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Medicare Program; Hospital Inpatient Prospective Payment System 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

May 6, 2022

Background & Summary

On April 18, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule to update the Fiscal Year (FY) 2023 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS) ("Proposed Rule") (fact sheet available here). Although CMS proposes to increase the inpatient payment rate for hospitals that successfully participate in the Hospital IQR Program and are meaningful electronic health record (EHR) users, based on various policy changes and circumstances described in the Proposed Rule, CMS anticipates hospitals will experience a decrease of approximately $263 million in FY 2023.

The Proposed Rule contains several policy proposals, including using the most recently available data with certain modifications related to COVID-19 for purposes of setting inpatient hospital payment rates, delaying implementation of the "three-way split criteria" as related to MS-DRGs, using more than one year of audited data for purposes of uncompensated care payments, capping wage index decreases, establishing a publicly-reported hospital designation on maternity care and revising the Conditions of Participation (CoP) for hospitals and critical access hospitals (CAHs) to report data elements for COVID-19, seasonal influenza and future pandemics. Also, consistent with statutory requirements, CMS proposes a five-year extension of the Rural Community Hospital and Frontier Community Health Integration Project (FCHIP) demonstrations.

In addition, CMS proposes several policies to address health equity in various programs, including the Hospital Inpatient Quality-Reporting (IQR) Program, the Medicare Promoting Interoperability (PI) Program, the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Condition Reduction Program (HACRP) and the Hospital Value-Based Purchasing (VBP) Program. CMS also provides several requests for information on topics such as health equity, digital quality measurement, N95 add-on payments and climate change.

Comments are due **no later than 5PM on June 17, 2022**. Vizient looks forward to working with members to help inform our letter to the agency.

Proposed IPPS Payment Rate Updates for FY 2023

After accounting for inflation and other adjustments required by law, the Proposed Rule increases IPPS operating payment rates by 3.2 percent in FY 2023 for hospitals that successfully participate in the Hospital IQR Program and are meaningful electronic health record (EHR) users. The Proposed Rule includes an initial market-basket update of 3.1 percentage points, minus 0.4 percentage points for productivity as mandated by the Affordable Care Act (ACA). Regarding the MS-DRG Documentation and Coding Adjustment, which partially restores cuts as a result of the American

Taxpayer Relief Act (ATRA), CMS proposes a 0.5 percentage point positive adjustment. These changes are reflected in the below table.

Proposed IPPS Payment Rate Updates for FY 2023

Proposed Policy	Average Impact on Payments (Rate)
Estimated market-basket update	3.1%
Productivity Adjustment*	-0.4%
MS-DRG Documentation and Coding Adjustment	0.5%
Estimated payment rate update for FY 2023 (before applying budget neutrality factors)	**3.2%**

*In the Proposed Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP). CMS notes that the data and methods are unchanged and that the agency refers to this as the productivity adjustment.

In addition, CMS proposes four applicable percentage increases applied to the standardized amount, as demonstrated in the below table. To determine the proposed applicable percentage increase, CMS adjusted the proposed market-basket rate-of-increase by considering (1) whether a hospital submits quality data; and (2) whether a hospital is a meaningful EHR user. In addition, CMS applies a 0.4 percentage point reduction for the productivity adjustment. Also, hospitals may be subject to other payment adjustments under the IPPS which are not reflected in the below table (e.g., reductions under the HRRP and the HACRP; upward and downward adjustments under the Hospital VBP Program). In the Proposed Rule, CMS also provides a table (pg. 1565) that displays information regarding the proposed FY 2023 standardized amount.

Proposed FY 2023 Applicable Percentage Increases for the IPPS

FY 2022	Hospital submitted quality data and is a Meaningful EHR User	Hospital submitted quality data and is not a Meaningful EHR User	Hospital did not submit quality data and is a Meaningful EHR User	Hospital did not submit quality data and is not a meaningful EHR user
Proposed market basket rate-of-increase	3.1	3.1	3.1	3.1
Proposed adjustment for not submitting quality data	0	0	-0.775	-0.775
Proposed adjustment for not being a Meaningful EHR User	0	-2.325	0	-2.325
Proposed Productivity Adjustment*	-0.4	-0.4	-0.4	-0.4
Proposed applicable percentage increase applied to standardized amount	**2.7**	**0.375**	**1.925**	**-0.4^**

*In the Proposed Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP). CMS notes that the data and methods are unchanged and that the agency refers to this as the productivity adjustment.
^ Section 1886(b)(3)(B)(xi) of the Social Security Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2023

The ACA required changes, which began in 2014, regarding the way disproportionate share hospital (DSH) payments are made to hospitals. Under this payment formula, hospitals receive 25 percent of the Medicare DSH funds that they would have received under the prior formula ("empirically justified"). The other 75 percent flows into a separate pool that is reduced relative to the number of uninsured who received care and then distributed based on the proportion of total uncompensated care each Medicare DSH provides. This pool is distributed based on three factors:

- **Factor 1:** 75 percent of the Office of the Actuary estimate of the total amount of estimated Medicare DSH payments
- **Factor 2:** Change in the national uninsured rates
- **Factor 3:** Proportion of total uncompensated care each Medicare DSH provides

For FY 2023, CMS estimates total DSH payments will be $9.85 billion, which is a decrease of approximately $834 million compared to FY 2022, according to a CMS fact sheet. This decrease is partially because of an anticipated decrease in the uninsured population. CMS estimates the empirically justified Medicare DSH payments for FY 2023 to be approximately $3.32 billion, which is a decrease from FY 2022 (in the FY 2022 IPPS Final Rule CMS projected the empirically justified Medicare DSH payments to be $3.50 billion). Also, CMS estimates the uncompensated care payments will be approximately $6.54 billion, a decrease of $654 million compared to FY 2022. The payments have redistributive effects, which are based on a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that are projected to be eligible to receive Medicare DSH payments. The calculated payment amount is not directly tied to a hospital's number of discharges.

To calculate Factor 1 and model the impact of this Proposed Rule, CMS describes the various data sources it utilized, including the Office of the Actuary's (OACT's) January 2022 Medicare DSH estimates (based on data from the September 2021 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2022 IPPS final rule Impact File). For FY 2023, CMS provides that Factor 1 would be approximately $9.949 billion and notes it will use more recent data as they become available for purposes of estimates when the FY 2023 IPPS final rule is published.

For Factor 2, CMS proposes to use a methodology similar to the methodology applied in rulemaking for FYs 2018-2022. To calculate Factor 2, CMS used various data sources to project the change in the national uninsured rates in both calendar year (CY) 2022 and CY 2023. CMS notes that projected rates of growth in enrollment for private health insurance and the uninsured are based largely on the OACT's models and that greater detail is available in an OACT report. Notably, OACT estimated the uninsured rate to be 8.9 percent for CY 2022 and 9.3 percent in CY 2023. Using a weighted average approach to estimate the rate of uninsurance, CMS finds Factor 2 would be 65.71 percent, a decrease from the FY 2022 IPPS final rule which indicated Factor 2 is 68.57 percent.

For FY 2023, to calculate Factor 3, CMS proposes to use the two most recent years of cost report data (i.e., FY 2018 and 2019 cost reports). For FY 2024 and subsequent FYs, CMS proposes to use a three-year average of the uncompensated care data from the three most recent fiscal years for which audited data is available to determine Factor 3 (i.e., for FY 2024, CMS would use audited data from FYs 2018-2020).

For the Indian Health Services (IHS) and Tribal hospitals, as well as Puerto Rico hospitals, CMS would determine Factor 3 based on the average of the uncompensated care data reported on Worksheet S-10 of their FY 2018 and FY 2019 cost reports.

In addition, regarding new and newly merged hospitals, in the Proposed Rule, CMS provides clarity regarding the use of additional audited data.

CMS also proposes changes related to the per discharge amount of interim uncompensated care payments. Since FY 2014, CMS has made interim uncompensated care payments during the fiscal year on a per discharge basis. Traditionally, CMS used a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the hospital's uncompensated care payment per discharge. However, due to the COVID-19 public health emergency (PHE) potentially leading to discharge underestimations, for FY 2022, CMS based this average on data from only FYs 2018 and 2019. For FY 2023, CMS proposes to base this calculation on the average of FY 2018, FY 2019, and FY 2021 historical discharge data, as opposed to using data from FY 2020. CMS clarifies that any change to the per discharge uncompensated care payment amount will not change how the total uncompensated care payment amount will be reconciled at cost report settlement.

CMS welcomes comment on the proposals noted above. In addition, CMS provides a supplemental data file, which includes information reflecting alternative policies under consideration.

Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

In the Proposed Rule, CMS provides an overview of various court decisions related to a patient's eligibility for inpatient hospital services which effects the methodology for the Medicaid fraction. The Medicaid fraction is used in the calculation to determine Medicare DSH payments. These court decisions were in opposition to CMS's interpretation and prompted CMS to clarify its policy in the Proposed Rule regarding the circumstances in which an inpatient day can be counted in the Medicaid fraction. In FY 2022 IPPS rulemaking, CMS proposed a regulatory revision to clarify that for an inpatient day to be counted in the Medicaid fraction[1] of the Medicare DSH calculation, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion (a hospital that receives payments from an uncompensated or undercompensated care pool by a section 1115 waiver could not count these patient days for purposes of the Medicaid fraction). However, CMS declined to finalize this policy in the portion of the FY 2022 IPPS Final Rule that was released on December 27, 2021. In the Proposed Rule, CMS again proposes changes to how days are counted in the Medicaid fraction if there is a section 1115 demonstration. CMS proposes that, effective for discharges occurring on or after October 1, 2022, the patients who are "regarded as eligible" for Medicaid for purposes of determining the Medicaid fraction are those whose Medicaid coverage includes essential health benefits (as provided in regulation). CMS notes that this proposed change may impact expenditures but that it lacks information needed to make such an estimate. **The agency seeks comment on this proposal.**

[1] The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Proposed Changes to Related Medicare Severity Diagnosis-Related Group (MS-DRG) and Relative Weights

Under the IPPS, the DRG classifications and relative weights are adjusted (at least annually) to account for changes in resource consumption. Adjustments are to reflect changes in treatment patterns, technology and other factors that may alter the relative use of hospital resources. To calculate proposed MS-DRG relative weights for FY 2023, CMS proposes to use the FY 2021 MedPAR claims data and FY 2020 Health Cost Report Information System (HCRIS) data, but with certain modifications to account for COVID-19.

Since CMS proposes to use 2021 MedPAR claims data, the agency considered the impact of COVID-19 hospitalizations in 2021 relative to 2023 expectations. CMS notes that it anticipates a decline in COVID-19 hospitalizations of Medicare beneficiaries as compared to FY 2021. As a result, CMS proposes to determine the MS-DRG relative weights for FY 2023 by averaging the relative weights as calculated with and without COVID-19 cases in the FY 2021 data. CMS believes averaging the relative weights in this manner will result in a reasonable estimation of the case mix for FY 2023, based on information currently available. In the Proposed Rule, CMS details each step of this calculation (pg. 236-237 of the Proposed Rule) and indicates it plans to update this calculation for the final rule using the March 2022 update of the FY 2021 MedPAR file. The proposed 19 national average cost-to-charge ratios (CCRs) for FY 2023 are provided in the Proposed Rule (pg. 245). These CCRs are used in the methodology CMS uses to determine the proposed relative weights, which are available in Table 5 associated with the Proposed Rule.

Also, to avoid relative weight fluctuations, CMS proposes a permanent 10-percent cap on the reduction to an MS-DRG's relative weight in a given fiscal year, beginning FY 2023. CMS proposes to apply a budget neutrality adjustment to the standardized amount for all hospitals to ensure that application of the proposed 10-percent cap does not result in an increase or decrease of estimated aggregate payments. CMS notes that this proposed policy would limit declines in the relative weight for 27 MS-DRGs. **CMS seeks comments on its proposal to apply a 10-percent cap on decreases in an MS-DRG relative weight from one fiscal year to the next.**

FY 2024 MS-DRG Classification Change Requests

In the Proposed Rule, CMS indicates it is changing the deadline to request changes to the MS-DRGs to October 20th each year (as opposed to November 1st) to allow additional time for the review and consideration of any proposed updates.

In addition, beginning with the FY 2024 MS-DRG classification change requests, CMS indicated is will only accept requests submitted via the Medicare Electronic Application Request Information System™ (MEARIS™), which is a new electronic application intake system. This system will be available to submit new technology add-on payment (NTAP applications and requests for ICD-10-PCS procedures codes, in addition to MS-DRG application change requests. CMS further clarifies that beginning with the FY 2024 MS-DRG application change requests, the agency will no longer consider requests sent via email.

Criteria to Create a New Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC) Subgroup within a Base MS-DRG

In the Proposed Rule, CMS restates its FY 2021 IPPS final rule policy to expand the criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG to include the NonCC subgroup for a three-way severity level split. This previously finalized criteria, when applied, would result in some MS-DRGs that are currently split into three severity levels shifting to a two severity-level split. As a result of the volume of MS-

DRG changes associated with implementing this policy and the COVID-19 PHE, in the FY 2022 IPPS final rule, CMS delayed applying the updated criteria until FY 2023.

In the agency's evaluation of requests to split an existing base MS-DRG into severity levels, typically, the most recent two years of data are analyzed and compared. For FY 2023, CMS analyzed how applying the NonCC subgroup criteria to all MS-DRGs currently split into three severity levels would affect the MS-DRG structure and found, among other disruptive changes, that 123 MS-DRGs would be deleted (41 MS-DRGs X 3 severity levels) and 75 MS-DRGs would be created. However, due to the ongoing PHE and to maintain stability, for FY 2023, CMS proposes to not apply the NonCC subgroup criteria to the existing MS-DRGs with a three-way severity level split. CMS indicates that the agency will address the application of the NonCC subgroups criteria to existing MS-DRGs with a three-way severity level split in future rulemaking.

Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies

In the FY 2022 IPPS final rule, CMS included a policy of assigning procedure codes describing CAR T-cell, non-CAR T-cell and other immunotherapies to Pre-MDC MS-DRG 018. Due to commenters' recommendation that CMS continue to assess the appropriateness of therapies assigned to Pre-MDC MS-DRG 018, the agency provided the results of its data analysis using the September 2021 update of the FY 2021 MedPAR file (pg. 69 of the Proposed Rule). CMS's analysis did not prompt the agency to propose any changes to the assignment of procedure codes, as they appear to be aligned on resource use. CMS indicates it will continue to engage with stakeholders and explore potential refinements for these therapies under the IPPS, but does not propose changes to this policy.

CMS also indicates that it is in the process of making modifications to the MedPAR files to include information for claims with the payer-only condition code "ZC" in the future. The ZC code is used to identify a case where the CAR T-cell, non-CAR T-cell or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product. Since there is a payment adjustment for MS-DRG 018 when the patient is involved in a clinical trial (with the expectation that the patient obtains CAR T-cell therapy through the clinical trial), the ZC code would help ensure the clinical trial payment adjustment is not applied for the case.

Proposed Changes to the MS-DRG Diagnosis Codes for FY 2023

In the FY 2008 IPPS final rule, CMS provided a process for subdividing diagnosis codes into three different levels of CC severity (i.e., MCC, CC or NonCC). In the FY 2021 IPPS final rule, given significant diagnosis code changes had occurred since 2008, CMS indicated it would continue plans for a comprehensive CC/MCC analysis, using a combination of claims data analysis and application of nine guiding principles (as provided in the FY 2021 IPPS final rule). As part of this plan for a comprehensive CC/MCC analysis, in the FY 2022 IPPS final rule, CMS finalized a new edit within the Medicare Code Editor (MCE) for "unspecified" codes, effective with discharges on and after April 1, 2022.

In the Proposed Rule, CMS notes that since this new edit has only recently become effective and stakeholders need time to acclimate to the new edit, it does not believe it is appropriate to change the designation of any ICD-10-CM diagnosis codes, including the unspecified codes, at this time. Rather, CMS clarifies that it continues to solicit feedback regarding the guiding principles and other possible ways CMS can incorporate meaningful indicators of clinical severity. **CMS is also interested in feedback on how the agency may support documentation and reporting of the most specific diagnosis codes to improve the reliability and validity of the coded data.**

Request for Information: Reporting Social Determinants of Health Diagnosis Codes

Notably, as CMS views health equity as a guiding priority, the agency also provides a Request for Information (RFI) on how the reporting of diagnosis codes in categories Z55-Z65 (these relate to social determinants of health (SDoH)), may improve the agency's ability to recognize severity of illness, complexity of illness and/or utilization of resources under the MS-DRGs. The diagnosis codes for which CMS is soliciting comments are shown in Table 6P.5a, which is available on the CMS website. **CMS seeks comment on a range of questions including whether the agency should consider requiring more robust documentation and claims data reporting to help inform CMS decisions regarding the most appropriate CC subclass (i.e., NonCC, CC or MCC) assignment for each SDoH Z code as a secondary diagnosis**. A complete list of questions for this RFIs is provided on pg. 185-186 of the Proposed Rule. CMS will take feedback into consideration for future policy development.

Comment Solicitation on Possible Mechanisms to Address Rare Diseases and Conditions

CMS indicates that it has heard from some stakeholders that there may be barriers to treating patients with orphan-designated drugs in the Medicare hospital inpatient setting, such as insufficient Medicare reimbursement and rigid hospital formularies. **CMS seeks comment on how the agency can address perceived access issues for beneficiaries with rare diseases and conditions that are represented by low volumes in claims data.** In addition, the agency seeks to identify sufficiently large sets of claims data with a resource/cost similarity and clinical similarity in developing diagnostic-related groups rather than smaller subsets.

Proposed Add-On Payments for New Services and Technologies for FY 2023

Under the IPPS, a service or technology may be considered for a new technology add-on payment (NTAP) if: (1) the medical service or technology is new; (2) the medical service or technology is costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. In addition, certain transformative new devices and antimicrobial products may qualify under an alternative inpatient NTAP pathway.

