAC Reduction Program** ***(Display pages 947 – 1,006)*****:** CMS adopting its proposal to suppress the PSI-90 measure and the CDC NHSN HAI measures from the calculation of measure scores and Total HAC scores for the FFY 2023 program, thereby not penalizing any hospitals.

  CMS will continue to provide measure results for the CDC NHSN HAI measures to hospitals via their hospital-specific reports. For the PSI-90 measure, CMS is not adopting its proposal to suppress the calculating and publically reporting of measure results for the FFY 2023 program due to the identification of a method for excluding COVID-19 patients from program calculations. Therefore, PSI-90 measure scores will also be provided to hospitals via their hospital-specific reports and will be displayed on Care Compare after a 30-day preview period.

  Currently, a hospital must have 3 or more eligible discharges for at least one component indicator in order to receive a PSI-90 score for the HAC program. However, due to a small subset of hospitals having a reliability close to zero for this measure due to the current minimum threshold, CMS is making a technical change to the minimum criteria to receive a PSI-90 score in the HAC program, beginning FFY 2023. Specifically, a hospital will be required to meet both of the following criteria in order to receive a PSI-90 score:

    - One or more component PSI measure with at least 25 eligible discharges; and
    - Seven or more component PSI measures with at least 3 eligible discharges.

  In FFY 2017 CMS adopted a policy for NHSN HAI data submission for newly opened hospitals that referred to the date that a hospital filed a notice of participation with the Hospital IQR Program. However, in FFY 2019 CMS transferred collection of the CDC NHSN HAI measures from Hospital IQR to HAC, and therefore the requirement did not apply. In this rule, CMS is adopting its proposal to update the CDC NHSN HAI data submission requirements for newly opened hospitals beginning FFY 2023, such that hospitals with a Medicare Accept Date within the last 12 months of the performance period will be considered new. These newly-opened hospitals will not receive a measure score for any of the CDC NHSN HAI measures in HAC.

  CMS also clarifies that the "No Mapped Locations" policy has been removed as of FFY 2023 and hospitals whom historically were able to receive a "no mapped locations" exemption for CLABSI and CAUTI from the HAC program will no longer receive that exemption. Instead, hospitals requesting to be exempt from reporting should submit an IPPS Measure Exception Form on the QualityNet website. If a hospital does not submit the form and not submit data, then they will receive max z-score for these measures.

  Details and information on the HAC currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hac.

Quality-Based Payment Policies—FFYs 2024 and Beyond

For FFYs 2024 and beyond, CMS is finalizing new policies for its quality-based payment programs.

- **VBP Program** ***(Display pages 879 – 946 and 1,462 – 1,479)*****:** CMS had already adopted VBP program rules through FFY 2023 and some program policies and rules beyond FFY 2023. CMS is adopting further program updates through FFY 2028, which include:

- National performance standards for a subset of the FFYs 2025 and 2028 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking).

Due to the impact of the COVID-19 PHE, CMS is adopting its proposal to update baseline periods for the FFY 2025 program for Person and Community Engagement and Safety domains from CY 2021 to CY 2019.

CMS will resume the use of the pneumonia measure in the FFY 2024 program, with an exclusion of patients with a principal or secondary COVID-19 diagnosis from both the numerator and denominator.

Lastly, CMS requested information on the potential inclusion of the NHSN Health-care Associated *Clostridioides difficile* Infection Outcomes Measure and the NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure into the VBP program. CMS discusses these measures and responds to comments on Display pages 1,462 – 1,479.

- **RRP** ***(Display pages 837 – 878)*****:** CMS is adopting its proposal to resume the use of the pneumonia measure in the FFY 2024 program, with an exclusion of patients with a principal or secondary COVID-19 diagnosis from both the numerator and denominator.

  In the proposed rule, CMS requested comment on future inclusion of health equity performance in RRP. Specifically, CMS requested comment on (1) the benefit, potential risks, unintended consequences, and costs of incorporating hospital performance for beneficiaries with social risks factors; (2) linking performance in caring for socially at-risk populations and payment reductions by calculating the reductions based on readmission outcomes for socially at-risk beneficiaries compared to other hospitals or to performance for other beneficiaries within the hospital; and (3) measures or indicators of social risk that should be used to measure hospital's performance in achieving equity. Comments can be found on Display pages 872 – 878.

- **HAC Reduction Program** ***(Display pages 947 – 1,006 and 1,462 – 1,479)*****:** CMS is adopting its proposal to update the PSI-90 measure specifications to risk-adjust for COVID-19 diagnoses, beginning with the FFY 2024 HAC program.

