California Hospital Association

Federal Regulatory Summary

from the California Hospital Association

SUMMARY OF PROPOSED RULE – MAY 2022

FFY 2023 Inpatient Prospective Payment System

In the May 10 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule describing federal fiscal year (FFY) 2023 policies and rates for Medicare's inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). The policy and payment provisions in the proposed rule will be effective for FFY 2023 discharges, beginning October 1 — if finalized. The public comment period on the rule ends on June 17.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. Payment and policy changes for the FFY 2023 LTCH PPS final rule are addressed in a separate summary.

To Comment

Comments are due to CMS June 17 by 2 p.m. (PT) and can be submitted electronically at www.regulations.gov; search the site for "CMS-1771-P."

Member Forum

Register for CHA's FFY 2023 IPPS proposed rule webinar at noon (PT) on May 25 to learn more about these policies and provide input for CHA's comments. Registration is available on the CHA website.

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org, or Chad Mulvany, vice president of federal policy, at (202) 270-2143 or cmulvany@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analytics coordinator, at areth@calhospital.org.

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Proposed FFY 2023 Payment Changes

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 market basket 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, disproportionate share hospital (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
Market basket/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%*

Retrospective Coding Adjustment

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 four-year period, resulting in a cumulative rate offset of approximately -3.2%.

Effects of the Inpatient Quality Reporting (IQR) and Electronic Health Records (EHR) Incentive Programs

The IQR market basket (MB) penalty imposes a 25% reduction to the full MB and the EHR Meaningful Use penalty imposed a 75% reduction to the full MB; therefore, 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 Market Basket 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 Market Basket Update (prior to other adjustments)	*+2.7%*	*+1.925%*	*+0.375%*	*-0.4%*

CMS estimates that 25 hospitals will not receive the full MB rate of increase because they failed the quality data submission process or chose not to participate in IQR; 158 hospitals will not receive it because they are not meaningful EHR users; and 19 hospitals are estimated to be subject to both reductions.

Impact Analysis — California

The CHA DataSuite analysis estimates that California hospitals will experience an increase of $476 million (+4.1%) in overall Medicare hospital inpatient payments in FFY 2023, as compared to FFY 2022. However, the impact will vary based on the type of hospital.

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2022 IPPS Payments	**$10,961,592,100**		**$792,794,300**		**$11,754,385,800**	
Provider Type Changes	$4,565,300	0.0%	($747,200)	-0.1%	$3,818,100	0.0%
Marketbasket Update (Includes Budget Neutrality)	$327,839,500	3.0%	$13,374,600	1.7%	$341,215,700	2.9%
ACA-Mandated Marketbasket Reductions	($42,375,100)	-0.4%	*Not Applicable*		($42,375,100)	-0.4%
MACRA-Mandated Coding Adjustment	$53,395,700	0.5%	*Not Applicable*		$53,395,700	0.5%
MS-DRG Weight 10% Reduction Cap Budget Neutrality	($2,618,400)	0.0%	($163,300)	0.0%	($2,781,600)	0.0%
Wage Index/GAF (Wage Data and Reclassification)	$88,825,500	0.8%	$5,733,300	0.7%	$94,558,300	0.8%
> Change in Labor Share	$0	0.0%	*Not Applicable*		$0	0.0%
Wage Index/GAF (Other Changes)	$4,021,900	0.0%	$151,800	0.0%	$4,172,800	0.0%
> Expiration of Previous 5% Stop Loss Transition Budget Neutrality	$1,490,300	0.0%	$143,700	0.0%	$1,633,600	0.0%
> Expiration of Previous 5% Stop Loss Transition Wage Index	$4,378,300	0.0%	$261,800	0.0%	$4,640,100	0.0%
> Current 5% Stop Loss Transition Wage Index	$643,600	0.0%	$42,400	0.0%	$685,900	0.0%
> Current 5% Stop Loss Transition Budget Neutrality	($4,808,100)	0.0%	($461,700)	-0.1%	($5,268,900)	0.0%
> Change in Imputed Floor	$0	0.0%	$0	0.0%	$0	0.0%
> Removal of Previous Bottom Quartile Budget Neutrality	$20,870,700	0.2%	$1,928,100	0.2%	$22,797,800	0.2%
> Removal of Previous Bottom Quartile Wage Index	$1,228,300	0.0%	$138,700	0.0%	$1,367,000	0.0%
> Current Bottom Quartile Increase	$0	0.0%	$0	0.0%	$0	0.0%
> Current Bottom Quartile Budget Neutrality	($19,781,500)	-0.2%	($1,901,300)	-0.2%	($21,681,500)	-0.2%
Transitional DSH Year-Over-Year	$248,500	0.0%	($253,000)	0.0%	($4,500)	0.0%
DSH: UCC Payment Changes [1]	($22,153,500)	-0.2%			($22,153,500)	-0.2%
> DSH UCC Distribution Factor Change	$20,116,200	0.2%	*Not Applicable*		$20,116,200	0.2%
Change in Hospital Specific Rate	$0	0.0%			$0	0.0%
MS-DRG Updates	$21,688,900	0.2%	$1,667,600	0.2%	$23,355,600	0.2%
Quality Based Payment Adjustments [2]	$34,252,300	0.3%	$2,583,000	0.3%	$36,835,400	0.3%
Net Change due to Low Volume Adjustment	($12,920,600)	-0.1%	($765,900)	-0.1%	($13,686,800)	-0.1%
Estimated FFY 2023 IPPS Payments	**$11,416,361,800**		**$814,375,700**		**$12,230,737,000**	
Total Estimated Change FFY 2022 to FFY 2023 ¥	***$454,769,700***	***4.1%*** ▲	***$21,581,400***	***2.7%*** ▲	***$476,351,600***	***4.1%*** ▲

CMS' detailed impact estimates are displayed in Appendix A of the proposed rule (page 28705), which is partially reproduced below.

Hospital Type	All Proposed Rule Changes
All Hospitals	1.4%
Urban	1.4%
Urban Pacific	1.3%
Rural	1.1%
Rural Pacific	2.3%

Outlier Payments

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.

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 that 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.

Medicare DSH — Uncompensated Care DSH

Medicare makes DSH and uncompensated care (UCC) payments to IPPS hospitals that serve a number of low-income patients above a certain threshold. Low income is defined as Medicare-eligible patients who also receive supplemental security income, and Medicaid patients who are not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC, the proportion of inpatient days for each of these subsets of patients is used.

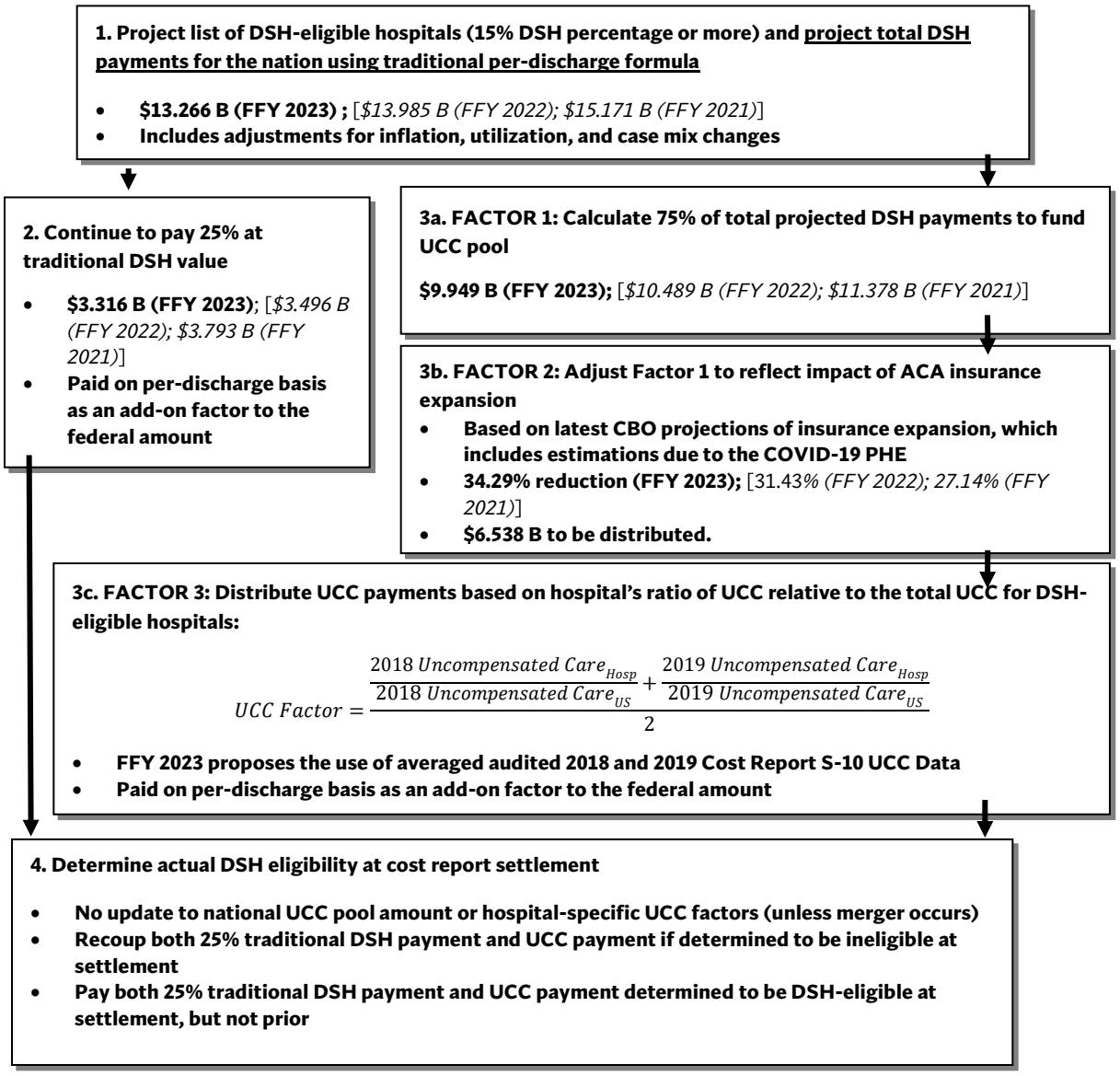
Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the Affordable Care Act (ACA) required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would be made under Section 1886(d)(5)(F) without application of the ACA
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the Secretary's estimates of the factors used to determine and distribute UCC payments. UCC payments are made only to hospitals eligible to receive DSH payments that are paid using the national standardized amount.

Therefore, sole community hospitals paid on the basis of hospital specific rates and hospitals not paid under the IPPS are ineligible to receive UCC payments.

The schematic below describes the DSH payment methodology mandated by the ACA along with how the program is 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.

The regulatory impact analysis presented in Appendix A of the proposed rule includes the estimated effects of the changes to UCC payments for FFY 2023 across all hospitals by

geographic location, bed size, region, teaching status, type of ownership, and Medicare utilization percent. CMS' analysis includes 2,380 hospitals that are projected to be eligible for DSH in 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.

Proposed FFY 2023 Factor 1

CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. CMS used the Office of the Actuary's (OACT) January 2022 Medicare DSH estimates, which were based on the September 2021 update of the HCRIS and the FFY 2022 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's January 2022 Medicare estimate of DSH payments for FFY 2023 is $13.266 billion. The proposed Factor 1 amount is 75% of this amount, or $9.949 billion. The proposed Factor 1 for 2023 is about $540 million less than the final Factor 1 for FFY 2022.

Proposed FFY 2023 Factor 2

Factor 2 adjusts Factor 1 based on the percentage change in the uninsured since implementation of the ACA. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of Congressional Budget Office data as the source of change in the uninsured population. The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or the District of Columbia.

For FFY 2023, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for CYs 2022 and 2023 is 8.9% and 9.3%, respectively. CMS calculates the proposed Factor 2 for FFY 2023 (weighting the portion of calendar years 2022 and 2023 included in FFY 2022) as follows:

- Percent of individuals without insurance for CY 2013: 14%
- Percent of individuals without insurance for CY 2022: 8.9%
- Percent of individuals without insurance for CY 2023: 9.3%
- Percent of individuals without insurance for FFY 2023 (0.25 times 0.089) + (0.75 times 0.093): 9.2%

Proposed Factor 2 = 1-|((0.092-0.14)/0.14)| = 1 - 0.3429 = 0.6571 (65.71%)

CMS calculated Factor 2 for the FFY 2023 proposed rule to be 65.71%, and the UCC amount for FFY 2023 to be $9.949 billion x 0.6571 = $6.538 billion which is approximately $654 million less than the FFY 2022 UCC payment total of about $7.192 billion; the percentage decrease is 9.1%.

Proposed Factor 3 for FFY 2023

Factor 3 equals the proportion of hospitals' aggregate UCC attributable to each IPPS hospital. CMS continues to define UCC as the amount on line 30 of Worksheet S-10, which is the cost of

charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29). The product of Factors 1 and 2 determines the total pool available for UCC payments. This result multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

CMS proposes to determine Factor 3 for FFY 2023 using the average of the audited FFY 2018 and FFY 2019 Worksheet S-10 reports instead of basing it on a single year. In addition, CMS proposes for FFY 2024 and subsequent fiscal years to use a three-year average of the UCC data from the three most recent fiscal years for which audited data are available to determine Factor 3. CMS believes that these proposals address concerns from stakeholders regarding year-to-year fluctuations in UCC payments.

Consistent with its past methodology, CMS proposes that if a hospital does not have data for all three years, it would determine Factor 3 based on an average of the hospital's available data. This is a transition from CMS' most recent policy related to Factor 3, which used a single year of audited Worksheet S-10 data in the methodology to determine Factor 3. This policy was finalized for FFY 2020, 2021, and 2022.