Table II.F.-01 (pg. 268 of the Proposed Rule) provides a list of technologies for which CMS proposes to discontinue NTAPs for FY 2023. Table II.F.-02 (pg. 273) lists the technologies for which the agency is proposing to continue making new technology add-on payments for FY 2023 because they are still considered "new" for purposes of NTAPs. Also, CMS proposes to discontinue add-on payments for 13 technologies that were provided a one-year extension of NTAPs in FY 2022 because, due to the COVID-19 PHE, older data was relied upon for rate-setting purposes. Under the traditional pathway for NTAP applications, CMS indicated that it received 18 applications for FY 2023. Under alternative NTAP pathways, CMS received 19 applications.

Notably, regarding VEKLURY® (Remdesivir), CMS indicates there may be unique considerations in determining the start of the newness period, as the product was initially distributed at no cost as a COVID-19 treatment. **As a result, CMS proposes to continue this NTAP for FY 2023 but welcomes stakeholder feedback.**

New COVID-19 Treatments Add-On Payment

In response to the COVID-19 PHE, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) under the IPPS for certain COVID-19 cases. While CMS initially indicated the NCTAP would last until the end of the PHE, in the FY 2022 IPPS final rule, the agency extended the NCTAP through the end of the FY in which the PHE ends for all eligible products. CMS provided this

policy to mitigate potential financial disincentives for hospitals to provide these new treatments, and to minimize any potential payment disruption immediately following the end of the PHE.

Proposed Use of National Drug Codes (NDCs) to Identify Cases Involving Use of Therapeutic Agents Approved for New Technology Add-on Payments

In the FY 2016 IPPS final rule, CMS established the use of Section "X" New Technology codes within the ICD-10-PCS classification to more specifically identify new technologies or procedures that have historically not been captured. In response to stakeholder opposition (including the ICD-10 Coordination and Maintenance Committee) to the creation of such new ICD-10-PCS codes for purposes of representing unique drugs and therapeutic agents, CMS proposes for FY 2024 to instead use NDCs to identify cases involving the use of therapeutic agents approved for NTAPs. CMS notes that adequate time is likely needed for regular use of NDCs with the NTAP for health care providers and hospital professionals. As a result, CMS proposes a transitional period for FY 2023, where CMS would utilize both NDCs and the ICD-10-PCS Section X codes to identify when an NTAP would apply. CMS indicates that since some therapeutic agents with an NTAP do not have an NDC (e.g., blood, blood products), CMS would identify these based on the assigned ICD-10-PCS procedure code and/or ICD-10-CM diagnosis code. **CMS invites public comment on its proposal to utilize NDCs to identify claims involving the use of therapeutic agents approved for new technology add-on payments**.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires that the Secretary of Health and Human Services adjust the standardized amounts for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. Data included in the wage index includes data from the Medicare Cost Report and the Hospital Wage Index Occupational Mix Survey. The wage index must be updated annually, and any updates or adjustments must be budget neutral – meaning the overall, aggregate payment to hospitals cannot change. CMS provides wage index tables (Tables 2, 3, and 4A and 4B) on the Proposed Rule website.

The proposed FY 2023 wage index values are based on Medicare cost report data for cost reporting periods beginning October 1, 2018 and until October 1, 2019. For wage index purposes, CMS notes that these cost reports will be referred to as "FY 2019 cost report," the "FY 2019 wage data," or the "FY 2019 data." CMS reiterates its ongoing practice for the wage index to generally use the most current data and information available, which is usually data on a four-year lag. In the Proposed Rule, CMS notes its consideration of the best available data for purposes of the wage index, particularly given the potential impact of COVID-19. Based on the agency's review and analysis of the FY 2019 wage data, CMS found that the data is not significantly impacted by the COVID-19 PHE. However, based on the agency's description, the specifics of this analysis are unclear, as the agency does not reference specific tables or files for the public to review to confirm the agency's conclusion. For example, in the Proposed Rule (pg. 641), CMS states "A comparison of providers shows similar trends in those with cost reports ending during the PHE as compared to providers without cost reports ending during the PHE. The data also shows that changes in the Average Hourly Wage (AHW) for providers were consistent between providers with cost reports ending during the PHE as compared to providers without cost reports ending during the PHE. It appears that the overall impact of the COVID-19 PHE on the FY 2019 wage data has been minimal.

Additionally, the changes in the wage data from FY 2018 to FY 2019 show similar trends in the change of the data from FY 2017 to FY 2018."[2]

Proposed Occupational Mix Adjustment to the FY 2023 Wage Index

CMS uses an occupational mix adjustment to control for the effect of hospitals' employment choices on the wage index. For the FY 2023 wage index, CMS used Worksheet S-3 wage data of 3,112 hospitals and occupational mix surveys of 3,010 hospitals. CMS notes it had a "response" rate of 97% and will apply proxy data for hospitals that did not reply, new hospitals or hospitals that submitted erroneous or aberrant data, as done in prior years. To compute the FY 2023 occupational mix adjustment, CMS is not proposing any changes to the methodology and plans on applying the occupational mix adjustment to 100 percent of the FY 2023 wage index. In applying this methodology, the proposed FY 2023 occupational mix adjusted national average hourly wage is $47.71.

CMS compared the proposed FY 2023 occupational mix adjusted wage indexes for each core-based statistical area (CBSA) to the proposed unadjusted wage indexes for each CBSA. The results indicate a smaller percentage of urban areas (55.8 percent) would benefit from the occupational mix adjustment than would rural areas (57.4 percent).

Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Flood, Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment

Rural Floor Policy

The "rural floor" policy provides that wage indexes applied to urban hospitals in a state cannot be lower than the wage index for rural areas in that state. In addition, CMS applies a national budget neutrality adjustment when implementing the rural floor policy.

While CMS does not propose changes to the rural floor policy (or the related budget neutrality adjustment) for FY 2023, the agency does reference litigation (e.g., *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, No. 1:20-cv-00707 (D.D.C.) related to the FY 2020 rural floor policy and budget neutrality adjustment. Although CMS may appeal, the agency indicates that on April 8, 2022, the district court in *Citrus* found that the Secretary did not have authority under a separate law to establish a rural floor lower than the rural wage index for a state. CMS then notes that while this decision involves only FY 2020, the court's decision may have implications for FY 2023 payment rates. Also, CMS reiterates that while it is proposing to continue the rural floor wage index policy for FY 2023, it may decide to take a different approach in the final rule based on public comments or developments in the court proceedings.

Based on the proposed FY 2023 wage index and calculation of the rural without the wage data of hospitals that have reclassified as rural, CMS estimates 192 hospitals would receive an increase in their FY 2023 proposed wage index due to the application of the rural floor.

[2] While Vizient did not anticipate that the COVID-19 Public Health Emergency would directly impact the FY 2019 wage data, CMS's approach to determining whether to use a given year's wage data may be relevant to future rulemaking so was included in this summary for context.

"Imputed Floor" Policy

From FYs 2005 - 2018, CMS utilized an imputed floor policy for hospitals in all-urban states, and it was considered as a factor in the national budget neutrality adjustment. Section 9831 of the American Rescue Plan Act (ARPA) requires that for discharges occurring on or after October 1, 2021, the area wage index applicable to any hospital in an all-urban state may not be less than the minimum area wage index for the fiscal year for hospitals in that State established using the methodology that was in effect for FY 2018.

Unlike the imputed floor policy that was in effect from FYs 2005 – 2018, the ARPA provided that the imputed floor wage index shall not be applied in a budget neutral manner. In the FY 2022 IPPS final rule, CMS adopted the ARPA requirements to implement the "imputed floor" policy. For FY 2023, CMS proposes to continue to apply the FY 2022 "imputed floor" policy. Based on available data for the Proposed Rule, CMS indicates that hospitals in the following states would be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2023: New Jersey, Rhode Island, Delaware, Connecticut, and Washington, DC.

State Frontier Floor Policy

The ACA requires that the wage index for hospitals in low density states (known as the Frontier Floor Wage Index) cannot be below 1.0000. In the Proposed Rule, CMS indicates 44 hospitals would receive the Frontier Floor adjustment so their FY 2023 wage index would be 1.0000. These hospitals are in Montana, North Dakota, South Dakota and Wyoming. Although Nevada meets the definition of a frontier state, all hospitals in Nevada currently receive a wage index value greater than 1.0000.

Low Wage Index Hospital Policy

For FY 2023, CMS proposes to continue the low wage hospital index policy (which includes a budget neutrality adjustment) for hospitals whose wage index values are in the bottom quartile. Under the policy, which was established for FY 2020, CMS increases the wage index for each hospital by half the difference between the otherwise applicable final wage index value for a year for the hospital and the 25th percentile wage index value for that year across all hospitals. In the Proposed Rule, CMS notes that the low wage index hospital policy and related budget neutrality adjustment are the subject of litigation (*Bridgeport Hospital, et al., v. Becerra*, No. 1:20-cv-01574 (D.D.C.)). On March 2, 2022, the District Court found that the Secretary did not have authority to adopt the low wage index policy and ordered additional briefing on the appropriate remedy. While CMS indicates the court's decision is subject to potential appeal, the agency clarifies it may have implications for FY 2023 payment rates and that it may decide to take a different approach in the final rule, depending on public comments or developments in the court proceedings.

Based on the data for the Proposed Rule and CMS's proposal to continue to apply the low wage index hospital policy as done in FY 2020-2022 (i.e., as a uniform budget neutrality factor applied to the standardized amount), the FY 2023 proposed 25th percentile wage index value across all hospitals is 0.8401.

