Memorandum

August 1, 2022

FY 2023 IPPS and LTCH PPS Rule Finalizes 4.3 Percent Overall Increase for Hospitals; Includes New Equity Measures; Establishes "Birthing-Friendly" Designation

Today, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2023 inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) final rule (press release; IPPS/LTCH fact sheet; maternal health fact sheet), which applies to acute care hospital and LTCH payments beginning Oct. 1, 2022. Under the final rule, acute care hospitals would receive an estimated 4.3 percent increase ($2.6 billion) in operating payments for FY 2023 and LTCHs would receive a projected 2.3 percent increase ($71 million).

- **What it is.** The wide-ranging final rule would affect payments for discharges occurring on or after Oct. 1, 2022 at 3,067 acute care hospitals and approximately 340 LTCHs.

- **Why it is important for you.** CMS finalizes a 4.3 percent increase in payments to hospitals, a 1.1 percent increase over the proposed update, which reflects more recent economic data. The agency makes changes to quality reporting requirements including the addition of a measure assessing a hospital's commitment to health equity. The rule also finalizes a proposal for a "Birthing-Friendly" hospital designation. Aligned with the other FY 2023 proposed payment rules released to date, the agency finalizes a proposal for a permanent policy to cap wage index decreases at 5 percent. The final rule also describes stakeholder responses to requests for information (RFIs), including questions about how the agency can help hospitals determine the threat climate change presents to operations, what CMS should consider when using measurement and stratification to advance health equity, and potential changes to a definition of digital quality measures.

- **Potential next steps.** The rule will take effect October 1, 2022.

Highlights of the final rule follow:

- **Changes to the Inpatient Prospective Payment System (IPPS)** – Under the final rule, acute care hospitals that successfully participate in the hospital inpatient quality reporting (IQR) program and are meaningful users of electronic health records (EHRs) would receive an estimated 4.3 percent increase in operating payments for FY 2023, consisting of a +4.1 percent market basket update; -0.3 percent multifactor productivity adjustment; and +0.5 percent adjustment required by MACRA. CMS notes this update reflects the most recent data available, including a revised outlook regarding the U.S. economy, which accounts for the 1.1 percent increase from the proposed rule. Overall, the agency estimates payments will increase by $2.6 billion in FY 2023 due to the proposed increase in operating and capital IPPS payment rates, partially offset by decreases in outlier payments for extraordinarily costly cases, and other proposed changes.

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CMS also finalizes its proposal to use FY 2021 data for purposes of the FY 2023 IPPS and LTCH PPS rate setting but with modifications to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries at IPPS hospitals and LTCHs as compared to FY 2021. More information about this change is available beginning on p. 39.

- **Long-Term Care Hospital Prospective Payment System (LTCH PPS) (p. 1087)** – CMS estimates LTCH PPS payments for FY 2023 for discharges paid the standard LTCH payment will increase by approximately 2.3 percent (or $71 million) in FY 2023 due to a rate update of 3.8 percent (resulting from a market basket update of +4.1 percent and a -0.3 percent multifactor productivity adjustment).

- **Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (p. 50)** – CMS finalizes a 0.5 percentage point positive adjustment to the standardized amount of Medicare payment to acute care hospitals for FY 2023, consistent with MACRA. Below are some of the highlights from the section:

    - **Pre-MDC: MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies**: In the proposed rule, CMS noted that the agency previously finalized its proposal to assign procedure code describing CAR T-cell, non-CAR T-cell, and other immunotherapies to Pre-MDC MS-DRG 018 and to revise the title for Pre-MDC MS-DRG 018 to "Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies" in FY 2022. When the policy was finalized, commenters recommended the agency continue to work with stakeholders on ways to improve the predictability and stability of hospital payments for these complex, novel cell therapies and continue to monitor and assess the appropriateness of therapies assigned to MS-DRG 018.

      In the FY 2023 final rule, CMS states that it appreciates stakeholder feedback on this topic and will continue to evaluate the recommendations and options provided by commenters and will monitor available claims data.