Proposed Scaling Factor

CMS proposes to apply a scaling factor to the Factor 3 values calculated for all DSH-eligible hospitals to address the effect of calculating Factor 3 using data from multiple fiscal years. This will ensure total UCC payments to hospitals that are projected to be eligible for DSH for a fiscal year will be consistent with the estimated amount available to make UCC payments for that fiscal year. Specifically, CMS proposes to adopt a policy under which it divides 1 (the expected sum of all DSH-eligible hospitals' Factor 3 values) by the actual sum of all DSH-eligible hospitals' Factor 3 values and then multiply the quotient by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount for each hospital. A similar scaling factor was used in both FFY 2018 and FFY 2019 when the Factor 3 calculation included multiple years of data.

New Hospital for Purposes of Factor 3

CMS proposes to modify its new hospital policy that was initially adopted in FFY 2020 to determine Factor 3 for new hospitals. It defines new hospitals as hospitals that do not have cost report data for the most recent year of data being used in the Factor 3 calculation. Thus, hospitals with claim control numbers (CCNs) established on or after October 1, 2019, would be subject to the new hospital policy in FFY 2023.

The proposed rule indicates CMS will continue its policy established in FFY 2020 that, if a new hospital has a preliminary projection of being eligible for DSH payments, it may receive interim empirically justified DSH payments. New hospitals, however, would not receive interim UCC payments during FFY 2023 because CMS would have no FFY 2018 or FFY 2019 UCC data on which to determine those interim payments. In these cases, the Medicare administrative contractor (MAC) will make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement based on its FFY 2023 cost report. Factor 3 for new hospitals would be calculated using a denominator based solely on UCC costs from cost reports for the most recent fiscal year for which audits have been conducted.

Newly Merged Hospitals

CMS proposes to continue its policy to treat hospitals that merge after the development of the final rule similar to new hospitals. Consistent with its current policy, CMS proposes that the newly merged hospital's final UCC payment would be determined at cost report settlement where the numerator of the newly merged hospital's Factor 3 would be based on the newly merged hospital's cost report for the current fiscal year. If the hospital's cost reporting period is less than 12 months, CMS would annualize its data for purposes of the Factor 3 calculation. CMS would also apply a scaling factor, as discussed previously.

In addition, CMS continues its policy that the interim UCC payments for the newly merged hospital would be based only on the data for the surviving hospital's CCN available after the time of the development of the final rule. At cost report settlement, CMS would determine the newly merged hospital's final UCC payment based on the UCC costs reported on its FFY 2023 cost report.

Proposed CCR Trim Methodology

CMS proposes to 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 UCC costs, and a dollar threshold that is the median total UCC cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible. 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.

Per Discharge Amount of Interim UCC Payments

CMS typically calculates a per-discharge amount of interim UCC by dividing the hospital's total UCC payment amount by its three-year average of discharges. This per-discharge payment amount is used to make interim UCC payments to each projected DSH-eligible hospital. These interim payments are reconciled following the end of the year.

CMS proposes to modify its calculation for FFY 2023 to be based on the average of FFYs 2018, 2019, and 2021 historical discharge data, rather than FFYs 2019, 2020, and 2021. It believes that using a three-year average with the FFY 2020 discharge data would underestimate discharges, due to the decrease in discharges during the pandemic.

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flows for hospitals, CMS continues its voluntary process through which a hospital may submit a request to its MAC for a lower per discharge interim UCC payment amount, including a reduction to zero, once before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to provide documentation to support a likely significant recoupment — for example, 10% or more of the hospital's total UCC payment or at least $100,000. The only change that would be made would be to lower the per-discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This does not change how the total UCC payment amount will be reconciled at cost report settlement.

Process for Notifying CMS of Merger Updates and to Report Upload Issues

CMS publishes a table on the CMS website, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules, containing a list of the mergers known to CMS and the computed UCC payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.

For FFY 2023, CMS is again proposing that after the publication of the FFY 2023 IPPS/LTCH PPS final rule, hospitals would have 15 business days from the date of public display to review and submit comments on the accuracy of the table and supplemental data file published in conjunction with the final rule. CMS states that it currently expects to use data from the March 2022 HCRIS extract for the FFY 2023 final rule, which CMS states increases its confidence that hospitals would be able to comment on mergers and report any upload discrepancies during the comment period for this proposed 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.

1115 Waiver Days in the Medicaid Fraction

A number of court decisions have affected the inclusion of certain patient days in the numerator of the Medicaid fraction when calculating a hospital's 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.

Updates to MS-DRGs

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 two 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 three years prior to the fiscal year under study. CMS believes utilization

patterns reflected in the FFY 2021 IPPS claims data were impacted by the COVID-19 public health emergency (PHE); 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 them.

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, it applies the following 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 of these criteria to warrant being created:

- A 3% reduction in the variance of costs
- At least 5% of patients in the MS-DRG who fall within the subgroup
- 500 or more cases in the subgroup
- Average costs between the subgroups that show at least a 20% difference
- A $2,000 difference in average costs between subgroups

Beginning in FFY 2021, CMS expanded the criteria to include non-CC subgroups, predicting 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 these 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 three severity levels) would be deleted and 75 new DRGs

would be created. These updates would also impact the payment rates proposed for these 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 in FFY 2023. CMS intends to address the application of the non-CC subgroup criteria to eligible MS-DRGs in future rulemaking.

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. For comparison purposes, the FFY 2022 DRGs are available in Table 5 on the CMS website.

Proposed Cap for Relative MS-DRG Weight Reductions

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.

CAR-T Cell Therapies

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.

Providers do not typically pay for the cost of a drug for clinical trials. Therefore, CMS proposes 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 use of immunotherapy.

New Technology Payments

Circumstances around FFY 2022 rate-setting and the COVID-19 PHE led CMS to adopt a one-time exception to continue add-on payments for certain technologies approved for payment in FFY 2021, but would have otherwise been 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 pages 28216-28217 of the proposed rule 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 in FFY 2024, where only NDC codes would be utilized.

Table II.F.-01 on page 28211 of the proposed rule shows the 11 technologies that are proposed to have their add-on payment discontinued for FFY 2023 since their three-year anniversary date will occur before April 1, 2023. Table II.F.-02 on pages 28213-28214 of the proposed rule shows the 15 technologies proposed to continue to receive add-on payments for FFY 2023.

New COVID-19 Treatment Add-on Payments Extend through the End of the PHE

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 which the cost of the case exceed the standard DRG payment.

In the FFY 2022 IPPS final rule, CMS finalized discharges that 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 on the CMS website.

Request for Information (RFI): Social Determinants of Health (SDOH) Diagnosis Codes

The proposed rule contains an RFI on the following topics that pertain to the 96 diagnosis codes having to do with SDOH (Z codes found in categories Z55–Z65) to determine if 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 CMS' 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, CMS is interested in hearing from large urban hospitals, rural hospitals, and other hospital types about their experiences. CMS also seeks 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.

CMS also invites 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."

Proposed FFY 2023 Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index (AWI). Additional details about this methodology can be found in the regulation. A complete list of the proposed wage indexes for payments in FFY 2023 is available in Table 2 on the CMS website.

Core-Based Statistical Areas (CBSAs) for the Proposed FFY 2023 Hospital Wage Index

Hospitals are assigned to labor market areas and the wage index reflects the weighted (by hours) average hourly wage reported on Medicare cost reports. CMS uses Office of Management and Budget (OMB) CBSAs delineations as labor market areas. CMS is currently using OMB delineations from 2015 (based on the 2010 census) updated by OMB Bulletin numbers 13-01, 15-01, 17-01, 18-04, and 20-01.

Worksheet S-3 Wage Data

CMS calculates the FFY 2023 wage index using data from FFY 2019 submitted cost reports. CMS is not proposing any changes to the categories of included and excluded costs for FFY 2023 relative to prior years. CMS' proposed rule calculations of the FFY 2023 wage index are based on wage data of 3,112 hospitals. The data file used to construct the proposed wage index includes FFY 2019 data submitted to CMS as of February 5, 2022. Hospitals with later cost report begin dates may have cost reporting periods that include the COVID-19 pandemic. However, CMS reports that the COVID-19 pandemic appears to have minimal impact on the wage data used for the FFY 2023 proposed rule wage index.

General wage index policies are unchanged from prior years. CMS notes that it proposes to exclude 86 providers due to aberrant wage data that failed edits for accuracy. However, if data aberrancies for these providers are resolved in a timely manner, CMS will include data from these providers to set the final rule FFY 2023 wage indexes.

Occupational Mix Adjustment

CMS is required to collect data every three years on the occupational mix of employees for each Medicare participating short-term, acute care hospital to construct an occupational mix adjustment to the wage index. Data from the 2019 occupational mix survey is used for the mix adjustment applied to the FFY 2023 wage index. CMS reports having occupational mix data for 97% of hospitals (3,010 of 3,112) used to determine the wage index. Consistent with the statute, CMS will apply the 2019 occupational mix survey data to the FFY 2023 wage index. The FFY 2023 national average hourly wage, adjusted for occupational mix, is $47.71.

Rural Floor

The rural floor is a provision of statute that prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates that the rural floor will increase the proposed rule FFY 2023 wage index for 192 urban hospitals requiring a budget neutrality adjustment factor of 0.993656 (-0.63%) applied to hospital wage indexes. CMS proposes to continue a policy adopted in FFY 2020 to exclude the wage data of a hospital that is reclassifying from urban to rural in calculating the rural floor for a state. Such a hospital's wage data will be used to calculate the rural wage index but not the rural floor wage index that applies to hospitals that are not treated as rural for IPPS payment purposes.

On April 8, 2022, the DC District Court (*Citrus vs. Becerra*) found that the Secretary did not have authority under section 4410(a) of the Balanced Budget Act of 1997 to establish a rural floor lower than the rural wage index for a state. CMS is continuing to evaluate the court's decision which is subject to appeal. Although CMS proposes to continue this policy for FFY 2023, the rule states the agency may take a different approach in the final rule, depending on public comments or developments in the court proceedings. CHA is pursing similar, separate litigation on behalf of its members for FFY 2020.

Imputed Floor

The rural floor cannot apply in all urban states, as there is no rural area wage index upon which to determine the floor. CMS adopted an imputed floor for all urban states beginning in FFY 2005 (benefiting only New Jersey hospitals) and in FFY 2013 adopted an alternative methodology benefiting hospitals in all urban states (i.e., Delaware and Rhode Island) that did not benefit from the original methodology. Both methodologies were applied in a budget-neutral manner — necessitating a reduction in payments to all hospitals to offset the cost. CMS allowed both imputed floor methodologies to expire after FFY 2018.

Section 9831 of the American Rescue Plan Act (ARPA), enacted by Congress on March 11, 2021, re-established the imputed floor. However, the provision was exempted from IPPS budget neutrality requirements, eliminating the need for a reduction in payment to hospitals to offset its cost. In addition to states that previously benefited from the imputed floor, the ARPA provision applies in Washington, D.C., Puerto Rico, and in one state (Connecticut) that has rural areas but no hospitals that are being paid using a rural wage index.

The imputed floor adjustment is estimated to increase IPPS operating payments by approximately $140 million. There are an estimated 69 providers in Connecticut, Delaware, Washington, D.C., New Jersey, and Rhode Island that will receive the imputed floor wage index.

Frontier Floor Wage Index

The ACA requires a wage index floor for hospitals in the low-population-density states of Montana, Nevada, North Dakota, South Dakota, and Wyoming. CMS indicates that 44 hospitals will receive the frontier floor value of 1.0000 for FFY 2023. As all hospitals in Nevada have a wage index of over 1.0, the provision will have no effect on Nevada hospitals. This provision is not budget neutral, and CMS estimates an increase of approximately $64 million in IPPS operating payments due to the frontier floor.

Revisions to FFY 2023 Wage Index Based on Geographic Reclassifications

The Medicare Geographic Classification Review Board (MGCRB) approved 491 hospitals for wage index reclassifications starting in FFY 2023. Because reclassifications are effective for three years, there are a total of 1,083 hospitals reclassified for FFY 2023. These include 288 hospitals initially approved for wage index reclassifications starting in FFY 2021 and 304 approved for reclassifications starting in FFY 2022 that will continue for FFY 2023. The deadline for withdrawing or terminating a wage index reclassification for FFY 2023 approved by the MGCRB is 45 days from publication of the FFY 2023 proposed rule in the *Federal Register* (June 24, 2022). Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process will be incorporated into the final FFY 2023 wage index values.

Lugar Hospitals and Counties

A "Lugar" hospital is located in a rural county adjacent to one or more urban areas that is automatically reclassified to the urban area from which the highest number of its workers commute. The out-migration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Out-migration adjustments are fixed for three years. A hospital can either be reclassified or receive the out-migration adjustment, but not both. Lugar status is automatic. A Lugar hospital must decline its reclassification using the same process as other hospitals to receive the outmigration adjustment (e.g., notify CMS within 45 days of proposed rule publication that it is declining is Lugar reclassification).

The proposed rule restates the following policies with respect to how Lugar hospitals may decline their urban status to receive the outmigration adjustment:

- Waiving deemed urban status results in the Lugar hospital being treated as rural for all IPPS purposes
- Waiving deemed urban status can be done once for the three-year period that the outmigration adjustment is effective

If a Lugar hospital waives its reclassification for three years, it must notify CMS to reinstate its Lugar status within 45 days of the IPPS proposed rule publication for the following fiscal year.

In some circumstances, a Lugar hospital may decline its urban reclassification to receive an outmigration adjustment that it would no longer qualify for once it is reclassified as rural. In these circumstances, CMS will decline the Lugar hospital's request and continue to assign it a higher urban wage index (which itself could result in the county requalifying for the outmigration adjustment based on data in the final rule).

