Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

APRIL 2022

FFY 2023 MEDICARE IPPS PROPOSED RULE (CMS-1771-P)

On April 18, the Centers for Medicare & Medicaid Services (CMS) posted the unpublished desk copy of the federal fiscal year (FFY) 2023 Inpatient Prospective Payment System (IPPS) proposed rule, effective Oct. 1, 2022 through Sept. 30, 2023. CMS will publish this proposed rule in the *Federal Register* on May 10.

CMS proposes an overall increase in IPPS payments of 3.2%. However, the proposed payment increases are offset by proposed decreases to outlier payments, negative policy adjustments to disproportionate share payments, and the expiration of Medicare Low-Volume and Medicare Dependent Hospital programs. Combined, the policies proposed in this rule result in a net decrease of 0.3% in FFY 2023 compared with FFY 2022. Comments on this proposed rule are due to CMS by June 17. All page numbers in this summary refer to the unpublished version of the proposed rule.

IPPS Rate Update (pp. 44-52, *Tables 1A-1E)*: CMS proposes a 3.1% market basket update, a 0.4 percentage point Affordable Care Act-mandated productivity reduction, and a 0.5 percentage point increase to partially restore cuts made under the American Taxpayer Relief Act (ATRA) of 2012. The market basket update for hospitals that fail to submit quality data will decrease by an additional one-quarter, and hospitals that do not meet meaningful use requirements are subject to a three-quarter reduction to the initial market basket.

	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
Percentage increase applied to standardized amount	3.2%	0.88%	2.43%	-0.1%

After FFY 2022 methodological modifications due to the COVID-19 Public Health Emergency (PHE), CMS reverted to its normal rate-setting methodology, using the most recent year of complete data available in calculating rates. For FFY 2023, this includes using FFY 2021 MedPAR claims and FFY 2020 cost report data. However, CMS proposes several modifications to its FFY 2023 MS-DRG updates to account for the potential impact of COVID-19 (discussed more below).

The table below summarizes proposed FFY 2023 standardized amounts. CMS proposes a labor-related share of 67.6% for IPPS hospitals with wage index values greater than 1.0000, and a labor-related share of 62% for IPPS hospitals with wage index values less than or equal to 1.0000.

Wage Index	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
> 1.0000	Labor: $4,269.46 Non-Labor: $2,046.31	Labor: $4,172.80 Non-Labor: $1,999.98	Labor: $4,237.24 Non-Labor: $2,030.87	Labor: $4,140.59 Non-Labor: $1,984.54
<= 1.0000	Labor: $3,915.78 Non-Labor: $2,399.99	Labor: $3,827.12 Non-Labor: $2,345.66	Labor: $3,886.23 Non-Labor: $2,381.88	Labor: $3,797.58 Non-Labor: $2,327.55

CMS proposes a capital standard federal payment rate of $480.29.

Disproportionate Share Hospital (DSH) Payment Changes (*pp. 700-776*): For FFY 2023, CMS estimates the empirically justified DSH payments to be $3.32 billion, and the remaining 75% pool to be approximately $9.95 billion. After adjusting the 75% pool for uninsured individuals, CMS estimates an uncompensated care amount of approximately $6.54 billion. This represents a decline of about $834 million compared to FFY 2022.

Additionally, CMS proposes a methodological change to how it calculates Medicare DSH payment adjustments. In FFY 2023, CMS will use the average of two years of audited worksheet S-10 data to calculate Factor 3 of the DSH adjustment. Thus, for FFY 2023 CMS proposes using FFYs 2018 and 2019 audited cost report worksheet S-10 data when calculating DSH payment adjustment. For FFY 2024 and forward, CMS proposes using the average of three years of audited worksheet S-10 data. Additional methodological modifications are outlined in the proposed rule.

