Policy Update

CMS Releases FY 2023 IPPS Proposed Update

Summary

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) posted the FY 2023 Inpatient Prospective Payment System (IPPS) proposed update, along with proposed policy and regulation changes. The proposed rule would update Medicare payment policies and quality reporting programs relevant for inpatient hospitals, and would build on key priorities to address health disparities and improve the safety and quality of maternity care.

The proposed rule is available here. A CMS factsheet on the proposed rule is available here, and an additional factsheet on the maternal health and equity measures included in the proposed payment rule is available here. The proposed rule is scheduled to be published in the *Federal Register* on May 10, 2022, and comments are due on June 17, 2022.

Key Takeaways

1. CMS estimates that the overall proposed update and other rule changes would decrease IPPS payments to hospitals in FY 2023 by approximately $300 million. Payment updates and policy changes to graduate medical education (GME) would increase IPPS payments, but projected reduction in the uncompensated care payment pool, outlier payment and new technology add-on payments (NTAP), as well as expiration of Medicare Dependent Hospitals and low-volume hospital payment adjustments, would more than offset the projected increase. This estimate does not factor in changes in hospital admissions, real case-mix intensity or the mandatory sequestration adjustment.

2. The proposed FY 2023 standardized amount for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and that are meaningful electronic health record (EHR) users would be $6,315.77, an increase of 3.2% compared to the final FY 2022 standardized amount.

3. CMS proposes to use the FY 2021 MedPAR data and the FY 2020 cost reports for the FY 2023 rate setting, with proposed modifications to rate setting methodologies.

4. CMS does not propose to extend the add-on payment for the 11 technologies with NTAP periods expiring at the end of FY 2023. This proposed policy would end the one-year extension provided in FY 2022 because of the COVID-19 public health emergency (PHE) for technologies that had expiring NTAP periods.

5. In response to the pandemic's continued impact on hospitals, CMS proposes waiving penalties for certain quality programs and modifications to measures and measure calculations. The agency also seeks to advance health equity goals through these programs.

6. CMS proposes limitations on the Section 1115 patient days that may be included in the calculation of the Medicare disproportionate share hospital (DSH) adjustment and to use the two most recent years of audited Worksheet S-10 data to distribute uncompensated care payments.

7. CMS proposes to make changes to the calculation of GME full time equivalent (FTE) caps for certain hospitals and to allow certain urban and rural hospitals participating in Rural Training Tracks to enter into Medicare GME affiliation agreements in order to share FTE caps.

8. CMS solicits feedback on several requests for information (RFIs), including RFIs focused on climate change, maternal health equity and moving to digital quality measures.

Standardized Amount

Key Takeaway: CMS proposes an increase of 3.2% for hospitals that successfully participate in CMS reporting programs.

The standardized amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies various other statutorily mandated or inspired adjustments.

The standardized amount varies based on an individual hospital's participation in the Hospital IQR and EHR programs. The proposed FY 2023 standardized amount for hospitals that successfully participate in both programs is $6,315.77. This represents an increase of 3.2% over the final FY 2022 standardized amount ($6,121.65).

The 3.2% increase to the standardized amount reflects a 3.1% market basket update, less a 0.4% productivity adjustment, plus a 0.5% adjustment for documentation and coding mandated by Section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 for FY 2018 through FY 2023. In addition to these statutory updates, the standardized amount is subject to budget neutrality adjustments discussed in the final rule. Hospitals that fail to submit quality data are subject to a -0.775% adjustment, and hospitals that fail to be meaningful EHR users are subject to a -2.325% adjustment.

The proposed FY 2023 standardized amounts, shown in the table below, are the sum of the labor-related and non-labor-related shares without adjustment for geographic factors. The labor-related share reflects the proportion of the federal base payment that is adjusted by a hospital's 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
FY 2023 Proposed Standardized Amount	$6,315.77	$6,172.78	$6,268.11	$6,125.13
FY 2022 Final Standardized Amount	$6,121.65	$6,000.11	$6,081.13	$5,959.61
Percent Change	3.2%	2.9%	3.1%	2.8%

Medicare Severity Diagnosis-Related Group Updates

New Deadline and Intake System for MS-DRG Change Requests

Key Takeaway: CMS proposes to change the deadline to request Medicare Severity Diagnosis-Related Group (MS-DRG) changes to October 20 of each year, and to accept MS-DRG related requests through a new electronic application intake system beginning with FY 2024.