    - **Request for Information on SDOH of Health Diagnosis Code**: In the proposed rule, CMS solicited public comments on how the reporting of diagnosis codes in categories Z55-Z65 (Z codes) may improve the agency's ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRG. The Z codes describe a range of issues related 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.

      CMS noted that stakeholders provided feedback on how the agency might otherwise foster the documentation and reporting of the Z codes to more accurately reflect each health care encounter and improve the reliability and validity of the coded data.

    - **Comment Solicitation on Possible Mechanisms to Address Rare Disease and Conditions Represented by Low Volumes within the MS-DRGs Structure**: In an effort to reduce health disparities, CMS solicited public comments involving how the reporting of certain diagnosis

codes may improve the agency's ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs, as well as provide feedback on mechanisms to improve the reliability and validity of the coded data. CMS expressed its appreciation for the input provided by commenters and acknowledged the challenge of low volume rare disease as part of a reporting and reimbursement structure.

- **Add-On Payments for New Services and Technologies for FY 2023:** CMS is finalizing its proposal to publicly post completed new technology add-on payment (NTAP) applications at the time the IPPS proposed rule is released to increase transparency. This will become effective for FY 2024. CMS is not finalizing its proposal to use National Drug Codes (NDCs) to identity claims involving the administration of therapeutic agents approved for NTAP.

  CMS will continue the NTAP for 15 technologies currently receiving add-on payments. Additionally, CMS approved eight technologies for the NTAP for FY 2023, including three technologies that submitted under the traditional NTAP pathways and five technologies submitted under the alternative pathway for new medical devices that are part of the FDA Breakthrough Devices program. CMS estimates that Medicare spending on new technology add-on payments will be approximately $784 million for FY 2023.

  CMS also notes that it is returning to its practice of using the latest available data to recalibrate FY 2023 MS-DRG relative weights, and subsequently, CMS will discontinue add-on payments for technologies for which the three-year anniversary date of the product's entry into the market occurs prior to the latter half of the fiscal year.

- **Hospital Wage Index for Acute Care Hospitals (p. 545)** – CMS finalizes revisions to the wage index for acute care hospitals and the annual update of the wage data.

  - **Continuation of the Low Wage Index Hospital Policy** – CMS continues to implement the four-year policy first effective under the FY 2020 IPPS/LTCH PPS final rule, which is designed to reduce the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values. The policy will continue to be applied in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals.

  - **Application of the Rural Floor** – CMS explains that based on the district court's decision in *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, and the comments received from stakeholders, the agency is not finalizing its rural floor wage index policy as proposed, which would have excluded hospitals that have reclassified from urban to rural from the calculation of the rural floor. Instead, CMS will calculate the rural floor as it was calculated before FY 2020 for FY 2023 and subsequent years. See discussion starting on p. 577.

  - **Proposed Permanent Cap on Wage Index Decreases** – CMS finalizes a 5-percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the

circumstances causing the decline. The agency also finalizes the application of this policy in a budget neutral manner through a national adjustment to the standardized amount.

- **Other** – Additional details pertaining to the wage index include:

  - Worksheet S–3 Wage Data for the Proposed FY 2022 Wage Index (p. 552);
  - Verification of Worksheet S–3 Wage Data (p. 554);
  - Method for Computing the Proposed FY 2023 Unadjusted Wage Index (p. 563);
  - Occupational Mix Adjustment to the FY 2023 Wage Index (p. 571);
  - Analysis and Implementation of the Proposed Occupational Mix Adjustment and the FY 2023 Occupational Mix Adjusted Wage Index (p. 574);
  - FY 2023 Wage Index Tables (p. 595);
  - Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications (p. 596);
  - Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (p. 608);
  - Reclassification From Urban to Rural Under Section 1886(d)(8)(E) of the Act Implemented at 42 CFR 412.103 (p. 610);
  - Process for Requests for Wage Index Data Corrections (p. 613); and
  - Labor-Related Share for the FY 2023 Wage Index (p. 623).

- **Payment Adjustment for Medicare Disproportionate Share Hospitals (p. 641)** – CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments will decrease by a combined $0.3 billion in FY 2023.