Low-Volume Hospitals (*pp. 789-797*): Beginning in FFY 2023, low-volume hospital adjustments will revert to the methodologies and qualifying criteria in effect prior to FFY 2011. Specifically, low-volume hospitals must be located more than 25 road miles from another hospital and have less than 800 inpatient discharges during the fiscal year, regardless of payer. Additionally, the 25% low-volume add-on payment will only be made to qualifying hospitals with less than 200 discharges per year, regardless of payer. Hospitals with between 200 and 799 discharges will not receive a payment adjustment.

CMS proposes that hospitals must submit a written request for low-volume hospital status to their Medicare Administrative Contractor (MAC) no later than Sept. 1, 2022 in order for the 25%

add-on payment adjustment to be applied to payments for discharges beginning on or after Oct. 1, 2022. Hospitals that qualified for the low-volume hospital payment adjustment in FFY 2022 may continue to receive the adjustment for FFY 2023 without reapplying if they meet both the discharge and mileage criterion applicable for FFY 2023.

There are currently 11 low-volume adjustment hospitals in Illinois. In collaboration with the American Hospital Association (AHA), IHA is asking Congress to make permanent low-volume hospital criteria that were in place for FFYs 2011-22. This criteria includes a distance criteria of 15 or more miles from another hospital, and a total inpatient discharge rate of 3,800 or less during the fiscal year. Finally, we are asking for the payment adjustment methodology in place during FFYs 2019 through 2022, which used a continuous, linear sliding scale ranging from an additional 25% payment for low-volume hospitals with 500 or fewer discharges to a 0% add-on payment for low-volume hospitals with more than 3,800 discharges in the fiscal year.

Medicare-Dependent, Small Rural Hospital (MDH) Program (*pp. 798-800*): Absent Congressional action, the MDH program will expire at the end of FFY 2022. Beginning with discharges occurring on or after Oct. 1, 2022, all hospitals that previously qualified for MDH status will be paid based on IPPS federal rates.

There are currently eight MDH hospitals in Illinois. In collaboration with the AHA, IHA is asking Congress make the MDH program permanent. Should that not happen, we remind MDH hospitals that qualify for sole community hospital (SCH) status that they must apply for SCH status by Sept. 1, 2022 to ensure approval by Oct. 1.

Indirect and Direct Graduate Medical Education Payment (*pp. 802-824*): In *Milton S. Hersey Medical Center, et al. v. Becerra*, the plaintiffs challenged CMS' proportional reduction method, arguing it unlawfully reduced the weighting factor of 0.5 used for full-time equivalent (FTE) fellows that are outside the initial residency period of their training. The court sided with the plaintiffs, stating that CMS' proportional reduction methodology was inconsistent with the statutory weighting factors.

In response to this ruling, CMS proposes that if a hospital's unweighted number of FTE residents exceeds the limit, and the number of weighted FTE residents also exceeds that limit, 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 limit. This policy would be retroactive, effective for cost reporting periods beginning on or after Oct. 1, 2001.

Separately, CMS also proposes allowing an urban and a rural hospital participating in the same Rural Training Program (RTP) to enter into a "Rural Track Medicare GME Affiliation Agreement." This agreement would allow urban and rural hospitals jointly training residents to share cap slots, better facilitating and allowing cross training of residents. Please see the proposed rule for additional details.

Hospital and Critical Access Hospital (CAH) Conditions of Participation (CoP) (*pp. 1395-1407*): During the COVID-19 PHE, CMS has issued two separate interim final rules with comment (IFCs) that require hospitals and CAHs to submit specific data elements as a CoP on both COVID-19 and Seasonal Influenza (for more information, please see *85 FR 54820* and *85 FR 85866*). These reporting requirements are currently tied to the COVID-19 PHE declaration, meaning reporting will not be required as a CoP once the PHE ends. However, CMS stated it may need to monitor the impact of COVID-19 beyond the declared PHE.

Additionally, federal agencies are exploring ways to ensure more regulatory flexibility in preparation for the next potential pandemic or epidemic. To that end, CMS proposes revisions to the hospital and CAH infection prevention and control and antibiotic stewardship program CoPs to extend the current COVID-19 reporting requirements and to establish new reporting requirements for any future PHEs related to a specific infectious disease or pathogen.

