Policy Update

CMS Releases FY 2023 IPPS Final Rule

Summary

On August 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released the FY 2023 Inpatient Prospective Payment System (IPPS) final rule updating Medicare payment policies and quality reporting programs relevant for hospital inpatient services, and building on key priorities to address health disparities and improve the safety and quality of maternity care.

The final rule is available here.

A CMS factsheet on the final rule is available here.

An additional factsheet on the maternal health provisions is available here.

The final rule is scheduled to be published in the *Federal Register* on August 10, 2022, and will be effective on October 1, 2022.

Key Takeaways

1. CMS estimates that the overall finalized update and other rule changes will increase IPPS payments to hospitals in FY 2023 by more than $1 billion. Payment updates and policy changes for graduate medical education (GME) programs will increase IPPS payments, but projected reductions in the uncompensated care payment pool, outlier payments and new technology add-on payments (NTAP), as well as expiration of Medicare-dependent hospital and low-volume hospital payment adjustments, will offset some of the payment increases. This estimate does not factor in changes in hospital admissions, real case-mix intensity or the mandatory sequestration adjustment.
2. The finalized 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 $6,375.74, representing a payment update of 4.3% over FY 2022.
3. CMS did not extend the add-on payment for 11 technologies with NTAP periods expiring at the end of FY 2023. The agency also discontinued the one-year NTAP extension for the 13 technologies for which the add-on payment would have otherwise ended in FY 2022.
4. In response to the pandemic's continued impact on hospitals, CMS finalized proposals waiving penalties for certain quality programs as well as modifications to measures and measure calculations. The agency also includes three health-equity-based quality measures.
5. CMS decided not to finalize proposed limitations on the Section 1115 patient days that may be included in the calculation of the Medicare disproportionate share hospital (DSH) adjustment and adopted its proposal to use the two most recent years of audited Worksheet S-10 data to distribute uncompensated care payments.

6. CMS finalized proposed changes to the calculation of GME full-time equivalent (FTE) caps when hospital weighted FTE counts exceed the direct GME FTE cap, and will allow certain urban and rural hospitals participating in rural training tracks to enter into Medicare GME affiliation agreements in order to share FTE caps.

7. CMS will establish a public-facing "birthing-friendly" hospital designation to promote quality and safety of maternity care. CMS will also incorporate feedback on several requests for information (RFIs), including those focused on climate change, maternal health equity, measuring disparities in care quality and moving to digital quality measures, into future policy development.

Standardized Amount

Key Takeaway: CMS finalized a payment update of 4.3% for hospitals that successfully participate in CMS reporting programs.

The 4.3% payment update reflects a 4.1% market basket update, less a 0.3% 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. This update reflects the most recent data available, including a revised US economy outlook, and as a result is 1.1% higher than the proposed update for FY 2023. CMS noted that this is one of the largest updates finalized for the IPPS in recent years; however, hospital stakeholders have continued to voice concerns about the implications of economy-wide inflation and rising labor costs impacting inpatient operations.

The payment update is used to determine the standardized amount, a dollar-based unit used to set payment rates to hospitals for inpatient services furnished to Medicare beneficiaries. The standardized amount is subject to budget neutrality adjustments discussed in the final rule and varies based on an individual hospital's participation in the Hospital IQR and EHR programs. The final FY 2023 standardized amount for hospitals that successfully participate in both programs is $6,375.74. This represents an increase of 4.2% over the final FY 2022 standardized amount ($6,121.65).

Hospitals that fail to submit quality data are subject to a -1.025% adjustment to their payment update, and hospitals that fail to be meaningful EHR users are subject to a -3.075% adjustment to their payment update.

