IPPS Proposed Rule Discussion

May 25, 2022

California Hospital Association

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Welcome

Bob Mion
Director, Publishing and Marketing
California Hospital Association

California Hospital Association

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Questions

We have built-in time at the end of the presentation for Q&A.

Please submit your questions using the Q&A box (usually located at the bottom of your screen) as they come to you throughout the presentation.

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Welcome! Today's Speakers

Chad Mulvany
Vice President, Federal Policy

Chad Mulvany is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA's Washington, DC Office, Chad collaborates with CHA's vice president, federal policy, CHA's senior vice president, federal relations, CHA issue managers and national hospital associations on analysis and policy development for advocacy purposes.

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Welcome! Today's Speakers

Megan Howard
Vice President, Federal Policy

As Vice President, Federal Policy for CHA, Megan Howard is responsible for providing leadership on federal regulatory issues related to health care finance, quality and patient safety, and hospital and post-acute provider related issues. Also based in CHA's Washington, DC office, Megan works with Chad, CHA issue managers and national hospital associations on analysis and policy development for advocacy purposes.

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Agenda & Objectives

- Provide an overview of the federal fiscal year (FFY) 2023 inpatient prospective payment system (IPPS) proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) including:
  - Payment Update
  - Medicare DSH Updates
  - Area Wage Index Proposals
  - IME/GME Proposals
  - Other Payment Proposals
  - Value-Based Quality Programs and Hospital Inpatient Quality Reporting Program
  - Promoting Interoperability Program
- Solicit member feedback on proposed changes for CHA's comment letter
- Comments are due to CMS by 2 p.m. (PT) on June 17

28108 Federal Register / Vol. 87, No. 90 / Tuesday, May 10, 2022 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 482, 485, and 495

[CMS–1771–P]

RIN 0938–AU84

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would: Revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals; make changes relating to Medicare graduate medical education (GME) for teaching hospitals; update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). In addition it would establish new requirements and revise existing requirements for eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program; provide estimated and newly established performance standards for the Hospital Value-Based Purchasing (VBP) Program; and propose updated policies for the Hospital Readmissions Reduction Program, Hospital Inpatient Quality Reporting (IQR) Program, Hospital VBP Program, Hospital-Acquired Condition (HAC) Reduction Program, PPS-Exempt Cancer Hospital Reporting (PCHQR) Program, and the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). It would also revise the hospital and critical access hospital (CAH) conditions of participation (CoPs) for infection prevention and control and antibiotic stewardship programs; and codify and clarify policies related to the costs incurred for qualified and non-qualified deferred compensation plans. Lastly, this proposed rule would provide updates on the Rural Community Hospital Demonstration Program and the Frontier Community Health Integration Project.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the ADDRESSES section, no later than 5 p.m. EDT on June 17, 2022.

ADDRESSES: In commenting, please refer to file code CMS–1771–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may (and we encourage you to) submit electronic comments on this regulation to https://www.regulations.gov. Follow the instructions under the "submit a comment" tab.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1771–P, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1771–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see refers readers to the beginning of the SUPPLEMENTARY INFORMATION section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS-DRG Relative Weights, Wage Index, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Solo Community Hospitals (SCHs), Medicare-Dependent Small Rural Hospital (MDH) Program, Low-Volume Hospital Payment Adjustment, and Critical Access Hospital (CAH) Issues.

Emily Lipkin, (410) 786–3633 and Jim Mildenberger, (410) 786–4551, Long-Term Care Hospital Prospective Payment System and MS-LTC-DRG Relative Weights Issues.

Allison Pompey, (410) 786–2348, New Technology Add-On Payments and New COVID-19 Treatments Add-on Payments Issues.

Mady Hue, *marily.hue@cms.hhs.gov*, and Andrea Hassler, *andrea.hassler@cms.hhs.gov*, MS–DRG Classifications Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jorta Smith, *jorta.smith@cms.hhs.gov*, Frontier Community Health Integration Project Demonstration Issues.

Sophia Chan, *sophia.chan@cms.hhs.gov*, Hospital Readmissions Reduction Program—Administration Issues.

Jennifer Robinson, *jennifer.robinson@cms.hhs.gov*, Hospital Readmissions Reduction Program—Measures Issues.

Jennifer Tate, *jennifer.tate@cms.hhs.gov*, Hospital-Acquired Condition Reduction Program—Administration Issues.

Yuling Li, *yuling.li@cms.hhs.gov*, Hospital-Acquired Condition Reduction Program—Measures Issues.

Julia Venanzi, *julia.venanzi@cms.hhs.gov*, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs—Administration Issues.

Melissa Hager, *melissa.hager@cms.hhs.gov*, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Ora Dawedeit, *ora.dawedeit@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting—Administration Issues.

Leah Domino, *leah.domino@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting Program—Measure Issues.

Christy Hughes, *christy.hughes@cms.hhs.gov*, Long-Term Care Hospital Quality Reporting Program—Data Reporting Issues.

Elizabeth Holland, *elizabeth.holland@cms.hhs.gov*, Medicare Promoting Interoperability Program.

CAPT Scott Cooper, USPHS, (410) 786–9465, and Dawn Linn, *dawn.linn@cms.hhs.gov*, Conditions of Participation Pandemic Reporting Requirements for Hospitals and Critical Access Hospitals.