CMS is required by statute to adjust the DRG classifications and relative weights at least annually to reflect changes in treatment patterns, technology and any other factors that may change the relative use of hospital resources. Providers and other stakeholders can submit MS-DRG change requests for CMS to consider in the annual rate setting process. In recent years, CMS has updated the deadline to request MS-DRG changes to allow for more review time. For FY 2023, CMS maintained the deadline of November 1.

Beginning with FY 2024, CMS proposes to change the deadline to request MS-DRG changes to October 20 of each year to allow for additional time for review and evaluation. CMS also proposes to change the submission process by implementing a new electronic intake system, Medicare Electronic Application Request Information System ™ (MEARIS ™). MEARIS ™ is now live and available for users to submit requests for ICD-10-PCS procedure codes and other requests. Beginning with FY 2024, CMS will only accept MS-DRG classification change requests submitted via MEARIS ™ and will no longer accept such requests sent via email.

Data and Methodology Change for Rate Setting

Key Takeaway: CMS proposes to use the FY 2021 MedPAR data and the FY 2020 cost reports for the FY 2023 rate setting, with proposed modifications to rate setting methodologies.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS relies on claims data captured in the MedPAR file and cost report data captured in the Healthcare Cost Report Information System file. In a traditional year, for rate setting purposes, CMS would use the most recent data available at the time of rulemaking, which normally captures claims from discharges that occurred for the fiscal year two years prior to the fiscal year addressed in the rulemaking. In light of the PHE, however, CMS decided to use FY 2019 MedPAR claims data rather than FY 2020 MedPAR data for the FY 2022 rate setting.

For the FY 2023 rate setting, CMS proposes to return to its historical practice of using the most recent available data, including the FY 2021 MedPAR claims and the FY 2020 cost reports. However, CMS believes that fewer Medicare beneficiaries will be hospitalized for COVID-19 in FY 2023 compared to FY 2021. In light of this assumption, CMS proposes two modifications to the FY 2023 rate setting methodologies:

1. CMS proposes to calculate the relative weights for FY 2023 by first calculating two sets of weights, one including and one excluding COVID-19 claims, then averaging the two sets of relative weights to determine the FY 2023 relative weight values.
2. CMS proposes to use charge inflation factors and cost to charge ratio (CCR) adjustment factors derived from the two years prior to the COVID-19 PHE period (FY 2019 and FY 2018) for projecting the outlier fixed-loss cost threshold for FY 2023. Under CMS's existing policy, CMS would ordinarily use the most recent MedPAR files (FY 2021 and FY 2020) to compute average annual rate-of-change in charges per case. However, CMS's analysis shows abnormally high charge inflation factors calculated using these two most recent MedPAR files compared to recent historical levels prior to the COVID-19 PHE period. CMS believes the charge inflation for the period prior to the COVID-19 PHE provides a more reasonable approximation of the increase in costs that will occur from FY 2021 to FY 2023 because the number of higher-cost COVID-19 cases is expected to decline. CMS observed similar higher CCR adjustment factors using the two most recent years of Provider-Specific Files. CMS seeks comment on the alternative of using the FY 2021 data without the proposed modifications to the usual

methodologies.

Refinement of MS-DRG Classification

Key Takeaway: CMS proposes to further delay implementation of a major modification to the MS-DRG classification.

The current MS-DRGs provide up to three levels of severity for a particular condition based on the presence of a complication or comorbidity (CC) or a major complication or comorbidity (MCC). In FY 2021, CMS finalized a proposal to apply expanded three-way severity split criteria. CMS believes that applying these criteria would better reflect resource stratification and avoid low volume counts for the NonCC level MS-DRGs. In FY 2022, CMS finalized a delay in implementing this proposal due to the PHE.