Outmigration Adjustment

CMS proposes to apply the same policies for the FFY 2023 outmigration adjustment that it has been using since FFY 2012. CMS estimates the outmigration adjustment will increase IPPS payments by $55 million to 245 hospitals in FFY 2023. This provision is not budget neutral.

Reclassification from Urban to Rural

A qualifying IPPS hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Not later than 60 days after the receipt of an application from an IPPS hospital that satisfies the statutory criteria, CMS must treat the hospital as being located in the rural area of the state in which the hospital is located.

The FFY 2023 rule proposes to clarify that urban-to-rural reclassification applies to the main campus and any remote location situated in an urban area (or deemed to be located in an urban), not to a remote location in a rural area, as it cannot qualify for urban to rural reclassification. If a remote location of a hospital is located in a different CBSA than the main campus of the hospital, it is CMS' longstanding policy to assign that remote location a wage index based on its own geographic area. These hospitals also allocate wages and hours for the calculation of the wage index based on the number of FTEs at each. In calculating wage index values, CMS identifies the allocated wage data for these remote locations in Table 2 with a "B" in the 3rd position of the hospital's CMS claim number (CCN). CMS only found one such hospital for the FFY 2023 wage index.

In the circumstance described above, not all locations of a multicampus hospital will receive the same wage index. However, if a multicampus hospital applies for urban to rural reclassification, all of its urban campuses will be reclassified as rural and receive the same rural wage index. If the hospital then applies and is approved for an MGCRB reclassification, all campuses of the multicampus hospital will be reclassified and receive the same wage index. If the hospital then cancels the MGCRB reclassification, each of its campuses will then be paid the rural wage index for the state in which it is located. Therefore, CMS urges multicampus hospitals to consider the impact of canceling an MGCRB reclassification in combination with the wage index that it will be paid as a result of an urban-to-rural reclassification on all of its campuses.

Process for Requests for Wage Index Data Corrections

CMS details its established multistep, 15-month process for the review and correction of the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes.

CMS posts the wage index timetable for FFY 2023 on its website. The website includes all the public use files made available during the wage index development process.

Labor Related Share

CMS updates the labor-related share every four years. The labor-related share was last updated in the FFY 2022 final rule. CMS is currently using a national labor-related share of 67.6%. If a hospital has a wage index of less than 1.0, its IPPS payments will be higher with a labor-related share of 62%. If a hospital has a wage index that is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 67.6%. Consistent with the statute, CMS is not applying budget neutrality when using the lower 62% labor share when a hospital has a wage index less than 1.0.

Permanent Cap on Wage Index Decreases

CMS proposes to a 5% cap on annual reductions to hospital wage indexes effective for FFY 2023. The proposed cap would be implemented in a budget neutral manner with a budget neutrality factor of .9997.

The cap is proposed to be applied regardless of the reason for the decrease. If an IPPS hospital'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 hospital'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.

The proposed rule indicates the policy would likely apply equally to all hospitals in the same labor market area, as the hospital average hourly wage data in the CBSA (and any relative decreases compared to the national average hourly wage) would be similar. While in certain circumstances this policy may result in some hospitals in a CBSA receiving a higher wage index than others in the same area, CMS believes the impact would be temporary.

CMS is also proposing that a new IPPS hospital 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.

Continuation of the Low Wage Index Hospital Policy

Despite opposition from CHA and other stakeholders, in the FFY 2020 IPPS final rule CMS adopted a policy intended to address concerns that the current wage index system perpetuates and exacerbates the disparities between high- and low-wage index hospitals. CMS finalized the policies to be effective for a minimum of four years to be properly reflected in the Medicare cost report for future years. Therefore, for FFY 2023, CMS proposes to continue the following specific policies:

- 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. For FFY 2023, the proposed 25th percentile wage index value across all hospitals is 0.8401.
- CMS proposes to apply a budget neutrality adjustment of -0.18% for this policy.
- Remove the wage data from urban hospitals reclassifying as rural from the calculation of the rural floor wage index
- Not apply a floor on a county's wage index based on the rural area wage index that results from a hospital in that county reclassifying from urban to rural

On March 2, 2022, the D.C. District Court in *Bridgeport Hospital vs. Becerra* found that the Secretary did not have authority under section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital policy for FFY 2020 and ordered additional briefing on the appropriate remedy. The proposed rule states CMS continues to evaluate the court's decision, which is subject to appeal. Although CMS proposes to continue this policy for FFY 2023, it may take a different approach in

the final rule, depending on public comments or developments in the court proceedings. CHA is pursing similar, separate litigation on behalf of its members for FFYs 2020, 2021, and 2022.

Rural Referral Center: Annual Updates to Case-Mix Index and Discharge Criteria

CMS provides updated criteria for determining Rural Referral Center (RRC) status, including updated minimum national and regional case-mix index (CMI) values and updated minimum national and regional numbers of discharges. In FFY 2020 and 2021 CMS used FFY 2019 CMI values and FFY 2018 cost reports due to the COVID-19 PHE. However, for FFY 2023, CMS proposes to use FFY 2021 data to set the CMI criteria.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2023, a rural hospital must have 275 or more beds. Those with fewer than 275 beds available for use can obtain RRC status if they meet specific geographic criteria, and have:

- More than 5,000 discharges (3,000 for an osteopathic hospital) in its cost reporting period that began during FFY 2021
- A CMI greater than or equal to the lower of 1.8251 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's region census region (Pacific Census Region, 1.85605)

The median regional CMIs in the proposed rule reflect the December update of the FFY 2021 MedPAR containing data from claims received through December 2021. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

Low-Volume Hospital Adjustment

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 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.

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 must meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital
- Have fewer than 200 total discharges (all payer) during the fiscal year

Consistent with historical practice, CMS proposes that for a hospital to receive low-volume status for FFY 2023 it must submit a written request 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 the request by September 1, 2022, 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.

Medicare-Dependent Small Rural Hospitals (MDH)

Beginning with discharges occurring on or after October 1, 2022, all hospitals that previously qualified for MDH status will no longer be eligible for this special payment methodology. While the MDH program was set to expire previously, Congress has always extended the program. However, CMS is advising hospitals of the MDH program expiration and the potential to address the reduction in payment by becoming a sole community hospital (SCH).

The SCH regulations to allow MDHs to apply for SCH status in advance of the expiration of the MDH program. These regulations allow SCH status to begin the day following the MDH program's expiration. In order for an MDH to receive SCH status effective October 1, 2022, the MDH must apply for SCH status at least 30 days before the expiration of the MDH program, or by September 1, 2022. The MDH also must request that, if approved, the SCH status be effective with the expiration of the MDH program. If the MDH does not apply by the September 1, 2022, deadline, the hospital would instead be subject to the usual effective date for SCH classification, which is the date the MAC receives the complete application.

Indirect and Direct Graduate Medical Education Costs

CMS proposes the indirect medical education (IME) adjustment factor to remain at 1.35 for FFY 2023.

Additionally, in the rule, CMS proposes policies addressing a recent court decision regarding CMS' proportional reduction methodology applied to the weighted graduate medical education (GME) full-time equivalent (FTE) count when the weighted FTE count exceeds the FTE cap, proposes Nursing and Allied Health Education Programs Medicare Advantage add-on rates for calendar year (CY) 2020 and CY 2021, and creates "Rural Track Medicare GME Affiliation Agreements."

Weighted GME Count – Hershey v. Becerra

Medicare pays hospitals for direct GME and IME costs based on the number of FTE residents they train. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive.

For direct GME, resident FTE counts are weighted 1 during the initial residency period and 0.5 beyond the initial residency period. Generally, residents are counted at 1 FTE for the period of their initial residency Board certification and at 0.5 FTE in subspecialty training. The caps that have been in place since 1997 have been on the unweighted resident counts. However, Medicare makes direct GME payment based on the weighted resident count.

When a hospital's unweighted FTE count exceeds its unweighted FTE cap, CMS has used the following formula to calculate the weighted count:

$$\frac{FTE\ Cap}{Unweighted\ Count} \times Weighted\ Count\ = Weighted\ Cap\ Adjusted\ Count$$

This methodology was adopted through notice and comment rulemaking and used since 1997. For each resident above the cap added who is beyond the initial residency period, the hospital's weighted count declines. Therefore, a hospital is penalized for adding residents in sub-specialty training as opposed to receiving no additional payment that would occur if each additional unweighted resident being added is not counted at all. Effectively, this results in each resident beyond the initial residency period being weighted at less than 0.5 FTE according to the court. As a result, this policy became the subject of litigation in *Hershey v. Becerra*.

On May 17, 2021, the U.S. District Court for the District of Columbia found that the proportional reduction methodology improperly modified the weighting factors statutorily assigned to residents beyond the initial residency period. The court ordered CMS to pay the plaintiffs according to a more favorable method.

In response to the court's decision, CMS proposes to implement a modified policy applicable to all teaching hospitals, effective October 1, 2001. The policy is effective October 1, 2001, instead of October 1, 1997, because CMS is unaware of any open or reopenable notice of program reimbursements for the 1997-2001 period.

The rule indicates that CMS' new policy would cover cost reporting periods for which many notice of program reimbursements (NPRs) have already been final settled. Any rule finalized that retroactively adopts a proposed new policy would not be the basis for reopening final settled NPRs as is consistent with longstanding CMS policy.

CMS proposes the following:

- If the hospital's weighted FTE count is equal to or less than the FTE cap, no adjustment is necessary.
- If the hospital's weighted FTE count is greater than the FTE cap, CMS will adjust the weighted FTE to make the total weighted FTE count equal the FTE cap as follows:

$$\frac{Weighted\ Primary\ Care\ and\ OBGYN\ FTEs}{Weighted\ FTEs\ All\ Residents} \times FTE\ Cap$$

$$+$$

$$\frac{Weighted\ All\ Other\ FTEs}{Weighted\ FTEs\ All\ Residents} \times FTE\ Cap$$

$$= Adjusted\ Weighted\ Count$$

The rule provides detailed instructions as to how these calculations would be done on the Medicare cost report.

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. CMS is required to include Medicare Advantage (MA) utilization in determining the Medicare share of reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization were funded through a reduction to analogous payments made to teaching hospitals for direct GME and limited to $60 million per year.

CMS uses cost reporting periods ending in the fiscal year that is two years prior to the current CY to determine each eligible hospital's share of the $60 million pool in a given year. Each hospital's payment is based on its relative share of national nursing and allied health education payments and MA utilization.

For 2020 and future years, CMS proposes to use the annual IPPS rule — instead of sub-regulatory guidance as has been its prior practice — to make public key information used to determine nursing and allied health education MA payments and the reduction that is needed to direct GME MA payments to fund the payments going to eligible hospitals.

For FFYs 2020 and 2021, the statutory formula for distributing nursing and allied health education payment will result in the capped payments of $60 million being distributed necessitating a reduction of 3.71% and 3.22% respectively to MA direct GME payments.

Medicare GME Affiliation Agreements and Rural Training Tracks

When CMS first implemented the Rural Track Program (RTP) regulations, it specified that the caps associated with rural tracks are separate and distinct from a hospital's general FTE caps. As a result, the rural track FTE limitations are not part of the regular FTE caps that hospitals may aggregate in Medicare GME affiliation agreements. This means that the flexibility afforded in affiliated group arrangements is not available when urban and rural hospitals jointly train residents in RTPs once caps are established at the end of the five-year growth window.

In the FFY 2023 rule, CMS proposes to allow urban and rural hospitals that participate in the same separately accredited 1-2 family medicine RTP to enter affiliation agreements for the RTP. CMS proposes the following requirements for RTP=affiliated groups:

- Representatives of each urban and rural hospital must attest that the affiliated group is only for residents in the RTP and no other programs.
- Only separately accredited 1-2 family medicine programs that have rural track FTE limitations in place prior to October 1, 2022, are eligible.
- These affiliated group arrangements may become effective July 1, 2023 — the beginning of the first residency training year after the October 1, 2022, effective date of this IPPS rule.

CMS explains that precluding RTPs not separately accredited in the 1-2 format and that are not in family medicine from entering into affiliation agreements is proposed to distinguish accredited 1-2 family practice programs from other RTPs recognized under section 127 of the Consolidated Appropriations Act (CAA, 2021). The CAA, 2021 allows for cap adjustments for RTPs other than those that are separately ACGME accredited in family practice and allows for cap adjustments when new training sites are added to existing RTPs. As these provisions are effective October 1, 2022, and allow for new RTPs to be exempt from FTE caps for five years, CMS believes it is premature to allow these newer programs to participate in affiliated groups. If finalized, CMS may reassess this proposed policy at a future date once FTE caps for these CAA, 2021 RTPs are set.

The rule specifies detailed requirements that must be fulfilled for an urban and rural hospital to participate in an affiliation agreement for a separately accredited 1-2 family practice program to aggregate FTE caps for an RTP. These rules are generally parallel to those that apply to other affiliated group arrangements.

Rate-of-Increase for TEFRA Hospitals

Hospitals subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) continue to be paid based on reasonable costs subject to a per discharge limit updated annually. These hospitals include 11 cancer hospitals, children's hospitals, and hospitals located in the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Religious non-medical health care institutions are also paid reasonable costs subject to a limit. The annual update to the TEFRA limit is 3.1%.

Qualified and Non-Qualified Deferred Compensation Plans

Currently, certain costs incurred on behalf of deferred compensation plans may be allowable costs to the extent they are related to the reasonable and necessary cost of providing patient care and represent costs actually incurred by the provider submitting the cost report. Reasonable cost principles pertaining to deferred compensation plans are in section 2140.1 of the Provider Reimbursement Manual - Part 1 (PRM-1).