CALIFORNIA HOSPITAL ASSOCIATION 6

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Payment Update

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Proposed Rate Update

	Final FFY 2022	Proposed FFY 2023	Percent Change
Operating Rate	$6,121.65	$6,315.77	+3.17%
Capital Rate	$472.59	$480.29	+1.63%

	Operating Rate Adjustment
ACA-Adjusted Update (3.1% MB minus 0.4 PPT productivity adjustment)	2.7%
MACRA-Mandated **Retrospective** Coding Adjustment	+.5%
Wage Index Transition Adjustments	-.01%
MS-DRG Weight Cap Policy	-.02%
Annual Budget Neutrality Adjustments	-.01%
Net Rate Change*	**3.17%**

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FFY 2023 Update with EHR and IQR

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Baseline MB Update	+2.7%			
Net of ACA Reductions				
IQR Penalty	—	-0.775 PPT	—	-0.775 PPT
EHR Meaningful Use Penalty	—	—	-2.325 PPT	-2.325 PPT
MB Update, less EHR/IQR	+2.7%	+1.925%	+0.375%	-0.4%

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Fixed Loss Outlier Threshold

- CMS targets outlier payments at 5.1%
- Current FFY 2022 threshold is **$30,988**
- Outlier payments must be reduced by 1.8% to achieve this goal
- Proposes a fixed loss outlier threshold of **$43,214** for FFY 2023
- Methodology altered due to COVID-19 impact

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Estimated California Impact

California Hospital Association

California

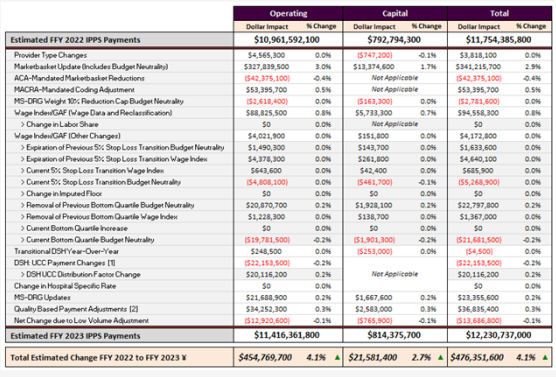
	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2022 IPPS Payments	**$10,961,592,100**		**$792,794,300**		**$11,754,385,800**	
Provider Type Changes	$4,565,300	0.0%	($747,200)	-0.1%	$3,818,100	0.0%
Marketbasket Update (Includes Budget Neutrality)	$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%*** ▲

Source: CHA DataSuite

DataSuite IPPS Analysis

California Hospital Association

Hospital Report



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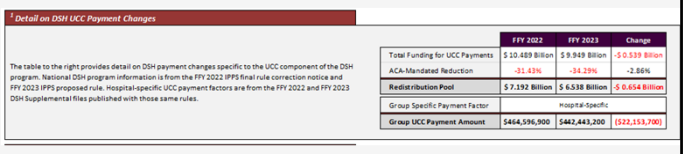
DSH Breakout

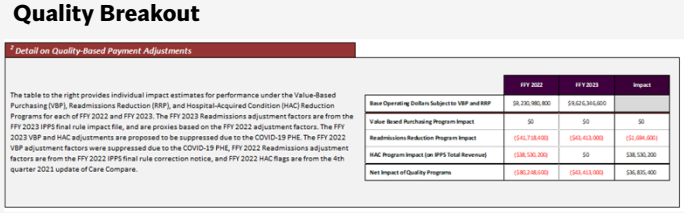


[1] Detail on DSH UCC Payment Changes

The table to the right provides detail on DSH payment changes specific to the UCC component of the DSH program. National DSH program information is from the FFY 2022 IPPS final rule correction notice and FFY 2023 IPPS proposed rule. Hospital-specific UCC payment factors are from the FFY 2022 and FFY 2023 DSH Supplemental files published with those same rules.

	FFY 2022	FFY 2023	Change
Total Funding for UCC Payments	$ 10.489 Billion	$ 9.949 Billion	-$ 0.539 Billion
ACA-Mandated Reduction	-31.43%	-34.29%	-2.86%
Redistribution Pool	**$ 7.192 Billion**	**$ 6.538 Billion**	**-$ 0.654 Billion**
Group Specific Payment Factor		Hospital-Specific	
Group UCC Payment Amount	**$464,596,900**	**$442,443,200**	**($22,153,700)**

Quality Breakout



[2] Detail on Quality-Based Payment Adjustments

The table to the right provides individual impact estimates for performance under the Value-Based Purchasing (VBP), Readmissions Reduction (RRP), and Hospital-Acquired Condition (HAC) Reduction Programs for each of FFY 2022 and FFY 2023. The FFY 2023 Readmissions adjustment factors are from the FFY 2023 IPPS final rule impact file, and are proxies based on the FFY 2022 adjustment factors. The FFY 2023 VBP and HAC adjustments are proposed to be suppressed due to the COVID-19 PHE. The FFY 2022 VBP adjustment factors were suppressed due to the COVID-19 PHE, FFY 2022 Readmissions adjustment factors are from the FFY 2022 IPPS final rule correction notice, and FFY 2022 HAC flags are from the 4th quarter 2021 update of Care Compare.