For FY 2023, CMS proposes to further delay implementation of the three-way split criteria because of the magnitude of the impact during the ongoing PHE. CMS's analysis shows that approximately 41 MS-DRGs would be subject to change based on the three-way severity level split criteria finalized in FY 2021. CMS found that applying these criteria would result in the deletion of 123 MS-DRGs and the creation of 75 new MS-DRGs. These updates would also involve a redistribution of cases, which would impact the relative weights. CMS proposes to maintain the current MS-DRG classification for FY 2023. CMS indicates that it will address the implementation of the three-way split criteria in future rulemaking.

Social Determinants of Health Comment Solicitation

Key Takeaway: CMS solicits public comments on how the reporting of social determinants of health (SDOH) diagnosis codes may help improve the MS-DRG system.

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. In ICD-10-CM, the Z codes represent reasons for encounters and are provided for occasions when circumstances other than a disease, injury or external cause are recorded as "diagnoses" or "problems." The subset of Z codes that describe the SDOH are found in categories Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances). These codes describe a range of issues related, but not limited, to education and literacy; employment; housing; ability to obtain adequate amounts of food or safe drinking water; and occupational exposure to toxic agents, dust or radiation. Effective October 1, 2021, the Centers for Disease Control and Prevention National Center for Health Statistics added 11 new diagnosis codes describing SDOH to provide additional information regarding determinants such as housing, food insecurity and transportation.

CMS solicits public comments on how the reporting of SDOH diagnosis codes may improve the ability of the MS-DRG system to recognize severity of illness, complexity of service and/or utilization of resources. CMS is also interested in receiving feedback on how to foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each healthcare encounter and improve the reliability and validity of the coded data.

New Technology Add-On Payments

Cost Criterion for NTAP

Key Takeaway: CMS proposes to use FY 2021 MedPAR data to establish proposed FY 2024 threshold values.

Under the NTAP program, CMS provides additional payment for new medical services or technologies where the costs of the technology are not yet reflected in the MS-DRG weights. One criterion for assessing whether a new technology qualifies for the add-on payment is whether the charges for the technology meet or exceed certain threshold amounts. Historically, CMS has evaluated this cost criterion using threshold amounts established in the prior year's final rule. In this rule, as finalized in the FY 2021 IPPS Final Rule, CMS proposes to use the proposed threshold amounts for the upcoming fiscal year for any proposed new MS-DRGs to evaluate whether the technology meets the cost criterion.

As a standard part of its calculation of the threshold criteria, CMS calculates relative weights for the upcoming fiscal year. Because of the pandemic's impact, CMS proposes to use an average of the FY 2023 relative weights, calculated without and with COVID-19 cases in the FY 2021 data. As an alternative, CMS provides the FY 2024 threshold criteria absent the averaging methodology noted above. Under the two different approaches, almost 75% of the threshold criteria are within $100 of each other, and 97.9% are within $1,000.

CMS proposes no changes to the other criteria considered when evaluating a new technology's eligibility for the add-on payments (*i.e.*, newness and substantial clinical improvement).

Extension for Technologies with Expiring NTAP Period

Key Takeaway: CMS does not propose a one-year extension for technologies whose NTAP period is scheduled to expire at the end of FY 2022.

The NTAP period normally includes the first two to three years that the product is on the market, after which the costs are captured in the MS-DRG weights. CMS evaluates the eligibility of new technologies for this additional payment annually based on their newness date (typically defined as the date of market entry). Under current policy, CMS only extends add-on payments for an additional year if the three-year anniversary of the newness date occurs in the latter half of the upcoming fiscal year.

As noted, CMS proposes to use FY 2021 MedPAR data for the FY 2023 rate setting process for IPPS. Because the FY 2021 MedPAR data is likely to fully reflect the costs of new technologies with expiring NTAP periods, CMS does not propose a one-time NTAP extension for these technologies. If finalized as proposed, this policy would apply to 11 technologies (see Table II.F.-01). CMS proposes no further action for the technologies that benefited from a one-time extension in the FY 2022 IPPS, and therefore an additional 13 technologies would have their NTAP periods expire at the end of FY 2022 (see Table II.F.-03).

