Illinois Health and Hospital Association

Medicare Payment Fact Sheet

August 2022

FY 2023 Medicare IPPS Proposed Rule (CMS-1771-F)

On Aug. 1, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) final rule, effective Oct. 1, 2022 through Sept. 30, 2023. CMS finalized a 4.3% rate increase relative to FY 2022.

IPPS Rate Update: CMS finalized a 4.1% market basket update, a 0.3 percentage point Affordable Care Act-mandated productivity reduction, and a 0.5 percentage point increase to partially restore cuts made under the American Taxpayer Relief Act (ATRA) of 2012. The initial market basket update for hospitals that fail to submit quality data will decrease by an additional one-quarter, and hospitals that do not meet meaningful use requirements are subject to a three-quarter initial market basket reduction.

	Submitted quality data and is a Meaningful EHR user	Submitted quality data and is NOT a Meaningful EHR user	DID NOT submit quality data and is a Meaningful EHR user	DID NOT submit quality data and is NOT a Meaningful EHR user
Percentage increase applied to standardized amount	4.30%	1.23%	3.28%	0.20%

CMS used the most recent year of complete data available in calculating rates. For FY 2023, this includes using FY 2021 MedPAR claims and FY 2020 cost report data. To account for the impact of COVID-19, CMS finalized several modifications to its calculation of Medicare Severity Diagnosis Related Group (MS-DRG) relative weights.

CMS also finalized a decrease for outlier payments, resulting in a 1.7 percentage point decrease to the rate update. The finalized fixed-loss amount is $38,859, which is substantially lower than the proposed threshold of $43,214.

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

Wage Index	Submitted Quality Data and is a Meaningful EHR User	Submitted Quality Data and is NOT a Meaningful EHR User	DID NOT Submit Quality Data and is a Meaningful EHR User	DID NOT Submit Quality Data and is NOT a Meaningful EHR User
> 1.0000	Labor: $4,310.00 Non-Labor: $2,065.74	Labor: $4,182.32 Non-Labor: $2,004.54	Labor: $4,267.44 Non-Labor: $2,045.34	Labor: $4,139.76 Non-Labor: $1,984.15
<= 1.0000	Labor: $3,952.96 Non-Labor: $2,422.78	Labor: $3,835.85 Non-Labor: $2,351.01	Labor: $3,913.92 Non-Labor: $2,398.86	Labor: $3,796.82 Non-Labor: $2,327.09

CMS finalized a capital standard federal payment rate of $483.76.

Disproportionate Share Hospital (DSH) Payment Changes: CMS increased its estimate of total empirically justified DSH payments to $3.49 billion (proposed at $3.32 billion), and estimates the remaining 75% pool at approximately $10.46 billion (proposed at $9.95 billion). After adjusting the 75% pool for uninsured individuals, CMS estimates a FY 2023 uncompensated care amount of approximately $6.87 billion (proposed at $6.54 billion). This represents a decline of about $314 million compared to FY 2022.

CMS finalized a methodological change to how it calculates Medicare DSH payment adjustments. In FY 2023, CMS will use the average of federal FYs 2018 and 2019 audited worksheet S-10 data to calculate Factor 3 of the DSH adjustment. For FY 2024 and forward, CMS will use the average of three years of audited worksheet S-10 data.

CMS did not finalize its proposal to revise regulations related to the calculation of the Medicaid fraction of the Medicare DSH calculation. CMS will revisit this issue in future rulemaking.

Low-Volume Hospitals: CMS finalized its proposal to use the pre-FY 2022 definition of a low-volume hospital and methodology for calculating the payment adjustment. Specifically, low-volume hospitals must be located more than 25 road miles from another hospital and have less than 800 inpatient discharges during the fiscal year, regardless of payer. Additionally, the 25% low-volume add-on payment will only be made to qualifying hospitals with less than 200 discharges per year, regardless of payer. Hospitals with between 200 and 799 discharges will not receive a payment adjustment.

Hospitals must submit a written request for low-volume hospital status to their Medicare Administrative Contractor (MAC) no later than Sept. 1, 2022 in order for the 25% add-on payment adjustment to be applied to payments for discharges beginning on or after Oct. 1, 2022. Hospitals that qualified for the low-volume hospital payment adjustment in FY 2022 may continue to receive the adjustment for FY 2023 without reapplying if they meet both the discharge and mileage criterion applicable for FY 2023.

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

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

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

Indirect and Direct Graduate Medical Education Payment: In response to the ruling in *Milton S. Hershey Medical Center, et al. v. Becerra*, CMS finalized a policy to address situations regarding the full-time equivalent (FTE) cap when a hospital's weighted FTE count is greater than the FTE cap. In such scenarios, the respective primary care, obstetrics and gynecology, and other weighted FTE counts are adjusted to make the total weighted FTE count equal the cap.