  - **Uncompensated Care Payments** – Beginning on p. 652, CMS finalizes distribution of approximately $6.5 billion in uncompensated care payments for FY 2023, a decrease of approximately $654 million from FY 2022. CMS also revises Factor 3 by: (1) using the average of audited FY 2018 and FY 2019 reports to determine Factor 3; (2) using a three-year average of uncompensated care data from the most recent fiscal years of available audited data; (3) applying a scaling factor to Factor 3 values; (4) modifying the definition of "new hospitals" and the methodology of calculating Factor 3 for new hospitals; and (5) modifying the uncompensated care data trim methodology by using multiple years of cost reports to determine Factor 3.

  - **Treatment of Section 1115 Demos for Medicare DSH Purposes** – CMS is not finalizing its proposal to revise its regulation pertaining to the calculation of the Medicaid fraction of the DSH calculation. CMS stated it will review the issue of Section 1115 demonstration days for the purposes of DSH adjustment in future rulemaking.

- **Medicare GME (p. 786)** – As in the proposed rule, CMS does not address implementation of section 126 of the Consolidated Appropriations Act (CAA), 2021, which makes available an additional 1,000 FTE resident cap slots beginning in FY 2023 (details). Instead, the rule finalizes two policies, the first makes GME

calculation changes pursuant to a recent Court ruling, and the second establishes Rural Training Programs (RTP) Medicare GME affiliation agreements:

- **Methodological Changes Pursuant to Court Ruling** – CMS finalizes its proposal to modify the direct GME full-time equivalent (FTE) cap policy pursuant to the *Milton S. Hershey Medical Center et al. v. Becerra* ruling (Court). The Court ruled that CMS' proportional reduction methodology – i.e., the method by which CMS calculated direct GME payments to teaching hospitals when those hospitals' weighted FTE counts exceeded their direct GME FTE cap – was improper, ordering CMS to pay the plaintiffs according to a more favorable method.

  As such, CMS finalizes its proposal to apply the FTE cap when a hospital's weighted FTE count is greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their initial residency period to an amount less than 0.5. This policy applies to all teaching hospitals prospectively (for cost reporting periods beginning on or after Oct. 1, 2022) and retrospectively for certain providers and cost years. On the latter, however, CMS notes that a final rule codifying this retrospective adoption of the new policy would not be the basis for reopening settled notice of amount of program reimbursements. See the discussion beginning on p. 789.

- **Allowance of Medicare GME Affiliation Agreements Within Certain Rural Track FTE Limitations** – CMS finalizes, without changes, its proposal to permit urban and rural hospitals that participate in the same separately accredited family medicine RTP and have rural track FTE limitations to enter into "Rural Track Medicare GME Affiliation Agreements." Stipulations require such a group participate in a rural track program and have rural track FTE limitations in place prior to Oct. 1, 2022. Agreements are effective for the academic year beginning July 1, 2023. See the discussion beginning on p. 815.

- **Hospital Readmissions Reduction Program (HRRP) (p. 837)** – CMS finalizes resumption of the CMS 30-Day Pneumonia Readmission Measure but postpones incorporation of the measure until FY 2024 to provide stakeholders with an opportunity to review the final rule. Additionally, CMS finalizes its proposal to include a covariate adjustment for patient history of COVID-19 in the twelve months prior to admission beginning in FY 2023.

  CMS included a RFI on the possible inclusion of health equity performance in the HRRP in the proposed rule. In response, the agency reports that several commenters described the potential benefits of incorporating equity, including improved care for at-risk patients, improved understanding of the effects of social risk factors, and improved care for all patients. However, CMS also explained commenters were concerned that linking payment to performance on equity measures may disproportionately penalize safety net hospitals or other providers that treat high complexity patients and could lead to hospitals being held accountable for factors outside of their control. The agency says that commenters offered many suggestions for proxy measures until CMS can develop a system to collect patient-level data, but commenters were generally concerned about the challenges of sociodemographic data collection.

- **Hospital Value-Based Purchasing (VBP) Program (p. 879)** – CMS notes that the agency previously finalized a measure suppression policy and several measure suppression factors for the duration of the COVID-19 PHE to provide quality program flexibility and account for the impact of changing conditions. CMS details that they are not making any changes to measure suppression policy for FY 2023.