  In additional, will suppress CY 2021 data for the CDC NHSN HAI measures for the FFY 2024 program. This results in the following performance periods:

  - FFY 2024: PSI-90 from January 1, 2021 – June 30, 2022 and HAI from January 1, 2022 – December 31, 2022.

  Separately, CMS requested comment on the potential inclusion of the digital NHSN Healthcare-associated *Clostridioides difficile* Infection Outcomes Measure and the digital NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure into the HAC program. CMS discusses these measures and responds to comments on Display pages 1,462 – 1,479.

Updates to the IQR Program and Electronic Reporting Under the Program

Display pages 1,177 – 1,521

CMS is adopting two measures for the IQR program beginning with the CY 2023 reporting period/FFY 2024 payment determination:

- Medicare Spending per Beneficiary (MSPB) Hospital (updated measure); and
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure.

CMS adopting 1 new measure beginning with the CY 2023 reporting period/FFY 2025 payment determination:

- Hospital Commitment to Health Equity (HCHE).

CMS is finalizing 6 new measures beginning with the CY 2024 reporting period/FFY 2026 payment determination:

- Screening for Social Drivers of Health (SDOH-1) (with voluntary reporting for CY 2023);
- Screen Positive Rate for Social Drivers of Health (SDOH-2) (with voluntary reporting for CY 2023);
- Cesarean Birth (ePC-02) eCQM (with self-select reporting for CY 2023);

- Severe Obstetric Complications (ePC-07/SMM) eCQM (with self-select reporting for CY 2023);
- Hospital-Harm—Opioid-Related Adverse Events (HH-ORAE) eCQM (self-select); and
- Global Malnutrition Composite Score (GMCS) eCQM (self-select).

CMS is finalizing 1 new measure beginning with the CY 2026 reporting period (July 1, 2025 – June 30, 2026)/FFY 2028 payment determination:

- Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary THA/TKA (voluntary reporting for CY 2025 and CY 2026);

In addition, CMS is finalizing its proposal to expand the measure outcome of the Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective THA/TKA Measure (NQF #3474) to include 26 clinically vetted mechanism complication ICD-10 codes, beginning with the FFY 2024 payment determination. The measure "outcome" is the hospital-level, risk-standardized payment associated with a 90-day episode-of-care for primary elective THA and/or TKA.

Another refinement CMS is adopting is to the Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) measure (NQF #2881). Beginning with the FY 2024 payment determination, CMS will increase the minimum case count for reporting from 25 cases to 50 cases.

Beginning fall 2023, CMS is establishing a publicly-reported hospital designation to capture the quality and safety of maternity care. The designation will be awarded to hospitals based on their reporting of "Yes" to both questions in the Maternal Morbidity Structural measure. With this, CMS solicited comment on the designation name and additional data sources to consider for purposes of awarding this hospital designation. Comments can be found on Display pages 1,450 – 1,457.

CMS also requested comment on additional activities to advance maternal health equity. Comments can be found on Display pages 1,460 – 1,461.

Lastly, CMS sought comment on the potential of the following new measures for the IQR program. The measures and corresponding Display pages are as follows:

- NHSN Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure (Display pages 1,463 – 1,472); and
- NHSN Hospital-Onset Bacteremia & Fungemia Outcome measure (Display pages 1,472 – 1,479).

Tables in the final rule on Display pages 1,422 – 1,430 outline the previously adopted and newly adopted Hospital IQR Program measure set for the FFYs 2024 – 2028 payment determination and subsequent years.

Reporting and Submission Requirements for eCQMs

Display pages 1,482 – 1,521

CMS is adopting its proposal to modify eCQM reporting and submission requirements beginning with the CY 2024 reporting period/FFY 2026 payment determination, outlined below:

Reporting Period/Payment Determination	Final # of Self-Selected Calendar Quarters Required	Final eCQMs required
CY 2022 reporting period/FFY 2024 payment determination	3	• 3 self-selected • Safe Use of Opioids eCQM
CY 2023 reporting period/FFY 2025 payment determination	4	• 3 self-selected • Safe Use of Opioids eCQM
CY 2024 reporting period/FFY 2026 payment determination (and subsequent years)	4	• 3 self-selected • Safe Use of Opioids • ***Adopted*** Cesarean Birth

		• ***Adopted*** Severe Obstetric Complications

In the FFY 2020 final rule, CMS adopted the application of the zero denominator declarations policy and case threshold exemptions policy to hybrid measure reporting, with the indication that these policies would not be necessary during the voluntary reporting period for hybrid measures, but would be optional. The *"…zero denominator declarations allow a hospital whose EHR is capable of reporting hybrid measure data to submit a zero in the denominator for the reporting of a measure if the hospital does not have patients that meet the denominator criteria of that hybrid measure.... Similarly, the case threshold exemptions policy allows for a hospital with five or fewer inpatient discharges per quarter or 20 or fewer inpatient discharges per year in a given denominator declaration be exempted from reporting on that individual hybrid measure."*

CMS is finalizing the removal of both previously mentioned policies as an option for reporting of hybrid measures beginning with the FFY 2026 payment determination. CMS does not believe these policies are applicable for hybrid measures due to the process of reporting the measure data because hybrid measures do not require that hospitals report a traditional denominator.