In the FFY 2023 rule, CMS proposes codifying and clarifying additional policies related to deferred compensation plans. The rule indicates that CMS is not proposing any changes to current policies or how those costs are audited.

Principles

A deferred compensation plan is an agreement between a provider and its participating employees, in which the agreeing parties can make contributions to the plan for the exclusive benefit of its participating employees. Deferred compensation is salary earned in the current period that is not received until a subsequent period, usually after retirement. Defined contribution plans and defined benefit plans generally specify contributions and benefits as a percentage of employee salary, respectively. Deferred compensation based on non-allowable compensation is unallowable.

Requirements for Non-Qualified and Qualified Deferred Compensation Plans

Employer contributions for the benefit of employees under a deferred compensation plan are allowable when, and to the extent that, costs are incurred by the provider. Contributions to a funded deferred compensation plan are allowable costs when they are made to the plan, to the extent they fall under a computed limit. Benefits paid for an unfunded deferred compensation plan are allowable costs only when actually paid to the participating employees (or their beneficiaries), and only to the extent considered reasonable.

Recognition of Contributions or Payments to Qualified and Non-Qualified Deferred Compensation Plans

Rules and requirements that determine when payments or contributions are recognized and included in allowable costs will vary depending on whether a plan is qualified or non-qualified. In addition, certain special rules apply to contributions to qualified and non-qualified deferred compensation plans that are deposited into trusts.

Documentation Requirements

The FFY 2023 rule proposes to codify that a provider of services must maintain and make available upon request documentation to substantiate the costs incurred for the plans included in its Medicare cost report. These proposed requirements for documentation are based on the existing regulatory requirements that require providers of services to maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Administrative and Other Costs Associated with Deferred Compensation Plans

CMS proposes to codify current policies set forth in sections 2140, 2141, and 2142 of PRM-I, regarding the treatment of certain administrative and other costs related to deferred compensation plans.

Treatment of Costs Associated with the Pension Benefit Guaranty Corporation (PBGC)

Providers of services who offer a qualified defined benefit plan (QDBP) may incur costs related to the PBGC premiums. This section of this proposed rule establishes which costs incurred by providers of services who maintain a QDBP and pay premiums for basic benefits to the PBGC are allowable under the program.

Hospital Performance-Based Quality Programs

As finalized in the FFY 2022 IPPS final rule, CMS continues to apply measure suppression policies in response to the COVID-19 PHE to the Medicare programs performance-based hospital quality programs: the Hospital Readmissions Reduction Program (HRRP), the Hospital Value-Based Purchasing (VBP) Program, and the Hospital Acquired Conditions (HAC) Reduction Program. Under CMS' proposals — described in more detail below — the agency will not apply payment penalties for any hospitals in the hospital VBP or HAC reduction programs and will modify HRRP measure specifications to address the impact of the COVID-19 PHE on readmissions measures.

Hospital Readmissions Reduction Program

The HRRP reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital

subject to the HRRP receives an adjustment factor between 1 (no reduction) and 0.9700, for the greatest possible reduction of 3% of base operating DRG payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio (ERR) to the median ERR for the hospital's peer group. "Payment" refers to base operating DRG payments, "dx" refers to an HRRP condition (i.e., acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA), chronic obstructive pulmonary disease (COPD), and coronary artery bypass grafting (CABG)), and "NMM" is a budget neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions. For additional information on the methodology, see CHA's FFY 2018 IPPS final rule summary.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

CMS retains the six previously adopted readmissions measures: AMI, HF, PN, THA/TKA, COPD, and coronary artery bypass grafting CABG. However, CMS continues its previously finalized policy to suppress the pneumonia readmission measure for the FFY 2023 program and proposes technical modifications for the measure with plans to resume its use in the FFY 2024 program. In addition, CMS announces technical specification updates for all HRRP measures beginning with the FFY 2023 program year to account for the lasting health impacts of COVID-19.

CMS makes no changes to the factors used by CMS in removing measures, the use of sub-regulatory processes to make non-substantive changes to measures and other program features, or the methodology for calculating the payment adjustment.

A CHA DataSuite analysis estimates that the HRRP will result in an overall Medicare payment reduction for California hospitals of approximately $43.4 million for FFY 2023, an increased reduction of approximately $1.69 million compared to FFY 2022.

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia PN Hospitalization measure (NQF #0506) (PN Readmission Measure)

In the FFY 2022 IPPS final rule, CMS finalized the suppression of the PN readmission measure for the FFY 2023 program year. As a result, the measure will be assigned a weight of zero for the FFY 2023 program scoring.

In the proposed rule, CMS announces its intent to resume scoring on this measure beginning with the FY 2024 program year. In preparation for resumption of the measure, CMS will make the same technical updates it made to the other five program measures for FFY 2022 — specifically, CMS will exclude patients with principal or secondary diagnoses of COVID-19 from the denominator beginning in FFY 2024.

Technical Updates to All HRRP Measures

CMS will use its established subregulatory process for updating the HRRP technical measure specifications to include a covariate adjustment for patients with a history of COVID-19 in the 12 months prior to admission. CMS believes that the covariate adjustment is appropriate to capture lasting effects of COVID-19 illness ("long COVID"), as these may affect readmission risks for all the conditions and procedures included in the HRRP measure set. The update will begin with program year FY 2023 for the five HRRP measures not suppressed and with FY 2024 for the PN readmission measure.

Clarification of the Extraordinary Circumstance Exception (ECE) Policy for the HRRP

In response to stakeholder inquiries during the COVID-19 PHE, CMS provides several clarifications on its ECE policies for the HRRP:

- An ECE granted under the HRRP would exclude all claims data from the period for which the ECE is being granted.
- A hospital granted an ECE is not automatically and completely exempted from payment reductions under the HRRP, even though the hospital's data specified under the terms of the ECE would be excluded from payment reduction calculations.
- While excepted data would be excluded from payment reduction calculations, the hospital receiving an ECE would still be required to submit claims data as usual for services provided during the period covered by the ECE.

Request for Public Comment on Possible Future Incision of Health Equity Performance in the HRRP

CMS seeks comments on approaches to updating the HRRP to incorporate performance for socially at-risk populations. CMS seeks comments on approaches that would encourage providers to improve health equity and reduce health care disparities without disincentivizing hospitals to treat socially at-risk beneficiaries or disproportionately penalizing hospitals that treat a large proportion of socially at-risk beneficiaries. CMS notes that any future changes to the HRRP would be made through the notice-and-comment rulemaking process.

Hospital VBP Program

As required by law, the available funding pool for the hospital VBP Program is equal to 2% of the base operating DRG payments to all participating hospitals. CMS calculates a VBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. The adjustment factor may be positive, negative, or result in no change in the payment rate that would apply absent the program.

As a result of the measure suppression policies described below, CMS proposed to apply an overall budget neutral VBP adjustment for all hospitals. Notably, CMS finalized the same policy in FY 2022, so there is no differential impact compared to FFY 2023.

In general, the previously adopted measures, domain weights (25% each across the four domains), case minimums, and payment adjustment methodologies would be continued. However, CMS proposes several policies applying its measure suppression policy to address the impact of the COVID-19 PHE, resulting in a proposed special scoring methodology where no hospital would receive a TPS. Table 2 in the appendix of this summary lists previously adopted measures for the program.

Proposed Hospital VBP Program Measure Suppression and Technical Updates in Response to the COVID-19 PHE

As described earlier in this summary, CMS proposes several applications of its measure suppression policy to address concerns that VBP payments may become inequitable due to the ongoing impacts of the COVID-19 PHE. In its FFY 2022 IPPS final rule, CMS previously finalized several actions for the FFY 2023 VBP Program:

- Suppression of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following Pneumonia (PN) Hospitalization measure (NQF #0506) (MORT-30-PN) in the Clinical Outcomes domain
- Technical updates to the remaining five measures in the Clinical Outcomes domain to exclude admissions with either a principal or secondary diagnosis of COVID-19 from the numerators and denominators of the measures

For the FFY 2023 payment year, CMS proposes to suppress all the measures in two of the four program domains — the Person and Community Engagement domain (the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure) and the Safety domain (five Healthcare-Associated Infection (HAI) measures).

In addition to previously finalized updates to exclude patients with COVID-19, CMS proposes additional technical updates to measure specifications to include a covariate adjustment for patient history of COVID-19 within 12 months of an admission for treatment of a condition or performance of a procedure covered by a VBP measure. The covariate will be added to the risk adjustment models for the MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, and COMP-HIP-KNEE measures effective beginning with program year FFY 2023. CMS will also update the MORT-30-PN measure beginning with the FFY 2024 program year when it intends to resume the measure in the program. CMS believes that adding the covariate adjustment to the previously modified specifications (i.e., excluding patients with COVID-19 diagnoses) for these clinical outcome measures further mitigates COVID-19 effects on measure scores, bringing the observed clinical outcome measure rates close to pre-COVID-19 values.

Proposed Special Scoring Rule for FFY 2023

CMS notes that under its proposed measure suppression policies, only five Clinical Outcomes domain measures and one Efficiency and Cost Reduction domain measure would remain available for scoring and for determining value-based payment adjustments in FY 2023. As a result, CMS proposes to adopt a special scoring and payment rule similar to its FY 2022 policy. Under the special rule, CMS proposes to calculate a score for all VBP measures regardless of suppression status but will only calculate achievement and improvement scores for the unsuppressed measures resulting in two domain scores. CMS will provide hospitals with confidential hospital-specific reports of measure rates for all unsuppressed measures along with their domain scores for Clinical Outcomes and Efficiency and Cost Reduction. CMS proposes to publicly report rates for the unsuppressed measures along with explanations about measure suppression and COVID-19 PHE effects on hospital performances.

However, CMS proposes that it will not calculate TPS for hospitals. CMS proposes to continue to make the statutory 2% reduction to each hospital's base operating DRG payment amount. Absent

the availability of TPS, each hospital will be assigned a budget-neutral, value-based incentive payment percentage, returning to the hospital the amount lost through the DRG payment rate reduction (i.e., the hospital's base operating DRG payment will remain unchanged for FFY 2023). CMS states its intent to resume the use of measure data for scoring and payment adjustment purposes beginning with program year FFY 2024.

CMS also notes that the proposed special scoring rule would have ramifications for some clinicians participating in the Merit-Based Incentive Payment System (MIPS) pathway of Medicare's Quality Payment Program (QPP). MIPS permits certain clinicians who meet the eligibility criteria for facility-based measurement to be scored for the MIPS Quality and Cost performance categories based on the VBP TPSs for their hospitals. If a TPS is not available, a clinician would not be eligible for facility-based measurement and would need to participate in the QPP through another MIPS option.

Proposed Performance and Baseline Periods

To account for downstream effects of measures suppressed for program year FFY 2023, CMS proposes to update baseline and performance periods for certain measures for program year FFY 2025. Specifically, CMS proposes changes to the Safety and the Person and Community Engagement domains are proposed, shown below.

Proposed Program Year FFY 2025 Baseline and Performance Periods Updates by Measure

Measure	Baseline Period	Performance Period
Person and Community Engagement Domain		
HCAHPS	1/1/19 – 12/31/19	1/1/23 – 12/31/23
Safety Domain		
CAUTI	1/1/19 – 12/31/19	1/1/23 – 12/31/23
CLABSI	1/1/19 – 12/31/19	1/1/23 – 12/31/23
SSI	1/1/19 – 12/31/19	1/1/23 – 12/31/23
CDI	1/1/19 – 12/31/19	1/1/23 – 12/31/23
MRSA	1/1/19 – 12/31/19	1/1/23 – 12/31/23

No changes are proposed to periods for the Clinical Outcomes or Efficiency and Cost Reduction domain measures. CHA refers readers to Tables V.H.-04 through V.H.-08 of the proposed rule for full details of baseline and performance periods for FFY 2025-27.

Proposed Performance Standards

CMS notes that it had previously established performance standards for the hospital VBP Program payment years FFYs 2025 through 2027 in prior regulations. CMS proposes several policies that would impact those previously established standards, such as proposed changes to the baseline periods. CHA refers readers to Tables V.I.-09 through V.I.-13 in the proposed rule for additional details.

Request for Information on Future Adoption of New NHSN HAI Digital Quality Measures

CMS seeks comments about the potential future adoption of two NHSN HAI digital quality measures — the Healthcare-Associated Clostridioides difficile Infection Outcome Measure and

the Hospital-Onset Bacteremia & Fungemia Outcome Measure — into the hospital IQR Program and hospital VBP Program.

Hospital-Acquired Conditions (HAC) Reduction Program

Under the HAC Reduction Program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. However, for FFY 2023, CMS proposes policies that will result in no hospital receiving a penalty due to the impacts of the COVID-19 PHE. While CMS does not propose any changes to the measure set, CMS proposes to apply COVID-19 measure suppression policies and additional technical changes to measure specifications. Table 3 in the appendix of this summary lists previously adopted measures for the HAC Reduction Program.

Because CMS will not apply penalties as described below, CHA DataSuite analysis estimates that overall, FFY 2023 payments to California hospitals will increase by approximately $38.5 million compared to FFY 2022.

HAC Reduction Program Flexibility in Response to COVID-19 PHE for FY 2023

In response to concerns that HAC Reduction Program payments may become inequitable due to COVID-19 impacts, CMS proposes to suppress measure data for all HAC Reduction Program measures — the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) HAI measures and PSI-90 — from the calculation of measure scores and the Total HAC score, and not to report measure results for the CMS PSI 90 measure. If these proposals are finalized, no hospitals will receive payment reductions under the HAC reduction program for 2023. CMS would continue to confidentially report results for the five CDC NHSN HAI measures to hospitals and publicly report the information (Care Compare and Provider Data Catalog) after the usual review and correction period.