	FFY 2022	FFY 2023	Impact
Base Operating Dollars Subject to VBP and RRP	$8,230,980,800	$9,626,346,600	
Value Based Purchasing Program Impact	$0	$0	$0
Readmissions Reduction Program Impact	($41,718,400)	($43,413,000)	($1,694,600)
HAC Program Impact (on IPPS Total Revenue)	($38,530,200)	$0	$38,530,200
Net Impact of Quality Programs	($80,248,600)	($43,413,000)	$36,835,400

Data Source for MS-DRG Classifications and Weights

- CMS typically uses the following data when calculating rates for the fiscal year under study:
  - Medicare Provider Analysis and Review (MedPAR) claims from 2 years prior (FFY 2021 data for FFY 2023 rule)
  - Hospital Cost Reports beginning 3 years prior (FFY 2020 data for FFY 2023 rule)
- Utilization patterns reflected in the FFY 2021 IPPS claims data were impacted by the COVID-19 PHE.
- To address this, CMS proposes to modify the calculation of the MS-DRG relative weights by averaging two sets of weights, one including COVID-19 claims and one excluding COVID-19 claims.

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MS-DRGS: Significant Weight Change

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%

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MS-DRG Weight Cap

- CMS is proposing 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.
- CMS is also proposing to apply a budget neutrality adjustment of 0.999765 to the standardized amount for all hospitals.

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Social Determinants of Health (SDOH): Z-Code Reporting

- CMS requests feedback on topics pertaining "Z codes" related to SDOH
- Comments used to determine if a future proposal to change severity level designations of these codes is needed. Questions include:
  - How the reporting of certain Z codes improve CMS' ability to recognize utilization of resources under the MS-DRGs?
  - Whether CMS should require the reporting of certain Z codes?
  - What are the additional provider burden and potential benefits of documenting and reporting of certain Z codes?
  - Whether codes in category Z59 (Homelessness) have been underreported and if so, why?

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Uncompensated Care (UCC)
Medicare Disproportionate Share Hospital (DSH)

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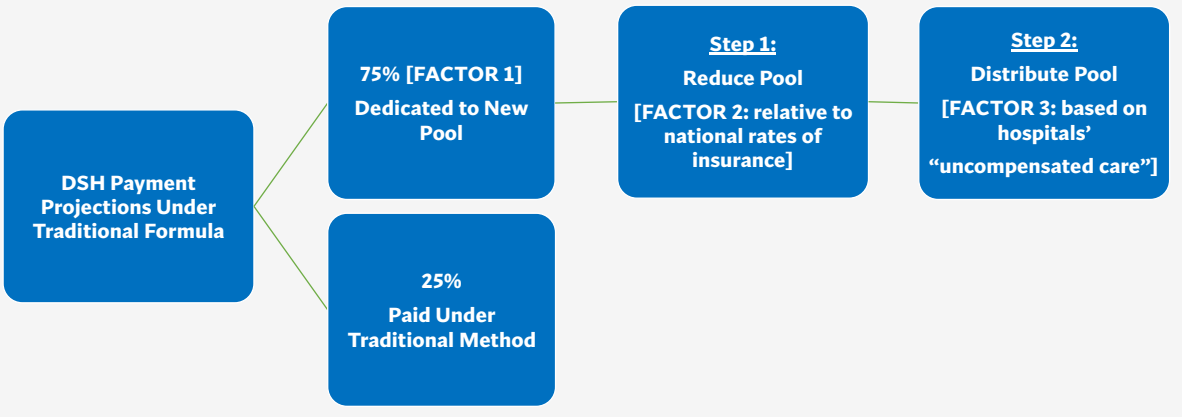
Medicare DSH



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Uncompensated Care DSH

A significant decrease in Factor 1 and Factor 2 drives a reduction in the total UCC DSH pool.

Factors 1 and 2: Comparison of FFYs Proposed 2023 vs. Final 2022

Factor	FFY 2023	FFY 2022	Change from Prior Year
1: Base Funding	$9.949 B	$10.489 B	-$.54 B
2: Available Pool	$6.538 B (34.29% reduction)	$7.192 B (31.43% Reduction)	-$.65 B

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Factor 1

Decreases in projected Medicare discharges drives the decrease in Factor 1.

Difference in Factors between FFY 2022 Final and FFY 2023 Proposed IPPS Rules

FY	Update	Discharges	Case Mix	Other	Total	Est DSH Pmt $, Billions
2020	0.000	0.005	0.000	(0.002)	0.003	(0.204)
2021	0.000	(0.066)	0.000	0.018	(0.049)	(0.834)
2022	0.000	(0.052)	0.023	0.005	(0.024)	(1.174)

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Factor 2

The proposed rule likely underestimates the increase in the uninsured due to the termination of a number COVID-19 related coverage expansions.