The expiration of NTAP periods for 24 technologies is likely the driving factor behind the estimated $835 million decrease in NTAP payments for FY 2023.

NTAP Applications for FY 2023

Key Takeaway: CMS sees a decline in the number of NTAP applications reviewed in this rule.

In the proposed rule, CMS discusses 26 NTAP applications. Excluding the multiple applications withdrawn prior to the publication of the proposed rule, 13 devices and drugs applied through the traditional pathway, and 13 went through the alternative pathways (12 devices with breakthrough or pending breakthrough status, and one product designated as a qualified infectious disease product). The number of FY 2023 NTAP applications reviewed represents a 29.7% decrease over applications reviewed for FY 2022, due in part to the 11 withdrawn applications.

With no proposed extension of the NTAP eligibility period, CMS proposes to continue add-on payments for 15 technologies (see Table II.F.-02).

In response to the PHE and in light of the development of new drugs and biologics for COVID-19 treatment, CMS established a new COVID-19 treatment add-on payment (NCTAP) in FY 2021, starting with discharges on or after November 2, 2020, that met certain criteria. Acknowledging the pandemic's continued financial impact on hospitals, CMS proposes to continue the NCTAP for qualified technologies that do not qualify for the NTAP. Where technologies qualify for both NCTAP and NTAP, CMS proposes to reduce the NCTAP by any incremental payment through the NTAP pathway. Consistent with the policy established in FY 2022, the NCTAP would remain in effect until the end of the fiscal year following the end of the PHE.

NTAP Policy Proposals for FY 2023

Key Takeaway: CMS proposes to post NTAP applications online starting in FY 2024.

Historically, CMS has published tracking forms completed for each device or drug for which an applicant seeks an NTAP. These forms present a high-level overview of the technology (*e.g.*, applicant name, technology name and brief description) and give insight into applications for stakeholders in advance of the publication of the proposed rule. Based on feedback from stakeholders and as part of a stated effort to increase transparency, CMS proposes to publicly post completed applications and key relevant materials starting with FY 2024, with the exception of cost data, volume data and any materials not releasable to the public due to copyright. By posting these materials online, CMS proposes to streamline discussion of the applications in the proposed rule to highlight any questions or concerns raised as part of the application review.

Key Takeaway: CMS proposes National Drug Codes (NDCs) for reporting of therapeutic agents eligible for NTAP.

To be eligible for NTAP on a case-by-case basis, hospitals must report the assigned ICD-10-PCS code for the drug or device deemed eligible. Based on feedback from stakeholders, CMS proposes to use NDCs to identify NTAP-eligible therapeutic agents rather than ICD-10-PCS. This policy, if finalized, would be phased in over a two-year transition period with eligible therapeutic agents reported by NDC or ICD-10-PCS in FY 2023 and by NDC only in FY 2024 (with few exceptions).

Quality Data Reporting Requirements for Specific Providers and Suppliers

Mitigating Quality Reporting Burdens and Quality Program Penalties

Key Takeaway: In response to the pandemic's continued impact on hospitals, CMS proposes to waive penalties and modify measures and measure calculations for certain quality programs. The agency also seeks to advance health equity goals through these programs.

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition Reduction Program, Hospital IQR Program, Medicare and Medicaid Promoting Interoperability Programs, and PPS-Exempt Cancer Hospital Quality Reporting Program. These programs feature a mix of financial rewards and penalties as well as the public release of quality data.

In this proposed rule, CMS seeks to lessen the burden of quality reporting and reduce financial risks during the pandemic, and makes proposals to advance larger health equity goals.

Hospital IQR Program

Hospitals are required to report data on measures to receive the full annual percentage increase for IPPS services that would otherwise apply.