The 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 is the portion 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 Final Standardized Amount	$6,375.74	$6,186.86	$6,312.78	$6,123.91
FY 2022 Final Standardized Amount	$6,121.65	$6,000.11	$6,081.13	$5,959.61
Percent Change	4.2%	3.1%	3.8%	2.8%

Medicare Severity Diagnosis-Related Group Updates

New Deadline and Intake System for Change Requests

Key Takeaway: CMS will change the deadline and submission process for Medicare Severity Diagnosis-Related Group (MS-DRG) change requests 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 will change the deadline to request MS-DRG changes to October 20 of each year to allow additional time for review and evaluation. CMS will also change the submission process by implementing a new electronic intake system, the Medicare Electronic Application Request Information System™ (MEARIS™). Moving forward, CMS will only accept 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 will use the FY 2021 MedPAR data and the FY 2020 cost reports for the FY 2023 rate setting.

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 public health emergency (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 proposed 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 believed that fewer Medicare beneficiaries would be hospitalized for COVID-19 in FY 2023 compared to FY 2021. In light of this assumption, CMS proposed 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.

After consideration of public comments, CMS finalized its approach to calculate MS-DRG relative weights for CY 2023 as proposed.

Fixed-Loss Cost Threshold for High-Cost Outlier Payments

Key Takeaway: CMS adopted technical modifications that reduced the fixed-loss cost threshold for high-cost outlier payments by 10%.

Medicare also makes supplemental payments, known as outlier payments, to compensate hospitals for cases whose treatment costs are substantially higher than standard DRG payments. The purpose of Medicare IPPS outlier payments is to protect hospitals from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above DRG payment plus a fixed-loss cost threshold amount. CMS resets the fixed-loss cost threshold each year to ensure that projected (FY 2023) outlier payments are not less than 5% nor more than 6% of total operating DRG payments plus outlier payments.

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. For FY 2023, CMS proposed to use charge inflation factors and cost-to-charge ratio 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. Under this approach, the proposed fixed-loss cost threshold would be $43,214, a 39% increase from the FY 2022 threshold ($30,998). According to CMS, had the agency used the most recent year's data, as it ordinarily does, the outlier threshold would be $58,798.

For this final rule, CMS adopted its proposed approach with two technical modifications to account for COVID-19 cases. CMS calculated two fixed-loss cost thresholds, one using FY 2021 claims data including COVID-19 cases and incorporating payment increases, and one using FY 2021 claims data excluding COVID-19 cases. CMS then averaged these two fixed-loss cost thresholds. The final fixed-loss cost threshold for FY 2023 is $38,859, which is 10% lower than proposed.

Refinement of MS-DRG Classification

Key Takeaway: CMS finalized its proposal 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, or a major complication or comorbidity. For FY 2021, CMS finalized a proposal to apply expanded three-way severity split criteria. CMS believes that applying these criteria will better reflect resource stratification and avoid low volume counts for the non-complication-or-comorbidity level MS-DRGs. For FY 2022, CMS finalized a delay in implementing this proposal due to the PHE.

With overwhelming support from commenters, CMS agreed to further delay the application of the three-way severity level split for FY 2023.

Social Determinants of Health Diagnosis Codes

Key Takeaway: CMS will consider public comments on the reporting of social determinants of health (SDOH) diagnosis codes in future policy development.

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age that are believed to 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.

In the proposed rule, CMS sought 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 also asked for 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.

Many commenters applauded CMS's efforts to encourage reporting of SDOH diagnosis codes, while others complained about significant administrative burden, lack of standard definitions of the SDOH Z codes and

unclear benefits for patients. CMS also received recommendations such as providing reimbursement incentives for documenting and reporting of SDOH Z codes and including new SDOH Z codes for consideration. CMS will take the comments into consideration in future policy development.

New Technology Add-On Payments

Cost Criterion for NTAP

Key Takeaway: CMS will use FY 2021 MedPAR data to establish threshold values for FY 2024 NTAP applications.

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 decided to use the threshold amounts for the upcoming fiscal year for any 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 finalized its policy to use an average of the FY 2023 relative weights calculated without and with COVID-19 cases in the FY 2021 data.

CMS made 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).