Out-Migration Adjustment

Beginning FY 2005, CMS has provided a process to make an "out-migration adjustment" to the hospital wage index based on commuting patterns of hospital employees. For FY 2023, CMS indicates the out-migration adjustment will continue to be based on the data derived from the custom tabulation of the American Community Survey utilizing 2008 – 2012 (5-year) microdata. CMS notes that in the future, it may consider using the next Census or other available data, as appropriate. Table 2 associated with the Proposed Rule includes the proposed out-migration adjustment for the FY 2023 wage index and Table 4A provides a list of counties eligible for the out-migration adjustment, and the number of years adjustments will be in effect.

Proposed Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

Hospitals may apply for geographic reclassification for purposes of payment under the IPPS to the Medicare Geographic Classification Review Board (MGCRB). Such reclassification applications are due no later than 13 months prior to the start of the fiscal year for which reclassification is requested (i.e., September 1 of the previous fiscal year). To reclassify, generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. CMS notes that by the time the Proposed Rule was drafted, the MGCRB had completed its review of FY 2023 reclassification requests and 491 hospitals were approved for wage index reclassifications starting in FY 2023.

In addition, CMS proposes various regulatory changes that would align its policy for withdrawals, termination and cancelations (reinstatements) with its policy for applications, and ensure requests are submitted to the MGCRB through the method for submission that they can most efficiently process.

Proposed Labor-Related Share for the FY 2023 Wage Index

The labor-related share is used to determine the proportion of the base payment rate to which the area wage index should be applied and includes a cost category if such costs are labor intensive and vary with the local market. CMS notes that in the FY 2022 IPPS Final Rule, the agency rebased and revised the hospital market basket. In the Proposed Rule, CMS does not provide any further changes to the labor-related share. For FY 2023, for all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are less than or equal to 1.000, CMS proposes to apply the wage index to a labor related share of 62 percent of the national standardized amount. For all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.000, for FY 2023, CMS proposes to apply the wage index to a proposed labor-related share of 67.6 percent of the national standardized amount.

Proposed Permanent Cap on Wage Index Decreases

In the FY 2020 IPPS final rule, CMS finalized a policy of applying a 5 percent cap on any decrease in a hospital's wage index from the hospitals final wage index in 2019 to provide a transitional period as various policy changes could lead to significant decreases in the wage index value for some hospitals. The transitional policy was initially expected to last for two years but was extended in FY 2022 due to the COVID-19 PHE. CMS also applied a budget neutrality adjustment to the standardized amount for FYs 2020-2022 for all hospitals to achieve budget neutrality for the transition policy. For FY 2023 and subsequent years, CMS proposes permanently adopted the 5 percent cap policy.

Proposed Payment Adjustment for Low-Volume Hospitals

Beginning in FY 2005, an additional payment to each qualifying low-volume hospital (LVH) under the IPPS was made (referred to as the LVH adjustment). The LVH adjustment is based on total per discharge payments (e.g., capital, DSH, IME and outlier payments). Additional changes to temporarily expand eligibility for the LVH adjustment were provided in the ACA and subsequent legislation (e.g., hospitals had to have fewer than 1,600 discharges for individuals entitled to Medicare Part A and be located within 15 miles of other hospitals). The Bipartisan Budget Act of 2018 (Pub. L. 115–123) later modified the definition of an LVH and the methodology for calculating the payment adjustment for FYs 2019 through 2022. In addition, the law provided that the adjustment would apply only for discharges occurring in FYs 2019-2022.

In the Proposed Rule, CMS indicates that beginning with FY 2023 and subsequent years, the LVH qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to changes provided by the ACA, which were temporary. More specifically, to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have fewer than 200 discharges (including both Medicare and non-Medicare discharges) during the fiscal year. In the Proposed Rule, CMS provides additional information regarding the process to request low-volume hospital status to the MAC, noting a September 1, 2022, deadline.

Outlier Payment Adjustment

Costs incurred by a hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount. The "outlier threshold" or "fixed loss" is a dollar amount by which the costs of a case exceed payments.

In the Proposed Rule, CMS proposes to establish the FY 2023 outlier threshold using hospital CCRs from the December 2021 update to the Provider-Specific File (PSF), with certain edits. CMS notes that the operating and capital CCR adjustment factors that CMS would normally use are above 1.0 (typically, they are below 1.0). CMS expects that this abnormally high CCR adjustment factor (as compared to historical levels) is partially due to the high number of inpatient COVID-19 cases in FY 2021. Since CMS anticipates fewer COVID-19 hospitalizations, for FY 2023, CMS proposes to adjust the CCRs from the December 2021 update of the PSF by comparing the percentage change in the national average case-weighted operating CCR and capital CCR from the March 2019 update of the PSF to the national average case-weighted operating CCR and capital CCR from the March 2020 update of the PSF (the last update of the PSF prior to the PHE). CMS believes it is appropriate to use such data since it anticipates CCRs will not continue to increase at such abnormally high rates for FY 2023.

CMS seeks comment on this approach and on an alternative approach. Under the alternative approach, CMS would use the data it would ordinarily use (e.g., charge data from FYs 2020 to 2021), but with different modifications (e.g., budget neutrality and other rate setting adjustments, including the charge inflation factor). CMS notes that if the proposed modifications were not used, the proposed outlier threshold would be too high and estimated outlier payment would be less than CMS's goal of 5.1 percent of total payments. Under the alternative approach, CMS estimates an outlier threshold of $58,798 rather than the proposed threshold of $43,214.

Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program

In the Proposed Rule, CMS notes that the Medicare-Dependent, Small Rural Hospital (MDH) Program is not authorized by statute beyond September 30, 2022. As a result, beginning October 1, 2022, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based on the IPPS.

Indirect and Direct Graduate Medical Education

Payments to hospitals for the direct costs of an approved graduate medical education (GME) program are based on a methodology that determines a hospital-specific base-period per resident amount (PRA). In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of FTE residents working in all areas of the hospital

complex (and non-provider sites, when applicable), and the hospital's Medicare share of total inpatient days.

In addition, under IPPS, there is an indirect medical education (IME) adjustment for hospitals that have residents in an approved GME program. The hospital's IME adjustment applied to the DRG payments is calculated based on the ratio of the hospital's number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital to the number of inpatient hospital beds. The calculation of both direct GME payment and the IME payment adjustment is affected by the number of FTE residents that a hospital is permitted to count. Consistent with prior policy, for discharges occurring during FY 2023, the IME formula multiplier is 1.35. CMS estimates application of the multiplier results in an increase in the IPPS payment amount of 5.5 percent for every approximately 10 percent increase in the hospital's resident-to-bed ratio.

GME Payments to Teaching Hospitals When Those Hospitals' Weighted FTE Counts Exceed their Direct GME Cap

In the Proposed Rule, CMS references a recent U.S. District Court decision that ruled against CMS's method of calculating direct GME payments to teaching hospitals when a hospital's weighted FTE counts exceed their direct GME FTE cap. Medicare statute provides that residents training beyond their initial residency period are given half the weight of residents in their initial residency period. As a result of the court's decision, CMS proposes a modified direct GME payment policy for all teaching hospitals that has the potential to be applied retroactively. Specifically, effective for cost reporting periods beginning on or after October 1, 2022 (and generally, for cost reports that are reopenable or open), CMS proposes changes to the weighted FTE counts if two circumstances are met: (1) the hospital's unweighted number of FTE residents exceeds the FTE cap; and (2) the number of weighted FTE residents also exceeds that FTE cap. If these circumstances are met, then the respective primary care and obstetrics and gynecology weighted FTE counts, and other weighted FTE counts, are adjusted to make the total weighted FTE count equal the FTE cap. CMS estimates the impact of this proposed change for FY 2023 to be $170 million.

Proposal to Allow Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations

CMS proposes to allow urban and rural hospitals that participate in the same separately accredited 1-2 family medicine rural track program (i.e., 1 year of training in a large, urban residency program followed by 2 years in a rural community) and have rural track FTE limitations to enter into "rural track Medicare GME affiliation agreements". CMS notes that such affiliation agreements may be appealing because cap slots may be shared, and cross-training of residents can be better facilitated.

Also, CMS proposes to only allow urban and rural hospitals to participate in rural track Medicare GME affiliated groups if they have rural track FTE limitations in place prior to October 1, 2022. CMS provides that eligible urban and rural hospitals may enter into rural track Medicare GME affiliation agreements effective with the July 1, 2023 academic year. CMS clarifies that under this proposal, no newly funded cap slots will be created.

Hospital Readmissions Reduction Program (HRRP)

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. The 21st Century Cures Act requires comparing peer groups of hospitals with respect to the number of their Medicare-Medicaid dual-eligible beneficiaries (dual-eligibles) in determining the extent of excess readmissions. The HRRP currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery.