  In addition to the PHE-driven suppression policy, CMS is finalizing the following changes for the FY 2023 VBP Program, given significant changes in hospital performance scores since the start of the PHE:

  - **Suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):** CMS states that there has been significant deviation in national performance on the measure during the pandemic due effects of the pandemic and staffing shortages. The agency notes that hospitals will continue to report the measure so that CMS can monitor the effects on quality and consider appropriate polices.

  - **Suppress the Five Hospital Acquired Infection (HAI) Measures:** The agency details that there has also been significant deviation on these measures due to staffing and unprecedented changes in clinical guidelines, care delivery or practice, treatments, drugs or related protocols, or equipment or diagnostic tools or materials.

  - **Update the Baseline Period for Certain Measures:** CMS notes that it previously finalized baseline periods for the FY 2024, 2025, 2026, 2027, and 2028 program years for all the measures included in the Hospital VBP Program, but the change to suppress the HCAHPS measure and the five HAI measures will impact the baselines. To ensure that the agency has reliable data that are not unfairly affect by the COVID-19 PHE, CMS is finalizing a baseline period of January 1, 2019, through December 31, 2019, for the "Person and Community Engagement Domain Measure" and the safety domain measures. The agency also provides tables on p. 890-892 that captures the baseline and performance periods for the FY 2024 through 2028 program years.

  Additionally, CMS is finalizing revisions to the scoring and payment methodology so that hospitals will not receive Total Performance Scores, but instead award each hospital a payment incentive multiplier that results in a value-based incentive payment that is equal to the amount withheld for the fiscal year (i.e., 2 percent).

- **Hospital Acquired Conditions (HAC) Reduction Program (p. 947)** – CMS finalizes the following updates and changes to the HAC Reduction Program, which incentivizes hospitals to reduce the incidence of HACs:

  - **Measure Suppression (p. 947)** – CMS finalizes its proposal to suppress all five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) hospital-acquired infection (HAI) measures and the CMS PSI 90 measure from the HAC Reduction Program for FY 2023 to account for circumstances related to COVID-19. CMS notes that the

agency's analysis of the measures suggest that comparability of measure performance has been impacted by the COVID-19 PHE. Therefore, all hospitals will receive a Total HAC Score of zero and no penalty. CMS will publicly report the measure scores and CDC NHSN HAI measure results via the Care Compare tool and the Provider Data Catalog and confidently report them via hospital-specific report. CMS will not provide the CMS PSI 90 measure results publicly nor confidentially. Similarly, CMS finalizes its proposal to suppress CY 2021 CDC NHSN HAI measure data from the FY 2024 HAC Reduction Program to account for concerns on performance comparability during the PHE. CMS will not suppress CMS PSI 90 scores for the FY 2024 program year due to updates described below.

- **Measure Specifications (p. 988)** – CMS finalizes its proposal to increase the minimum volume threshold measure for the CMS PSI 90 measure. CMS also finalizes its proposed update to risk-adjust for COVID-19 diagnoses (p. 992).

- **Newly-opened hospitals** – CMS finalizes its proposal to update the definition of "newly-opened hospitals" regarding CDC NHSN HAI data submission requirements beginning in the FY 2023 program year. Newly opened hospitals will include any hospital with a Medicare Accept Date within the last 12 months of the performance period. Newly-opened hospitals do not receive measure scores for CDC NHSN HAI measures and thus would not be subject to a 1 percent payment reduction. Due to the finalized measure suppression, no hospitals will be impacted by this change in the FY 2023 program year.

- **No mapped locations policy** – CMS clarifies that the "no mapped locations" policy, which was a data reporting exemption for certain hospitals, is removed from the HAC Reduction Program beginning with the FY 2023 program year.

CMS also sought comments on the potential adoption of two digital CDC NHSN measures in the HAC Reduction Program: (1) the NHSN Healthcare-associated *Clostridioides difficile* Infection Outcome measure and (2) the NHSN Hospital-Onset Bacteremia & Fungemia Outcome. More information can be found on p. 997 about these RFIs.