Thus, CMS proposes revising the current COVID-19 and Seasonal Influenza reporting requirements for hospitals and CAHs, requiring continued reporting beyond the PHE declaration until April 30, 2024. Additionally, CMS proposes that for any future PHE declarations, hospitals and CAHs will be required to report specific data elements to the CDC's National Health Safety Network (NHSN) or other CDC-supported surveillance systems as determined by the Secretary of the U.S. Department of Health and Human Services (Secretary). The proposed requirements would apply to local, state, and national PHEs as declared by the Secretary.

Medicare Severity Diagnosis-Related Groups (MS-DRGs) (*pp. 53-629*): CMS proposes a 0.5 percentage point positive adjustment to the standardized amount for FFY 2023, constituting a permanent adjustment to payment rates consistent with the requirements of Medicare Access and CHIP Reauthorization Act (MACRA) section 414. This is the final adjustment prescribed under MACRA, and when combined with the positive adjustments from FFYs 2019 through 2022, results in a cumulative 2.9588 percentage point positive adjustment to the standardized amount.

Beginning with FFY 2024 MS-DRG classification change requests, CMS is changing the request deadline to Oct. 20 to allow additional time for the review and consideration of any proposed updates. Thus, Individuals that wish to submit MS-DRG classification change requests for FFY 2024 must submit those requests by Oct. 20, 2022. CMS is also changing the process for submitting requested updates to the MS-DRG classifications, beginning with the FFY 2024 MS-DRG classification change requests. CMS is currently implementing a new electronic application intake system: Medicare Electronic Application Request Information System (MEARIS). CMS will begin using MEARIS for MS-DRG classification change requests in FFY 2024, and will no longer consider any such requests sent via email.

In the FFY 2022 IPPS proposed rule, CMS considered changing the severity level designation of "unspecified" diagnosis codes to a Non-Complication or Comorbidity (NonCC) when there were other codes available that further specified the anatomic site. However, instead of making any changes, CMS implemented a Medicare Code Editor (MCE) code edit for "unspecified" codes,

effective with discharges on and after April 1, 2022. CMS is still not making any classification changes, but requested feedback regarding the MCE and other ways it can incorporate meaningful indicators of clinical severity.

To that end, CMS also requests feedback on future reporting of diagnosis codes in categories Z55-Z65 representing social determinants of health. While there are a range of issues associated with requiring Z-codes, CMS believes including such codes on inpatient claims could enhance quality improvement activities, help in tracking factors that influence people's health, and provide further insight into existing health inequities. There are 96 diagnosis codes describing social determinants of health in categories Z55-Z65 (see Table 6P.5a on CMS' website).

New Technology Add-On Payments (NTAPs) (*pp. 247-629*): CMS proposes continuing NTAPs for 15 new technologies (see Table II.F.-02 on *pp. 273-274*), discontinuing NTAPs for 11 technologies with three-year anniversary dates that occur prior to April 1, 2023 (see Table II.F.-01 on *p. 268*), and discontinuing NTAPs for 13 new technologies that received a one-year extension in FFY 2022 because their three-year anniversary date occurs before the second half of FFY 2022 (see Table II.F.-03 on pp. 277-278).

CMS used this proposed rule to review 13 new NTAP applications via the traditional pathway, and 13 new NTAP applications via the alternative pathway.

Wage Index (*pp. 630-699, Tables 2 and 3*):

Rural Floor: In the FFY 2020 IPPS final, CMS removed urban to rural reclassifications from the calculation of the rural floor to prevent payment increases under the rural floor caused by such reclassifications. CMS proposes continuing to calculate the rural floor without the wage data of hospitals that have reclassified as rural for FFY 2023. However, the FFY 2020 rural floor policy and related budget neutrality adjustment are the subject of pending litigation in *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra* (hereafter referred to as *Citrus*). On April 8, 2022, the district court in *Citrus* found that the Secretary did not have authority to establish a rural floor lower than the rural wage index for a state. Although *Citrus* involves only FFY 2020, the court's decision may affect FFY 2023 payment rates. Thus, while CMS proposes continuing this policy, it notes it may change its approach in the final rule depending on public comments or developments in the court proceedings.