Due to the impact of COVID-19, in the FY 2022 IPPS final rule, CMS finalized suppression of the CMS 30-Day Pneumonia Readmission Measure for the FY 2023 program year. In the Proposed Rule, CMS proposes to resume use of this measure in the HRRP beginning with the FY 2024 program year. However, patients with principal or secondary COVID-19 diagnosis from both the cohort and the outcome would be excluded. CMS is also providing technical specification updates to control for patients with a clinical history of COVID-19 in the 12 months prior to the index admission. **CMS welcomes comment on the proposal to resume use of the CMS 30-Day Pneumonia Readmissions Measure beginning with the FY 2024 program year.**

In the FY 2022 IPPS final rule, CMS noted that it would publicly report a suppressed measure's data with appropriate caveats, given the impact of COVID-19. In the Proposed Rule, CMS indicates it is postponing reporting of the CMS 30-Day Pneumonia Readmission Measure, which would typically be included in the July update of the Compare website, to provide stakeholders an opportunity to review the Proposed Rule prior to the release of the Hospital Specific Reports (HSRs).

Request for Public Comment on Possible Future Inclusion of Health Equity Performance in the Hospital Readmissions Reduction Program

In the Proposed Rule, CMS reiterates the agency's commitment to achieving equity in health care outcomes and identifies the HRRP as one mechanism to support this goal. Currently, the HRRP uses beneficiaries' dual eligibility for Medicare and Medicaid as a proxy for a beneficiary's social risk. Dual eligibility, as required by the statute, is also used to divide hospitals into peer groups for comparison under the program. **CMS seeks comment on approaches to update the HRRP to incorporate performance for socially at-risk populations. CMS also seeks comments on variables associated with or measures of social risk and beneficiary demographics that are already collected, as well as broader definitions of dual eligibility (e.g., those enrolled in a Medicare Savings Program or the Medicare Part D Low Income Subsidy) for inclusion in the HRRP.** CMS notes that it would initially use such variables to stratify results within HSRs as confidential feedback to hospitals.

Also, CMS indicates it is considering the use of various indices to measure social rick (e.g., Area Deprivation Index, AHRQ Socioeconomic Index[3], CDC's Social Vulnerability Index). **CMS seeks comment on the addition of one or more of these indices or proposals for other indices that capture multiple dimensions of social risk and that have a demonstrated relationship to health outcomes or access to health care resources, that can be added to the HRRP along with dual eligibility factors for stratifying data.** CMS requests that commenters include information on the availability of public data sources and documentation of the methods and testing when suggesting variables or indices to measure social risk. CMS also notes that support from a national level assessment of the impact of social risk can be particularly useful to demonstrate the relevance of a proposed indicator. CMS indicates that changes to the HRRP regarding social risk measurement using an index would be made through future rulemaking.

[3] Bonito A., Bann C., Eicheldinger C., Carpenter L. (2008). Creation of New Race-Ethnicity Codes and Socioeconomic Status (SES) Indicators for Medicare Beneficiaries. Final Report, Sub-Task 2. (Prepared by RTI International for the Centers for Medicare & Medicaid Services through an interagency agreement with the Agency for Healthcare Research and Policy, under Contract No. 500-00-0024, Task No. 21) AHRQ Publication No. 08- 0029-EF. Rockville, MD, Agency for Healthcare Research and Quality.

Hospital Value-Based Purchasing (VBP) Program

The ACA established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person and Community Engagement. Typically, the applicable incentive payment percent is required by statute (e.g., 2 percent). In the Proposed Rule, CMS provides estimated and newly established performance standards for the Hospital VBP Program, in addition to measure suppressions and a special scoring methodology.

Measure Suppression Policy for the Duration of the COVID-19 PHE

In the Proposed Rule, CMS provides an overview of the measure suppression policies CMS provided in the FY 2022 IPPS final rule. As part of the previously finalized measure suppression policy, CMS indicated it would still provide confidential feedback reports to hospitals on all measures and that the agency would continue to publicly report suppressed data, but with appropriate caveats noting the limitations of the data due to the COVID-19 PHE. While CMS does not propose changes to these policies, it indicates that the agency may not be able to provide hospitals with feedback reports for FY 2023 until after August 1, 2022.

For the FY 2023 program year, CMS reviewed and analyzed the data to determine how COVID-19 has impacted the validity of data used to calculate measures in the Hospital VBP program. As a result, CMS proposes a measure suppression policy for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and five Hospital Acquired Infection (HAI) measures. Also, in the FY 2022 IPPS final rule for the FY 2023 program year, CMS finalized a proposal to suppress the Hospital 30-Day, All Cause, Risk Standardized Mortality Rate Following Pneumonia (PN) Hospitalization measure (NQF #0468) (MORT-30-PN).

The five HAI measures CMS proposes to suppress are: (1) National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure; (2) NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure; (3) American College of Surgeons - Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure; (4) NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure; and (5) NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure.

Proposed Scoring and Payment Methodology for the FY 2023 Program Year Due to the COVID-19 PHE

Since CMS proposes to suppress six measures in the Hospital VBP Program for FY 2023, the agency also proposes a special rule for scoring. Specifically, although CMS proposes to continue to calculate measure rates for all measures in the FY 2023 program year, the agency would not consider these suppressed measures for scoring. For scoring, CMS proposes to only calculate achievement and improvement points, as well as a domain score, for remaining measures in the Clinical Outcomes domain and the Efficiency and Cost Reduction domain that are not suppressed. Also, CMS proposes that it would not award Total Performance Scores (TPSs) to any hospital for FY 2023 and outlines a policy so that payment adjustments would be neutral for hospitals. Thus, no hospitals would receive a positive or negative incentive payment. CMS notes that it aims resume the use of measure data for scoring and payment adjustment purposes beginning with the FY 2024 program year.

In the Proposed Rule, CMS also provides additional information regarding the FY 2023 program year payment details if the proposed special scoring and payment adjustment policies are not

finalized. More information is provided in the Proposed Rule (pgs. 875-880) regarding this alternative approach. **CMS welcomes feedback on its proposed approach.**

Technical Measure Specification Updates to Include Covariate Adjustment for COVID-19 Beginning with the FY 2023 Program Year

In the Proposed Rule, CMS notes that it continues to evaluate the effects of COVID-19 on the Hospital VBP Program measures set. Based on CMS's evaluation, it found that lasting effects of COVID-19 could affect a patient's risk of mortality or complications following an index admission and, as a result, impact a hospital's performance on one or more of the four condition-specific mortality measures or the procedure-specific complication measure included in the Hospital VBP Program. As a result, CMS indicates, effective the FY 2023 program year, it is further modifying the technical measure specifications for the MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, and COMP-HIP-KNEE measures to include a covariate adjustment for patient history of COVID-19 in the 12 months prior to the admission. More information regarding application of the covariate adjustments is available in the Measure Updates and Specifications Reports available on the CMS Measure Methodology website.

In addition, even though the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN) measure will be suppressed for the FY 2023 program year, CMS will include the aforementioned COVID-19 covariate adjustment. CMS notes that it will resume including hospital performance on the MORT-30-PN measure in the payment adjustment calculations using the updated MORT-30-PN measure, beginning in FY 2024. Also, CMS is making various updates to the technical specifications for this measure which can be found on the CMS Measure Methodology website, additional resources are on the QualityNet website.

Proposal to Update Baseline Periods for Certain Measures Due to COVID-19 and Performance Standard Updates

Although CMS previously finalized baseline periods for the FY 2024, 2025, 2026, 2027, and 2028 program years for all measures included in the Hospital VBP Program, CMS is concerned with using COVID-19 impacted data for the FY 2025 baseline periods for scoring and payment purposes. Thus, CMS proposes several updates to the baseline periods in the Proposed Rule for the FY 2025 program year. The below table provides an overview of previously adopted and proposed baseline and performance periods for the FY 2025 program year, including as effected by the Proposed Rule policies. Additional tables in the Proposed Rule (pgs. 890-892) provide similar information but for program years 2024-2028.

Measures	Baseline Period for FY 2025 Program Year (PY)	Performance Period for the FY 2025 PY
Person and Community Engagement Domain		
HCAHPS	Jan. 1, 2019 – Dec. 31, 2019 (Note: the baseline period has been updated)	Jan. 1, 2023 – Dec. 31, 2023
Clinical Outcomes Domain		
Mortality measures (MORT-30-AMI, MORT-30-HF, MORT-30-COPD, MORT-30-CABG, MORT-30-PN (updated cohort))	July 1, 2015 – June 30, 2018	July 1, 2020 – June 30, 2023
COMP-HIP-KNEE	April 1, 2015 – March 31, 2018	April 1, 2020 – March 31, 2023 (Note: Per prior policy, Q1 and Q2 2020 data that was submitted will not be used)

Safety Domain		
NHSN measures (CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, CDI, MRSA Bacteremia)	Jan. 1, 2019 – Dec. 31, 2019 (Note: the baseline period has been updated)	Jan. 1, 2023 – Dec. 31, 2023
Efficient and Cost Reduction Domain		
Medicare Spending Per Beneficiary (MSPB)	Jan. 1, 2021 – Dec. 31, 2021	Jan. 1, 2023 – Dec. 31, 2023

Also, Table V.I.-09 of the Proposed Rule (pg. 894) provides previously established and newly estimated performance standards for the FY 2025 program year, and Table V.I.13 (pg. 897-898) provides newly established performance standards for the FY 2028 program year.

Hospital-Acquired Conditions (HAC) Reduction Program

The ACA established the HAC Reduction Program (HACRP) to reduce the incidence of HACs by requiring hospitals to report on a set of measures (CMS PSI 90 and CDC NHSN HAI measures). Hospitals in the worst performing quartile (25 percent) would receive a one percent payment reduction. A hospital's Total HAC Score and its ranking in comparison to other hospitals in any given year will depend on several different factors.