- **RFIs on Quality Reporting Requirements (p. 1018)** – In the proposed rule, CMS requested comment on several targeted areas that relate to Medicare quality reporting programs. Below, we summarize the original RFI and provide key detail on CMS's response to stakeholder feedback.

  - **RFI on the impact of climate change and health equity**, including how CMS can support hospitals, nursing homes, and other facilities in addressing climate-related impacts and their disproportionate effects on underserved populations. The agency noted that comments may inform policies to assist in providers' response to climate-related threats. Comments were sought on, among other topics, available analyses of climate-related risks, the degree to which these overlap with existing work to meet emergency preparedness standards, and the extent to which facilities have emissions reduction targets. The RFI is aligned with the EO on Tackling the Climate Crisis at Home and Abroad.

In response, CMS said that the vast majority of commenters suggested CMS incentivize and provide funding for participation in climate change initiatives. Several proposed a value-based purchasing program as a potential format for such participation, CMS added. The agency also spoke to stakeholder feedback regarding how CMS can better assess the impact of climate change on patients, suggesting changes such as updating screening tools to include climate change health impact topics as well as undertaking additional analysis to better understand the impact of climate change. CMS also reflected that several stakeholders reminded the agency that climate change "is not just a hospital issue." In response, CMS said it would take these comments into consideration and that it especially appreciated the many commenters who offered to volunteer to be a part of groups to help develop and future policies on this topic.

- **RFI on overarching principles for measuring health care quality disparities in hospital quality programs**, with comments specifically sought on the five goals enumerated beginning on p. 1112: 1) Identification of goals and approaches for measuring health care disparities and using measure stratification across CMS programs; 2) guiding principles for selecting and prioritizing measures for disparity reporting across CMS programs; 3) principles for social risk factor analysis and demographic data selection and use; 4) identification of meaningful performance differences; and 5) guiding principles for reporting disparity results. CMS noted that through the RFI, it aims to inform future policies for measure stratification as a quality measurement tool for addressing disparities. This RFI is driven by the EO on Advancing Racial Equity and Support for Underserved Communities through the Federal Government.

  In response, CMS said commenters generally supported the goals of measure stratification set out in the proposed rule and suggested that these efforts could lead to a better understanding of longitudinal, geographic and provider disparity trends. Commenters also urged CMS to consider any additional provider burden associated with disparity measurement, the agency added. Related to this, comments also spoke to the difficulty in collecting patient data and recommended that CMS consider how it can support hospitals and other providers to improve the collection of patient self-reported social risk and demographic data. CMS said it would take these comments and others into consideration for future policy development. See more on p. 1131.

- **RFI on advancement of digital quality measurement and use of FHIR in hospital quality programs**, which addressed the transition to digital quality measures (dQMs), approaches to data standardization, and work to move toward FHIR eCQM reporting (e.g., FHIR APIs). The RFI begins on p. 1147 and specifically includes a request for input on a revised definition of dQMs. It also builds on a similar RFI included in the FY 2022 IPPS rulemaking.

  In response, CMS said many commenters expressed strong support on their efforts to transition to digital quality measurement and support for leveraging the FHIR standard and FHIR APIs. Commenters added that doing so would not only improve quality measurement and patient outcomes, but that doing so would also reduce provider burden. In terms of timeline, some

commenters said that transitioning to dQMs would be feasibly by 2025, while others expressed some concern with this rollout timeline and requested the transition be extended beyond 2025 until technology evolves further. CMS said it appreciated the feedback and would take it into account throughout the transition planning and implementation of dQMs.

- **RFI on Trusted Exchange Framework and Common Agreement (TEFCA)**, with feedback sought on key use cases that could enable widespread exchange through TEFCA and how CMS should encourage information exchange via TEFCA through CMS programs, among other questions beginning on p. 1171.

  In response, CMS noted that it received a "wide range of comments" on this RFI. The agency first said that many commenters did not recommend requiring TEFCA participation at this time and pointed out there was confusion about TEFCA in the provider community. Others added that there are costs associated with participation and that this may be a barrier for many providers. CMS said it would share this input with the Office of the National Coordinator for Health Information Technology (ONC) and that it would also take commenters' feedback into consideration in future policy development.