FFY 2023 Factor 2 Calculation: Uninsured Rate

	2022	2023	Difference/ Total
Uninsured (millions)	29.5	31	1.5
Total Population (millions)	330.9	333.1	
Uninsured Rate	8.92%	9.31%	0.39%
Factor 2 Weighting	25%	75%	
Factor 2	2.23%	6.98%	9.21%

Projected Uninsured Does Not Appear to Include:

- Exchanges: -3 million
- Medicaid -7 to 8 million

Sources:
1) https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00113
2) https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf
3) https://www.urban.org/sites/default/files/2022-04/What%20If%20the%20American%20Rescue%20Plan%20Act%20Premium%20Tax%20Credits%20Expire.pdf

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Factor 3

- CMS proposes to use the average of the audited FFY 2018 and FFY 2019 Worksheet S-10 reports instead of basing it on a single year.
- FFY 2024 and subsequent fiscal years CMS would use a three-year average of the UCC data from the three most recent fiscal years for which audited data are available.
- If a hospital does not have data for all three years, Factor 3 will be based on an average of the hospital's available data.

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UCC Per Discharge Amounts

- CMS proposes to use a hospital's 3-year average discharges to estimate interim UCC payments per discharge.
- Years proposes using FFY 2018, 2019, and 2021
- Will not to use 2020 due to concerns about COVID-19's volume impact
- Would be reconciled at cost report settlement as in past years

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Section 1115 Medicaid Days

- CMS proposes revising the Medicaid fraction to include only those patients receiving health insurance that covers all essential health benefits under section 1115 waiver
- Proposed for FFY 2022 but did not implement
- Changes would be prospective

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DSH - Other

- Hospitals are proposed to have 60 days from the public display of the FFY 2023 IPPS proposed rule and 15 business days from public display of the FFY 2023 final rule to determine accuracy of the DSH data table.
- Any changes would be posted to the CMS website prior to 10/1/2022.
- Comments regarding issues that are specific to data and supplemental data files for this proposed rule can be submitted to Section3133DSH@cms.hhs.gov.

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Area Wage Index Proposals

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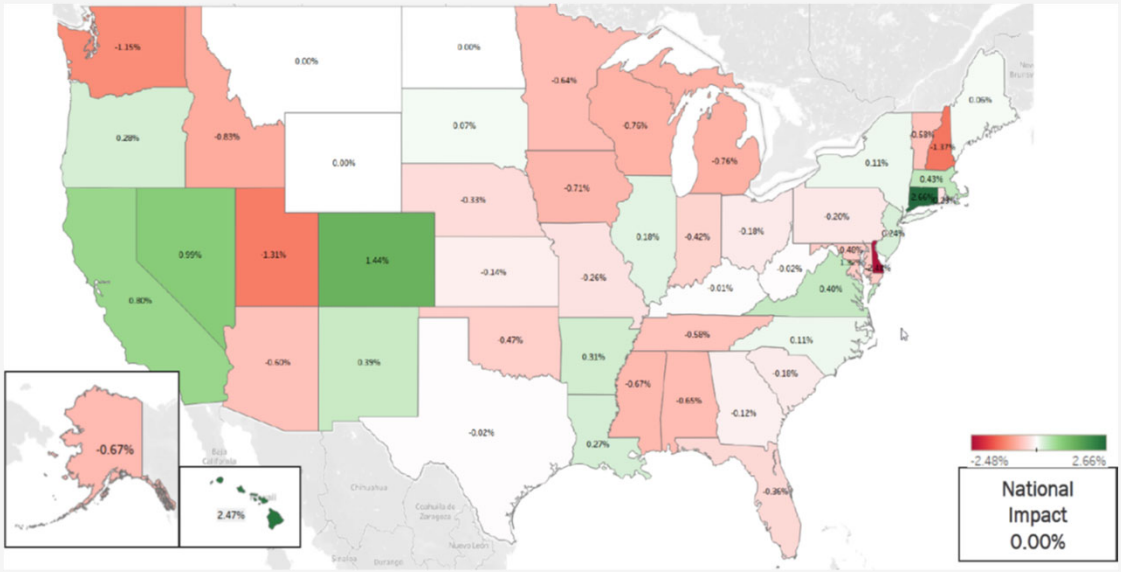
Impact of Standard Wage Index Changes



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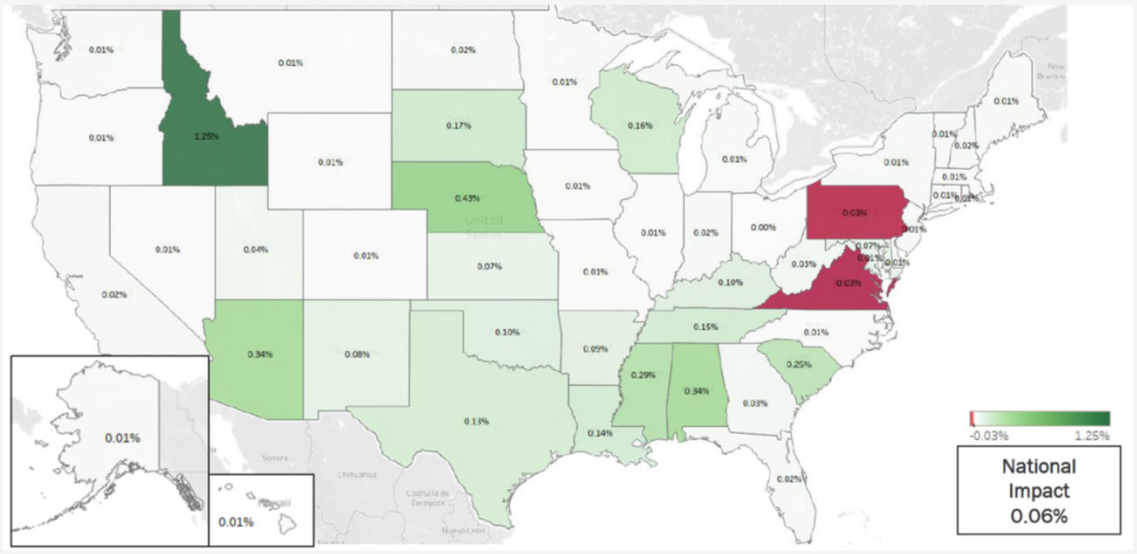
Low Wage Index Policy