No Extension for Technologies with Expiring NTAP Period

Key Takeaway: CMS did not grant 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 believed to be 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 used FY 2021 MedPAR data for the FY 2023 rate-setting process for the IPPS. Because the FY 2021 MedPAR data is likely to fully reflect the costs of new technologies with expiring NTAP periods, CMS decided not to use its authority to grant an NTAP extension for technologies no longer considered new in FY 2023. This policy impacted 11 technologies (see Table II.F.-02). CMS took no further action for the technologies that benefited from a one-time extension in the FY 2022 IPPS, and therefore an additional 13 technologies have NTAP periods expiring 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 $747 million decrease in NTAP payments for FY 2023.

NTAP Applications for FY 2023

Key Takeaway: CMS saw a decline in the number of NTAP applications reviewed in this rule compared

to the FY 2022 final rule.

In the final rule, CMS discussed 11 NTAP applications. Excluding the multiple applications withdrawn prior to the publication of the proposed rule and technologies that did not get through the US Food and Drug Administration by July 1, 2022, five devices and drugs applied through the traditional pathway, and six went through the alternative pathways (five 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 64.5% decrease over applications reviewed in the FY 2022 final rule, due in part to the 15 withdrawn or ineligible applications.

With no proposed extension of the NTAP eligibility period, CMS will continue add-on payments for 15 technologies (see Table II.F.-01 in the Final Rule).

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 will continue the NCTAP for qualified technologies that do not qualify for the NTAP. Where technologies qualify for both NCTAP and NTAP, CMS reduces the NCTAP by any incremental payment through the NTAP pathway. Consistent with the policy established in FY 2022, the NCTAP remains in effect until the end of the fiscal year following the end of the PHE.

NTAP Policy Proposals for FY 2023

Key Takeaway: CMS finalized a policy 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 will begin publicly posting completed applications and key relevant materials starting with FY 2024, with the exception of cost data, volume data, information in the confidential section of the application, and any materials not releasable to the public because of copyright. Based on stakeholder feedback, the applications will not be posted until the release of the FY2024 proposed rule.

Key Takeaway: CMS did not finalize its proposal to establish 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 proposed to use NDCs to identify NTAP-eligible therapeutic agents rather than ICD-10-PCS. This policy was not finalized, however, in light of numerous concerns expressed in the final rule, including the potential increased burden on hospitals to implement these potentially highly manual changes and the limited number of hospitals that would likely adopt this change as part of the transition in FY 2023. CMS intends to reassess this proposal in future rulemaking with additional details provided to stakeholders.

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 finalized proposals to waive penalties and modify measures as well as measure calculations for certain quality 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 (HACRP), 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 final rule, CMS aimed to lessen the burden of quality reporting and reduce financial risks during the pandemic. CMS also finalized 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.

Finalized as proposed:

- **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
- Three of the 10 newly adopted measures are health equity focused measures:
    - Under the adopted **hospital commitment to health equity measure**, hospitals must 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
    - The adopted **screening for social drivers of health measure** assesses hospitals in five domains (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety), while the **screen for positive rate for social drivers of health measure** is intended to create more actionable information to address health equity gaps
        - Voluntary reporting in 2023 and mandatory reporting in 2024/FY 2026 payment determination

Finalized proposed updates related to electronic clinical quality measures (eCQMs) and hybrid measures:

- Increase in the current policy percentage submission requirement of the requested medical records to successfully complete validation, and increase in the reporting and submission requirements
- Removal of the zero denominator declarations and case threshold exemptions policies for

Hospital IQR Program

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hybrid measures beginning with the FY 2026 payment determination

Finalized proposed refinements to two measures:

- Adoption of the refined **Medicare spending per beneficiary** hospital measure
- Refinement to an existing acute myocardial infarction measure

Acknowledged feedback on potential development of two National Healthcare Safety Network (NHSN) measures:

- Feedback on the potential future inclusion of two digital **NHSN** measures

Hospital Readmissions Reduction Program

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

Finalized as proposed:

- 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 beginning with the FY 2024 program year**

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.

Finalized as proposed:

- **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**)
- Updates to the baseline periods for certain measures for the FY 2025 program year
- Revision of the scoring and payment methodology for the FY 2023 program year such that hospitals will not receive total performance scores
- Technical updates to the measures in the clinical outcomes domain

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.