- **Hospital Inpatient Quality Reporting (IQR) Program (p. 1177) –** CMS finalizes an array of changes to quality measures and requirements for the Hospital IQR Program. See p. 1422-1429 for tables summarizing previously finalized and new Hospital IQR Program Measures for payment determinations for FY 2024 through FY 2028 and for subsequent years. CMS also finalizes the establishment of a publicly-reported hospital designation to capture the quality and safety of maternity care. CMS will continue to collaborate with CDC and consider submitted comments regarding the potential future adoption of two NHSN measures during future notice-and-comment rulemaking.

  - **New Measures Adopted for the Hospital IQR Program Measure Set (p. 1179) –** CMS finalizes the adoption of 10 new measures, including four electronic clinical quality measures (eCQMs):

    - **Hospital Commitment to Health Equity measure (p. 1180)**, beginning with the CY 2023 reporting period/FY 2025 payment determination;
    - **Screening for Social Drivers of Health measure (p. 1210)**, beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;
    - **Screen Positive Rate for Social Drivers of Health measure (p. 1246)**, beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;
    - **Cesarean Birth eCQM (p. 1262)**, for which hospitals can self-select beginning with the CY 2023 reporting period/FY 2025 payment determination and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;
    - **Severe Obstetric Complications eCQM (p. 1283)**, for which hospitals can self-select beginning with the CY 2023 reporting period/FY 2025 payment determination and

mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;

- **Hospital-Harm—Opioid-Related Adverse Events eCQM (p. 1303)**, for which hospitals can self-select beginning with the CY 2024 reporting period/FY 2026 payment determination;
- **Global Malnutrition Composite Score eCQM (p. 1320)**, for which hospitals can self-select beginning with the CY 2024 reporting period/FY 2026 payment determination;
- **Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (p. 1340)**, beginning with two voluntary reporting periods in CYs 2025 and 2026, followed by mandatory reporting for the reporting period which runs from July 1, 2025, through June 30, 2026, impacting the FY 2028 payment determination;
- **Medicare Spending Per Beneficiary (MSPB) Hospital measure (p. 1373)** beginning with the FY 2024 payment determination; and
- **Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA measure (p. 1392)** beginning with the FY 2024 payment determination.

o **Refinements to Current Measures in the Hospital IQR Program Measure Set (p. 1406) –** Additionally, CMS finalized refinements to two measures currently in the Hospital IQR Program measure set:

- **Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (p. 1407)** beginning with the FY 2024 payment determination – CMS finalizes its proposal to expand the measure outcome to include "26 clinically vetted mechanism complication ICD-10 codes" listed on pp.1410-1411, and therefore align with the finalized THA/TKA Complication measure.
- **Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) Measure (p. 1414)** beginning with the FY 2024 payment determination – CMS finalizes its proposal to increase the minimum case count of 25 to a minimum case count of 50 during the measurement period "in an effort to balance the need to include as many hospitals as possible while maintaining acceptable measure reliability."

o **Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care (p. 1431)** – CMS finalizes its proposal to establish a hospital quality designation that will be publicly reported on a CMS website beginning Fall 2023. The designation will be awarded to hospitals that report "Yes" to both questions in the Maternal Morbidity Structural measure, which captures whether hospitals are: (1) currently participating in a structured state or national Perinatal QI Collaborative; and (2) implementing patient safety practices or bundles as part of these QI initiatives. Data collection for this measure began with fourth quarter 2021 data,

which hospitals were required to report by May 2022. CMS reiterates its intent to expand the criteria for awarding the designation through future notice-and-comment rulemaking.

In the proposed rule, CMS also sought comment on additional activities to advance maternal health equity, such as through the Conditions of Participation (CoPs) and through quality reporting programs (see questions on p. 1459-1461). The agency notes it will consider the recommendations it received from commenters as it develops additional strategies to address maternity care quality, safety, and equity in the Hospital IQR Program though potential new CoPs and other activities. CMS plans to continue outreach to interested parties on future maternal health actions.