Lastly, beginning with CY 2022 eCQM data and affecting the FFY 2025 payment determination, CMS is updating the eCQM validation process from the requirement to submit timely and complete data from 75 percent of requested records to 100 percent of requested records. This will not impact finalized chart-abstracted measure validation policies.

Request for Information – Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity

Display pages 1,101 – 1,108

Research has shown that climate change causes harm to individuals through catastrophic events and chronic disease and therefore CMS is concerned for the health of individuals and wants to maintain uninterrupted operations in service of patients. In the proposed rule, CMS sought comment on how hospitals, nursing homes, hospices, home health agencies, and other providers can better prepare for the harmful impacts of climate change on their patients. CMS also asked for guidance on how it can support these healthcare settings in doing so.

Comments can be found on Display pages 1,105 – 1,108.

Request for Information – Overarching Principles for Measuring Healthcare Quality Disparities across CMS Quality Programs

Display pages 1,108 – 1,146

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing care and support.

CMS had requested comment on several following topics having to do with health equity in five key areas:

- identification of goals and approaches for measuring health care disparities and using measure stratification across CMS quality programs;
- guiding principles for selecting and prioritizing measures for disparity reporting across CMS quality programs;
- principles for social risk factor and demographic data selection and use;
- identification of meaningful performance differences; and
- guiding principles for reporting disparity results.

Comments can be found on Display pages 1,131 – 1,146.

Request for Information – Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

Display pages 1,147– 1,171

CMS has a continued focus on the use of digital data and advancements in technology to improve interoperability of healthcare data to improve quality measurement systems and to reduce reporting burden.

In the proposed rule, CMS asked for feedback on its definition of digital quality measures (dQM) as a "software that processes digital data to produce a measure score or measure scores" and challenges related to non-electronic health record (EHR) data sources.

In addition, CMS is considering what, if any, additional CMS-specific implementation guides may be necessary to support future digital quality measurement. With this, CMS is considering how to best leverage the FHIR Application Programing Interface (API) technology to access and electronically transmit interoperable data and requested comment on additional venues to engage with implementers during the transition process.

Comments can be found on Display pages 1,156 – 1,171.

Request for Information – Advancing the Trusted Exchange Framework and Common Agreement

Display pages 1,171 – 1,176

The 21st Century Cures Act of 2016 requires Health and Human Services (HHS) to develop or support a trusted exchange framework, including a common agreement among health information networks nationally. On January 18, 2022 the Trusted Exchange Framework and Common Agreement (TEFCA) Version 1 were released. *"The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement for Nationwide Health information Interoperability Version 1 (also referred to as Common Agreement) is a contract that advances those principles."*

CMS requested comment on the TEFCA Version 1 and related concepts for future exploration. Comments can be found on Display pages 1,175 – 1,176.

Promoting Interoperability Program

Display pages 1,547 – 1,673

The Medicare Promoting Interoperability program provides incentive payments and payment reductions for the adoption and meaningful use of certified electronic health record technology.

CMS is finalizing its proposal that, beginning with CY 2023 reporting, the Query of PDMP measure will be required for eligible hospitals and CAHs participating in the program. The measure will be expanded to include drugs from Schedules II, III, and IV, with the two exclusions that were proposed and one additional exclusion:

- *"Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions for controlled substances that include drugs from Schedules II, III, and IV, and is not located within 10 miles of any pharmacy that accepts electronic prescriptions for controlled substances at the start of their EHR reporting period;*
- *Any eligible hospital or CAH that cannot report on this measure in accordance with applicable law; and*
- *Any eligible hospital or CAH for which querying a PDMP would impose an excessive workflow or cost burden prior to the start of the EHR reporting period they select in CY 2023."*

CMS would maintain the 10 point value for the measure and the maximum total points available for Electronic Prescribing Objective would remain at 20 points.

Separately, CMS is also finalizing its proposal to add the Enabling Exchange Under TEFCA measure as optional, worth the total 30 points for the Health Information Exchange (HIE) objective. The measure will require a yes/no response. Eligible hospitals and CAHs will have three reporting options for this objective:

(1) "Report on both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure;
(2) Report on the HIE Bi-Directional Exchange measure; or
(3) Report on the Enabling Exchange Under TEFCA measure."