Finalized as proposed:

- **No penalty** under the program for FY 2023
- Suppression, revisions and technical changes to several measures, including adjusting for a **COVID-19 diagnosis and data submission requirements for newly opened hospitals beginning FY 2024**
- Clarification of the removal of the no mapped location policy beginning with the FY 2023 program year
- Acknowledgment of feedback on the addition of **two digital NHSN measures for potential future adoption**

PPS-Exempt Cancer Hospital Quality Reporting Program

The Affordable Care Act established this quality reporting program for PPS-exempt cancer hospitals.

Finalized as proposed:

- Public display of several measures (30-Day Unplanned Readmissions for Cancer Patients Measure (PCH-36) and the four end-of-life measures (PCH-32, PCH-33, PCH-34 and PCH-35))
- Adoption and codification of a patient safety exception into the measure removal policy
- Acknowledgment of feedback on the addition of **two digital NHSN measures for potential future adoption**

Medicare and Medicaid Promoting Interoperability Programs

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

Finalized as proposed:

- 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

Conditions of Participation for Hospitals and CAHs to Report Data Elements for COVID-19 and Seasonal Influenza

CMS also finalized the revision of the hospital and critical access hospital (CAH) infection prevention and control requirements to continue COVID-19 reporting until April 30, 2024 (unless the Secretary determines an earlier end date). The agency did not finalize the other proposed reporting requirements in the event of a future PHE declaration.

Wage Index

Low Wage Index Hospital Policy

Key Takeaway: CMS will 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 (*i.e.*, reducing) the standardized amount applied across all IPPS hospitals.

This FY 2020 low wage index hospital policy and the related budget neutrality adjustment were challenged in federal court, and in March 2022, a district court found that CMS lacked the 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. CMS proposed to continue the low wage index policy for FY 2023 pending these ongoing judicial proceedings, and finalized that proposal in the final rule: CMS will continue the low wage index hospital policy and the related budget neutrality adjustment for FY 2023..

Rural Floor

Key Takeaway: CMS will undo revised processes for calculating state-specific rural wage index floors put in place in FY 2020.

As a result of a second loss in federal district court, CMS is undoing changes made in FY 2020 concerning how it calculates the rural floor wage index.

Medicare law provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. This law is often referred to as the "rural floor," because the prevailing rural wage index of the state becomes the floor or minimum wage index value for the rest of the state, including the state's urban areas. Pursuant to this law, some hospitals, often organized by state hospital associations, sought to maximize the wage index values applicable to hospitals in urban areas of their state by strategically reclassifying hospitals to inflate the prevailing average hourly wage and wage index applicable in those rural areas, and then by extension, to urban areas. CMS disfavored this manipulation and in FY 2020 implemented a change to the methodology for calculating the rural floor wage index whereby CMS removed urban-to-rural reclassifications from the calculation of the rural floor.

In April 2022, a federal district court ruled in favor of a hospital plaintiff challenging CMS's authority to implement this policy change. As a result, in the final rule CMS finalized a policy that calculates the rural

floor as it was calculated before FY 2020. For FY 2023 and subsequent years, CMS will include the wage data of hospitals that have reclassified from urban to rural in the calculation of the rural floor.

Before CMS implemented the FY 2020 policy change, the hospitals' maneuverings to increase their rural floor resulted in substantial redistribution of dollars among states; hospitals in other states were disadvantaged by resulting budget neutrality adjustments.

Permanent Cap on Wage Index Decreases

Key Takeaway: CMS will limit year-to-year decreases in the wage index to 5% on a per hospital-basis.

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 proposed 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. In the final rule, CMS finalized that policy proposal. Under this policy, a hospital's wage index will not be less than 95% of its final wage index for the prior fiscal year. CMS will continue to apply the wage index cap policy in a budget-neutral manner through a national adjustment to the standardized amount.

Disproportionate Share Hospital Payment

Exclusion of Section 1115 Patient Days in Medicare DSH Adjustment

Key Takeaway: CMS decided not to finalize its proposed changes in the treatment of Section 1115 waiver days for purposes of the Medicare DSH payment adjustment.