Separately, CMS finalized allowing an urban and a rural hospital participating in the same Rural Training Program (RTP) to enter into a Rural Track Medicare GME Affiliation Agreement. This agreement allows urban and rural hospitals jointly training residents to share cap slots, better facilitating cross training of residents.

Hospital and Critical Access Hospital (CAH) Conditions of Participation (CoP): CMS issued two separate interim final rules with comment (IFCs) during the COVID-19 public health emergency (PHE) that require hospitals and CAHs to submit specific data elements as a CoP on both COVID-19 and Seasonal Influenza (for more information, please see *85 FR 54820* and *85 FR 85866*). These reporting requirements are currently tied to the COVID-19 PHE declaration, meaning reporting will not be required as a CoP once the PHE ends.

However, stating the potential need to monitor the impact of COVID-19 beyond the PHE, as well as more regulatory flexibility in preparation for the next potential pandemic or epidemic, CMS proposed modifications to these temporary CoPs.

CMS will revise the current COVID-19 and Seasonal Influenza reporting requirements for hospitals and CAHs, requiring continued reporting beyond the PHE declaration until April 30, 2024. CMS did not finalize its proposal to establish a data reporting CoP for future PHEs, but will continue exploring this policy as it believes a long-term policy for hospital data reporting during PHEs is necessary.

New Technology Add-On Payments (NTAPs): CMS will continue NTAPs for 15 new technologies (see Table II.F.-01), discontinue NTAPs for 11 technologies with three-year anniversary dates that occur prior to April 1, 2023 (see Table II.F.-02), and discontinue NTAPs for 13 new technologies that received a one-year extension in FY 2022 because their three-year anniversary date occurs before the second half of FY 2022 (see Table II.F.-03).

Wage Index:

Rural Floor: In response to the April 8, 2022 district court finding in *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, CMS did not finalize its proposal to continue calculating the rural floor without the wage data of hospitals that reclassify from urban to rural. Instead, CMS finalized a policy to include such hospitals in the calculation of the rural floor.

Low Wage Index Hospital Policy: CMS will continue its FY 2020 low-wage-index hospital policy. Under this policy, CMS will increase the wage index of hospitals that fall below the 25th percentile. This policy is budget neutral.

Permanent Cap on Wage Index Decreases: CMS made permanent a 5% cap on wage index decreases, regardless of the circumstances leading to the hospital's wage index decline. In other words, a hospital's wage index will not be less than 95% of its final wage index for the previous federal fiscal year. This policy is budget neutral.

The final FY 2023 wage index value for Illinois are in Table 3 on CMS' FY 2023 IPPS final rule website.

Medicare Promoting Interoperability Program: The calendar year (CY) 2023 electronic health record (EHR) reporting period for the Medicare Promoting Interoperability Program is a minimum of any continuous 90-day period within CY 2023. The EHR reporting period in CY 2024 is a minimum of any continuous 180-day period in CY 2024.

Query of Prescription Drug Monitoring Program (PDMP) Measure: Beginning with the CY 2023 EHR reporting period, CMS will require the Query of PDMP measure for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. CMS is expanding the Query of PDMP measure to include Schedule II opioids, as well as Schedule III and IV drugs beginning with the CY 2023

EHR reporting period. CMS also finalized changes to the measure description, and will require the query of the PDMP for prescription drug history to occur prior to the transmission of an electronic prescription for a Schedule II opioid or Schedule III or IV drug. The measure will include all permissible prescriptions and dispensing of Schedule II opioids and Schedule III or IV drugs, no matter how small the dose prescribed. However, multiple prescriptions for such drugs prescribed on the same date, by the same eligible hospital or CAH, will not require multiple queries of the PDMP. Finally, eligible hospitals and CAHs may query the PDMP using data from certified electronic health record technology (CEHRT) in any manner allowed under state law.

Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA): CMS finalized the addition of the Enabling Exchange Under TEFCA measure to the Health Information Exchange Objective beginning with CY 2023 EHR reporting period. This is one of three reporting options hospitals and CAHs have for this Objective.

Active Engagement with Public Health and Clinical Data Exchange Objective: CMS finalized a change to the three active engagement options available to hospitals and CAHs for the Public Health and Clinical Data Exchange Objective. CMS consolidated current options 1 and 2 into a new combined option called Pre-production and Validation, and renamed the current option 3 to Validated Data Production beginning with CY 2023 EHR reporting periods. Beginning in CY 2024, eligible hospitals and CAHs will only be permitted to remain in the Pre-production and Validation option for one EHR reporting period. Then they must progress to the Validated Data Production option.

Proposed Changes to EHR Reporting Period Methodology: Finalized changes to performance-based scoring for the CY 2023 EHR reporting period are in Table IX.H.-04. Finalized exclusion redistributions for the CY 2023 EHR reporting period are in Table IX.H.-05.