Low Wage Index Hospital Policy: Since FFY 2020, CMS has implemented a budget neutrality adjustment to offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile. CMS proposes continuing this practice, and the FFY 2023 proposed 25th percentile wage index value is 0.8401 (note this value is below Illinois' proposed rural floor for FFY 2023).

However, the FFY 2020 low wage index hospital policy and the related budget neutrality adjustment are the subject of pending litigation, including in *Bridgeport Hospital, et al., v. Becerra*, (hereafter referred to as *Bridgeport*). On March 2, 2022, the district court found that the Secretary did not have authority to adopt the low wage index hospital policy and ordered

additional briefing on the appropriate remedy. Although *Bridgeport* involves only the FFY 2020 policy, the court's decision – which is not final at this time and is also subject to potential appeal – may impact FFY 2023 payment rates. Therefore, although CMS proposes continuing the low wage index hospital policy and the related budget neutrality adjustment for FFY 2023, it may change its approach in the final rule depending on public comments or developments in the court proceedings.

Proposed Permanent Cap on Wage Index Decreases: CMS proposes making permanent a 5% cap on wage index decreases, regardless of circumstances leading to the hospital's wage index decline. In other words, a hospital's wage index would not be less than 95% of its final wage index for the previous federal fiscal year. This policy would be budget neutral. CMS states it believes making this policy permanent increases the predictability of IPPS payments for hospitals and mitigates instability and substantial negative impacts to hospitals because of changes to the wage index. CMS also states it believes the proposed permanent policy would eliminate the need for transition adjustments to the wage index in the future due to specific policy changes or circumstances outside hospitals' control.

FFY 2023 Proposed Wage Index Information for Illinois Hospitals:

Core Based Statistical Area	Wage Index	Geographic Adjustment Factor (GAF)	Reclassified Wage Index	Reclassified GAF	FY 2023 Average Hourly Wage
Bloomington	0.9247	0.9478	0.8853	0.9200	44.3952
Cape Girardeau*	0.8477	0.8930			38.0855
Carbondale*	0.8477	0.8930			39.7179
Champaign-Urbana	0.8998	0.9302	0.8998	0.9302	43.1101
Chicago-Naperville-Evanston	1.0472	1.0321	1.0299	1.0204	50.2827
Danville	0.9499	0.9654	0.9334	0.9539	45.6133
Decatur	0.8825	0.9180			42.3748
Elgin	1.0226	1.0154	1.0049	1.0034	49.1009
Kankakee	0.9122	0.9390	0.8987	0.9295	43.7991
Lake County	0.9965	0.9976	0.9965	0.9976	47.3913
Peoria	0.8545	0.8979			41.0286
Rock Island*[a]	0.8477	0.8930	0.8477	0.8930	36.9649
Rockford	0.9653	0.9761	0.9406	0.9589	46.3539
St. Louis	0.9351	0.9551	0.9351	0.9551	44.9025

Springfield	0.8591	0.9012	0.8591	0.9012	41.1428
Rural	0.8477	0.8930	0.8358	0.8844	40.7013

Medicare Promoting Interoperability Program (*pp. 1297-1372*): CMS proposes several changes to the Medicare Promoting Interoperability Program. An overview of objectives and measures for the CY 2023 electronic health record (HER) reporting period are in Tables IX.H.-07 and IX.H.-08 (*pp. 1347-1360*).

Query of Prescription Drug Monitoring Program Measure (pp. 1300-1314): Beginning with the CY 2023 EHR reporting period, CMS proposes requiring the Query of PDMP measure for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program.

Addition of an Alternative Measure for Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) (pp. 1314-1326): CMS proposes an additional measure, Enabling Exchange Under TEFCA, through which an eligible hospital or CAH could earn credit for the Health Information Exchange Objective beginning with CY 2023 EHR reporting period. This would be one of three reporting options hospitals and CAHs would have for the Health Information Exchange Objective.