- For FFY 2023, CMS proposes to continue the following policies:
  - Hospitals in the bottom quartile will have their wage index increased by half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals.
  - Apply a budget neutrality adjustment of -0.18% for this policy.
- CMS is evaluating the "Bridgeport" decision and may "take a different approach" in the final rule.
- CHA continues to pursue separate litigation on behalf of its members.

28

Impact of Low-Wage Index Policy



29

Rural Floor Policy

- 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.
- CMS is evaluating the "Citrus" decision and may "take a different approach" in the final rule.
- CHA continues to pursue separate litigation on behalf of its members.

30

Wage Index – 5% Stop Loss Cap

- CMS proposes to a 5 percent 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
- The proposed rule indicates the policy would likely apply equally to all hospitals in the same labor market area

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Labor Related Share

- Hospitals with a wage index of 1 or greater will continue to have a labor related share of 67.6%
- Hospitals with a wage index less than or equal to 1.0 will continue to have a labor-related share of 62.0%
- Updating cost-of-living adjustments (COLA) for facilities in Alaska and Hawaii

32

IME/GME Proposals

33

General IME/GME

- CMS proposes the Indirect Medical Education (IME) adjustment factor to remain at 1.35 for FFY 2023.

34

Direct Graduate Medical Education Cap/Count

- CMS proposes to change the calculation of FTE caps based on the ruling in Hershey v. Becerra
- New calculation is retroactive to cost reporting periods beginning on/after October 1, 2001 in certain circumstances
- Policy is applied prospectively for cost reports beginning after October 1, 2022
- If weighted and unweighted FTE counts exceed FTE cap amount, weighted count will be adjusted to equal FTE Cap amount
- If weighted count does not exceed FTE cap, direct GME reimbursement will be based on weighted cap amount

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Direct Graduate Medical Education Cap/Count – (Cont.)

Current DME Count Calculation

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

36

Direct Graduate Medical Education Cap/Count – (Cont.)

Proposed DME Count Calculation Weighted FTE Count is > than the FTE Cap

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

$$+$$

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

$$= Adjusted\ Weighted\ Count$$

37

Rural Training Program (RTP) Affiliation Agreements

- 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
- RTPs must meet the following requirements to create an affiliated groups:
  - Each urban and rural hospital must attest that the affiliated group is only for residents in the RTP
  - Only separately accredited 1-2 family medicine programs that have rural track FTE limitations in place prior to October 1, 2022 are eligible
- Eligible urban and rural hospitals may enter into rural track Medicare GME affiliation agreements effective with the July 1, 2023, academic year

38

Other Payment Proposals

39

Medicare Dependent Hospitals (MDH)

- For discharges on and after October 1, 2022 hospitals will no longer be eligible for MDH status/payment
- Current MDHs may apply for Sole Community Hospital (SCH) status prior to the expiration of the MDH program
- The Rural Hospital Support Act would make the MDH program and enhanced Low Volume Adjustment permanent

40

Low Volume Adjustment

- Absent congressional action, the low volume adjustment will revert to pre-2011 qualification criteria
- These hospitals must:
  - Be located more than 25 road miles from another subsection (d) hospital; and
  - Have fewer than 200 total discharges (All Payer) during the fiscal year.
- The FFY 2023 LVA equals 25% of total IPPS payments for the qualifying hospital
- Hospitals must apply to the MAC prior to September 1, 2022, to receive the benefit for the full fiscal year

41

Domestically Produced N95 RFI

- The rule states N95s are critical during public health emergencies
- To help ensure an adequate supply of domestically produced N95s, CMS is considering payment adjustments beginning in 2023 as follows:
  - Biweekly payments reconciled at cost report settlement that account for the difference in costs between domestically made N95 respirators that were domestically made and those that were not
  - A claims add-on payment when hospitals meet or exceed a threshold of purchasing 50% or more wholly domestically sourced surgical N95 respirators
- CMS seeks comments on a range of issues to ensure availability of domestically manufactured N95s

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Pay-for-Performance Quality Programs

Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program, Hospital-Acquired Conditions Reduction Program

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Hospital Readmissions Reduction Program