Among other changes provided in the Proposed Rule which are detailed below, CMS also proposes to update the newly-opened hospital definition for the CDC NHSN HAI measure beginning in the FY 2023 program year. Also, CMS clarifies that beginning FY 2023 and subsequent years, the "No Mapped Locations" (NML) designation will no longer apply, and hospitals will be required to appropriately submit data to the NHSN or, if hospitals do not have the applicable locations for the CLABSI and CAUTI measures, the hospital must submit an IPPS Measure Exception Form to be exempt from CLABSI and CAUTI reporting for CMS programs. If the hospitals do not submit an IPPS Measure Exception Form and continue to not submit data to the NHSN, these hospitals would receive the maximum measure score under the HAC Reduction Program for not reporting data. CMS notes that the removal of the NML has been previously communicated (e.g., FAQs, User Guide) and NML only applies to a small subset of hospitals.

Flexibility for Changes that Affect Quality Measures During a Performance or Measurement Period in the HAC Reduction Program

For the HACRP, in the FY 2022 IPPS final rule, CMS finalized a measure suppression policy for the duration of the PHE where the agency could suppress measures from the FY 2022 and FY 2023 Total HAC Score Calculations considering the same Measure Suppression Factors as other programs, such as the Hospital VBP Program. Also, through application of an Extraordinary Circumstances Exception (ECE) policy and due to the pandemic, all data submitted through Q1 and Q2 of CY 2020 were to be excluded from HACRP performance calculations for FY 2022 and FY 2023. For Q3 and Q4 of CY 2020, CMS also indicated it would suppress CDC NHSN HAI and CMS PSI 90 data from performance calculations for FY 2022, FY 2023, and FY 2024.

In the Proposed Rule, CMS proposes additional updates to the HACRP suppression policy. Specifically, CMS proposes to suppress the CMS PSI 90 measure and the five CDC NHSN HAI measures from the calculation of measure scores and the Total HAC Scores. As a result, hospitals would not be penalized for the HACRP FY 2023 program year (all hospitals would receive a total HAC score of zero). In addition, CMS proposes to not calculate or report (to hospital or publicly) measure results for the CMS PSI 90 measure for the HACRP FY 2023 program year. CMS will

continue to provide the measure results for the CDC NHSN HAI measures to hospitals via their hospital-specific reports (HSRs). CMS will continue to report CDC NHSN HAI measure data to the CDC to help inform policies in the future.

CMS notes that it would resume calculating measure scores in the FY 2024 program year for the HACRP. However, CMS proposes to suppress CY 2021 CDC NHSN HAI data from the FY 2024 HACRP because it is unable to risk-adjust or otherwise account for COVID-19 diagnoses. Thus, for the FY 2023 program year, CMS proposes that the resulting applicable period for the CDC NHSN HAI measure would be the from Jan. 1, 2022 – Dec. 31, 2022.

Also, beginning with the FY 2024 program year, CMS indicates it is updating the measure specifications for the PSI 90 measure to risk-adjustment for COVID-19 diagnoses. For this measure, the applicable period would remain unchanged (i.e., January 1, 2021 – June 30, 2022). Also, CMS notes a technical update to the PSI 90 software to include COVID-19 diagnosis as a risk-adjustment parameter for the FY 2024 program year and subsequent years. In the Proposed Rule (pg. 919), CMS provides a table outlining the applicable periods for FYs 2023 – 2025 for the HACRP if the policies it provides are finalized.

CMS invites comments on these COVID-19-related proposals for the HACRP.

Technical Specification Update to the Minimum Volume Threshold for the CMS PSI 90 Measure

CMS uses a sub-regulatory process to incorporate technical measure specification updates into the measure specifications adopted for the HACRP. In addition to the COVID-19 related specification change noted above for FY 2024, CMS also indicates that beginning with the FY 2023 program year, the agency is instituting an increased minimum volume threshold for the CMS PSI 90 measure because a small subset of hospitals have a low reliability score for their CMS PSI 90 composite score, due to the current minimum volume threshold for this measure. As a result of this change, CMS anticipates 2.5% of all hospitals would no longer receive a Total HAC Score, so there will be a decrease in the number of hospitals in the worse-performing quartile.

Hospital Inpatient Quality Reporting (IQR) Program

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. To receive the full payment increase, hospitals must report data on measures selected by the Secretary for each fiscal year.

In the Proposed Rule, CMS proposes to adopt ten new measures (as provided in the table below) and refine two current measures beginning with the FY 2024 payment determination (Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA; and Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)). Table IX.E.09 of the Proposed Rule (pg. 1201-1203) provides a list of measures of the previously finalized and newly proposed Hospital IQR Program measure set for the FY 2024 payment determination. Similar tables for the FYs 2025-2028 payment determinations are also provided in the Proposed Rule (pg. 1202-1208).

In addition, CMS seeks comment on the potential future development and inclusion of two NHSN measures (Healthcare-Associated *Clostridioides difficile* Infection Outcome; and Hospital-Onset Bacteremia & Fungemia Outcome).

Proposed New Measure	Timeline
Hospital Commitment to Health Equity measure Table IX.E-01 (Proposed Rule, pg. 1074) provides the five attestation domains and the element within each that a hospital must affirmatively attest to receive credit	Beginning with the CY 2023 reporting period/FY 2025 payment determination
Screening for Social Drivers of Health measure*	Beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
Screen Positive Rate for Social Drivers of Health measure*	Beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
Cesarean Birth eCQM	Inclusion in the measure set beginning with the CY 2023 reporting period/FY 2025 payment determination and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
Severe Obstetric Complications eCQM	Inclusion in the measure set beginning with the CY 2023 reporting period/FY 2025 payment determination and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
Hospital-Harm—Opioid-Related Adverse Events eCQM	Beginning with the CY 2024 reporting period/FY 2026 payment determination
Global Malnutrition Composite Score eCQM	Beginning with the CY 2024 reporting period/FY 2026 payment determination
Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)**	Beginning with two voluntary reporting periods followed by mandatory reporting for the reporting period which runs from July 1, 2025, through June 30, 2026, impacting the FY 2028 payment determination
Medicare Spending Per Beneficiary (MSPB) Hospital measure	Beginning with the FY 2024 payment determination
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA measure	Beginning with the FY 2024 payment determination

*These two measures would be the first patient-level measurement of social drivers of health in the Hospital IQR Program.
**In the Proposed Rule (pgs. 1246-1250), CMS details the proposed data submission and reporting requirements for this measure as a new type of measure to the Hospital IQR Program. Table IX.E-17 of the Proposed Rule (pg. 1250) provides the proposed mandatory reporting of pre-operative and post-operative periods for this measure.

Proposed Reporting and Submission Requirements for eCQMs for the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years

For CY 2022, Medicare PI participants were required to report on three self-selected eCQMs and one mandatory eCQM (Safe Use of Opioids – Concurrent Prescribing). The reporting period is three

self-selected quarters of CY 2022 data. In the Proposed Rule, CMS proposes to modify the current eCQM reporting and submission requirements. Specifically, CMS proposes that beginning with the CY 2024 reporting period/FY 2026 payment determination hospitals would be required to report four calendar quarters of data for six eCQMs: (1) three self-selected eCQMs; (2) the Safe Use of Opioids—Concurrent Prescribing eCQM; (3) the proposed Cesarean Birth eCQM; and (4) the proposed Severe Obstetric Complications eCQM. CMS notes this proposal is made in conjunction with other policies provided in the Proposed Rule regarding adoption of additional measures related to maternal health. **CMS requests comment on the proposal to increase the number of mandatory eCQMs to be reported from one to three (total increase of required eCQMs from four to six).**

Data Submission and Reporting Requirements for Hybrid Measures

CMS notes that the Hospital IQR Program recently adopted policies to include hybrid measures into the program's measure set (e.g., Hybrid Hospital-Wide Readmission measure; Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure). In addition, the agency adopted policies related to data submission and reporting requirements for hybrid measures under the Hospital IQR Program. In the Proposed Rule, CMS proposes to remove zero denominator declarations and case threshold exemptions as options for the reporting of hybrid measures beginning with the FY 2026 payment determination.

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

In the Proposed Rule, CMS proposes to establish a hospital quality designation that would be publicly reported on a CMS website beginning Fall 2023. CMS provides that the designation would be awarded based on a hospital's attestation of submission of the Maternal Morbidity Structural measure, which was adopted in the FY 2022 IPPS final rule and is designed to determine hospital participation in a state or national Perinatal Quality Improvement collaborative and implementation of patient safety practices. **CMS requests feedback on potential additional activities that the agency could undertake to advance maternal health equity.** The agency notes that in future rulemaking, it intends to propose a more robust set of criteria for awarding the designation that may include other maternal health-related measures that may be finalized for the hospital IQR program measure set in the future.

In addition, CMS is considering other quality measurement data sources, such as patient experience measures and quality measures used in other quality reporting programs or care delivery settings. Also, CMS provides an RFI in the Proposed Rule (pg. 1215-1218) with several questions regarding how CMS can address the U.S. maternal health crisis through policies and programs, including through Conditions of Participation (CoPs) and measures in other quality reporting programs.