CMS is not finalizing its proposal that the TEFCA measure be calculated by reviewing only the actions for patients whose records are maintained using certified electronic health record technology (CEHRT) because this measure only requires attestations and not calculations.

In addition, CMS is adding the Antimicrobial Use and Resistance (AUR) Surveillance measure to the Public Health and Clinical Data Exchange objective, beginning CY 2024 (proposed to begin CY 2023) with a yes/no response. No additional points will be associated with the reporting of the measure, but it is still required to satisfy the objective.

There are currently three options for eligible hospitals and CAHs to demonstrate active engagement, which is *"…when an eligible hospital or CAH is in the process of moving towards sending 'production data' to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry."* Although the three options provide flexibility to meet the measures under the Public Health and Clinical Data Exchange objective, they do not provide incentive to move through the options to get to option 3. Therefore CMS is consolidating options 1 and 2 into one option beginning with CY 2023 reporting. The new options are as follows:

(1) "Option 1. Pre-production and Validation (a combination of current option 1, completed registration to submit data, and current option 2, testing and validation);
(2) Option 2. Validated Data Production (current option 3, production)."

CMS is also adopting its proposal to require eligible hospitals and CAHs to report their level of active engagement for any of the measures associated with the Public Health and Clinical Data Exchange objective, beginning CY 2023. With this, beginning CY 2024 CMS will also require that eligible hospitals and CAHs spend only one EHR reporting period at each level of active engagement.

CMS finalized various proposals that would affect the scoring of the objectives and measures for the CY 2023 EHR reporting period, outlined below:

Final Performance-Based Scoring Methodology Beginning with the CY 2023 EHR Reporting Period			
Objectives	**Measures**	**2023: Maximum Points**	**Redistribution if Exclusion Claimed**
Electronic Prescribing	e-Prescribing	10 points	10 points to HIE Objective
	Query of PDMP	10 points ***(adopted as required)***	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	15 points ***(adopted)***	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	15 points ***(adopted)***	No exclusion
	OR		
	HIE Bi-Directional Exchange measure	30 points ***(adopted)***	No exclusion
	OR		
	Enabling Exchange under TEFCA	30 points ***(adopted)***	No exclusion

Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points ***(adopted)***	
Public Health and Clinical Data Exchange	<u>Required with yes/no response</u> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Reporting	25 points ***(adopted)***	If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information
	<u>Optional to report one of the following</u> • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)	

CMS will also publicly publish Medicare Promoting Interoperability Program data beginning with the CY 2023 reporting period on Care Compare. This will include the total score of up to 105 points and the CMS EHR certification ID. CMS will not publish individual measure scores at this time. This will be available as early as fall CY 2024 and include a 30-day preview period for eligible hospitals and CAHs to review their data before it is published.

Consistent with the Hospital IQR program, CMS will add 4 additional eCQMs from the Hospital IQR programs measure set beginning with the CY 2024 reporting period (2 with self-select for CY 2023 but mandatory for CY 2024). This increases eCQM reporting from 4 eCQMs to 6 eCQMs. The measures are listed in the IQR section of this brief.

Lastly, in the proposed rule CMS requested information on how to further promote equitable patient access and use of health information without adding unnecessary burden on the hospital or healthcare provider. Comments can be found on Display pages 1,670 – 1,673.

Request for Comment – IPPS and OPPS Payment Adjustments for Wholly Domestically Made National Institute for Occupational Safety and Health (NIOSH)-approved Surgical N95 Respirators

Display pages 1,716 – 1,717

CMS sought comment on potential payment adjustments under the IPPS and Outpatient PPS (OPPS) to offset costs incurred by hospitals when acquiring wholly domestically made (including raw materials) NIOSH-approved surgical N95 respirators. CMS proposed a payment adjustment in the CY 2023 OPPS proposed rule to begin on January 1, 2023, which would be implemented in a budget neutral manner.

This adjustment would be a biweekly interim lump-sum payment to the hospital and would be reconciled at cost report settlement. The payments would initially be based on the estimated difference in reasonable costs of a hospital to purchase domestic NIOSH-approved surgical N95 respirators compared to non-domestic respirators. In future years, the payment would be based on information from the prior year's surgical N95 supplemental cost reporting form (which would be a new cost reporting form collected from hospitals). Payment amounts would be determined by the MAC. More information regarding this proposal can be found in the CY 2023 OPPS proposed rule *Federal Register* pages 44,689 – 44,696.

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