- FFY 2023:
  - CMS previously finalized the suppression of the pneumonia readmission measure
  - Continue to exclude patients with COVID-19 diagnosis, including suppressed pneumonia readmission measure
  - CMS proposes to include a covariate adjustment for patient history of COVID-19 within 12-months of the admission
    - Beginning with FFY 2023 for non-suppressed measures, FFY 2024 for pneumonia readmission measure
  - CHA estimates an aggregate decrease in payments to California hospitals of $1.69 million compared to FFY 2022
- FFY 2024:
  - CMS intends to resume use of the modified pneumonia readmission measure

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Hospital Value Based Purchasing Program

- For FFY 2023, CMS previously finalized:
  - Suppression of the 30-day pneumonia mortality measure
  - Technical updates to remaining clinical outcomes domain measures to exclude patients with COVID-19 diagnosis
- CMS further proposes for FFY 2023:
  - Suppression of all measures in the Person and Community Engagement domain (HCAHPS measure) and the Safety domain (NHSN HAI measures)
  - Covariate adjustment for patient history of COVID-19 within 12 months of admission for clinical outcomes domain measures
- For FFY 2023, CMS proposes to assign each hospital a 2% incentive payment equal to the VBP withhold (i.e. no positive or negative adjustment)
- CMS intends to resume use of suppressed measures (with technical modifications) and normal scoring in FFY 2024

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Hospital Acquired Conditions Program

- For FFY 2023:
  - CMS proposes to suppress all program measures and not apply a penalty to any hospital
  - CMS would calculate and provide confidential feedback reports for NHSN HAI measures; CMS will not calculate or report on PSI-90
  - Proposed policy results in an estimated $38.5 million aggregate payment increase for California hospitals compared to FFY 2022
- For FFY 2024:
  - CMS proposes to modify PSI-90 measure to include diagnosis of COVID-19 in the risk adjustment model
  - CMS proposes to suppress NHSN HAI measure data from 2021, resulting in a proposed applicable period of Jan. 1, 2022 – Dec. 31, 2022
  - CMS intends to resume scoring and penalties in FFY 2024

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Hospital Inpatient Quality Reporting Program

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Proposed IQR Measures

Proposed Measure	Voluntary Reporting	Mandatory Reporting	Payment Determination
Hospital Commitment to Health Equity	N/A	CY 2023	FFY 2025
Screening for Social Drivers of Health	CY 2023	CY 2024	FFY 2026
Screen Positive Rate for Social Drivers of Health	CY 2023	CY 2024	FFY 2026
Cesarean Birth eCQM	CY 2023	CY 2024	FFY 2026
Severe Obstetric Complications eCQM	CY 2023	CY 2024	FFY 2026
Hospital-Harm – Opioid Related Adverse Events eCQM	CY 2024*		FFY 2026
Global Malnutrition Composite Score eCQM	CY 2024*		FFY 2026
Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure Following Elective Primary Total Hip/Knee Arthroplasty	1/1/23- 6/20/23; 7/1/23- 6/30/24	7/1/2024- 6/30/2025	FFY 2028
Medicare Spending Per Beneficiary	N/A	CY 2022	FFY 2024
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip/Knee Arthroplasty	N/A	CY 2022	FFY 2024

*Available for eCQM self-selection

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Proposed Measure: Hospital Commitment to Health Equity

- CMS proposes a structural process measure, "Hospital Commitment to Health Equity," beginning with the CY 2023 reporting/FY 2025 payment year
  - Measure specifications available for download
- The measure includes 5 domains and hospital can earn one point per domain for a total possible score of 5
- Hospitals must attest to each element within an attestation domain to earn credit for the domain – no partial credit will be awarded
- CMS would publicly report the number of domains a hospital attests to

Proposed Measure: Hospital Commitment to Health Equity

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.

Proposed Measures: Screening for Social Drivers of Health

- Screening for Social Drivers of Health
  - The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission screened for one or all five health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- Screen Positive Rate for Social Drivers of Health
  - Calculated as five separate rates for each of the HRSNs
- CMS proposes voluntary reporting for CY 2023, and mandatory reporting beginning with CY 2024
- CMS does not propose a specific tool hospitals must use to collect screening information, references SIREN screening tool comparison table
- Measure specifications available for download

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Proposed Maternal Health and Perinatal Care eCQMs

- Cesarean Birth eCQM
  - Assesses the rate of low-risk, nulliparous term singleton vertex (NTSV) pregnancies delivered by Cesarean section (C-sections)
  - Excludes patients with abnormal fetal presentations or placenta previa, as well as patients with COVID-19 diagnosis
  - Measure specifications
- Severe Obstetric Complications eCQM
  - Assesses the proportion of patients with severe obstetric complications that occur during inpatient delivery hospitalizations
  - Extensively risk-adjusted, with separate risk adjustment models cases in which blood transfusion is the only qualifying numerator event
  - Measure specifications
- CMS proposes voluntary reporting for CY 2023; mandatory reporting beginning with CY 2024

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Proposed eCQMs for Self-Selection

- Hospital Harm—Opioid-Related Adverse Events eCQM (NQF #3501e)
  - Measures the proportion of inpatient encounters where patients have been administered an opioid followed by administration of naloxone within 12 hours
  - Measure has been revised since it was last proposed to shorten the window of naloxone administration to 12 hours and exclude the administration of naloxone in the operating room
  - Measure specifications
- Global Malnutrition Composite Score eCQM (NQF #3592e)
  - 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
  - Measure specifications
- Both measures would be available for eCQM self-selection for CY 2024 reporting/FFY 2026 payment

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THA/TKA PRO-PM Measure

- 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)
  - Reports the hospital-level risk-standardized improvement rate (RSIR) in patient reported outcomes following elective primary THA/TKA for Medicare fee-for-service beneficiaries aged 65 years and older.
  - Previously adopted for the Comprehensive Care for Joint Replacement (CJR) model
  - Uses four sources of data for the calculation of the measure: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data.
  - PRO data would be collected 90 to zero days prior to surgery and 300 to 425 days following surgery
  - The measure result is calculated by aggregating all patient-level results across the hospital.