Proposals

- **Adoption of 10 measures** on a range of topics, including health equity, social drivers of health, obstetrics, opioids, total hip and total knee surgeries, and Medicare spending
- Under the proposed **health equity measure**, a requirement that hospitals attest to their commitment to health equity in five areas: equity as a strategic priority, data collection efforts, data analysis efforts, participation in quality improvement, and demonstrated leadership engagement
    - Reporting for CY 2023 reporting period/FY 2025 payment determination and subsequent years
- Under the proposed **screening for social drivers of health measure**, assessment of hospitals in five domains (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety), plus a second measure titled **screen for positive rate for social drivers of health** intended to create more actionable information to address health equity gaps
    - Voluntary reporting in 2023 and mandatory reporting in 2024
- A proposed **global malnutrition composite score electronic clinical quality measure** (eCQM), proposed adoption of the refined **Medicare spending per beneficiary** hospital measure, proposed refinement to an existing acute myocardial infarction measure and the potential future inclusion of two digital **National Healthcare Safety Network** (NHSN) measures

Hospital Readmissions Reduction Program

HRRP reduces payments to hospitals with excess readmissions of selected applicable conditions.

Proposals

- Resumption of the use of measures that were previously removed from the program
- Technical changes to measure calculation to either exclude or adjust for **patients with a history of COVID-19**
- Incorporation of provider performance for **socially at-risk populations**

Hospital Value-Based Purchasing Program
The HVBP Program withholds participating hospitals' Medicare payments by 2% and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.

Proposals

- **Suppression and technical changes** to several measures
- Revision of scoring so all hospitals receive an incentive payment equal to the amount withheld for the fiscal year (2%) (*e.g.*, **neutral adjustment)**

Hospital Acquired Condition Reduction Program
Hospitals report on a set of measures on hospital-acquired conditions. Hospitals with scores in the worst performing quartile are subject to a 1% payment reduction.

Proposals

- **No penalty** under the program for FY 2023
- Suppression, revisions and technical changes to several measures, including adjusting for a **COVID-19 diagnosis**
- Request for comments on the addition of **two digital NHSN measures**

PPS-Exempt Cancer Hospital Quality Reporting Program
The Affordable Care Act established this quality reporting program for PPS- exempt cancer hospitals.

Proposals

- Public display of several measures
- Request for comments on the addition of **two digital NHSN measures**

Medicare and Medicaid Promoting Interoperability Programs
The Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established in 2011.

- Modifications to the **electronic prescribing objective's query of prescription drug monitoring program** measure as well as other measures and objectives
- Modifications to the scoring methodology for FY 2023, **public reporting of certain data** and adoption of new eCQMs

Wage Index

Low Wage Index Hospital Policy

Key Takeaway: CMS proposes to maintain a policy that supports hospitals in low wage index areas.

Medicare payments to hospitals (and various other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (*e.g.*, the perceived cost of labor is higher in New York City than in rural Oklahoma). CMS updates the wage index each year based on hospital cost report data and other inputs and policies.

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile and stated that it intended this policy to be effective for at least four years. Affected hospitals had their wage index value increased by half the difference between the otherwise applicable wage index value for a given hospital and the 25th percentile wage index value across all hospitals. CMS achieved budget neutrality for this change by adjusting the standardized amount applied across all IPPS hospitals.

This FY 2020 low wage index hospital policy and the related budget neutrality adjustment are the subject of pending litigation. In March 2022, a 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. While the lawsuit technically involves only FY 2020, the court's decision (which is not final at this time and is also subject to potential appeal) may have implications for FY 2023 and beyond. While CMS proposes to continue this low wage index hospital policy for FY 2023, the agency indicates that it might take a different approach in the final rule depending on public comments or developments in the court proceedings.

Permanent Cap on Wage Index Decreases

Key Takeaway: CMS proposes to apply a permanent 5% cap on year-to-year decreases in wage index.