Public Reporting of Medicare Promoting Interoperability Program Data: Beginning with the CY 2023 EHR reporting period, CMS will publicly report certain Medicare Promoting Interoperability Program data, starting with public reporting of the total score of up to 105 points for each eligible hospital and CAH. CMS will also publicly report the EHR certification ID that represents the CEHRT used by the eligible hospital or CAH.

Clinical Quality Measures: Previously finalized eCQMs for the CY 2022-2024 reporting periods are in Tables IX.H.-09 through -11. CMS also adopted four new eCQMs for the Promoting Interoperability Program:

- Severe Obstetric Complications eCQM (NQF NA);
- Cesarean Birth eCQM (NQF NA);
- Hospital Harm-Opioid-Related Adverse Event eCQM (NQF #3501e); and
- Global Malnutrition Composite Score eCQM (NQF #3592e).

The eCQMs finalized for the CY 2024 reporting period and subsequent years are summarized in Table IX.H.-13.

Hospital Acquired-Condition (HAC) Reduction Program: CMS finalized the suppression of all six measures in the HAC Program for FY 2023. This means no hospitals will be penalized under the HAC program for FY 2023.

CMS will continue reporting on hospital performance on the program's hospital associated infection (HAI) measures and the patient safety indicator (PSI) measure. CMS will also suppress CY 2021 HAI measure data, impacting the FY 2024 payment year. However, the PSI measure will not be suppressed for the FY 2024 payment year. Instead, CMS adopted a risk-adjustment methodology to account for patients with COVID-19 diagnoses.

Hospital Readmissions Reduction Program (RRP): CMS will resume scoring on the pneumonia readmissions measure for FY 2024. This measure is already suppressed for FY 2023. CMS will exclude patients with principal or secondary COVID-19 diagnoses from both the cohort and the outcome. Additionally, for all six RRP measures, CMS will include patient history of COVID-19 in the 12 months prior to the index hospitalization as a co-variate in the measures' risk adjustment models.

Hospital Value-Based Purchasing (VBP) Program: CMS finalized suppression of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures and the five healthcare associated infection measures (CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI) for FY 2023. Because so many VBP measures will be suppressed, all hospitals will receive a neutral payment adjustment for FY 2023 under the VBP. CMS will calculate and report VBP measure scores publicly where feasible and appropriate.

Hospital IQR Program: CMS finalized the addition of ten measures to the IQR, including:

- Hospital Commitment to Health Equity (CY 2023 reporting period/FY 2025 payment determination);
- Screening for Social Drivers of Health (voluntary CY 2023; mandatory CY 2024 reporting period/FY 2026 payment determination);
- Screen Positive Rate for Social Drivers of Health (voluntary CY 2023; mandatory CY 2024 reporting period/FY 2026 payment determination);
- Cesarean Birth eCQM (voluntary CY 2023; mandatory CY 2024 reporting period/FY 2026 payment determination;
- Severe Obstetric Complications eCQM (voluntary CY 2023 reporting period; mandatory CY 2024 reporting period/FY 2026 payment determination);
- Hospital-Harm—Opioid-Related Adverse Events eCQM (CY 2024 reporting period/FY 2026 payment determination);
- Global Malnutrition Composite Score eCQM (CY 2024 reporting period/FY 2026 payment determination);
- Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (mandatory July 1, 2025 - June 30, 2026/FY 2028 payment determination);
- Medicare Spending Per Beneficiary (MSPB) Hospital measure (FY 2024 payment determination); and
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA measure (FY 2024 payment determination).

CMS also finalized refining two Hospital IQR measures beginning with the FY 2024 payment determination: (1) Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA and/or TKA and (2) Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI).

Finally, CMS made modifications to eCQM reporting and submission requirements beginning with the CY 2024 reporting period/FY 2026 payment determination. Hospitals must report four calendar years of data for each required eCQPM: (1) three self-selected eCQMs; (2) the Safe Use of Opioids – Concurrent Prescribing eCQM; (3) the proposed Cesarean Birth eCQM; and (4) the proposed Severe Obstetric Complications eCQM.

Maternal Mortality: In the FY 2022 IPPS final rule, the Hospital IQR Program adopted the Maternal Morbidity Structural measure. This measure assesses whether hospitals are participating in a state or

national Perinatal Quality Improvement (QI) Collaborative; and implementing patient safety practices or bundles as part of these QI initiatives.

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

RFIs – Health Equity, including Climate Change: CMS summarized comments received on several RFIs related to health equity, CMS quality programs, and climate change. CMS indicated that it will continue to engage all interested parties via multiple avenues, including future notice-and-comment rulemaking, as it considers future policy development.

RFI – Payment Adjustments for N95 Respirators: CMS used comments made on this RFI to develop the payment adjustment proposed in the CY 2023 outpatient prospective payment system (OPPS) proposed rule. Please refer to IHA's summary of the CY 2023 OPPS proposed rule for more information.

Contact:

Cassie Yarbrough, Senior Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:

Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; etc. Available from: https://www.federalregister.gov/public-inspection/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Accessed August 5, 2022.