CMS also proposes technical specification updates to the CMS PSI 90 measure. Beginning with FY 2024, the measure's software will be modified to include a diagnosis of COVID-19 in the measure's risk-adjustment model. CMS states that its testing indicates that when the revised risk adjustment is incorporated, previously observed higher rates of adverse safety events for patients with COVID-19 diagnoses versus those without are no longer seen.

CMS notes that it intends to resume use of all HAC Reduction Program measures and return to measure scoring beginning in program year FY 2024 but will continue to monitor hospital performance on the measures to assess feasibility of resumption of measure scoring and calculating Total HAC Scores in future rulemaking.

Proposed Updates to CMS PSI 90 Case Volume

CMS announces additional updates to the PSI 90 measure unrelated to the COVID-19 PHE. Specially CMS will revise the minimum volume threshold to require a hospital meeting two criteria to be scored:

- One or more CMS PSI 90 component measures with at least 25 eligible discharges
- Seven or more CMS PSI 90 component measures with at least three eligible discharges

CMS states its analysis indicates that the updated specification will result in approximately 5% of hospitals no longer receiving a CMS PSI 90 score and 2.5% no longer receiving a Total HAC Score. The total number of hospitals in the lowest performing quartile will decrease slightly, and the majority of hospitals that will no longer receive Total HAC Scores will have fewer than 100 beds and as such are more likely to be rural than urban.

No Mapped Locations Policy

Under the HAC Reduction Program, hospitals have previously been able to receive a "no mapped locations (NML)" exemption. NHSN HAI measures are aggregated and reported using hospital internal locations ("mapped") rather than at the patient level. The NML exemption has been given to hospitals for two HAI measures (CAUTI and CLABSI) when a hospital (1) does not map an applicable internal location in the NHSN system (e.g., medical-surgical ward), (2) does not submit measure data, *and* (3) does not submit an IPPS Measure Exception Form.

CMS clarifies that for FFY 2023 and subsequent years, the NML designation will no longer be available. Hospitals will be required to submit mapped data or, lacking a location applicable to CAUTI and/or CLABSI, submit an IPPS Measure Exception Form. If a hospital does not submit data and has not submitted an IPPS Measure Exception Form, the hospital would receive the maximum measure score (lower scores represent better HAC measure performance).

HAI Data Submission Requirements for Newly Opened Hospitals

Beginning with program year FFY 2023 CMS proposes to update the definition of "newly opened" hospital applicable to the HAC Reduction Program. A hospital would be newly opened for a program year if its Medicare-Accept Date falls within the final 12 months of the 24-month performance period for HAI measures for that program year. CMS indicates that less than 0.25% of hospitals are impacted by the change.

Request for Information on Future Adoption of New NHSN HAI Digital Quality Measures

CMS seeks comments about the potential future adoption of two NHSN HAI digital quality measures — the Healthcare-Associated Clostridioides difficile Infection Outcome Measure and the Hospital-Onset Bacteremia & Fungemia Outcome Measure — into the hospital IQR and HAC Reduction Program.

Hospital IQR Program

The hospital IQR Program is a pay-for-reporting program under which hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update. Additional information on the IQR measures and reporting processes is available online.

CMS proposes several changes to the IQR Program, including the addition of 10 new measures, refinements to two existing measures, and several policy changes related to electronic clinical quality measure (eCQMs) reporting requirements and hybrid measures. In addition, CMS proposes to establish a publicly reported maternity care quality and safety designation for hospitals. Table 1 in the appendix to this summary shows the IQR Program measure sets for FFY 2021 through FFY 2026.

New Measures into the Hospital IQR Measure Set

CMS proposes 10 new measures to the IQR Program, including three measures focused on health equity, a patient-reported outcome (PRO) measure, four new eCQMs — two of which are related to maternal health and perinatal care — and two updated versions of claims-based measures previously removed from the IQR Program.

Hospital Commitment to Health Equity

CMS proposes adding a structural measure — Hospital Commitment to Health Equity — beginning with the CY 2023 reporting period/FFY 2025 payment determination and for subsequent years. The measure is intended to assess a hospital's commitment to health equity across five domains (e.g., Data Collection), each of which includes multiple elements (e.g., training staff in culturally sensitive collection of demographic and/or SDOH information). Hospitals must attest affirmatively to each of the elements within a domain to receive a point for the domain, and the maximum score is five points. A complete list of the measure's domains and elements are provided in the table below:

Attestation Statement	Elements (Affirmative attestation of all elements within a domain would be required for the hospital to receive a point for the domain in the numerator)
Domain 1: Equity is a Strategic Priority	
Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all the following elements.	(A) Our hospital strategic plan identifies priority populations who currently experience health disparities. (B) Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. (C) Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. (D) Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
Domain 2: Data Collection	
Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities.	(A) Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients. (B) Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. (C) Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.
Domain 3: Data Analysis	

Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.	(A) Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.
Domain 4: Quality Improvement	
Health disparities are evidence that high-quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients.	(A) Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
Domain 5: Leadership Engagement	
Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities.	(A) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Numerator: Number of domains for which a hospital attests to completing all of the required elements
Denominator: Five points (one for each domain available for attestation)
Calculation: A point is awarded for each domain to which a hospital attests affirmatively. No partial credit is awarded; all elements within a domain must be completed to attest affirmatively and receive a point for that domain.
Data Submission and Reporting: Web-based data collection using Hospital Quality Reporting (HQR) System and annual reporting per policy for hospital IQR Program structural measures. CMS proposes mandatory reporting beginning with CY 2023.

Measure specifications are available for download at QualityNet.

Screening for Social Drivers of Health

CMS proposes to add a structural process measure — Screening for Social Drivers of Health – beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FFY 2026 payment determination and for subsequent years. The measure is intended to promote adoption of screening for health-related social needs (HRSNs) by hospitals across five domains: food security, housing instability, transportation needs, utility difficulties, and interpersonal safety. CMS does not propose to require a specific, standardized screening tool, and refers readers to the Social Interventions Research and Evaluation Network (SIREN) website for comprehensive information about the most widely used HRSN screening tools. Measure specifications are available for download at QualityNet.

Numerator: Number of patients admitted to an inpatient hospital stay who are screened for one or more of the five included HRSN domains
Denominator: Number of patients admitted to an inpatient hospital stay
Exclusion: Patients younger than 18 years of age at the time of admission are excluded from the numerator and denominator. Also excluded from the denominator are patients who opt out of screening and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf.
Calculation: The numerator of patients admitted screened divided by the number of admissions
Data Submission and Reporting: Web-based data collection using Hospital Quality Reporting (HQR) System and annual reporting per policy for Hospital IQR Program structural measures.

Screen Positive Rate for Social Drivers of Health

CMS proposes adding this structural measure as a companion measure to the proposed Screening for Social Drivers of Health measure, intended to enhance standardized data collection for identifying high-risk individuals who could benefit from connection via the hospital to community-based services relevant to their HRSNs. The measure also could allow impact estimates for the effects of the included HRSN domains on hospitalizations and be valuable during discharge planning. CMS notes that the measure is not intended for comparisons among hospitals. Measure specifications are available for download at QualityNet.

Numerator: For each HRSN, the number of patients who screen positive on the date of admission
Denominator: For each HRSN, the number of patients screened
Exclusion: Patients younger than 18 years at the time of admission are excluded from the numerator and denominator. Also excluded from the denominator are patients who opt out of screening and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf.
Calculation: A separate rate is calculated for each screening domain, so that five rates are calculated by each hospital for screen-positive patients divided by screened patients.
Data Submission and Reporting: Web-based data collection using Hospital Quality Reporting (HQR) System and annual reporting per policy for Hospital IQR Program structural measures

Cesarean Birth eCQM

CMS proposes to add a Cesarean Birth eCQM beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FFY 2026 payment determination and for subsequent years. The measure is intended to facilitate safer maternal care by assessing the rate of low-risk, Nulliparous Term Singleton Vertex (NTSV) pregnancies delivered by Cesarean section (C-sections) as a step toward reducing the rate of non-medically indicated C-sections and their associated excess morbidity, mortality, and costs.

Numerator: The subset of patients in the denominator having C-section deliveries
Denominator: Nulliparous women with a singleton vertex fetus at ≥ 37 weeks of gestation who deliver a liveborn infant.
Inclusion: This is an all-payer measure.

Exclusion: Patients with abnormal fetal presentations (e.g., breech) or placenta previa. Patients with confirmed diagnoses of COVID-19 diagnoses with related respiratory conditions or having related respiratory procedures.
Calculation: Patients having NTSV deliveries by C-section divided by all NTSV deliveries.
Risk Adjustment: None. The NTSV descriptor identifies a relatively low-risk pregnancy, and CMS believes the exclusion criteria further reduces the risk of the eligible population.
Data Sources: Patient-level data are collected through hospital EHRs with measure calculation performed by the Certified EHR Technology (CEHRT) for submission to CMS.
Data Submission and Reporting: This measure would follow established policies for eCQM submission. As proposed, the measure could be voluntarily self-selected by a hospital for reporting during reporting period CY 2023 but would become mandatory — except for hospitals that do not have obstetrics departments and do not perform deliveries — beginning with the CY 2024 reporting period.

Severe Obstetric Complications eCQM

CMS proposes to add the Severe Obstetric Complications eCQM beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FFY 2026 payment determination and for subsequent years. The measure assesses the proportion of patients with severe obstetric complications that occur during inpatient delivery hospitalizations. It is intended to facilitate safer care by increasing awareness of major obstetric complications and their associated morbidity and mortality and through encouraging adherence to clinical guidelines.

Numerator: Inpatient hospitalizations for severe obstetric complications that are not present on admission and occur during the delivery hospitalization (see Table IX.E-03 in the rule for the qualifying diagnoses for inclusion in the numerator — e.g., sepsis — and section IX.E.5.d.(4). for the qualifying procedures — e.g., hysterectomy)
Denominator: Inpatient hospitalizations for patients at least 8 years of age and less than 65 years of age admitted for acute care who undergo a delivery procedure for a stillbirth or livebirth greater than or equal to 20 weeks' gestation
Calculation: Proportion of eligible patients with severe obstetric complications occurring during delivery hospitalizations, reported as a rate per 100,000 deliveries. Rates are calculated separately for patients with or without transfusion as their only qualifying numerator event.
Risk adjustment: This measure is extensively risk-adjusted, and separate risk-adjustment models are used for cases in which blood transfusion is the only qualifying numerator event. Variables used for adjustment include demographics (e.g., age), certain preexisting conditions (e.g., hypertension), laboratory values, vital signs on admission, and certain social risk factors (e.g., housing instability).
Data Sources: Patient-level data are collected through hospital EHRs with measure calculation performed by the hospital's CEHRT.
Data Submission and Reporting: This measure would follow established policies for eCQM submission. As proposed, the measure could be voluntarily self-selected by a hospital for reporting during reporting period CY 2023 but would become mandatory — except for hospitals that do not have obstetrics departments and do not perform deliveries — beginning with the CY 2024 reporting period.

Hospital Harm — Opioid-Related Adverse Events eCQM (NQF #3501e)

CMS proposes to add an outcome eCQM Hospital Harm — Opioid-Related Adverse Events (NQF #3501e) beginning with the CY 2024 reporting period/FFY 2026 payment determination and for subsequent years. The measure uses naloxone (opioid-antagonist) administration as a marker for adverse events, most of which are avoidable, triggered by opioid administration to inpatients. The measure is intended to provide information to hospitals to improve their monitoring of and response to inpatients given opioids. The measure has been refined and retested — and subsequently endorsed by the National Quality Forum — since it was previously proposed for the program.

Numerator: Proportion of inpatient encounters where patients have been administered an opioid followed by administration of naloxone within 12 hours
Denominator: Patients receiving at least one opioid dose during their hospitalizations.
Exclusions: Patients under 18 years of age are excluded. Patients receiving naloxone in the hospital's operating room are excluded. Use of naloxone during procedures performed outside of the operating room are included. If naloxone is administered more than once, only the first treatment episode is included.
Calculation: Inpatient encounters where patients have been administered an opioid followed by administration of naloxone within 12 hours divided by hospitalizations that include at least one opioid administration
Risk adjustment: This measure is not risk-adjusted as CMS believes opioid-related adverse events should be avoidable regardless of patient risk factors.
Data Sources: Patient-level data are collected through hospital EHRs with measure calculation performed by the hospital's CEHRT
Data Submission and Reporting: This measure would follow established policies for eCQM submission and be eligible for self-selection by hospitals for reporting beginning with the CY 2024 reporting period/FFY 2026 payment determination. (Mandatory reporting is not being proposed.)

Global Malnutrition Composite Score eCQM (NQF #3592e)

CMS proposes to add the Global Malnutrition Composite Score eCQM beginning with the CY 2024 reporting period/FFY 2026 payment determination and for subsequent years. The four measure components correspond to the four elements of recommended optimal nutritional care: screening, complete assessment of patients screening positive, documentation of degree of malnutrition, and nutritional care plan development. Tables IX.E.-04 through IX.E.-06 in the rule provide details of the component measures.

Numerator: Four component scores
Denominator: 100% for each component score
Exclusions: Patients with lengths of stay <24 hours are excluded from the denominator of each component.
Calculation: The component measures are first scored separately from 0-100%. The component scores are summed, and an unweighted average determined. The average is reported as the composite score.
Data Sources: Patient-level data are collected through hospital EHRs for each component measure, and composite measure calculation is performed by the hospital's CEHRT.

Data Submission and Reporting: This measure would follow established policies for eCQM submission and be eligible for self-selection by hospitals for reporting beginning with the CY 2024 reporting period/FY 2026 payment determination. (Mandatory reporting is not being proposed.)

Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO_PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #3559)

CMS proposes to add this measure beginning with two voluntary periods, followed by mandatory reporting for the reporting period that runs from July 1, 2025, through June 30, 2026, and impacts the FFY 2028 payment determination, and subsequent years. This PRO-PM is based on a measure developed for and used in the Comprehensive Care for Joint Replacement (CJR) model beginning in 2015 and that is still being collected. It uses standardized, validated survey instruments completed within three months pre-, and at about one year post-operatively to assess patient-perceived pain and function, the two main reasons for which THA and TKA operations are performed. Specifications are available for download on the CMS website.

Numerator: Risk-standardized proportion of patients meeting pre-defined thresholds for substantial clinical improvement
Denominator: Medicare beneficiaries 65 years of age or older undergoing elective primary THA or TKA as inpatients
Exclusions: Patients who die before discharge, leave against medical advice, or have staged procedures
Calculation: All patient-level results for a hospital are aggregated ("hospital-level") to produce a case-mix adjusted risk-standardized improvement rate. PRO tool response rates utilize matched, completed pre- and post-operative assessments.
Risk Adjustment: Preoperative mental health is accounted for using two validated PRO tools, and health literacy based on a standardized questionnaire. Other variables are included to adjust for non-response bias (e.g., patient demographics, race, dual eligible status).
Data Sources: Completed patient self-assessments, Medicare claims and beneficiary databases, and Census Bureau survey data
Data Submission and Reporting: Multiple submission mode options are available. Hospitals submit multiple data elements, drawn from prespecified reporting periods, during preset submission windows. There will be two voluntary reporting periods (one each in 2025 and 2026) followed by mandatory reporting starting in 2027 for payment determination (program) year FFY 2028. Data from the voluntary periods would not be publicly reported but indicators would identify hospitals choosing to voluntarily report. Public release of results and response rates would start with the first mandatory reporting cycle. Submission and reporting cycles for the voluntary and first mandatory periods are shown in Tables IX.E.-07 and IX.E.-08 in the proposed rule.

Medicare Spending Per Beneficiary (MSPB) Hospital (NQF #2158)

CMS proposes to add a refined version of the MSPB-Hospital claims-based measure beginning with the FFY 2024 payment determination. The original version was removed from the IQR Program beginning with the FFY 2020 payment determination at which point the measure's

associated costs were believed to outweigh benefits of its continued use. However, the original version has remained in the hospital VBP measure set in the Efficiency and Cost Reduction domain. CMS notes that it intends to propose replacement of the original measure in the VBP measure set with the refined measure once the statutory requirement for use and public reporting of the refined measure as part of the hospital IQR Program are met.

Refined specifications: The refined MSPB-Hospital measure differs from the original version by (1) new service inclusion and exclusion rules that reduce the capture of services outside of the control of providers, (2) allowing readmissions to trigger new episodes, and (3) modifying the measure calculation from sum of observed costs divided by sum of expected costs to mean of observed costs divided by expected costs. The changes are believed to measure costs for which hospitals should be held accountable more accurately while reducing the effects of outliers on final measure scores. Consideration was given to adjusting the measure for beneficiary social risk factors, but no adjustments were made after extensive analyses showed the impacts of social risk factors on the measure to be inconsistent and limited.

Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA (NQF #1550) (THA/TKA Complication Measure)

CMS proposes to add a refined version of the claims-based THA/TKA Complication Measure beginning with the FY 2024 payment determination. The original version was removed from the IQR Program beginning during FFY 2018 IPPS rulemaking as part of a CMS initiative to reduce provider burden. However, the original measure remains in the hospital VBP Program under the Clinical Outcomes domain. CMS notes that it intends to propose replacement of the original measure in the VBP measure set with the refined measure once the statutory requirement for use and public reporting of the refined measure as part of the hospital IQR Program are met.

Refined specifications: The refined THA/TKA Complication measure differs from the original version by the addition of 26 ICD-10 diagnostic codes for mechanical complications in the outcome (numerator) specifications. The data source for the codes are Part A claims. The list of added complication diagnoses is found in section IX.E.5.i.(4). of the rule and expanded information is available in the Hip and Knee Arthroplasty Complications (ZIP) folder.

In alignment with the current hospital VBP version of the measure, admissions with principal or secondary COVID-19 diagnoses are excluded from the numerator when assessing the medical complications of acute myocardial infarction within seven days, pneumonia within seven days, sepsis within seven days, or pulmonary embolism within 30 days. A covariate adjustment for a history of COVID-19 is also proposed. CMS proposes to begin publicly reporting the measure in 2023.

Proposed Refinements to Current IQR Program Measures

CMS proposes to refine the current THA/TKA Payment Measure by adding 26 ICD-10 diagnostic codes for complications of THA or TKA to the outcomes currently captured in the numerator of this measure. The 26 codes are listed in section IX.E.6.a.(4). of the rule and are the same as those proposed for addition to the THA/TKA Complication Measure as described previously in the rule and above in this summary. CMS proposes to add these diagnoses beginning with the FFY 2024 payment determination.

CMS also proposes to refine the Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) (NQF #2881) (AMI EDAC) measure by increasing the minimum case count from 25 to 50 cases to address reliability concerns identified during routine measure maintenance review. Hospitals not meeting the minimum case threshold would receive confidential feedback, but their results would not be publicly posted. Public reporting on Care Compare would occur for hospitals meeting or exceeding the threshold, after confidential reporting and a review and corrections period. CMS proposes that the refinement would be effective beginning with the FFY 2024 payment determination. Measure specifications are available for download (AMI EDAC ZIP file).

Proposed Establishment of a Publicly Reported Hospital Designation to Capture the Quality and Safety of Maternity Care

CMS notes that improving the quality and safety of maternal health — including reducing disparities in maternal health outcomes across race, ethnicity, and geographic area — is a priority of the Biden administration. CMS proposes to establish a hospital designation reflecting the quality and safety of maternal care that would be publicly reported on a public-facing CMS website beginning in Fall 2023. Initially, the designation would be awarded to hospitals that report "Yes" to both questions embedded in the Maternal Morbidity Structural Measure of the hospital IQR Program, as finalized in the FFY 2022 IPPS final rule. However, CMS states its intention to expand the requirements for hospitals to be awarded the designation in the future, pointing to the newly proposed maternal health and perinatal care eCQMs described earlier in this summary.

CMS seeks comments on the appropriate name for this designation and additional data sources beyond the Maternal Morbidity Structural Measure, and specially seeks suggestions for relevant patient experience-of-care measures.

RFI: Additional Activities to Advance Maternal Health Equity

CMS seeks additional comments on policy approaches to advancing maternal health equity. These approaches could involve but would not be limited to revisions to the Medicare and Medicaid Conditions of Participation (CoPs) and quality reporting programs. CHA refers readers to pages 28549-28550 of the proposed rule for specific questions posed by CMS.

Future Measures Under Consideration

CMS seeks comments on two digital National Healthcare Safety Network (NHSN) measures under consideration for future IQR program years. The first — Clostridioides difficile CDC NHSN Health-Associated Infection (HA-CDI) Outcome Measure — is a digital version of the current NHSN CDI measure, which would improve on the original version of the measure by requiring both microbiologic evidence of CDI in stool and evidence of antimicrobial treatment, rather than only CDI facility-wide Lab-ID event reporting. The second measure — CDC NHSN Hospital-Onset Bacteremia and Fungemia Outcome Measure — captures a wide range of bloodstream infections, rather than simply organism-specific (e.g., MRSA) or source-specific (CLABSI) infections. CMS is considering use of this measure in the hospital IQR Program and the PCHQR Program and as a replacement for the CAUTI and CLABSI measures in the hospital VBP and HAC reduction programs.

Reporting and Submission Requirements for eCQMs

As finalized in the FFY 2021 IPPS final rule, beginning with the CY 2022 reporting period (FFY 2024 payment), hospitals report on three self-selected eCQMs plus the Safe Use of Opioids — Concurrent Prescribing eCQM, using three quarters of data. CMS is proposing to modify the current reporting requirements by increasing eCQM reporting from four eCQMs (one mandatory and three self-selected) to six eCQMs (three mandatory and three self-selected) beginning with the CY 2024 reporting period/FY 2026 payment determination. As previously finalized, hospitals would have to begin reporting eCQM data for the full calendar year beginning with the CY 2023 reporting year (FFY 2025 payment). CMS proposes this increase consistent with the proposed addition of two new maternal health eCQMs for mandatory reporting: Cesarean Birth and Severe Obstetric Complications.

The current and proposed eCQM reporting requirements are listed in the table below:

Reporting Period/Payment Determination	Previously Finalized # of Self-Selected Calendar Quarters Required	Previously Finalized/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

As previously finalized, hospitals are required to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for the IQR Program, beginning CY 2023 reporting period/FFY 2025 payment determination. Consistent with the 21st Century Cures final rule, health IT developers must make updated certified electronic health record technology (CEHRT) by December 31, 2022.

Reporting and Submission Requirements for Hybrid Measures

CMS proposes to remove the zero-denominator declarations and case threshold exemptions policies for hybrid measures beginning with the FFY 2026 payment determination. These policies were adapted from eCQM policies to avoid penalizing hospitals that had no patients meeting the denominator criteria of hybrid measures. These hospitals identified themselves proactively through making zero-denominator declarations or claiming case threshold exemptions. However, CMS now believes that hybrid measure data reporting processes intrinsically pre-empt measure reporting when no patients meet a measure's denominator criteria. Hybrid measures are based on a combination of claims data and clinical data electronically submitted by hospitals. CMS performs the measure calculations and reports results back to data submitters (hospitals). During the process of merging the agency's claims data with EHR data received from the hospital, CMS

will automatically detect whether denominator criteria have been met by the hospital. Therefore, zero denominator declarations and case threshold exemptions are no longer needed.

Reporting and Submission Requirements for Patient-Reported Outcome-Based Performance Measures (PRO-PMs)

CMS proposes submission and reporting requirements for PRO-PM measures, as this is a new measure type for the IQR Program. CMS proposes that hospitals would have the choice of selecting from multiple data submission approaches for these measures, including sending data directly to CMS for measure calculation or utilizing an external entity such as a vendor or registry to submit to CMS on the hospital's behalf. As noted earlier in this summary, CMS proposes specific data collection, submission, and reporting requirements for the proposed THA/TKA PRO-PM Measure in Tables IX.E.-07 and IX.E.-08 in the proposed rule.

eCQM Validation Requirements

CMS proposes to modify the previously finalized eCQM validation process by increasing the requirement that hospitals submit timely and complete data from 75% of requested charts to 100%. The new submission threshold requirement would be effective beginning with CY 2022 eCQM data affecting the FFY 2025 payment determination and subsequent years. CMS notes that all hospitals selected to date for eCQM validation have met the 75% threshold, and 95% of them have voluntarily and successfully submitted 100% of requested records. CMS notes validation requirements for chart-abstracted measures are not affected by this eCQM validation proposal.

Quality Program Requests for Information

CMS includes several RFIs within its section on quality data reporting requirements, including RFIs on climate change and health equity, measuring health care quality disparities, and advancing digital quality measurement and health information exchange. Responses to the RFIs will be used to inform future rulemaking.

Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity RFI

CMS seeks comments from hospitals and other providers on issues related to climate change and its impact on patient outcomes and health equity. CMS requests information about hospital responses to climate change from several perspectives, including how their patient populations are being affected, especially underserved groups; how hospitals and the health care sector can effectively prepare for climate threats, such as extreme heat, storms, floods and wildfires; how CMS can support hospitals in crafting and implementing hospital responses; and approaches hospitals are using to reduce their own greenhouse grass emissions. CHA refers readers to pages 28478-28479 of the proposed rule for the list of specific questions CMS seeks feedback on.

Measuring Health Care Quality Disparities Across CMS Quality Programs RFI

CMS describes and seeks comments on key principles and approaches the agency will consider when addressing disparities through quality measure development and stratification. CMS focuses its discussion on five key areas for consideration and comment:

- **Identification of Goals and Approaches for Measuring Health Care Disparities and Using Measure Stratification Across CMS Quality Reporting Programs:** CMS discusses

its within- and between-provider disparity methods for presenting stratified quality measure results.

- **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting:** CMS discusses its approach to how it intends to prioritize which measures it will apply disparity reporting methods to, with a focus on existing valid and reliable measures related to treatment or outcomes where evidence of disparities has been shown.
- **Principles for Social Risk Factor and Demographic Data Selection and Use:** CMS describes several types of social risk factor and demographic data that could be used in stratifying measures for health care disparity measurement.
- **Identification of Meaningful Performance Differences:** CMS reviews several strategies for identifying meaningful differences in performance when measure results are stratified.
- **Guiding Principles for Reporting Disparity Results:** CMS reviews considerations for determining how quality programs will report measure results stratified by social risk factors and demographic variables to health care providers and to the public, as well as the ways different reporting strategies could hold health care providers accountable for identified disparities.

Continuing to Advance Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs RFI

CMS seeks broad input on the transition to digital quality measurement. First, CMS provides an updated version of its definition for digital quality measures (dQMs): quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. CMS also seeks input on data standardization needed across implementation guides to facilitate interoperability with a focus on FHIR-enabled application programming interfaces. CMS notes that it is testing the conversion of existing eCQMs for use with FHIR-based resources and intends to develop a unified CMS FHIR receiving system.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) RFI

CMS notes that the Office of the National Coordinator (ONC) for Health Information Technology (HIT) issued Version 1 of the TEFCA on January 18, 2022. Goals for TEFCA include establishing a universal policy and technical floor for interoperability, simplifying connectivity for organizations to securely exchange HIT to improve patient care, and enabling individuals to gather their own healthcare information. CMS seeks comments on the most important use cases for health information exchange under TEFCA, and how CMS should approach incentivizing or encouraging information exchange under TEFCA, such as potential requirements it could establish in its programs.