In FY 2020, CMS implemented a transition policy to place a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2019 so that a hospital's final wage index for FY 2020 would not be less than 95% of its final wage index for FY 2019. CMS applied a budget neutrality adjustment factor to the FY 2020 standardized amount for all hospitals to achieve budget neutrality for the transition policy. CMS extended the transition policy in FY 2021 and FY 2022 to mitigate short-term instability and fluctuations in hospital finances due to other circumstances.

For FY 2023 and subsequent years, CMS proposes to apply a permanent 5% cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year, regardless of the circumstances. Under this proposed policy, a hospital's wage index would not be less than 95% of its final wage index for the prior fiscal year. CMS also proposes to apply the proposed wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount.

Disproportionate Share Hospital Payment

Inclusion of Section 1115 Patient Days in Medicare DSH Adjustment

Key Takeaway: CMS proposes changes in the treatment of Section 1115 waiver days in the calculation of the Medicare DSH adjustment.

In the FY 2023 IPPS proposed rule, CMS again proposes revisions to the treatment of certain Section 1115 waiver days for purposes of the Medicare DSH adjustment. CMS proposes that those "regarded as eligible" for Medicaid includes only certain patients who receive health insurance or premium assistance that meets certain additional requirements under a Section 1115 waiver. This proposal is largely in response to a series of court cases that have interpreted the current regulatory language as requiring CMS to count patient days associated with CMS-approved Section 1115 demonstration projects for uncompensated care pools and premium

assistance programs in the Medicaid DSH calculation. CMS also proposed revisions to the calculation of the Medicaid DSH fraction in the FY 2022 IPPS proposed rule, which would have clarified that a patient is deemed to be eligible for Medicaid, for purposes of the DSH calculation, only if the patient is eligible for inpatient hospital services under a state Medicaid program that either (1) includes coverage for inpatient hospital care on that patient day or (2) directly receives inpatient hospital insurance on that patient day under a Section 1115 waiver. CMS ultimately declined to finalize the proposed changes to the DSH payment calculation related to the Medicaid fraction because of the volume of comments received on the subject.

CMS proposes to define those patients who are "regarded as" "eligible for medical assistance under a State plan" to mean patients who receive health insurance through a Section 1115 demonstration project or who purchase health insurance with the use of a premium assistance program that provides assistance for all or substantially all of the patients' health insurance costs. The health insurance purchased using the premium assistance program must provide "essential health benefits" as defined at 42 CFR, Part 440, for an alternative benefit plan. The premium assistance also must be equal to or greater than 90% of the cost of the health insurance. CMS also proposes to clarify its interpretation that patient days associated with care funded through a Section 1115 demonstration uncompensated care pool are not viewed as patient days for patients who are "regarded as" Medicaid-eligible. This proposal, if finalized, will effectively limit the types of Section 1115 waiver days that can be included in the Medicaid fraction of the DSH adjustment.

Uncompensated Care Payment

Key Takeaway: CMS proposes to distribute roughly $6.5 billion in uncompensated care payment for FY 2023, a decrease of approximately $654 million from FY 2022, using the two most recent years of audited Worksheet S-10 data.

Starting from FY 2014, CMS distributes a prospective amount of uncompensated care payments (UCP) to Medicare DSH hospitals based on their relative share of uncompensated care nationally. As required by statute, the UCP pool amount is equal to 75% of total amount of estimated Medicare DSH payments, adjusted for the change in the rate of uninsured individuals. For FY 2023, CMS proposes to distribute roughly $6.5 billion in UCP, a decrease of approximately $654 million from FY 2022. This total UCP amount reflects CMS Office of the Actuary's projections that incorporate the estimated impact of the COVID-19 pandemic.

For FY 2023, CMS proposes to use the two most recent years of audited Worksheet S-10 data (FY 2018 and FY 2019) to distribute UCP, in response to concerns that the use of only one year of data would cause significant variations in year-to-year UCP amounts. In addition, for FY 2024 and subsequent fiscal years, CMS proposes to use a three-year average of the audited Worksheet S-10 data, because FY 2024 will be the first year that three years of audited Worksheet S-10 data will be available at the time of rulemaking. For example, for FY 2024, CMS proposes to use audited Worksheet S-10 data from FY 2018, FY 2019 and FY 2020 cost reports to distribute UCP.

