Medicare Inpatient Prospective Payment System

Proposed Payment Rule Brief Provided by the Wisconsin Hospital Association

Program Year: FFY 2023

Overview and Resources

On April 18, 2022, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2023 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed 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, this rule includes the proposal of the following policies:

- 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);
- A rate increase amount (+0.5%) for the MACRA Coding Offset adjustment;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies including hospitals being eligible for DSH payments in FFY 2023 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;
- Creation of a permanent 5% cap on wage index decreases;
- Creation of a permanent 10% cap on MS-DRG weight decreases;
- Change the in Factor 3 calculation for Indian Health Service (IHS)/Tribal hospitals and Puerto Rico hospitals;
- 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 proposed rule update to be a decrease of approximately $0.3 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 proposed 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-proposed-rule-home-page.

On May 10, 2022, the *Federal Register* version of the proposed rule will be available at https://www.federalregister.gov/public-inspection/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-quality-programs-and-medicare.

Comments on the proposed rule are due to CMS by June 17, 2022 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1771-P."

Note: Text in italics is extracted from the April 18, 2021 DISPLAY copy of the proposed rule.

IPPS Payment Rates

DISPLAY pages 44 – 52, 55 – 57, 777 – 784, 946 – 949, 1,509 – 1,565, 1,568 – 1,594, and 1,646

The table below lists the federal operating and capital rates proposed 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	Proposed FFY 2023	Percent Change
Federal Operating Rate	**$6,121.65**	**$6,315.77**	**+3.17%**
Federal Capital Rate	**$472.59**	**$480.29**	**+1.63%**

The following table provides details for the proposed 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	**+3.1%**		**+1.7%**
ACA-Mandated Productivity Adjustment	**-0.4 percentage point (PPT)**		—
MACRA-Mandated Retrospective Documentation and Coding Adjustment	**+0.5%**	—	—
Lowest Quartile Wage Index Adjustment	**+0.02%**		**-0.03%**
Wage Index Cap Policy	**-0.03%**		
MS-DRG Weight Cap Policy	**-0.02%**		**-0.02%**
Annual Budget Neutrality Adjustments	**-0.01%**		**-0.02%**
Net Rate Update	***+3.17%***	***+2.66%***	***+1.63%***

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs *(DISPLAY pages 777 – 781, 1,510 – 1,511, and 1,571 – 1,572)***: 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 proposed update scenarios for FFY 2023 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Marketbasket Update (3.1% MB less 0.4 PPT productivity adjustment)	**+2.7%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.1%)	—	**-0.775 PPT**	—	**-0.775 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.1%)	—	—	**-2.325 PPT**	**-2.325 PPT**
Adjusted Net Marketbasket Update (prior to other adjustments)	***+2.7%***	***+1.925%***	***+0.375%***	***-0.4%***

- **Use of FFY 2021 Data and Methodology Modifications (*DISPLAY pages 44 – 52*):** 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; and
- Inflating the charges from the FYY 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 also proposes to 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.

CMS is also requesting comments on the use of FFY 2021 data for FFY 2023 rate setting without these proposed modifications, noting that the FFY 2023 outlier fixed-loss amount will be significantly higher under this alternative approach. Supplemental information, including relative weights and the fixed-loss amount, can be found in Appendix A of the proposed rule.

- **Retrospective Coding Adjustment** ***(DISPLAY pages 55 – 57 and 1,536)*****:** CMS is proposing 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 1,536 – 1,562)*****:** 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 is proposing to incorporate total outlier reconciliation dollars from the FFY 2017 cost reports into the outlier model using a similar methodology to FFY 2022.

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

  Analysis done by CMS determined outlier payments at 5.11% of total IPPS payments; CMS is proposing an outlier threshold of $43,214 for FFY 2023, which includes a charge inflation factor which is proposed to be calculated using the March 2019 MedPAR file of FFY 2018 charge data and the March 2020 MedPAR file of FFY 2019 charge data. This proposed threshold is 39.45% higher than the current (FFY 2022) outlier threshold of $30,988.
- **Stem Cell Acquisition Budget Neutrality Factor** (***DISPLAY page 1,513***): CMS is proposing to 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 630 – 699, 1,526 – 1,534, and 1,566 – 1,568

- **Permanent Cap on Wage Index Decreases** ***(DISPLAY pages 691 – 699 and 1,532 – 1,534)*****:** 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 is proposing to 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 is proposed to 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's capped wage index in the prior FFY. This cap is proposed to 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 proposed cap policy would apply to the reclassified wage index instead.