PPS-Exempt Cancer Hospital Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a Quality Reporting Program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting (PCHQR) Program follows many of the policies established for the hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking.

CMS proposes to revise the program's measure-removal policy, timelines for public display of two measures, and requests feedback about two potential, future-measure additions. CMS makes no changes to the program's measure set, policies for updating technical specifications, data submission procedural requirements, or exceptional circumstances exceptions. Table 4 of the Appendix of this summary lists the measure set for the program.

Proposed Revision to Measure Removal Policy

CMS proposes to create a patient safety exception to the PCHQR Program's measure removal policy, under which the agency could remove a measure from the program without rulemaking if it determines data submission on a measure raises specific patient safety concerns. CMS would be required to promptly notify PCHs and the public about the patient safety concerns and immediate measure removal, including through publication of a notice in the *Federal Register*.

Public Reporting of Measure Results

Public reporting of PCHQR Program measure data is proposed through rulemaking and generally follows a period of confidential reporting to hospitals. Data are posted to the Provider Data Catalog website. CMS proposes to begin public display of data from four end-of-life (EOL) measures beginning with program year FFY 2024 data. These measures were added to the program's measure set beginning with program year FFY 2020. CMS also proposes to begin public display of data from the 30-Day Unplanned Readmission for Cancer Patients measure with program year FFY 2024 data. This measure was added to the program's measure set beginning with program year FFY 2021. The specific refresh cycles during which public reporting of these five measures will begin will be announced by CMS through routine channels (e.g., CMS' website).

Potential Future Digital HAI Measure Adoption RFI

CMS notes that cancer patients are often immunosuppressed and therefore at increased risk for healthcare-associated infections (HAIs). CMS seeks comments on potential future inclusion of the two digital CDC NHSN HAI measures — Healthcare-associated Clostridioides difficile Infection Outcome and Hospital-Onset Bacteremia & Fungemia Outcome — described earlier in this summary.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction equal to three quarters of the market basket and would receive an update of 0.375% for FFY 2023 if they IQR program requirements. A hospital that fails to meet both the meaningful use and IQR Program requirements would receive an update factor of -0.4%.

CMS proposes several changes to the Promoting Interoperability Program, including making a voluntary measure mandatory, adding two new measures — one optional under the Health Information Exchange (HIE) objective, and one required under the Public Health and Clinical Data Exchange objective — as well as proposed updates to the scoring methodology beginning with CY 2023 reporting.

Reporting Periods for 2023 and 2024

CMS previously adopted a continuous 90-day reporting period for the Medicare Promoting Interoperability Program through CY 2023, and an increase to a minimum of any continuous 180-day period beginning with CY 2024.

CMS notes that due to the COVID-19 PHE, ONC extended the date to December 31, 2022, for health IT developers to make available 2015 Edition Cures Update CEHRT. After that date, providers must use only CHERT updated to the 2015 Edition Cures Update for an EHR reporting period or performance period in CY 2023. CMS does not propose any changes to this policy, but reminds readers that participants are only required to use technology meeting the CEHRT definitions during a self-selected EHR reporting period or performance period of a minimum of any consecutive 90 days in CY 2023, which would include the final 90 days of 2023.

Electronic Prescribing Objective Proposals

Mandatory Reporting of Query of Prescription Drug Monitoring Program (PDMP) Measure

Under the current program, the Query of PDMP measure is a voluntary measure that assesses the number of Schedule II opioid prescriptions that CEHRT data are used to conduct a query of a PDMP for prescription drug history (except where prohibited and in accordance with applicable law) as a percentage of the number of all Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or critical access hospital (CAH) during the EHR reporting period. In this proposed rule, CMS proposes modifications to the measure and mandatory reporting beginning with CY 2023.

The proposed measure would be expanded to include Schedule III and IV drugs, with two exclusions: 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. The proposed measure would read as follows:

> "For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a PDMP for prescription drug history."

The measure has been voluntary and eligible for bonus points since the 2019 reporting period. However, CMS now believes that the number of PDMPs that are integrated with HIEs, EHRs, and Pharmacy Dispensing Systems have increased to a degree that supports mandatory reporting of the measure. Hospitals would report a yes/no response to the measure and receive 10 points for a yes response. CMS notes that in the future, it may consider reporting of the measure with a numerator and denominator.

Proposed Technical Update to the E-Prescribing Measure

In the CY 2021 Physician Fee Schedule final rule, CMS finalized a technical change so the E-Prescribing measure, which removed the certification criterion related to drug-formulary and

preferred drug list checks. However, CMS neglected to revise the description for the CY 2022 Promoting Interoperability Program. It proposes the following conforming technical revisions:

- Measure Description: "For at least one hospital discharge, medication orders for permissible prescriptions (for new and changed prescriptions) are transmitted electronically using CEHRT"
- Measure Numerator: "[t]he number of prescriptions in the denominator generated and transmitted electronically"

Health Information Exchange (HIE) Objective Proposals

Proposed Addition of an Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)

Currently, the HIE Objective includes two options for reporting: 1) the HIE Bi-Directional Exchange, worth 40 points, and 2) the Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measures, each worth 20 points. Hospitals can report the HIE Bi-Directional Exchange measure as an alternative to the other two measures.

CMS proposes a third option for reporting under the HIE Objective with a new Enabling Exchange Under TEFCA measure. CMS discusses the TEFCA Version 1, which is intended to facilitate nationwide interoperability by establishing a common agreement and Qualified Health Information Network (QHIN) technical framework. Currently entities are applying to become designated as QHINs, which will connect their participants and sub-participants, and support QHIN to QHIN exchange. The Enabling Exchange Under TEFCA measure would enable an eligible hospital or CAH could earn credit for the HIE Objective by connecting to an entity that connects to a QHIN or connecting directly to a QHIN.

The Enabling Exchange Under TEFCA measure would be reported by attestation, and the measure would require a "yes/no" response. CMS proposes that the measure may be calculated by reviewing only the actions for patients whose records are maintained using CEHRT. Eligible hospitals and CAHs would attest to the following:

- Participating as a signatory to a Framework Agreement (in good standing that is not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and all unique patient records stored or maintained in the EHR for these departments, during the EHR reporting period in accordance with applicable law and policy.
- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under the Framework Agreement.

Eligible hospitals or CAHs would have to use the capabilities of CEHRT to support bi-directional exchange under a Framework Agreement, which includes capabilities that support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI).

Under CMS' proposed changes to the Promoting Interoperability Program's scoring methodology (described below), the measure would be worth 30 points — or full credit for the HIE Objective. If CMS does not finalize its proposal to require mandatory reporting of the Query of PDMP measure, the TEFCA measure and HIE Objective would be worth 40 points.

Public Health and Clinical Data Exchange Objective Proposals

Proposed Antimicrobial Use and Resistance (AUR) Surveillance Measure

Expressing concerns with rising antimicrobial-resistant infections and the misuse and overuse of antimicrobials, CMS believes that requiring an AUR surveillance measure under the Promoting Interoperability Program would enable the development of a true national picture of the threat posed by antimicrobial overuse and resistance. CMS notes that currently, approximately 2,000 acute care hospitals and 1,000 CAHs voluntarily report to the CDC's NHSN AUR Module.

Beginning with the EHR reporting period in 2023, CMS proposes to require reporting on a fifth measure under the Public Health and Clinical Data Exchange Objective:

- AUR Surveillance measure: The eligible hospital or CAH is in active engagement with CDC's NHSN to submit AUR data for the EHR reporting period and receives a report from NHSN indicating their successful submission of AUR data for the EHR reporting period.

To report this measure, eligible hospitals and CAHs would have to use technology certified to the criterion at 45 CFR 170.315(f)(6), "Transmission to public health agencies — antimicrobial use and resistance reporting." To receive credit, eligible hospitals and CAHs must report a "yes" response or an exclusion for which they are eligible. A "no" response or the failure to report a response would result in no credit for the measure and thus failure to meet the Objective. The measure would be calculated by reviewing *all* patient records, not just those whose records are maintained using CEHRT.

CMS proposes three measure exclusions for an eligible hospital or CAH:

- Does not have any patients in any patient care location for which data are collected by NHSN during the EHR reporting period
- Does not have electronic medication administration records (eMAR)/barcoded medication administration records or an electronic admission discharge transfer (ADT) system during the EHR reporting period, or
- Does not have an electronic laboratory information system (LIS) or electronic ADT system during the EHR reporting period

Proposed Revisions to Active Engagement

CMS defines "active engagement" under the Public Health and Clinical Data Registry Reporting Objective as, "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." CMS has previously clarified that "production data" refer to data generated through clinical processes involving patient care; it is used to distinguish between this data and "test data," which may be submitted for the purposes of enrolling in and testing electronic data transfers.

Previously, CMS established three options to demonstrate active engagement, in the hope that eligible hospitals would get to option three: (1) Complete registration to submit data, (2) Test and validate electronic submission of data, (3) Complete testing and validation of the electronic submission and electronically submit production data to the PHA or CDR.

In this rule, CMS proposes to consolidate current options 1 and 2 into one option beginning with the EHR reporting period in CY 2023. It does not propose any substantive changes to the individual options or requirements for selecting individual options. The two proposed options are:

- 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)
- Proposed Option 2. Validated Data Production (current option 3, production).

Currently, there is no requirement for 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. However, beginning with the CY 2023 EHR reporting period, in addition to submitting responses for the required measures and any optional measures a hospital chooses to report, CMS proposes to require eligible hospitals and CAHs to submit their level of active engagement using the options for active engagement (as proposed to be modified above) for each measure they report. If the proposal to reduce the number of options used to report active engagement is not finalized, one of the three current options would have to be submitted for each measure reported.

CMS further proposes, beginning with CY 2023, that eligible hospitals and CAHs may spend *only one* EHR reporting period at the Pre-production and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level for the next EHR reporting period for which they report a particular measure.

Public Health Reporting and Information Blocking

CMS cites a recently released FAQs from the ONC on information blocking, which say that if an actor is required to comply with another law that relates to the access, exchange, or use of electronic health information (EHI), failure to comply with that law may implicate the information blocking regulations. As an example, ONC notes that, if an actor fails to submit EHI to public health authorities where required by law, it could be considered an interference under the information blocking regulations.

Proposed Changes to the Scoring Methodology for the EHR Reporting Period in 2023

CMS proposes several changes to the scoring methodology to account for newly proposed measure requirements, and to reflect a new priority to incentivize more electronic reporting of health information. To be considered a meaningful user of EHR technology, an eligible hospital or CAH will be required to:

- Report on all the required measures across all four objectives, unless an exclusion applies
- Report “yes” on all required yes/no measures, unless an exclusion applies
- Attest to completing the actions included in the Security Risk Analysis measure

- Achieve a total score of at least 60 points

Failure to meet any of the first three requirements results in an automatic score of zero.

The table below compares the existing and proposed CY 2023 scoring methodology, including how CMS would redistribute points where an eligible exclusion is claimed:

Proposed Performance-Based Scoring Methodology Beginning with the CY 2023 EHR Reporting Period				
Objectives	**Measures**	**2022 Maximum Points**	**2023: Maximum Points (Proposed)**	**Redistribution if Exclusion Claimed (Proposed)**
Electronic Prescribing	e-Prescribing	10 points	10 points	10 points to HIE Objective
	Query of PDMP	10 points (bonus)	10 points ***(proposed to be required)***	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	20 points	15 points ***(proposed)***	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	20 points	15 points ***(proposed)***	No exclusion
	OR			
	HIE Bi-Directional Exchange measure	40 points	30 points ***(proposed)***	No exclusion
	OR			
	Enabling Exchange under TEFCA	N/A	30 points ***(proposed)***	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	25 points ***(proposed)***	No exclusion
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 ***(Proposed for 2023)***	10 points	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)	5 points (bonus)	

Note: The Security Risk Analysis measure, SAFER Guides measure, and information blocking attestations required by section 106(b)(2)(B) of MACRA are required but will not be scored. eCQM measures are required but will not be scored.

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

In alignment with proposals for the IQR program, CMS proposes the following reporting requirement for eCQMs:

- For CY 2022 reporting (FFY 2024 payment) hospitals report data for three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM for three self-selected calendar quarters.
- For CY 2023 reporting (FFY 2025 payment), hospitals report data for three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM for all four calendar quarters.
- For CY 2024 reporting (FFY 2026 payment) and subsequent years, hospitals report data for three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM, the Cesarean Birth eCQM, and the Severe Obstetric Complications eCQM (six total eCQMs) for all four calendar quarters.

CHA refers readers to the IQR Program section of this summary for a full discussion of CMS' eCQM proposals, including the newly proposed maternal health and perinatal care eCQMs that would be mandatory for reporting beginning in CY 2024.

Proposed Public Reporting of Promoting Interoperability Program Data

Beginning with the CY 2023 EHR reporting period, CMS proposes to publicly report a total score of up to 105 points for each eligible hospital and CAH under the Promoting Interoperability Program. The score would be posted on a CMS website with the hospital's CMS EHR certification ID that represents the CEHRT used by the eligible hospital or CAH. CMS would provide eligible hospitals and CAHs a 30-day preview period to review their data before publication, using the current policy and operational process for the Hospital IQR Program and use the Hospital Quality Reporting (HQR) system. CMS indicates that the total score and CMS EHR certification ID data could be publicly reported as early as the Fall of CY 2024.

Condition of Participation: Reporting COVID-19 and Influenza Infections

During the COVID-19 PHE, CMS has required — as a Medicare CoP — that hospitals and CAHs report specific information about COVID-19. This includes information such as the number of staffed beds in a hospital and the number of those that are occupied, information about its supplies, a count of patients currently hospitalized who have laboratory-confirmed COVID-19, current inventory supplies of any COVID-19-related therapeutics that have been distributed and delivered to the hospital (or CAH) under the authority and direction of the Secretary as well as the hospital's (or the CAH's) current usage rate for these COVID-19-related therapeutics.