Beginning in FY 2023, CMS proposes to discontinue the use of low-income insured days as a proxy for uncompensated care in determining UCP for Indian Health Service (IHS) and Tribal hospitals, and hospitals located in Puerto Rico. To mitigate the significant financial disruption for these hospitals, CMS also proposes to establish a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico beginning in FY 2023.

Graduate Medical Education

Key Takeaway: CMS proposes to change GME full time equivalent (FTE) caps for certain hospitals and allow certain urban and rural hospitals to enter into Rural Track Medicare GME Affiliation Agreements.

In response to litigation, CMS proposes to apply a retroactive and prospective change to the calculation of the

GME FTE caps for some hospitals. If a hospital's unweighted number of FTE residents exceeds the hospital's FTE cap, and the number of weighted FTE residents also exceeds the FTE cap, the weighted FTE count would be adjusted to make it equal the FTE cap. If the number of weighted FTE residents does not exceed that FTE cap, then the allowable weighted FTE count for direct GME payment would be the actual weighted FTE count.

CMS also proposes to allow urban and rural hospitals to enter into Rural Track Medicare GME Affiliation Agreements if they participate in the same separately accredited 1-2 family medicine rural track program and have established rural track FTE limitations. Urban and rural hospitals would only be allowed to participate in rural track Medicare GME affiliated groups if they have rural track FTE limitations in place prior to October 1, 2022 and would be permitted to enter into rural track Medicare GME affiliation agreements effective with the July 1, 2023, academic year.

Requests for Information

Key Takeaway: CMS releases RFIs to seek public input on establishing policies addressing climate change, measuring healthcare disparities across quality programs, disparities in maternal care and moving to digital quality measures

Climate Change RFI

A growing body of evidence finds that climate change is a threat to global public health that disproportionately harms underserved populations. Healthcare facilities that emit greenhouse gases contribute to climate change and thus exacerbate the problem.

With this RFI, CMS seeks comment on how hospitals, nursing homes, hospices, home health agencies and other providers can better prepare for the impact of climate change and what CMS can do to support these efforts. The RFI solicits information on the impact of climate change, the types of threats and emergencies resulting from climate change (*e.g.,* wildfires), and what type of action can be taken to prepare for climate changes and reduce emissions.

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs RFI

President Biden's Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government was released on January 20, 2021, and directed agency leadership to review, manage and establish policy using an equity lens. In response, the US Department of Health and Human Services has advanced the priority of health equity through many RFIs, policies and actions. In the 2022 IPPS proposed rule and many other 2022 CMS payment rules, the agency asked stakeholders to provide information about how the agency can improve reporting and application of health disparity data related to social risk factors and race and ethnicity. As a next step, in the 2023 IPPS proposed rule**,** CMS seeks public input on establishing policies to measure healthcare quality disparities across CMS quality programs**.** CMS seeks input on stratifying measures, prioritizing measures, using social risk factors and demographic data selection, identifying meaningful differences in performance results, and how to best report measure results.

The recently released FY 2023 skilled nursing facility and inpatient rehabilitation facility proposed rules included similar RFIs, and the upcoming CY 2023 physician and hospital outpatient proposed payment rules may do so as well.

Maternal Health Quality Designation and Equity RFI

Data shows a worsening maternal health crisis in the United States that disproportionally impacts certain racial and ethnic minorities. Addressing this crisis is a priority for the current Administration, which has put out a call to action to reduce maternal morbidity and mortality. To advance this priority, CMS proposes establishing the first-ever publicly reported hospital quality designation focused on maternal health, also referred to as a "birthing friendly" designation. The intent of the measure is for patients to easily identify high-quality and safe maternity care. Hospitals would be identified based on their response to the maternal morbidity structural measure. The measure would assess whether a hospital participates in a Statewide or National Perinatal Quality Improvement (QI) Collaborative initiative and implements patient safety practices and/or bundles related to maternal morbidity from that QI Collaborative. This proposal can be viewed as a companion to the provision in the American Rescue Plan that gives states an easier pathway to extend Medicaid and CHIP coverage 12 months after a pregnancy.