CMS is also proposing 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 continued transition is proposed to be implemented in a budget neutral manner with a net budget neutrality factor of 0.999704, after backing out the effects of the FFY 2022 adjustment.

- **Codes for Constituent Counties in CBSAs** ***(DISPLAY pages 635 – 637)*****:** Consistent with previous policies, CMS proposes to implement the use of newly created 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) are proposed to be implemented and will be located in CBSA 02. CMS notes that that there will be no impact or change for hospitals in these counties as a result of this proposal.

- **Rural Floor** ***(DISPLAY pages 657 – 658)*****:** In the FFY 2020 IPPS final rule, CMS finalized 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 are subject to pending litigation (*Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*). CMS proposes to continue its rural floor policies for FFY 2023, but may take a different approach based on public comment or further court proceedings.

- **Imputed Floor (*****DISPLAY pages 658 – 663):*** 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 would receive an imputed floor are New Jersey, Rhode Island, Delaware, Connecticut, Puerto Rico, and Washington, D.C based on the data available for the proposed rule. CMS includes the imputed floor adjustment in wage index tables accompanying this proposed rule.

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals** ***(DISPLAY pages 663 – 665, 1531 – 1532)*****:** 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 proposes to 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. Though this court decision involves only FFY 2020, is not final, and is subject to potential appeal, it could still affect FFY 2023 payment rates. As such, CMS is proposing to continue the low wage index policy for FFY 2023 but may take a different approach in the final rule based on public comments and developments in the court proceedings. CMS also proposes to 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 proposed rule, the value of the 25th percentile wage index is 0.8401, and the proposed net budget neutrality adjustment is 1.000176 after backing out the effects of the FFY 2022 adjustment.

- **CY 2019 Occupational Mix Adjustment** ***(DISPLAY pages 651 – 656)*****:** 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 proposed FFY 2023 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS proposes the FFY 2023 occupational mix adjusted national average hourly wage to be $47.71.

- **Labor-Related Share** ***(DISPLAY pages 688 – 690 and 1,566)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2023, CMS proposes to 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 1,566 – 1,568):*** 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