Antimicrobial Use and Resistance (AUR) Surveillance Measure (pp. 1326-1330): CMS proposes a new AUR Surveillance measure for the Public Health and Clinical Data Exchange Objective. The measure requires eligible hospitals or CAHs to be in active engagement with CDC's NHSN to submit AUR data for the CY 2023 EHR reporting period.

Active Engagement with Public Health and Clinical Data Exchange Objective (pp. 1330-1335): CMS proposes consolidating the three active engagement options available to hospitals and CAHs for the Public Health and Clinical Data Exchange Objective into two for the CY 2023 EHR reporting period. Hospitals and CAHs will be required to submit their level of active engagement for each measure they report, and eligible hospitals and CAHs may only spend one EHR reporting period in the Pre-Production and Validation level of active engagement per measure (Option 1). Then they must progress to the Validated Data Production level for the next EHR reporting period (Option 2).

Proposed Changes to EHR Reporting Period Methodology (pp. 1337-1341): The proposed changes above come with modifications to the maximum points assigned to the objectives in the Interoperability program. Table IX.H.-04 outlines the proposed objectives, measures, and maximum points for the CY 2023 EHR reporting period. Table IX.H.-05 displays the proposed exclusion redistribution for certain measures.

Public Reporting of Medicare Promoting Interoperability Program Data (pp. 1341-1343): CMS proposes publicly reporting certain Medicare Promoting Interoperability Program data beginning with the CY 2023 EHR reporting period, starting with public reporting of the total score of up to 105 points for each eligible hospital and CAH. CMS would also publicly report the EHR

certification ID that represents the CEHRT used by the eligible hospital or CAH. If finalized, the total score and CMS EHR certification ID data could be made available to the public as soon as operationally feasible. CMS is not proposing to publish individual measure scores at this time, but may do so under future rulemaking.

Clinical Quality Measures (pp. 1360-1366): Previously finalized eCQMs for the CY 2022-2024 reporting periods are in Tables IX.H.-09 through 10 (pp. 1361-1362). In an effort to continue aligning the eCQM reporting requirements for the Promoting Interoperability Program with the Hospital IQR program, CMS proposes the adoption of four new eCQMs for Promoting Interoperability Program. This includes the adoption of two new eCQMs for the CY 2023 reporting period (mandatory reporting beginning CY 2024): (1) Severe Obstetric Complications eCQM) and (2) Cesarean Birth eCQM. Beginning with the CY 2024 reporting period, CMS proposes adding (2) Hospital Harm-Opioid-Related Adverse Event eCQM and (2) Global Malnutrition Composite Score eCQM.

Hospital Acquired-Condition (HAC) Reduction Program (*pp. 902-932*): CMS proposes suppressing the CMS Patient Safety Indicator (PSI) 90 and five CDC NHSN healthcare associated infection (HAI) measures for FFY 2023. If finalized, no hospitals would be penalized under the HAC program for FFY 2023. CMS would continue reporting on hospital performance on the program's HAI measures, but proposed to not calculate or report measure results for the CMS PSI 90 measure for FFY 2023.

CMS also proposes suppressing CY 2021 CDC NHSN HAI data from the FFY 2024 HAC program, but would retain the PSI 90 measure with technical changes intended to risk-adjust for COVID-19 diagnoses. A summary of applicable periods for FFYs 2023-2025 are summarized on *p. 919*.

Finally, CMS requests feedback on the potential future adoption of the NHSN Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure and the NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure into the HAC Reduction Program. Note CMS also seeks feedback on the addition of these measures into the Hospital Inpatient Quality Reporting (IQR) program.

Hospital Readmissions Reduction Program (HRRP) (*pp. 829-855*): CMS proposes resumed scoring on the pneumonia readmissions measure for FFY 2024. This measure is already suppressed for FFY 2023. CMS proposes excluding patients with principal or secondary COVID-19 diagnoses from both the cohort and the outcome. Additionally, for all six HRRP measures, CMS proposes including patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models.