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THA/TKA PRO-PM Measure

- Hospitals can either send data directly to CMS for measure calculation, or utilize an external entity (vendor or registry) to submit on their behalf
- CMS proposes two initial voluntary reporting periods, with mandatory reporting beginning with the CY 2028 payment year:

Reporting	Performance Period	Pre-Op Data Collection Period	Pre-Op Submission Deadline	Post-Op Data Collection Period	Post-Op Submission Deadline	Hospital Specific Reports
Voluntary	Jan. 1, 2023-June 30, 2023	Oct 3, 2022-June 30, 2023	Oct 2, 2023	Oct 28, 2023 – Aug 29, 2024	Sept. 30, 2024	2025
Voluntary	July 1, 2023-June 30, 2024	April 2, 2023 – June 30, 2024	Sept. 30, 2024	April 26, 2024 – Aug 29, 2025	Sept. 30, 2025	2026
Mandatory	July 1, 2024-June 30, 2025	April 2, 2024 – June 30, 2025	Sept. 30, 2025	April 27, 2025 – Aug 29, 2026	Sept. 20, 2026	2027

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MSPB and THA/TKA Complication – Measure Updates

- Medicare Spending Per Beneficiary (MSPB) Hospital (NQF #2158)
  - Refined from previous IQR (and current VBP) measure to 1) allow readmissions to trigger new episodes, 2) update risk adjustment to account for inpatient stay in prior 30 days, and 3) revise measure calculation from ratio of sums to a mean of ratios
- Hospital-Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA (NQF #1550)
  - Refined to include 26 additional mechanical complication ICD-10 codes identified in the measure maintenance process
- CMS proposes to adopt these refined versions of previous IQR measures with the intention of adopting them in the VBP program in future rulemaking

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Refinements to Existing IQR Measures

- Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective THA and/or TKA
  - Refined to expand measure outcome to include 26 mechanical complication ICD-10 codes
  - Aligns with proposed addition of refined THA/TKA complication measure
- Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)
  - Increase minimum case count for reporting to from 25 to 50 cases to improve measure reliability
  - Hospitals with fewer than 50 cases would receive confidential feedback reports on measure performance, but results would not be publicly reported
- CMS proposes to modify hybrid measure reporting requirements to remove zero denominator declarations and case threshold exemptions beginning with FFY 2026

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Proposed eCQM Reporting Requirements

Reporting Period/Payment Determination	Quarters of Data Reported	eCQMs Reported
CY 2021/FFY 2023	2 Self-selected Quarters	4 eCQMs (Self-selected)
CY 2022/FFY 2024	3 Self-selected Quarters	4 eCQMs: • 3 Self-selected • Safe Use of Opioids – Concurrent Prescribing
CY 2023/FFY 2025	4 Quarters	4 eCQMs: • 3 Self-selected • Safe Use of Opioids – Concurrent Prescribing
CY 2024/FFY 2026 (and subsequent years)	**4 Quarters**	**(Proposed)** **6 eCQMs:** • **3 Self-selected** • **Safe Use of Opioids – Concurrent Prescribing** • **Cesarean Birth** • **Severe Obstetric Complications**

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Future Measures Under Consideration

- CMS seeks comments on the future inclusion of two digital quality measures (dQMs) for the Hospital IQR program, the HAC Reduction program, the Hospital VBP program, and the PPS-Exempt Cancer Hospital QRP:
  - NHSN Healthcare-Associated Clostridioides difficile Infection Outcome Measure
    - Utilizes EHR-derived data to report both microbiologic evidence of CDI in stool and evidence of antimicrobial treatment, along with patient encounter, demographic, and location information
    - Original version only requires CDI facility-wide Lab-ID event reporting
  - NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure
    - Would encompass all types of bacteremia and fungemia (current NHSN measures only capture CLABSI and MRSA)
    - Manual data entry is not available – CDC working to enable reporting via Fast Healthcare Interoperability Resources (FHIR)

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Proposed Maternal Quality Hospital Designation

- CMS proposes to establish a hospital designation reflecting the quality and safety of maternal care
- CMS proposes to publish this designation on a public-facing 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 finalized for FFY 2022
- CMS seeks comments on:
  - The name of the designation
  - Potential measures and data sources for future inclusion, and seeks specific suggestions for patient experience of care measures
  - Additional questions on how to advance maternal health equity, including if CMS should establish specific maternal care CoPs

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Quality Program Requests for Information