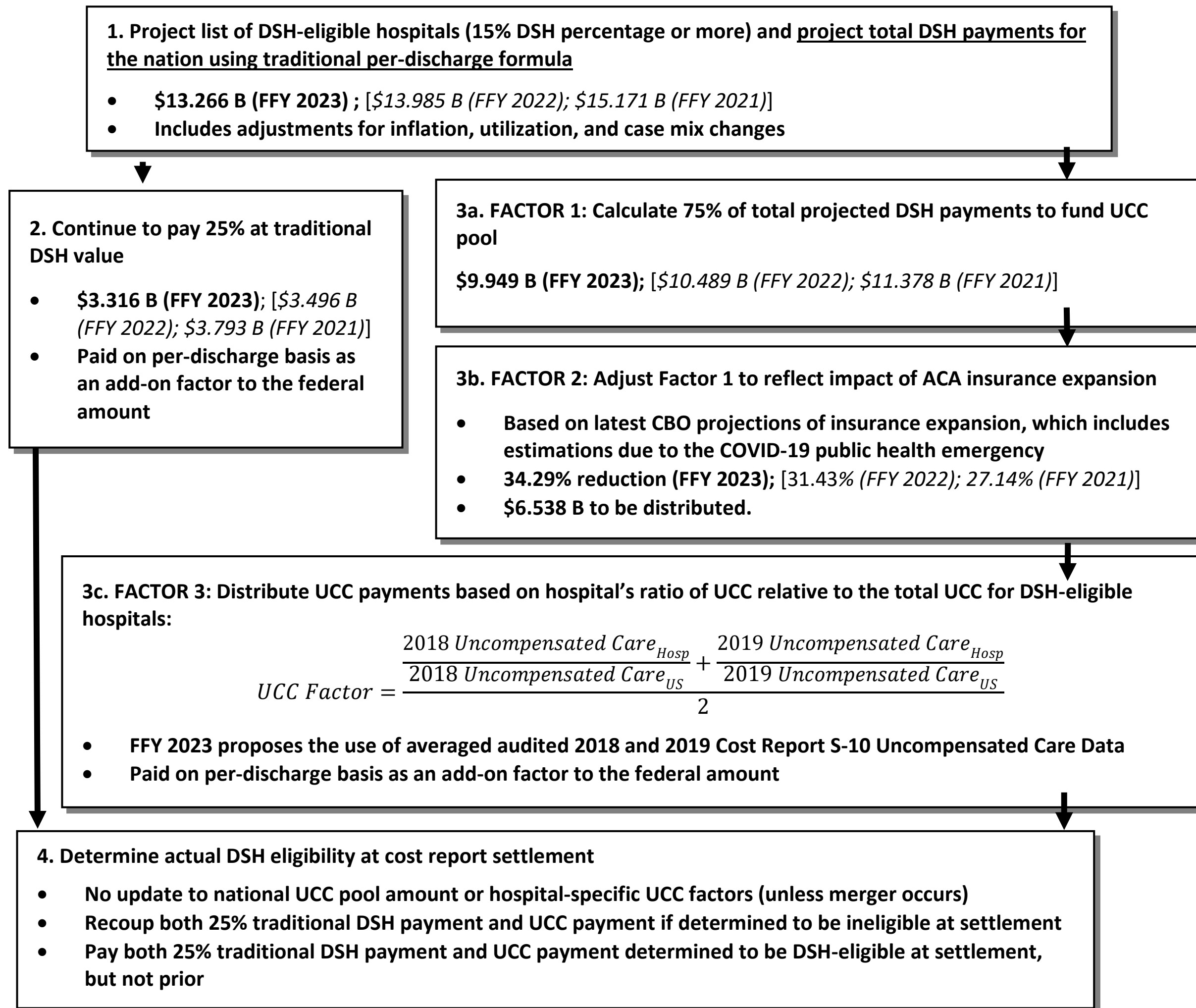
A complete list of the proposed wage indexes for payments in FFY 2023 is available on Table 2 on the CMS Web site at https://www.cms.gov/sites/default/files/2022-04/CMS-1771-P%20Tables%202,%203,%204A,%204B.zip.

DSH Payments

DISPLAY pages 700 – 776

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 700 – 757)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program has been proposed to change from FFY 2022 to FFY 2023:



The DSH dollars available to hospitals under the ACA's payment formula would decrease by $0.654 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 704 – 708)*****:** CMS is projecting that 2,380 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/sites/default/files/2022-04/FY%202023%20NPRM%20DSH%20Supplemental%20Data%20File.zip

- **Adjustment to Factor 3 Determination** ***(DISPLAY pages 725 – 757)*****:** In consideration of comments discussed in the FFY 2022 IPPS final rule, CMS is proposing 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 is proposing to 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 is proposing to 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 are proposed to 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, CMS proposes that the same cost report would not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFY, CMS proposes to use the most recent prior cost report that spans some portion of that FFY. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, CMS proposes to apply a scaling factor to the Factor 3 values for all of these hospitals, similarly to the scaling factor methodology used for FFYs 2018 and 2019. For each DSH-eligible hospital, this scaling factor is proposed to be 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 is proposing to 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. CMS also proposes that 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 is also being proposed to 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 proposes to 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 proposes to 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.

For the values provided with the FFY 2023 IPPS proposed rule, CMS utilized the December 2021 update of HCRIS. CMS intends to use the March 2022 update for all the final rule calculations, but may consider using more recent data if appropriate.

CMS is proposing to use a hospital's three-year average discharge number to estimate their uncompensated care payment per discharge. CMS believes that using a three-year average which includes FFY 2020 discharge data would underestimate discharges due to the COVID-19 pandemic affecting number of discharges. Instead, CMS is proposing to use the average of FFY 2018, FFY 2019, and FFY 2021 discharges to calculate interim payments. 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 the FFY 2023 IPPS final rule.