CMS seeks comments on updating the HRRP by including measures of hospitals' performance for socially at-risk populations across readmissions, treatment, or other measures. Specifically, CMS requested information on data variables associated with, or measures of, social risk and beneficiary demographics. CMS also seeks comment on potentially broadening the definition of

dual eligibility to include beneficiaries enrolled in a Medicare Savings Program or the Medicare Part D Low Income Subsidy.

Hospital Value-Based Purchasing (HVB) program (*pp. 856-901*): For FFY 2023, CMS proposes suppressing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures and the five healthcare associated infection measures (CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI). CMS also proposes a covariate adjustment accounting for patient history of COVID-19 in the 12 months prior to admission for mortality measures.

Due to a lack of scored measures, CMS proposes that all hospitals would receive neutral payment adjustments under the VBP for FFY 2023. CMS would still calculate and report HVBP measure scores publicly where feasible and appropriate.

Previously adopted baseline and performance period of the FFY 2024-2028 program years are in Tables V.I.-04 through -08 on pp. 890-892.

Finally, CMS requests feedback on the potential future adoption of the National Healthcare Safety Network (NHSN) Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure and the NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure into the Hospital VBP program. Note CMS also seeks feedback on the addition of these measures into the Hospital IQR program.

Hospital IQR Program (*pp. 1063-1256*): CMS proposes adding ten measures to the IQR, including:

- Hospital Commitment to Health Equity (CY 2023 reporting period/FFY 2025 payment determination);
- Screening for Social Drivers of Health (voluntary CY 2023; mandatory CY 2024 reporting period/FFY 2026 payment determination);
- Screen Positive Rate for Social Drivers of Health (voluntary CY 2023; mandatory CY 2024 reporting period/FFY 2026 payment determination);
- Cesarean Birth eCQM (voluntary CY 2023; mandatory CY 2024 reporting period/FFY 2026 payment determination;
- Severe Obstetric Complications eCQM (voluntary CY 2023 reporting period; mandatory CY 2024 reporting period/FFY 2026 payment determination);
- Hospital-Harm—Opioid-Related Adverse Events eCQM (CY 2024 reporting period/FY 2026 payment determination);
- Global Malnutrition Composite Score eCQM (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) (two voluntary reporting periods followed by mandatory reporting from July 1, 2025 - June 30, 2026/FFY 2028 payment determination;
- Medicare Spending Per Beneficiary (MSPB) Hospital measure (FY 2024 payment determination); and

- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA measure (FFY 2024 payment determination).

CMS also proposes refining two Hospital IQR measures beginning with the FFY 2024 payment determination: (1) Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA and/or TKA and (2) Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI). For the THA/TKA measure, CMS proposes the addition of 26 mechanical complication codes (pp. 1195-1197). For the AMI EDAC measure, CMS proposes increasing the minimum case count of 25 to a minimum case count of 50 during the measurement period to improve the measure's reliability (pp. 1199-1200).

Previously finalized measures can be found in the following tables:

- FFY 2024 Payment Determination: Table IX.E-09 (*p. 1201*);
- FFY 2025 Payment Determination: Table IX.E-10 (*pp. 1202-1203*);
- FFY 2026 Payment Determination: Table IX.E-11 (*pp. 1203-1204*);
- FFY 2027 Payment Determination: Table IX.E-12 (*pp. 1205-1206*); and
- FFY 2028 Payment Determination: Table IX.E-13 (*pp. 1207-1208*).

CMS requests feedback on the potential future inclusion of two measures in the Hospital QIR: (1) NHSN Healthcare-Associated *Clostridioides difficile* Infection outcome measure; and (2) NHSN Hospital-Onset Bacteremia & Fungemia outcome measure.