- **Potential Future Inclusion of Two Digital National Healthcare Safety Network (NHSN) Measures (p. 1462)** – CMS sought public comment on the future inclusion of the following measures in the Hospital IQR Program. The agency states that it will continue to collaborate with CDC and consider the comments submitted in future notice-and-comment rulemaking.
  - **NHSN Healthcare-Associated *Clostridioides difficile* Infection (CDI) Outcome Measure (p. 1463)**, which would track the development of new CDIs among patients already admitted to healthcare facilities.
  - **NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure (p. 1472)**, which would capture the development of new bacteremia and fungemia among patients already admitted to acute care hospitals.

- **Changes to Reporting and Submission Requirements for eCQMs (p. 1484) –** CMS finalizes changes to increase eCQM reporting and submissions requirements beginning with the CY 2024 reporting period/FY 2026 payment determination. Specifically, CMS requires hospitals to report four calendar quarters of data for each required eCQM:
  - Three self-selected eCQMs
  - Safe Use of Opioids—Concurrent Prescribing eCQM;
  - Cesarean Birth eCQM; and
  - Severe Obstetric Complications eCQM

- **Changes to Data Submission and Reporting Requirements for Hybrid Measures (p. 1498)** – CMS finalizes its proposal to remove "zero denominator declarations and case threshold exemptions" as an option for the reporting of hybrid measures beginning with the FY 2026 payment determination, which is when reporting of finalized hybrid measures will become mandatory. Zero denominator declaration allow a hospital to submit zero in the denominator for the reporting a measure if the hospital does not have patients that meet the denominator criteria. The case threshold exemption allows for a hospital with five or fewer inpatient discharges per quarter or 20 or fewer inpatient discharges per year to be exempted from reporting on that hybrid measure. "Hybrid measures do not require that hospitals report a traditional denominator as is required for the submission of eCQMs," explains CMS.

- **Data Submission and Reporting Requirements for Patient-Reported Outcome-Based Performance Measures (PRO-PMs) (p. 1504)** – CMS finalizes the adoption of the hospital level THA/TKA PRO-PM into the Hospital IQR Program measure set. CMS will allow hospitals to choose whether to send their data to CMS or a vendor for measure calculation. The agency will implement the adoption of the THA/TKA PRO-PM through a phased implementation approach, with two voluntary reporting periods for the CY 2025 and 2026 reporting periods prior to mandatory reporting beginning with the FY 2028 payment determination.

- **Changes to Validation of Hospital IQR Program Data (p. 1513) –** Currently, CMS requires hospitals submit timely and complete data for 75 percent of requested records. CMS finalizes its proposal to require hospitals to submit timely and complete data for 100 percent of requested records beginning with CY 2022 eCQM data for the FY 2025 payment determination and subsequent years.

- **PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) (p. 1522)** – CMS finalizes its proposal to remove a measure from the program without rulemaking if continued use of the measure raises specific patient safety concerns which aligns with other quality measurement programs.

  CMS also finalizes its proposal to begin public display of the four end-of-life (EOL) measures (EOL-Chemo, EOL-Hospice, EOL-ICU, and EOL-3DH) with modification, as well as the 30-Day Unplanned Readmissions for Cancer Patients measure.

- **Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (p. 1533) –** CMS is not proposing any new quality measures for the LTCH QRP, which currently has 18 measures for FY 2023 (see here). However, CMS issued separate RFIs on three topics: potential future measures, NHSN, and heath disparities. The agency did not respond to specific comments but intends to use the input to inform future measure development efforts.

  - **RFI: LTCH QRP Quality Measure Concepts under Consideration for Future Years (p. 1535)** – CMS requested input on the following measure concepts under consideration for future years: (1) cross-setting functional measure that would incorporate the domains of self-care and mobility; (2) health equity measures, such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities; and (3) COVID-19 vaccination coverage among patients. CMS received mixed comments regarding a health equity measure. Some commenters recommended CMS postpone consideration of a COVID-19 vaccination coverage among patient measure because the definition of "fully vaccinated" is evolving. Other commenters suggested CMS consider measures for malnutrition and patient-reported outcomes on patient experience, patient and workforce safety and reliability, clinical quality, and caregiver engagement.