For FY 2023, CMS proposes that hospitals will have 60 business days from the date of public display of the FFY 2023 IPPS PPS proposed rule to review and submit comments on the accuracy of Table 18 and DSH supplemental data file published along with the proposed rule. CMS is also proposing that hospitals will have 15 business days from the date of public display of the FFY 2023 IPPS PPS 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 proposed rule and the 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 758 – 764):*** In order to mitigate the impact of the proposed calculation changes in determining Factor 3 for IHS/Tribal and Puerto Rico hospitals, CMS proposes to establish a permanent supplemental payment to these hospitals. This payment would be calculated using each hospital's FFY 2022 UCC payments (or estimated UCC payments if not DSH eligible) as a base and then adjusting 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 would 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 0.909 to reflect the -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 would not receive a supplemental payment. CMS further proposes to align the eligibility and payment processes for the proposed supplemental payment with the process used to make UCC payments, which includes the process changes proposed for FFY 2023 and FFY 2024 and onwards, as well as reconciliation at cost report settlement as determined by the MAC.

  Regarding hospitals for which CMS has elected to not use S-10 data in the past, unlike in prior years**,** CMS is proposing to 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 calculated by utilizing the FFY 2013 data for Medicaid days combined with the most recent update of the SSI days. CMS is concerned that the age of this data makes it no longer a good proxy for the costs that these hospitals incur by treating the uninsured. For FFY 2023, CMS is proposing to use the average of Worksheet S–10 data from the audited FFY 2018 and FFY 2019 cost reports to calculate Factor 3, which is the same as all other hospitals. In order to avoid any significant financial disruption, CMS is proposing a new supplemental payment for IHS, tribal, and Puerto Rico hospitals for FFY 2023. CMS is seeking comments on alternatives to these proposals and how to best measure and define uncompensated care costs that may not be captured in Factor 3 calculations based on S-10 data.

- **Counting Days Associated with Section 1115 Demonstration Projects in the Medicaid Fraction** ***(DISPLAY pages 765 – 776):*** 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 is proposing 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. This proposed change would be effective for discharges occurring on-or-after October 1, 2022.

GME Payments

DISPLAY pages 800 – 824

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 is proposing 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.

Under this proposed 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 is proposing to 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 page 816 of the DISPLAY copy of the proposed rule shows the proposed Nursing and Allied Health (NAH) Education Programs Medicare Advantage add-on rates for CY 2020 and CY 2021 as well as the proposed data sources used to calculate each pool.

CMS also is proposing to 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 proposed agreement effective for the July 1, 2023 academic year. This policy is proposed to 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 the proposed affiliation agreement can be found on *DISPLAY* pages 822 – 823.

The Indirect Medical Education adjustment factor is proposed to remain at 1.35 for FFY 2023.

Updates to the MS-DRGs

DISPLAY pages 44 – 52, 53 – 55, 58 – 630, 825 – 828, and 1,522 – 1,526

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 is proposing to 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 74.9% of DRG weights changing by less than +/- 5%, 4.7% changing by +/- 10% or more, and 3.4% that are affected by the relative weight cap. 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	Proposed FFY 2023 Weight	Percent Change
MS-DRG 817: OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURES WITH MCC	2.3068	3.1383	36.05%
MS-DRG 933: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	2.2629	3.0630	35.36%
MS-DRG 836: ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	1.1735	1.5754	34.25%
MS-DRG 688: KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	0.6858	0.8659	26.26%
MS-DRG 969: HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC	5.8519	7.1985	23.01%

When CMS reviews claims data, they apply the 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 this 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 proposed 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 is proposing 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 proposed 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/fy2022-ipps-fr-table-5-fy-2022-ms-drgs-relative-weighting-factors-and-geometric-and-arithmetic-mean.zip.](https://www.cms.gov/files/zip/fy2022-ipps-fr-table-5-fy-2022-ms-drgs-relative-weighting-factors-and-geometric-and-arithmetic-mean.zip) For comparison purposes, the FFY 2022 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/sites/default/files/2021-08/CMS-1752-F%20Table%205.zip