CMS notes that these elements have been essential for planning, monitoring, and resource allocation during the COVID-19 PHE, however, under existing regulation these reporting requirements will no longer be required through the CoPs once the PHE declaration ends. In addition, CMS is concerned that the current reporting requirements are too limited in scope to

address future PHEs. To address these concerns, CMS proposes to revise the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements and to establish new reporting requirements for any future PHEs related to a specific infectious disease or pathogen.

Specifically, CMS proposes that beginning at the conclusion of the current COVID-19 PHE declaration and continuing until April 30, 2024, a hospital or a CAH must electronically report information about COVID-19 and seasonal influenza in a standardized format specified by the Secretary. For COVID-19 reporting, hospitals and CAHs would be required to report:

- Suspected and confirmed COVID-19 infections among patients and staff
- Total COVID-19 deaths among patients and staff
- Personal protective equipment and testing supplies in the facility
- Ventilator use, capacity, and supplies in the facility
- Total hospital bed and intensive care unit bed census and capacity
- Staffing shortages
- COVID-19 vaccine administration data of patients and staff
- Relevant therapeutic inventories and/or usage

For seasonal influenza, hospitals and CAHs would be required to report:

- Confirmed influenza infections among patients and staff
- Total influenza deaths among patients and staff
- Confirmed co-morbid influenza and COVID-19 infections among patients and staff

To address future PHEs, CMS proposes to require hospitals and CAHs to report specific data elements to the CDC's NHSN — or other CDC-supported surveillance systems — as determined by the Secretary. The proposed requirements would apply to local, state, and national PHEs as declared by the Secretary. Relevant to the declared PHE, CMS proposes requiring reporting of the following items daily (or less frequently as determined by the Secretary) to NHSN or other CDC-supported surveillance systems:

- 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

- Key co-morbidities and/or exposure risk factors of patients being treated for the pathogen or disease of interest that are captured with interoperable data standards and elements
- Person level information such as medical record identifier, race, ethnicity, age, sex, residential county and ZIP code, and relevant comorbidities for affected patients

CMS seeks comments on whether there is duplication of reporting of these items with those that may be required elsewhere but notes the importance of providing the federal government with this information during a PHE. CMS also acknowledges the uncertainties in planning for future emergencies and is interested in public comment on how to best align and incentivize preparedness, while also reducing burden and costs on regulated entities and ensuring appropriate flexibility.

RFI: Payment Adjustments for Domestically Made N95 Respirator Masks

In the FFY 2023 proposed rule, CMS seeks comments on how to ensure availability of domestically manufactured National Institute for Occupational Safety and Health (NIOSH) approved N95 respirators. To help ensure an adequate supply of domestically produced N95 respirators, CMS is considering payment adjustments under the IPPS and OPPS beginning in 2023 as follows:

- Biweekly interim lump-sum payments to hospitals that would be reconciled at cost report settlement that accounts for the marginal difference in costs between NIOSH-approved surgical N95 respirators that were wholly domestically made and those that were not; or
- A claims-based approach where Medicare could establish a MS-DRG add-on payment when hospitals meet or exceed a threshold of purchasing 50% or more wholly domestically sourced surgical N95 respirators

For the latter approach, CMS would establish a unique billing code that hospitals would use to attest that they met or exceeded the domestic sourcing threshold for the year. A similar approach would apply under the outpatient prospective payment system (OPPS) for each non-telehealth OPPS service. CMS seeks comment on the following:

- Which of the potential frameworks would be a more appropriate approach to provide payment adjustments for purchased wholly domestically made NIOSH-approved surgical N95 respirators? Please explain why.
- How can hospitals determine if the surgical N95 respirators they purchase are wholly domestically made NIOSH-approved surgical N95 respirators and eligible for these payment adjustments?
- For the lump-sum payment framework, what would be the most appropriate methodology to determine Medicare's share of costs for purchased wholly domestically made NIOSH-approved surgical N95 respirators? One potential methodology could use the ratio of Medicare inpatient cases to total inpatient hospital cases for all payers reported on the Medicare cost report.
- For the lump-sum payment framework, a hospital might use only wholly domestically made NIOSH-approved surgical N95 respirators. Such a hospital would not have any cost information to report for NIOSH-approved surgical N95 respirators that were not wholly domestically made. Strictly for purposes of calculating a cost differential in such

situations, should a national minimum cost be established for a NIOSH-approved surgical N95 respirator that is not wholly domestically made?

- For the claims-based payment framework, how should Medicare calculate the per claim add-on amount prospectively given the varying costs of NIOSH-approved surgical N95 respirators, and how should it be updated given year-by-year cost changes for NIOSH-approved surgical N95 respirators?
- For the claims-based payment framework, what are reasonable usage assumptions upon which to base the payment adjustments? For example, for OPPS, should the payment adjustments be based on assumption of one wholly domestically made NIOSH-approved surgical N95 respirator worn per face-to-face, in-person encounter? What assumptions should be made for IPPS? Should the claims-based payment adjustment be a percent add-on or a fixed add-on?
- Given that the OPPS authority that might be used for an OPPS payment adjustment is required by law to be budget-neutral, should the IPPS payment adjustment also be budget-neutral, or should it be applied in a non-budget neutral manner?
- What program integrity safeguards should Medicare institute in effectuating this policy? What documentation should hospitals be required to maintain?
- How can the policy mitigate price increases for wholly domestically made NIOSH-approved surgical N95 respirators and preserve incentives for hospitals to negotiate fair prices with N95 mask suppliers?
- For hospitals that meet the domestic sourcing threshold, should the submission of the claim be deemed sufficient for attestation of compliance with meeting or exceeding the domestic sourcing threshold, or is a separate attestation process necessary? For what time period should a hospital be attesting that it met the domestic sourcing threshold?
- Do special considerations for certain hospitals exist, such as hospitals with low volume of Medicare patients or those in a rural or urban safety net setting?
- For Group Purchasing Organizations that purchase wholly domestically made NIOSH-approved surgical N95 respirators on behalf of health systems, what considerations, if any, are needed to inform a payment adjustment policy?
- Other than information obtained from hospital cost reports or claims, what additional data sources should CMS consider to inform future adjustments?
- What data or circumstances should be taken into consideration to determine continuation of these payments beyond 2023?
- Are there other types of respiratory devices and PPE that should be considered for payment adjustments?
- Should CMS consider payment adjustments other than on the cost report or a claims-based approach?

Appendix — Quality Reporting Program Tables

Table 1

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure	2023	2024	2025	2026
Chart-Abstracted Process of Care Measures				
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X
PC-01 Elective delivery < 39 weeks gestation (NQF#0469)	X	X	X	X
Electronic Clinical Quality Measures				
ED-2 Time from admit decision to ED departure for admitted patients (NQF #0497) PC-05 Exclusive breast milk feeding (NQF #0480) STK-02 Antithrombotic therapy for ischemic stroke (NQF #0435) STK-03 Anticoagulation therapy for Afib/flutter (NQF #0436) STK-05 Antithrombotic therapy by end of hospital day 2 (NQF #0438) STK-06 Discharged on statin (NQF #0439) VTE-1 VTE prophylaxis (NQF #0371) VTE-2 ICU VTE prophylaxis (NQF #0372) Safe Use of Opioids – Concurrent Prescribing (NQF #3316c) HH-01 Hospital Harm-Severe Hypoglycemia (NQF #3503e) HH-02 Hospital Harm-Severe Hyperglycemia (NQF #3533e) *Hospital Harm Opioid Related Adverse Events HH-ORAE *ePC-02 Cesarean Birth *ePC-07/SMM Sever Obstetric Complications *Global Malnutrition Composite Score GMCS (NQF #3592e)	Report 4 of the following 9 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 Safe Use of Opioids	Report Safe Use of Opioids AND 3 of the following 8 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2	Report Safe Use of Opioids 3 of the following 12* eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 HH-01 HH-02 ePC-02* ePC-07*	Report Safe Use of Opioids AND Cesarean Birth* AND Severe Obstetric Complications* AND 3 of the following 9* eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS*
Healthcare-Associated Infection (HAI) Measures				
Healthcare Personnel Influenza Vaccination (NQF #0431)	X	X	X	X
Healthcare Personnel COVID-19 Vaccination	X	X	X	X
Mortality				
Stroke 30-day mortality rate	X	X	X	X
Readmission/Coordination of Care				
Hospital-wide all-cause unplanned readmission (NQF #1789)	X	X	X	Removed

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2023	2024	2025	2026
Excess days in acute care after hospitalization for AMI (NQF #2881)	X	Refine*	Refine*	Refine*
Excess days in acute care after hospitalization for HF (NQF #2880)	X	X	X	X
Excess days in acute care after hospitalization for PN (NQF #2882)	X	X	X	X
Claims and Electronic Data Measures (Hybrid)				
Hybrid HWR (all-cause readmission) (NQF #2879)		Voluntary		X
Hybrid HWM (all-cause mortality)			Voluntary	X
Patient Safety				
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X
THA/TKA complications	Removed	Refine*	Refine*	Refine*
Efficiency/Payment				
AMI payment per 30-day episode of care (NQF #2431)	X	X	X	X
Heart Failure payment per 30-day episode of care (NQF # 2436)	X	X	X	X
Pneumonia payment per 30-day episode of care (NQF #2579)	X	X	X	X
THA/TKA payment per 30-day episode of care	X	Refine*	Refine*	Refine*
MSPB-Hospital		Refine*	Refine*	Refine*
Patient Experience of Care				
HCAHPS survey (NQF #0166)	X	X	X	X
Patient-Reported Outcome-Based Performance Measure (PRO-PM)				
Hospital-Level THA/TKA PRO-PM*				Voluntary*
Structural Measures				
Maternal Morbidity*	X	X	X	X
Hospital Commitment to Health Equity HCHE *			X*	X*
Process Measures				
SDOH-1 Screening for social Drivers of Health*			Voluntary *	X*
SDOH-2 Screen Positive Rate for Social Drivers of Health*			Voluntary *	X*

*Proposed Measure

Table 2

Summary Table VBP-1: Measures and Domains by Payment Year					
Measure	**NQF #**	**2022**	**2023**	**2024**	**2025/2026**
Clinical Outcomes Domain					
Acute Myocardial Infarction (AMI) 30-day mortality rate	0230	X	X	X	X
Heart Failure (HF) 30-day mortality rate	0229	X	X	X	X
Pneumonia (PN) 30-day mortality rate	0468	X (Suppressed)	X (Suppressed)	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty	1550	X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate	1893	X	X	X	X
CABG 30-day mortality rate	2558	X	X	X	X
Safety Domain					
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)*	0531		Removed		
Central Line Associated Blood Stream Infection (CLABSI)	0139	X (Suppressed)	X (Suppressed)	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	0138	X (Suppressed)	X (Suppressed)	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X (Suppressed)	X (Suppressed)	X	X
Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X (Suppressed)	X (Suppressed)	X	X
Clostridium Difficile Infection (CDI)	1717	X (Suppressed)	X (Suppressed)	X	X
Person and Community Engagement Domain					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital	0166	X (Suppressed)	X (Suppressed)	X	X
3-Item Care Transition measure (CTM)	0228				
Efficiency and Cost Reduction Domain					
Medicare Spending per Beneficiary	2158	X (Suppressed)	X	X	X

*The predecessor measure, the AHRQ PSI–90 patient safety composite, was removed beginning with FFY 2019. Reporting of the successor measure was to start with FY 2023, but instead measure removal was finalized in the FY 2022 rule beginning with FY 2023.

Table 3

HAC Reduction Program Measures and Performance Periods for Payment Years 2022-2024				
	NQF #	**FFY 2022**	**FFY 2023**	**FFY 2024**
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531	X	X* (Suppressed)	X
Applicable (Performance) Period		*7/1/18 - 12/31/19*	*7/1/19 -12/31/19 plus 1/1/21 -6/30/21*	*1/1/21-6/30/22**
CDC NSHN Measures				
Central Line-associated Blood Stream Infection (CLABSI)	0139	X	X (Suppressed)	X
Catheter-associated Urinary Tract Infection (CAUTI)	0138	X	X (Suppressed)	X
Colon and Abdominal Hysterectomy Surgical Site Infections	0753	X	X (Suppressed)	X
Methicillin-resistant staphylococcus aureus (MRSA)	1716	X	X (Suppressed)	X
Clostridium difficile (CDI)	1717	X	X (Suppressed)	X
Applicable (Performance) Period CDC NHSN Measures		*1/1/2019-12/31/19*	*1/1/21 -12/31/21*	*1/1/21-12/31/22*

*CMS proposes it will not calculate or publicly report the suppressed PSI-90 measure

Table 4

PCHQR Program Measures for FFY 2023 and Subsequent Years	
Measure	**Public Display Began**
Safety and Healthcare Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	2019
NHSN CDI (NQF #1717)	2019
NHSN MRSA bacteremia (NQF #1716)	2019
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	2019
NHSN COVID-19 vaccination coverage among health care personnel	October 2022
NHSN CLABSI (NQF #0139)	Deferred until October 2022
NHSN CAUTI (NQF #0138)	Deferred until October 2022
Clinical Process/Oncology Care	
Oncology: Plan of Care for Pain (NQF #0383)	2016; Removed beginning with FY 2024
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210)	Proposed 2024
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	Proposed 2024
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	Proposed 2024
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	Proposed 2024
Patient Experience of Care	
HCAHPS (NQF #0166)	2016
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	April 2020; Removed beginning FY 2022
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	Not Displayed
Surgical Treatment Complications for Localized Prostate Cancer	Not Displayed