Medicare Promoting Interoperability Program

In 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology (CEHRT). More recently, CMS renamed the Medicare and Medicaid EHR Incentive Programs to the "Medicare and Medicaid Promoting Interoperability Programs" or "Promoting Interoperability (PI) Programs". Regarding Medicaid providers and the Medicaid aspect of the PI programs, CMS previously established that Medicaid-eligible hospitals cannot receive any incentives after CY 2021. Thus, the Proposed Rule focuses on the Medicare PI Program.

Under the Medicare PI Program, downward payment adjustments are applied to eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods. As noted in the Proposed Rule, the EHR reporting period in CY 2023 is a minimum of any continuous 90-day period within CY 2023. Alternatively, for CY 2024, the EHR reporting period is a minimum of any continuous 180-day period within CY 2024.

CEHRT Requirements

The Medicare PI Program and the Quality Payment Program (QPP) require the use of CEHRT technology. CEHRT technology is certified under the Office of the National Coordinator for Health Information Technology (ONC) Health Information Technology (IT) Certification Program, which provides certain certification requirements (e.g., 2015 Edition of health IT certification criteria). On May 1, 2020, ONC published a rule that updated the 2015 Edition of the health IT certification criteria (e.g., 2015 Edition Cures Update) and introduced new certification criteria. Also, in response to the COVID-19 pandemic, ONC subsequently provided that health IT developers would have until December 31, 2022, to make available CEHRT that meet the 2015 Cures update (an additional deadline of December 31, 2023, was provided for an electronic health information (EHI) export).

Given these changes, CMS clarifies that health care providers would not be required to demonstrate that they are using updated technology to meet the CEHRT definition immediately upon the December 31, 2022, transition date. Rather, the eligible hospital, CAH, or MIPS eligible clinician is not required to demonstrate meaningful use of technology meeting the 2015 Edition Cures update until the EHR reporting period of performance period they have selected.

Proposed Measure Changes

In the Proposed Rule and as described below, CMS proposes changes to several measures in the Electronic Prescribing Objective, Health Information Exchange Objective and Public Health and Clinical Data Exchange Objective. CMS invites comments on these proposals. Table IX.H.-04 (pgs. 1339-1340) in the Proposed Rule displays the performance-based scoring methodology for the EHR Reporting Period in CY 2023. Also, CMS proposes to publicly report certain Medicare PI data beginning with the CY 2023 EHR reporting period.

Electronic Prescribing Objective

In CY 2022, CMS maintained optional reporting of the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure. In the Proposed Rule, CMS proposes several changes to this measure. Beginning with the CY 2023 EHR reporting period, CMS proposes to require the Query of PDMP measure for eligible hospitals and CAHs participating in the Medicare PI program and to expand the measure to include schedule II-IV drugs. CMS proposes to maintain the associated points for this measure at 10 points. **CMS invites comment on these proposals and seeks feedback on whether to expand this measure to include Schedule V or other drugs with the potential for abuse.**

Health Information Exchange Objective

CMS believes that measures within the Health Information Exchange Objective encourage and leverage interoperability on a broader scale and promote health IT-based care coordination. In January 2022, ONC released the Trusted Exchange Framework (a set of non-binding principles for health information exchange) and the Common Agreement for Nationwide Health Information Interoperability Version 1 (the "Common Agreement") (collectively, "TEFCA"). The Common Agreement is a legal contract that a Qualified Health Information Exchange (QHIN) would sign with the ONC Recognized Coordinating Entity (RCE). The RCE is a private-sector entity that implements the Common Agreement and ensures QHINs comply with its terms. As a result, for 2022, CMS notes that prospective QHINs are expected to begin signing the Common Agreement and applying

for designation. In 2023, HHS expects stakeholders across the care continuum to have increasing opportunities to enable exchange under TEFCA.

Noting the alignment between enabling exchange under TEFCA and the existing Health Information Exchange (HIE) Bi-Directional Exchange measure, CMS proposes to add an additional measure, known as the "Enable Exchange Under TEFCA measure". Under this proposed measure, an eligible hospital or CAH could earn credit for the Health Information Exchange Objective by connecting to an entity that connects to a QHIN or connecting directly to a QHIN. Specifically, CMS proposes to add the new measure to Health Information Exchange Objective beginning with the EHR reporting period in CY 2023.

Also, CMS proposes three reporting options for the Health Information Exchange Objective: 1) report on both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, 2) report on the HIE Bi-Directional Exchange measure, or 3) report on the proposed Enabling Exchange Under TEFCA measure. More information regarding the points associated with these measures is provided below.

Public Health and Clinical Data Exchange Objective

Under this objective, eligible hospitals and CAHs must report on any four measures of their choice from six measures.[4] CMS proposes various changes to this objective.

Specifically, CMS proposes to add a new Antimicrobial Use and Resistance (AUR) Surveillance measure[5] and require its reporting under the Public Health and Clinical Data Exchange Objective, beginning with the CY 2023 EHR reporting period. Eligible hospitals and CAHs that report a "yes" response or an exclusion for which they are eligible would receive credit for reporting the measure. Eligible hospitals and CAHs that report a "no" response or fail to report any response would not receive credit for reporting the measure and would fail to satisfy the Public Health and Clinical Data Exchange Objective. CMS also proposes a list of exclusions for this proposed measure which relate to patient location and various technological capabilities. **CMS invites public comments, including on the feasibility of the timeline and any additional exclusions that CMS should consider for this measure for proposal in future rulemaking.**

In addition, beginning with the CY 2023 EHR reporting period, CMS proposes to require submission of the level of active engagement (i.e., pre-production and validation phase or validated data production phase), in addition to submitting the measures for the Public Health and Clinical Data Exchange Objective. In the Proposed Rule, CMS notes its desire for all eligible hospitals to reach the validated data phase since that is when electronic transmission of high-quality data is achieved.

Request for Information: Patient Access to Health Information Measure

In the Proposed Rule, CMS provides a broad request for information regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the hospital or health care provider. For example, CMS seeks feedback on whether the application programming interface (API) and app ecosystem is at the point where it would be beneficial for CMS to revisit adding a measure of patient access to their health

[4] The six measures are: Syndromic Surveillance Reporting; Immunization Registry Reporting; Clinical Data Registry Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Electronic Reportable Laboratory Result Reporting

[5] AUR surveillance measure: The eligible hospital or CAH is in active engagement with CDC's National Healthcare Safety Network (NHSN) to submit antimicrobial use and resistance (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.

information which assesses providers on the degree to which their patients actively access their health information. A complete list of questions is available in the Proposed Rule (pg. 1369-1372).

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

In the Proposed Rule, CMS proposes various changes that impact the scoring of the objectives and measure for the EHR reporting period in CY 2023. The below table outlines the proposed performance-based scoring methodology for the EHR reporting period in CY 2023. Table IX-H.-07 of the Proposed Rule (pg. 1347-1358) provides a summary of the proposed and previously finalized objectives and measures for the Medicare PI program for the EHR reporting period in CY 2023.

Objective	Measure	Max. Points/ CY 2023 vs. CY 2022 comparison	Required/ Optional
Electronic Prescribing	e-Prescribing	10 (no change)	Required
	Query of PDMP*	10* (no longer bonus points)	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15* (5 point decrease)	Required (eligible hospital or CAH's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15* (5 point decrease)	
	OR		
	Health Information Exchange Bi-Directional Exchange	30* (10 point decrease)	
	OR		
	Enabling Exchange under TEFCA*	30* (new)	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25* (15 point decrease)	Required
Public Health and Clinical Data Exchange	Report the following five measures:* • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Reporting*	25* (15 point increase)	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting	5 (bonus)*	Optional

*Indicates a proposal made in the Proposed Rule

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare Promoting Interoperability Program

Eligible hospitals and CAHs must report on clinical quality measures (eCQMs) selected by CMS using CEHRT, as part of being a meaningful EHR user under the Medicare PI Program. CMS aims to align requirements between the Hospital IQR Program and the Medicare PI Program. Since the agency proposes eCQM additions and removals for the Hospital IQR Program, the agency proposes similar changes to the Medicare PI program.

Overall Hospital Quality Star Ratings

In the Proposed Rule, CMS references the CY 2021 OPPS/ASC final rule where the agency finalized a methodology to calculate the Overall Hospital Quality Star Ratings, but does not propose any modifications.

Rural Community Hospital Demonstration Program

The Rural Community Hospital Demonstration Program, which was established in 2003 and extended multiple times in different laws, was extended by the Consolidated Appropriations Act, 2021 (CAA) for an additional five years. The demonstration program pays rural community hospitals under a reasonable cost-based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. In the Proposed Rule, CMS summarizes the status of the demonstration program, and the ongoing methodologies for implementation and budget neutrality. Based on the agency's analysis, CMS proposes to subtract $107,945,638 from the national IPPS rates for FY 2023.

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

In the Proposed Rule, CMS notes that hospitals and CAHs must be certified as meeting Federal participation requirements (e.g., Conditions of Participation (CoPs), Conditions for Coverage (CfCs)). During the COVID-19 PHE, CMS issued new CoPs to require that hospitals and CAHs report certain COVID-19-related data (e.g., number of staffed beds, supply information, count of patients with COVID-19, inventory of COVID-19-related therapeutics) in the frequency and format specified by the Secretary during the PHE. In December 2020, CMS expanded these reporting requirements to consider acute respiratory illness (e.g., Seasonal Influenza Virus, Influenza-like Illness, and Severe Acute Respiratory Infection).