In both the FY 2022 and the FY 2023 proposed rules, CMS proposed to define 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. In addition, the health insurance purchased using the premium assistance program must provide "essential health benefits" as defined at 42 CFR, Part 440, and the premium assistance must be equal to or greater than 90% of the cost of the health insurance. CMS also proposed 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. These proposed changes collectively would have effectively limited the types of Section 1115 waiver days that can be included in the Medicaid fraction of the DSH adjustment. For additional background on this issue, please see our *On the Subject*, available here.

Because of the number and nature of the comments received regarding this proposal, CMS decided not to finalize the proposal in the final rule. CMS noted that it will explore the change in future rulemaking.

Uncompensated Care Payment Adjustment

Key Takeaway: CMS finalized the distribution of roughly $6.8 billion in uncompensated care payment

(UCP) for FY 2023, a decrease of approximately $318 million from FY 2022.

Starting from FY 2014, CMS has distributed a prospective amount of UCP to Medicare DSH hospitals based on the hospital's relative share of uncompensated care nationally. As required by statute, the UCP pool amount is equal to 75% of the total amount of estimated Medicare DSH payments, adjusted for the change in the rate of uninsured individuals. For FY 2023, CMS finalized its proposal to distribute roughly $6.8 billion in UCP, a decrease of approximately $318 million from FY 2022. This total UCP amount reflects the CMS Office of the Actuary's projections that incorporate the estimated impact of the COVID-19 pandemic.

For FY 2023, CMS finalized the use of 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. Additionally, for FY 2024 and subsequent fiscal years, CMS finalized its proposal 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.

CMS also finalized a proposal to discontinue the use of low-income insured days as a proxy for uncompensated care in determining UCP for Indian Health Service and Tribal hospitals, and hospitals located in Puerto Rico. To mitigate the significant financial disruption for these hospitals because of this policy change, CMS finalized its proposal to establish a new supplemental payment for Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico beginning in FY 2023.

Graduate Medical Education

Changes to GME Payments Based on Litigation

Key Takeaway: CMS adopted its proposal to change GME FTE caps for certain hospitals.

In *Milton S. Hershey Medical Center, et al. v. Becerra*, the US District Court for the District of Columbia ruled against CMS's method of calculating direct GME payments to teaching hospitals when hospital weighted FTE counts exceed their direct GME FTE cap. In response to the court's holding, CMS proposed to modify its regulation to be consistent with statutory weighting factors.

CMS adopted its proposal without significant modification in the final rule. Effective for cost reporting periods beginning on or after October 1, 2001, if a hospital's unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds that FTE cap, the weighted FTE counts will be adjusted to make the total weighted FTE count 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 is the actual weighted FTE count. In addressing public comments, CMS confirmed its intention to make changes both prospectively and retrospectively. CMS cited the fact that the method for computing FTEs was not consistent with statutory requirements, and noted that the explicit statutory requirement that the US Department of Health and Human Services promulgate a rule governing GME reimbursement renders retroactive application here "necessary to comply with statutory requirements" under Section 1871(e)(1)(A)(i) of the Social Security Act.

Finally, in response to comments, CMS decided to apply the new methodology to additional FTE caps that many teaching hospitals received following redistribution of unused FTE cap slots as mandated by Section 422 of the Medicare Modernization Act (MMA), reasoning that the mathematical cap concept is the same for the FTE cap under Section 422 of the MMA as it is for the regular FTE cap.

Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations

Key Takeaway: CMS will allow certain urban and rural hospitals to enter into Rural Track Medicare GME Affiliation Agreements.