  - **RFI: Inclusion of the National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure in the LTCH QRP (p. 1537)** – CMS requested information on the future inclusion of the NHSN Healthcare-Associated *Clostridioides*

difficile Infection Outcome measure (HA-CDI) (MUC2021–098) as a digital quality measure in the LTCH QRP. The agency sought comments on the feasibility of electronically submitting quality data, considerations for the transition period, and anticipated challenges (see list of questions on p. 1537-1538). CMS received mixed comments on utilizing LTCH EHRs to collect data on LTCH QRP measures**.** Most commenters supported the concept of reducing provider burden through using fully digital measures, but several pointed out the costs associated with LTCHs adopting EHR systems that are capable of collecting and exchanging digital quality measure data. They asked CMS to provide incentive payments to IRFs, as was done for acute care hospitals through the Health Information Technology for Economic and Clinical Health (HITECH) Act. Commenters also suggested a transition period, such as two years, to give LTCHs time to implement or refine their EHR systems.

- **RFI: Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs (p. 1539)** – CMS sought comments on a "cross-setting framework to assess healthcare quality disparities." This framework entails five key considerations:

  - Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measures Stratification Across CMS Quality Programs;
  - Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting;
  - Principles for Social Risk Factor and Demographic Data Selection and Use;
  - Identifying Meaningful Performance Differences; and
  - Guiding Principles for Reporting Disparity Measures.

  CMS also sought input on two approaches to assessing drivers of healthcare quality disparities. First, through "performance disparity decomposition," CMS could consider methods that use data already available in enrollment, claims, and assessment data to assess the extent to which various social determinants of health (e.g., transportation, health literacy) and other mediating factors contribute to disparities. Second, CMS could develop more comprehensive measures of health equity that reflects organizational performance. The agency discussed the possibility of using the existing Health Equity Summary Score (HESSS) developed by CMS Office of Minority Health to assess Medicare Advantage plans for their performance on addressing social risk factors. The Hospital Inpatient Quality Reporting program is currently considering using a version of the HESS. Additionally, CMS discussed using the Hospital Commitment to Health Equity measure (MUC2021-106) to assess hospital leadership and engagement in equity-focused organizational competencies. Commenters were generally supportive of both approaches in order to more comprehensively assess quality of care provided to beneficiaries with social risk factors. See p. 1541-1546 for more details.

- **Condition of Participation (CoP) Requirements for Hospitals and CAHs to Continue Reporting Data for COVID-19 and Influenza After the PHE Ends as Determined by the Secretary (p. 1697)** – In the proposed rule, CMS suggested revising COVID-19 and seasonal influenza reporting standards for hospitals and CAHs to require electronic reporting of COVID-19 and seasonal influenza until April 30,

2024. Hospitals would have been required to report specific data elements to the NHSN or other CDC-supported surveillance systems for future public health emergencies under the proposal. CMS notes that commenters supported the overall policy goals but some expressed concern that the requirement would place undue burden on hospitals during emergencies when stress and burnout are already increased. As a result, CMS finalizes the proposal to report data on COVID-19 and seasonal influenza but limits the scope of the data categories and the agency withdraws the proposal to establish reporting requirements for infectious diseases for future PHEs. CMS notes it will consider long-term solutions for ensuring overall preparedness in the event of future emergencies.

- **Request for Comment on Payment for Domestically Made N95s (p. 1719)** – In the proposed rule, CMS indicated that a payment adjustment for wholly domestically made N95 respirators might be appropriate under IPPS or OPPS authorities. Comment was sought on the potential for the agency to account for additional resource costs through such a payment adjustment in 2023 and beyond.

  In the final rule, CMS notes that many commenters were supportive of the payment adjustment and acknowledged the importance of surgical N95 respirators in keeping health care workers and patients safe. The agency also noted that the majority of commenters supported an approach of CMS making biweekly interim lump-sum payments that would be reconciled at cost report settlement, but emphasized minimizing the administrative burden on hospitals when developing this payment policy.