Based on the agency's experience throughout the PHE, CMS is considering adopting a more flexible regulatory framework to support the response to a future pandemic or epidemic. As a result, CMS proposes to review the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements. For COVID-19 reporting, CMS proposes that beginning at the end of the current COVID-19 PHE declaration and continuing until April 30, 2024, a hospital (or CAH) must electronically report information about COVID-19 and Seasonal Influenza in a standardized format specified by the Secretary. Categories of reported COVID-related data elements include: suspected and confirmed COVID19 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; and relevant therapeutic inventories and/or usage. For seasonal influenza, the categories of data elements anticipated include confirmed influenza infections among patients and staff; total influenza deaths among patients and staff; and confirmed co-morbid influenza and COVID-19 infections among patients and staff.

Also, CMS seeks to establish new reporting requirements for any future PHE related to a specific infectious disease or pathogen. Specifically, CMS proposes that when the Secretary has declared a PHE, hospitals and CAHs would need 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. CMS acknowledges a lag time would likely exist between the PHE declaration and the collection of reporting requirements. A complete list of reporting requirements is noted in the Proposed Rule (pg. 1401). CMS anticipates

the method of notification would follow a similar model as what was done during the PHE (e.g., via memorandum) and proposes to require reporting on a daily basis unless otherwise specified.

CMS seeks comment on how to best align and incentivize preparedness, while also reducing burden and costs on regulated entities. In addition, the agency seeks feedback on challenges or unintended consequences that this may impose on facilities.

Request for Public Comments on IPPS and OPPS Payment Adjustments for Wholly Domestically Made NIOSH-approved Surgical N95 Respirators

In the Proposed Rule, CMS provides information regarding the availability of PPE during the COVID-19 PHE. The agency highlights surgical N95 respirators as one type of PPE that had constrained availability and where there was a reliance on overseas production. CMS also notes price increases for surgical N95s during the PHE, and use of non-NIOSH approved respirators (e.g., KN95s) which can pose counterfeiting and quality risks. As a result, the federal government is interested in encouraging the purchase of wholly domestically made NIOSH-approved surgical N95 respirators, but acknowledges that these are generally more expensive than foreign-made ones.

To support a wholly domestic supply chain for NIOSH-approved surgical N95 respirators, CMS notes that under IPPS and OPPS the Secretary could potentially make a payment adjustment (in a budget neutral manner) to ensure equitable payments. Also, CMS is considering such payment adjustments to apply to 2023 and potentially subsequent years. In the Proposed Rule, CMS seeks comment on the following two possible frameworks:

1. *Biweekly interim lump sum payments that would be reconciled as cost report settlement:* A hospital would separately report on its cost report the aggregate cost and total quantity of NIOSH-approved surgical N95 respirators it purchased that were wholly domestically made and those that were not—for cost reporting periods beginning on or after January 1, 2023. This information and other cost-report information would be used to calculate a Medicare payment for the estimated cost differential, specific to each hospital, incurred due to the purchase of wholly domestically made NIOSH-approved surgical N95 respirators. Medicare could also make a lump-sum payment for Medicare's share of these additional inpatient and outpatient costs at cost report settlement.
2. *MS-DRG add-on payment that could be applied to each applicable Medicare IPPS discharge:* Hospitals would need to meet or exceed a "domestic sourcing threshold" of 50 percent for wholly domestically sources surgical N95 respirators purchased by or for the hospital in 2023. CMS notes it could establish a unique billing code that eligible hospitals would append to their claim where they would attest to meeting their sourcing threshold for the year. If CMS were to adopt a claims-based approach for IPPS, the agency would aim to adopt a similar approach under OPPS using Ambulatory Payment Classification (APC) add-on payments for non-telehealth services.

CMS seeks comment on a variety of questions in the Proposed Rule (pgs. 1413-1416), such as which potential framework would be more appropriate and why, how can hospitals determine if the surgical N95 respirators they purchase are wholly domestically made NIOSH-approved surgical N95 respirators and eligible for payment adjustments, what program safeguards are needed, and for group purchasing organizations (GPOs) 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. CMS also requests comment on whether there are other types of respirator devices and PPE that should be considered for payment adjustment and future consideration, beyond 2023.

Request for Information (RFI): Overarching Principles for Measuring Equity and Health Care Quality Disparities across CMS Quality Programs

In the Proposed Rule, CMS reiterates its commitment to achieving equity in health care outcomes for beneficiaries by supporting health care providers' quality improvement activities to reduce health disparities, enabling beneficiaries to make more informed decisions, and promoting healthcare provider accountability for healthcare disparities. CMS provides an overview of various health equity-related efforts it has made, including introducing confidential reporting of hospital quality measure data stratified by dual eligibility in the Hospital IQR Program. CMS notes it is continuing to evaluate opportunities to expand its measure stratification reporting initiatives using existing sources of data.

In the RFI, CMS provides the following key data elements that it intends to account for as it considers advancing the use of measurement and stratification as tools to address health care disparities and advance health care equity. CMS welcomes feedback regarding each data element, each of which is further elaborated on in the IPPS portion of the Proposed Rule (pgs. 1027-1045):

- *Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Programs* – This section identifies potential approaches for measuring healthcare disparities through measure stratification in CMS quality reporting programs. CMS also notes that stratified results must be carefully examined for potential measurement or algorithmic bias and that results must be evaluated for selection bias.
- *Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting Across CMS Quality Reporting Programs* – This section describes considerations that could inform the selection of healthcare quality measures to prioritize for stratification. To help inform prioritization of the next generation of measures for stratified reporting, CMS seeks feedback on several systemic principles related to existing quality measures, measures with identified disparity in treatment or outcomes for a selected social or demographic factor, sample size and access and appropriateness of care.
- *Principles for Social Risk Factor and Demographic Data Selection and Use* – This section describes several types of social risk factor and demographic data that could be used in stratifying measures for healthcare disparity measurement. CMS also discusses efforts to develop data standards for collection of self-report patient social risk and demographic variables, such as health information technology certification requirements that provide for the capability to record race and ethnicity at a detailed level of granularity consistent with the CDC's Race & Ethnicity Code System. CMS also notes it is considering three sources of social risk and demographic data to enable reporting of stratified measure results: (1) billing and administrative data; (2) area-based indicators of social risk information and patient demographics (e.g., American Community Survey, AHRQ's SES Index, CDC/ATSRD SVI, HRSA's Area Deprivation Index); and (3) imputed sources of social risk information and patient demographics.
- *Identification of Meaningful Performance Differences* – This section reviews several strategies for identifying meaningful differences in performance when measure results are stratified. For example, this section addresses statistical differences, rank ordering percentiles, threshold approach and benchmarking.
- *Guiding Principles for Reporting Disparity Results* – This section reviews potential considerations CMS may make when determining how quality programs will report measure results stratified by social risk factors and demographic variables to healthcare providers. In addition, it outlines potential reporting strategies to hold healthcare providers accountable for identified disparities. CMS notes it is considering first confidentially reporting all stratified measure results, where adopted in a quality program, before CMS reports the results publicly.

Request for Information: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

In the Proposed Rule, CMS indicates that CMS policy and programs can help accelerate nationwide connectivity through TEFCA by health care providers and other stakeholders. CMS notes there may be opportunities for the agency to incentivize exchange under TEFCA through other programs that incentivize high quality care or through program features in value-based payment models. CMS also provides that it is considering future opportunity to encourage information exchange under TEFCA for payment and operations activities such as submission of clinical documentation to support claims adjudication and prior authorization processes. In the Proposed Rule (pg. 1061), CMS provides a series of questions on topics such as important use cases that could be enabled through widespread information exchange under TEFCA, incentives for information exchange under TEFCA for CMS programs, and concerns about enabling exchange under TEFCA.

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

As part of CMS's efforts to move to fully digital quality measurement in CMS quality reporting and value-based purchasing programs, the agency is seeking input on the transition to digital quality measurement. CMS notes the critical role of standardized data for EHR-based measurement (which is based on the FHIR standard) in this transition. While specific program requirements related to providing data for quality measurement and reporting would be addressed in future rulemaking, CMS provides a list questions in the Proposed Rule (pg. 1056) which may help inform future policy decisions.

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

CMS notes its belief that the health care sector should more fully explore how to effectively prepare for climate threats and that health care facilities should also study how to reduce emissions. CMS provides a complete list of questions in the Proposed Rule (pgs. 1020-1022). Topics included in the RFI relate to the availability of accessible information to help providers better understand climate threats to their patients, community and staff; the degree to which different provider types currently complete comprehensive climate change risk assessments; the degree to which efforts to prepare for climate change overlaps with work done to meet CMS's Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; and, the measures health systems and facilities use to track their progress on emissions reduction and use of renewable energy.

What's Next?

CMS is anticipated to publish the final IPPS regulation before August 1, 2022, with the changes being effective at the beginning of the federal fiscal year (October 1, 2022). The comment period closes on June 17, 2022.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern, Sr. Regulatory Affairs and Public Policy Director in Vizient's Washington, D.C. office.