The number of FTE residents that each teaching hospital may include in its indirect medical education adjustment and direct GME payment formulas is limited by the teaching hospital's FTE resident caps. In the final rule, CMS finalized a proposal that will allow certain urban and rural hospitals participating in rural training tracks to enter into Medicare GME affiliation agreements in order to share FTE caps. Urban and rural hospitals can enter "Rural Track Medicare GME Affiliation Agreements" effective with the July 1, 2023, academic year if they participate in the same separately accredited "1-2 format" family medicine rural track program or have established rural track FTE limitations. Programs that are not separately accredited in the 1-2 format or are not in family medicine would not be permitted to enter into such agreements, and urban and rural hospitals may only participate in rural track Medicare GME affiliated groups if they have rural track FTE limitations in place prior to October 1, 2022.

Requests for Information

Key Takeaway: CMS will establish a "birthing-friendly" hospital designation to promote quality and safety of maternal health, and will incorporate public input on other RFIs in future policy development.

Maternal Health Quality Designation and Equity RFI

Addressing maternal health is a priority for the current Administration. The White House recently posted a Blueprint for Addressing the Maternal Health Crisis and announced a CMS Maternal Health Action Plan.

In this rule, CMS finalized the proposal to establish the first-ever publicly reported hospital quality designation focused on maternal health, also referred to as a "birthing-friendly" designation. The intent of the designation is for patients to easily identify high-quality and safe maternity care. Hospitals will be identified based on their response to the maternal morbidity structural measure. It will assess whether a hospital participates in a statewide or national Perinatal Quality Improvement Collaborative initiative and implements patient safety practices and/or bundles related to maternal morbidity from that Quality Improvement Collaborative.

CMS also received ideas on addressing the US maternal health crisis through policies, programs, quality measures and conditions of participation. CMS will take feedback into consideration for future rulemaking.

Climate Change RFI

CMS sought comments 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 such efforts. The RFI solicited 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 change and reduce emissions. Commenters were largely supportive of the focus on climate change, specifically understanding the effects of climate change on patients and providers and determining how to track and reduce emissions. CMS will take all feedback into consideration for future rulemaking.

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, inauguration day, and directed agency leadership to review, manage and establish policy using an equity lens. 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 received public input on establishing policies to measure healthcare quality disparities across CMS quality programs**.** Commenters provided 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. CMS will continue to evaluate opportunities to expand its measure stratification reporting initiatives using existing sources of data and will take all comments into consideration in future policy development.

Continuing to Advance Digital Quality Measurement RFI

Following a similar RFI in the FY 2022 IPPS proposed rule, CMS sought 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 clarified that it plans to transition incrementally.

This RFI focused on the standardization necessary to improve the exchange of digital data and sought 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.

In the final rule, CMS acknowledged feedback on revisions to a potential new definition of digital quality measures, data standardization activities, and approaches to achieve FHIR eCQM across quality reporting programs and the Hospital IQR Program, but did not take any specific action. .

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 added a new Enabling Exchange Under TEFCA measure in the Medicare Promoting Interoperability Program to further the work being done under TEFCA. This measure provides 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 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**.**

Conclusion

This final IPPS rule presents an improved Medicare revenue outlook compared to the proposed rule but might fall short of expectations for US hospitals that face ongoing financial instability in the long shadow of the COVID-19 pandemic. Hospital Medicare payments in FY 2023 are projected to increase by more than $1 billion, an improvement compared to projected negative growth in the proposed rule. The final rule also reflects more recent data on the US economy, a lower fixed-loss cost threshold for high-cost outlier cases after CMS adopted technical modifications to address COVID-19 cases in its modeling, and a slightly larger

uncompensated care payment pool based on updated projections.

CMS also adopted policies to help bring stability to hospital finances. Moving forward, hospitals won't see a year-to-year wage index decrease of more than 5%. HVBP and HACRP penalties are waived for FY 2023. CMS also delayed proposals that would cause significant changes to the MS-DRG system. The final rule does not bring relief to the new technology sector, however, as CMS decided not to exercise its authority to grant NTAP period extensions.

Lastly, this final rule also accelerates the implementation of the Administration's key priorities. The rule adopts three health-equity-focused measures in hospital quality programs and establishes a "birthing-friendly" hospital designation to promote quality and safety of maternity health. Feedback received on several RFIs, including reporting of SDOH and effective preparation for climate change, may also be incorporated into future policy development.

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