- **Proposed Cap for Relative Weight Reductions** ***(DISPLAY pages 237 – 242, 1,524 – 1,526)*****:** 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, CMS is proposing, beginning FFY 2023, 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 is also proposing to apply a budget neutrality adjustment of 0.999765 to the standardized amount for all hospitals. This proposed cap would only apply to a given MS-DRG if it retains its MS-DRG number from the prior year. This cap would not apply to the relative weight for any new or renumbered MS-DRGs for the year. CMS has released alternate files along with this proposed rule showing how MS-DRG weights (and other affected data) would look without this proposed policy, which can be found on the IPPS proposed rule home page.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapies** ***(DISPLAY pages 66 – 110, 232 – 235, and 825 – 828)*****:** 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 proposes to 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 proposing an adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018, similarly to FFYs 2021 and 2022. The proposed adjustment of 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 247 – 630)***: CMS states that numerous new medical services or technologies are potentially eligible for add-on payments outside the PPS. Table II.F.-01 on *DISPLAY* page 268 shows the 11 technologies that are proposed to have their add-on payment discontinued for FFY 2023 since their 3-year anniversary date will occur before April 1, 2023. Table II.F.-02 on *DISPLAY* pages 273 – 274 shows the 15 technologies proposed to 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 proposing to discontinue 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 pages 277 – 278 shows these 13 technologies.

CMS is considering the implementation of 13 new technology add-on payments under the traditional pathway, and 13 under alternative pathways. To identify administration of therapeutic agents approved to receive the new technology add-on payment, CMS is proposing to transition to the use of National Drug Codes (NDC), rather than ICD-10-PCS Section X codes. This transition would start in FFY 2023 CMS will utilize NDCs along with Section X codes and end for FFY 2024, where only NDC codes would be utilized. Additionally, beginning in the FFY 2024 new technology add-on payment cycle, CMS proposes to 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, or any submitted materials that the applicant does not have the right to make public. CMS proposes all relevant materials would be publically posted no later than the issuance 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 175 – 186)*****:** CMS is requesting information on the following topics that pertain to the 96 diagnosis codes relating to SDOH (Z codes found in categories Z55 – Z65) so that 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 is inviting 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."*

Low-Volume Hospital Adjustment

DISPLAY pages 789 – 797

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, CMS proposes that subsection (d) hospitals are to 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.

CMS proposes that 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 proposed 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 proposed criteria.

RRC Status

DISPLAY pages 784 – 788

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 proposed FFY 2023 minimum case-mix and discharge values are available on the pages listed above.

Medicare-Dependent, Small Rural Hospital (MDH) Program

DISPLAY pages 798 – 800

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 1,395 – 1,407

In an effort to create a more flexible regulatory frame work for any future pandemic or epidemic, CMS is proposing to 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. Specifically, CMS proposes to revise 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.

Additionally, when a PHE is declared, CMS proposes that hospitals and CAHs be required to report on the following categories of data elements to the Center for Disease Control and Prevention's National Healthcare Safety Network (NHSN):

- *"suspected and confirmed infections of the relevant infectious disease pathogen among patients and staff;*
- *total deaths attributed to the relevant infectious disease pathogen among patients and staff;*
- *personal protective equipment and other relevant supplies in the facility;*
- *capacity and supplies in the facility relevant to the immediate and long term treatment of the relevant infectious disease pathogen, such as ventilator and dialysis/continuous renal replacement therapy capacity and supplies;*
- *total hospital bed and intensive care unit bed census, capacity, and capability;*
- *staffing shortages;*
- *vaccine administration status of patients and staff for conditions monitored under this section and where a specific vaccine is applicable;*
- *relevant therapeutic inventories and/or usage;*
- *isolation capacity, including airborne isolation capacity; and*
- *key co-morbidities and/or exposure risk factors of patients being treated for the pathogen or disease of interest in this section that are captured with interoperable data standards and elements."*

This reporting is proposed to limit any potentially personal identifiable information for affected patients and would also be reported on a daily basis, unless a lesser frequency is specified.

CMS is also seeking comment on how to best align and incentivize preparedness for possible future emergencies, while also reducing burden and costs, and ensuring flexibilities.

Quality-Based Payment Adjustments

DISPLAY pages 829 – 932

For FFY 2023, IPPS payments to hospitals are proposed to 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 program 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 856 – 901)*:** If the suppression of FFY 2023 VBP scores is not adopted (see below for detail), the FFY 2023 program would include hospital quality data for 20 measures in 4 domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP Program must be budget neutral and the FFY 2023 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.7 billion). Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0% reduction.

  In the FFY 2022 final rule, CMS finalized the suppression of the MORT-30-PN measure for FFY 2023 due to the impact of the COVID-19 pandemic. 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.