61

RFI on Measuring Healthcare Disparities

- CMS seeks comments on five key areas to inform its principles and approaches to addressing disparities through quality measure development and stratification:
  - Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs
  - Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting
  - Principles for Social Risk Factor and Demographic Data Selection and Use
  - Identification of Meaningful Performance Differences
  - Guiding Principles for Reporting Disparity Results

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RFI on Current State of Hospital Assessment on the Impact of Climate Change and Health Equity

- CMS seeks comments on how it can support hospitals and health care providers in:
  - Determining likely climate impacts on their patients, residents and consumers so that they can develop plans to mitigate those impacts
  - Understanding the threats that climate-related emergencies (e.g., storms, floods, extreme heat, wildfires) present to continuous facility operations (including potential disruptions in patient services associated with catastrophic events as a result of power loss, limited transportation, evacuation challenges, etc.)
  - Understanding how hospitals are currently working to reduce their emissions and track progress

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RFI on Digital Quality Measurement and Use of FHIR

CMS seeks comments on:

- Agency goals and strategies to achieve digital quality measurement
- A revised 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."
  - Data sources could be clinical assessment data, case management systems, EHRs, laboratory stems, PDMPs, medical/wearable devices, HIEs, registries, etc.
- Data standardization strategies and how to prioritize standards across implementation guides
- Approaches to achieve FHIR-based eCQM reporting
- Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

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Promoting Interoperability Program

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Promoting Interoperability Program Summary

- CMS proposes to:
- Require mandatory reporting of the Query of PDMP measure under the e-Prescribing Objective
- Adopt a new measure option under the Health Information Exchange Objective
- Add a new measure and modify levels of engagement requirements under the Public Health and Clinical Data Exchange Objective
- Revise program scoring methodology to incentivize increased reporting of public health information
- Adopt increased eCQM reporting requirements in alignment with the IQR program
- Publicly report Medicare Promoting Interopearbility Program total score
- Maintain previously finalized reporting periods of 90-days for 2023 and 180-days beginning in 2024

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e-Prescribing Objective Proposals

- For the Query of Prescription Drug Monitoring Program (PDMP) Measure, CMS proposes to:
  - Require mandatory reporting beginning with CY 2023
  - Award 10 points to hospitals who report "Yes" on the yes/no attestation for the measure
    - In the future, CMS is considering numerator/denominator scoring
  - Expand measure description to include Schedule II opioids and Schedule III, and IV drugs beginning the CY 2023
  - Adopt measure exclusion for hospitals without an internal pharmacy – or not within 10 miles of any pharmacy – that accepts electronic prescriptions for controlled substances, or where reporting conflicts with applicable law
- CMS proposes a technical update to the e-Prescribing measure to conform with changes previously finalized for eligible professionals

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Health Information Exchange Objective Proposals

- CMS proposes to adopt the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure beginning with CY 2023
  - Measure would be worth 30 points (full credit for the objective)
  - Hospitals would be required to report "Yes" to the following attestations:
    - 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
- Hospitals could continue to report either the Support Electronic Referral Loops by Sending Health Information measure AND the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, or the HIE Bi-Directional Exchange measure to receive credit under the objective

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Public Health and Clinical Data Exchange Objective Proposals

- CMS proposes to require reporting on a fifth measure under the objective beginning with CY 2023
  - Antimicrobial Use and Resistance (AUR) Surveillance Measure
    - 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.
    - The measure is calculated by reviewing all patient records
    - CMS proposes three measure exclusions
- CMS proposes to consolidate the existing three levels of active engagement into two, beginning with the CY 2023
  - Eligible hospitals and CAHs must demonstrate their level of active engagement as either proposed Option 1 (pre-production and validation) or proposed Option 2 (validated data production) to fulfill each measure
  - Hospitals would only be able to spend one EHR reporting period in the pre-production and validation option

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Scoring Methodology Proposals

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
Health Information Exchange (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.

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Conditions of Participation: Reporting COVID-19 and Influenza Infections

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Proposed Data Reporting CoP for COVID-19 and Future PHEs

- During the COVID-19 PHE, CMS modified conditions of participation (CoPs) to require hospitals and CAHs to report certain data related to COVID-19 to HHS
- CMS proposes to revise the hospital and CAH infection prevention and control and antibiotic stewardship program CoPs to:
  - Extend COVID-19 reporting requirements until April 30, 2024
    - Scope and frequency of reporting could be modified depending on circumstances as determined by the HHS Secretary
  - Establish reporting requirements for any future pandemics/epidemics
    - Applicable for future local, state, and national PHEs related to epidemics and pandemics
    - Hospitals would be required to report data to CDC's NHSN or other CDC-support surveillance system
    - May require patient-level information when reporting on infections and vaccinations

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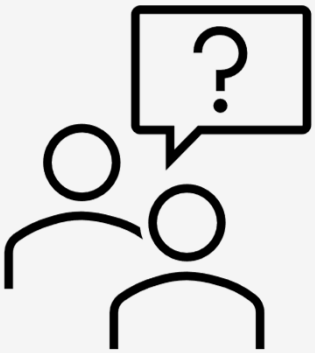
Questions



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Contact

Please contact us if you have questions we were not able to address today.

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Thank You

Thank you for participating in today's webinar.

For education questions, contact:
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