Finally, CMS proposes modifying eCQM reporting and submission requirements with the CY 2024 reporting period/FFY 2026 payment determination. Under the proposal, hospitals would be required to report four calendar years of data for each required eCQPM: (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. Table IX.E-15 (*p. 1236*) outlines the current and proposed eCQM reporting and submission requirements for the CY 2022 reporting period/FFY 2024 payment determination and subsequent years.

Maternal Mortality (*pp. 1208-1218*): In the FFY 2022 IPPS final rule, the Hospital IQR Program adopted the Maternal Morbidity Structural measure. This measure assesses whether hospitals are participating in a state or national Perinatal Quality Improvement (QI) Collaborative; and implementing patient safety practices or bundles as part of these QI initiatives.

Building on this measure, CMS proposes establishing a maternity care quality hospital designation. Beginning fall 2023, CMS would give this designation to hospitals that meet both criteria under the Maternal Morbidity Structural Measure and are currently reporting on the measure in the Hospital IQR program. CMS intends to expand the designation eligibility components into a more robust scoring methodology that may include other maternal health-related measures as appropriate for the Hospital IQR program measure data set, such as the Cesarean Birth and Severe Obstetric Complications eCQMs or future maternal health measures adopted in the Hospital IQR Program.

CMS also seeks comment on how to improve quality program measures to address maternal health inequities. CMS outlines specific questions on *pp. 1215-1218*.

RFI – Health Equity and Hospital Quality Programs (*pp. 1022-1046*): CMS requests comments on considerations in five specific areas:

- Identifying potential approaches for measuring healthcare disparities through measure stratification in CMS quality reporting programs;
- Considerations that could inform the selection of healthcare quality measures to prioritize for stratification;
- Several types of social risk factor and demographic data that could be used in stratifying measures for healthcare disparity measurement;
- Several strategies for identifying meaningful differences in performance when measure results are stratified; and
- Considerations CMS could take into account in determining how quality programs will report measure results stratified by social risk factors and demographic variables to healthcare providers, as well as the ways different reporting strategies could hold healthcare providers accountable for identified disparities.

CMS also invites stakeholders to submit additional comments about disparity measurement or stratification guidelines suitable for overarching consideration across CMS quality programs.

RFI – Health Equity and Climate Change *(pp. 1019-1022):* CMS requests information on the impact of climate change on outcomes, care, and health equity. Among other issues, CMS seeks comment on how it can support hospitals, nursing homes, hospices, home health agencies, and other providers in efforts to better prepare for the harmful impacts of climate change on patients. Specifically, HHS and CMS seek comments on how to support providers in more effectively:

- Determining likely climate impacts, both immediate and long-term, on their patients, residents and consumers so that they can develop plans to mitigate those impacts;
- Understanding exceptional threats that climate-related emergencies (e.g., extreme heat) present to continuous facility operations; and
- Understanding how to take action on reducing their emissions and tracking their progress in this regard.

RFI – Potential Payment Adjustments for N95 Respirators (*pp. 1408-1416*): CMS is considering the appropriateness of payment adjustments to hospitals under the IPPS and Outpatient Prospective Payment System (OPPS) to recognize additional resources costs occurred in acquiring National Institute for Occupational Safety and Health (NIOSH)-approved surgical N95 respirators that are wholly domestically made. The goal of payment adjustments would be to sustain a level of supply resilience for NIOSH-approved surgical N95 respirators during a PHE. CMS is considering such payment adjustments to apply to 2023 and potentially subsequent years. CMS presents two potential frameworks for such payments. The first framework is a biweekly interim lump-sum payment to hospitals that would be reconciled at cost report

settlement (pp. 1412-1413), and the second is a claims-based approach via a new MS-DRG add-on payment to be applied to each applicable Medicare IPPS discharge (p. 1413). CMS requests feedback on several specific questions such as how hospitals determine whether a respirator is wholly domestically made, and the pros and cons of these two frameworks (see pp. 1413-1416 for more information).

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Sources:

Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation. Available from: https://www.federalregister.gov/public-inspection/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-quality-programs-and-medicare. Accessed April 25, 2022.

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