  Similar to FFY 2022, due to the impact of the COVID-19 PHE, CMS is proposing 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);
  - Adopt a 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 is will also 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 recognizes that if these proposals are finalized it would have 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 proposing to suppress measures for the FFY 2023 VBP program and therefore not adjust hospital payments for the program year. While the proposals are not finalized, CMS has calculated and published proxy factors based on the FFY 2021 program (there was no FFY 2022 program due to the impact of the COVID-19 pandemic). Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors calculated using the traditional VBP methodology are published with the proposed rule are available in Table 16 on the CMS website at:
https://www.cms.gov/sites/default/files/2022-04/TABLE_16._PROXY_HOSPITAL_VALUE_BASED_PURCHASING__VBP__PROGRAM_0.zip.

Details and information on the program currently in place for the FFY 2021 program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

- **RRP** ***(DISPLAY pages 829 – 855)***: 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.

  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 902 – 932)*****:** If the suppression of FFY 2023 HAC scores is not adopted (see below for detail), the FFY 2023 HAC program would evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated

Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score. CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

In the FFY 2022 final rule, CMS adopted the extension of the COVID-19 data exclusion policy for Q3 and Q4 of 2020 for HAC. This results in the following FFY 2023 performance periods:

- FFY 2023: PSI-90 from July 1, 2019 – December 31, 2019 and January 1, 2021 – June 30, 2021, HAI from January 1, 2021 – December 31, 2021.

CMS is proposing 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.

If this proposal is finalized, CMS would 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 proposing not to calculate or publically report measure results for the FFY 2023 program. Reporting of all measures by hospitals would still be required.

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 proposed rule, CMS proposes to update the CDC NSHN 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, 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 proposing new policies for its quality-based payment programs.

- **VBP Program *(DISPLAY pages 856 – 901)*:** CMS had already adopted VBP program rules through FFY 2023 and some program policies and rules beyond FFY 2023. CMS is proposing 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 proposing 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 is requesting 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.

- **RRP** ***(DISPLAY pages 829 – 855)*****:** CMS is proposing 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. Beginning with the FFY 2023 program, CMS is also proposing to 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.

  Lastly, CMS requests comment on future inclusion of health equity performance in RRP. Specifically, CMS requests 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.

- **HAC Reduction Program** ***(DISPLAY pages 902 – 932)*****:** CMS is proposing to update the PSI-90 measure specifications to risk-adjust for COVID-19 diagnoses, beginning with the FFY 2024 HAC program.

  In additional, there is a proposal to suppress CY 2021 data for the CDC NHSN HAI measures for the FFY 2024 program. This would result 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 is requesting information 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.

Updates to the IQR Program and Electronic Reporting Under the Program

DISPLAY pages 1,063 – 1,256

CMS is proposing 2 new measures for the IQR program beginning with the CY 2022 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 is proposing 1 new measure beginning with the CY 2023 reporting period/FFY 2025 payment determination:

- Hospital Commitment to Health Equity.

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

- Screening for Social Drivers of Health (with voluntary reporting for CY 2023);
- Screen Positive Rate for Social Drivers of Health (with voluntary reporting for CY 2023);
- Cesarean Birth eCQM (with self-select reporting for CY 2023);
- Severe Obstetric Complications eCQM (with self-select reporting for CY 2023);
- Hospital-Harm—Opioid-Related Adverse Events eCQM (self-select); and
- Global Malnutrition Composite Score eCQM (self-select).

CMS is proposing 1 new measure beginning with the CY 2026 reporting period (July 1, 2015 – 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 proposing 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 proposing 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 is proposing to increase the minimum case count for reporting from 25 cases to 50 cases.

Beginning fall 2023, CMS is proposing to establish a publicly-reported hospital designation to capture the quality and safety of maternity care. The designation would be awarded to hospitals based on their reporting of "Yes" to both questions in the Maternal Morbidity Structural measure. With this, CMS is soliciting comment on the designation name and additional data sources to consider for purposes of awarding this hospital designation.

CMS is also requesting comment on additional activities to advance maternal health equity, with specific topics for comment listed on DISPLAY pages 1,215 – 1,218.

In this proposed rule, CMS is seeking 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 1,220 – 1,225); and
- NHSN Hospital-Onset Bacteremia & Fungemia Outcome measure (DISPLAY pages 1,225 – 1,231).

Tables in the proposed rule on DISPLAY pages 1,200 – 1,208 outline the previously adopted and newly proposed Hospital IQR Program measure set for the FFYs 2024 – 2028 payment determination and subsequent years.