CMS also seeks input on addressing the US maternal health crisis through the Advance Maternal Health Equity RFI. CMS seeks input on how policies, programs, quality measures and conditions of participation (CoPs) can improve maternal health outcomes, enhance the quality of maternity care and reduce maternal health disparities.

In this section of the proposed rule, CMS also proposes to revise the hospital and critical access hospital (CAH) infection prevention and control CoP requirements to continue COVID-19 reporting requirements commencing either upon the conclusion of the current COVID-19 PHE declaration or the effective date of this proposed rule, whichever is later, and lasting until April 30, 2024 (unless the Secretary determines an earlier end date). The agency also proposes additional requirements to address future PHEs related to epidemics and pandemics.

Through the various proposals in the quality section of the proposed rule, CMS seems to address three priorities: improving quality measurement in the inpatient setting, mitigating the impact of the pandemic by reducing reporting burdens and financial risks of these quality programs, and advancing the Administration's goals on health inequities and reducing disparities.

Advancing to Digital Quality Measurement RFI

Following a similar RFI in the FY 2022 IPPS proposed rule, CMS again seeks feedback on its effort to move to digital quality measurement for all quality reporting and value-based purchasing programs. CMS previously indicated that it sought to achieve this transition by 2025, but the agency now clarifies that it plans to transition incrementally.

This RFI focuses on the standardization needed to improve the exchange of digital data and seeks feedback on how to align with interoperability requirements already established under the 21st Century Cures Act. CMS is also considering whether to require a common standard—specifically, the Fast Healthcare Interoperable Resources (FHIR®)—to reduce reporting burden and facilitate the reporting and exchange of digital measures. The RFI notes that CMS would focus first on achieving FHIR-based eCQM reporting.

CMS states that it will not make updates to specific program requirements or respond to comments on this issue in the final rule, but will address updates and comments in future rulemaking.

Trusted Exchange Framework and Common Agreement RFI

The 21st Century Cures Act sought to improve data exchange by establishing a universal policy and technical floor for nationwide interoperability. On January 18, 2022, the Office of the National Coordinator for Health Information Technology announced a significant milestone by releasing the Trusted Exchange Framework, a set of non-binding principles for health information exchange, and Common Agreement

Version 1.7, a contract that advances those principles (TEFCA).

CMS proposes to add a new Enabling Exchange Under TEFCA measure in the Medicare Promoting Interoperability Program to further the work being done under TEFCA. This proposed measure would provide eligible hospitals and CAHs with the opportunity to earn credit for the Health Information Exchange objective if they are a signatory to a "Framework Agreement," as that term is defined in the Common Agreement, and meet other exchange requirements.

Beyond this measure, CMS is considering other ways that available CMS policy and program levers can advance information exchange under TEFCA. The proposed rule notes that these efforts can apply to payers as well as providers and seeks specific use cases that may be appropriate to advance TEFCA**.** The proposed rule also asks if enabling exchange under TEFCA could increase burden and/or costs, and, if so, how CMS could reduce these barriers.

Conclusion

The COVID-19 pandemic is still complicating the rulemaking process, as CMS proposes temporary policies to address abnormal data or to mitigate negative financial impact. It may also explain CMS's proposals that would make permanent several transitional policies to reduce year-to-year payment variations. This proposed rule also accelerates the implementation of the administration's key priorities, including improved safety and quality of maternity care, better reporting of SDOH and effective preparation for climate change, with several requests for information.

The policies in the proposed rule are subject to change as stakeholders provide comments and CMS drafts the final rule. While a 3.2% market basket update would be at the upper end of payment update in a normal year, it falls short of rising inflation and the escalating healthcare labor shortage, and is also mitigated by other policies in the proposed rule. Stakeholders should monitor comments and how they impact the ultimate decisions in the final rule.

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