Reporting and Submission Requirements for eCQMs

DISPLAY pages 1,233 – 1,256

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

Reporting Period/Payment Determination	Proposed # of Self-Selected Calendar Quarters Required	Proposed eCQMs required
CY 2022 reporting period/FFY 2024 payment determination	3	• 4 self-selected
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 • ***Proposed*** Cesarean Birth; and • ***Proposed*** Severe Obstetric Complications

In the FFY 2020 final rule CMS adopted to apply 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 proposing to remove 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 proposing to update 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 proposal 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 1,018 – 1,022

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. CMS is seeking 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 wants guidance on how it can support these healthcare settings in doing so.

Areas for comment can be found on DISPLAY pages 1,020 – 1,022.

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

DISPLAY pages 1,022 – 1,046

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 requests comment on several following topics having to do with health equity in five key areas found on DISPLAY pages 1,045 - 1,046:

- 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.

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

DISPLAY pages 1,046 – 1,056

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.

CMS is looking 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 is looking for comment on additional venues to engage with implementers during the transition process.

Specific areas for comment can be found on DISPLAY page 1,056.

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

DISPLAY pages 1,057 – 1,062

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 is requesting comment on the TEFCA Version 1 and related concepts for future exploration, with specific topics for comment laid out on DISPLAY pages 1,061 – 1,062.

Promoting Interoperability Program

DISPLAY pages 1,297 – 1,372

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 proposing that beginning with CY 2023 reporting, the Query of PDMP measure will be required for eligible hospitals and CAHs participating in the program. 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.

If this proposal is finalized, CMS is proposing two exclusions to go along with it:

- *"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; and*
- *Any eligible hospital or CAH that cannot report on this measure in accordance with applicable law."*

CMS is also proposing to expand the Query of PDMP measure to include drugs from Schedules II, III, and IV.

Separately, CMS is proposing the addition of the Enabling Exchange Under the TEFCA measure, worth the total 30 points (if the scoring methodology proposals are finalized, otherwise 40 points) for the Health Information Exchange (HIE) objective. The measure would require a yes/no response. Eligible hospitals and CAHs would 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 proposed Enabling Exchange Under TEFCA measure,"*

In addition, CMS is proposing to add the Antimicrobial Use and Resistance (AUR) Surveillance measure to the Public Health and Clinical Data Exchange objective, beginning CY 2023 with a yes/no response. No additional points would 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 proposing to consolidate options 1 and 2 into one option beginning with CY 2023 reporting. The new options would be as follows:

(1) *"Proposed 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) *Proposed Option 2. Validated Data Production (current option 3, production)."*

CMS is also proposing 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, CMS would also require that eligible hospitals and CAHs spend only one EHR reporting period at each level of active engagement.

In this proposed rule, CMS is making various proposals that would affect the scoring of the objectives and measures for the CY 2023 EHR reporting period, outlined below:

Proposed 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 ***proposed to be required)***	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	15 points ***(proposed)***	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	15 points ***(proposed)***	No exclusion
	OR		
	HIE Bi-Directional Exchange measure	30 points ***(proposed)***	No exclusion
	OR		
	Enabling Exchange under TEFCA	30 points ***(proposed)***	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points ***(proposed)***	
Public Health and Clinical Data Exchange	Required with yes/no response • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Reporting	25 points ***(proposed)***	If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information
	Optional to report one of the following • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)	

CMS is also proposing to publicly publish Medicare Promoting Interoperability Program data beginning with the CY 2023 reporting period on Care Compare. This would include the total score of up to 105 points and the CMS EHR certification ID. CMS is not proposing to publish individual measure scores at this time. This would be available as

early as fall CY 2024 and including 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 is proposing to 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, CMS is requesting information on how to further promote equitable patient access and use of health information without adding unnecessary burden on the hospital or healthcare provider. Specific topics for comment can be found on DISPLAY pages 1,369 – 1,371.

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 1,408 – 1,416

CMS seeks 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 gives two potential frameworks for this adjustment:

- Biweekly interim lump-sum payments to hospitals, reconciled at cost report settlement; and
- Claims-based approach using a MS-DRG add-on payment applied to each applicable Medicare IPPS discharge.

CMS also seeks comment on the several questions, listed on DISPLAY pages 1,413 – 1,415.

###