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An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

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Final FY 2023 Medicare IPPS and LTCH PPS Update Issued

The Centers for Medicare and Medicaid Services (CMS) have released the final rule to update the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2023.

The rule also makes changes relating to Medicare graduate medical education (GME); establishes new requirements and revises existing requirements for hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program; updates policies for the Hospital Readmissions Reduction Program Hospital; the Inpatient Quality Reporting (IQR) Program; the Hospital VBP Program; the Hospital-Acquired Condition (HAC) Reduction Program; the PPS-Exempt Cancer Hospital Reporting (PCHQR) Program; and the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). It will also revise the hospital and critical access hospital (CAH) conditions of participation (CoPs) for infection prevention and control and antibiotic stewardship programs; and codifies and clarifies policies related to the costs incurred for qualified and non-qualified deferred compensation plans.

The document is currently on public display at the ***Federal Register*** office and is scheduled for publication on August 10. A display version of the 2,087-page rule is currently available at: https://public-inspection.federalregister.gov/2022-16472.pdf.

The IPPS tables for this final rule are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled "FY 2023 IPPS Final rule Home Page" or "Acute Inpatient—Files for Download."

CMS says the LTCH PPS tables are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/LongTermCareHospitalPPS/index.html. Note: this link does not open. Use https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices.

We have added a copy of CMS' table of contents with page numbers at the end of this analysis. The table of contents does not include the Addendum material nor Appendix A which contains regulatory impact analyses.

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In the following table CMS provides a summary of the costs and benefits associated with major provisions of the rule. (Page 22)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Adjustment for MS-DRG Documentation and Coding Changes	Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MACRA) replaced the single positive adjustment CMS intended to make in FY 2018 once the recoupment required by section 631 of the ATRA was complete with a 0.5 percentage point positive adjustment to the standardized amount of Medicare payments to acute care hospitals for FYs 2018 through 2023. (The FY 2018 adjustment was subsequently adjusted to 0.4588 percentage point by section 15005 of the ***21st Century Cures Act***.) For FY 2023, CMS is making an adjustment of +0.5 percentage point consistent with the MACRA.
Medicare DSH Payment Adjustment and Additional Payment for Uncompensated Care and Supplemental Payment	For FY 2023, CMS is updating its estimates of the three factors used to determine uncompensated care payments. CMS is continuing to use uninsured estimates produced by the Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA) in conjunction with more recently available data in the calculation of Factor 2. For FY 2023 CMS is using the two most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2018 cost reports and the FY 2019 cost reports to calculate Factor 3. In addition, for FY 2024 and subsequent fiscal years, CMS will use a three-year average of the data on uncompensated care costs from Worksheet S-10 for the three most recent fiscal years for which audited data are available. **CMS projects that the amount available to distribute as payments for uncompensated care for FY 2023 will decrease by approximately $318 million**, as compared to the uncompensated care payments that will be distributed in FY 2022.
Application of Rural Floor	Based on the district court's decision in Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra, CMS is not finalizing its rural floor wage index policy as proposed. Rather, CMS is finalizing a policy that calculates the rural floor as it was calculated before FY 2020. For FY 2023, and subsequent years, CMS is finalizing a policy to include the wage data of hospitals that have reclassified from urban to rural under section 1886(d)(8)(E) of the Act (as implemented in the regulations at § 412.103) and have no additional form of reclassification (MGCRB or Lugar) in the calculation of the rural floor, and to include the wage data of such hospitals in the calculation of "the wage index for rural areas in the State in which the county is located" as referred to in section 1886(d)(8)(C)(iii) of the Act. The law requires that a national budget neutrality adjustment be applied in implementing the rural floor.
Changes to GME Payments Based on Milton S. Hershey Medical Center, et al. v. Becerra Litigation	After reviewing the statutory language regarding the direct GME FTE cap and the court's opinion in Milton S. Hershey Medical Center, et al. v. Becerra, CMS is implementing a modified policy to be applied retroactively for all teaching hospitals, Specifically, effective for cost reporting periods beginning on or after October 1, 2001, CMS is specifying that if the hospital's unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds that FTE cap, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the 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. **CMS estimates the impact of this proposed change for FY 2023 to be approximately $170 million.**
Update to the IPPS Payment Rates and Other Payment Policies	Acute care hospitals are estimated to experience an increase of approximately **$1.4 billion** in FY 2023, primarily driven by: (1) a combined $2.4 billion increase in FY 2023 operating payments, including supplemental payments for eligible IHS/Tribal hospitals and Puerto Rico hospitals, as well as changes in uncompensated care payments, and (2) a combined decrease of $1.0 billion resulting from estimated changes in new technology add-on payments (including the expiration of payments for technologies that were provided a one-year extension in FY 2022), the change to the GME weighting methodology, the expiration of the temporary changes to the low-volume hospital payment adjustment, and capital payment, as modeled for this final rule.
Update to the LTCH PPS Payment Rates and Other Payment Policies	Based on the best available data for the 339 LTCHs in CMS' database, the agency estimates that the changes to the payment rates and factors will result in an estimated increase in payments in FY 2023 of approximately **$71 million**.
Changes to the Hospital Readmissions Reduction Program	For the FY 2023 program year, MS-DRG reductions in payments are based on a hospital's risk-adjusted readmission rate during a multi-year period for acute myocardial infarction (AMI), heart failure (HF), chronic obstructive pulmonary disease (COPD), elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG) surgery. Overall, in this rule, CMS estimates that 2,273 hospitals will have their base operating MS-DRG payments reduced by their determined estimated FY 2023 hospital-specific readmission adjustment. As a result, CMS estimates that the Hospital Readmissions Reduction Program would save **approximately $320 million in FY 2023**.
Value-Based Incentive Payments under the Hospital VBP Program	CMS estimates that there would be no net financial impact to the Hospital VBP Program for the FY 2023 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. CMS is finalizing its proposals which will result in hospitals not receiving a Total Performance Score (TPS) for FY 2023. The estimated amount of base operating MS-DRG payment amount reductions for the FY 2023 program year and, therefore, the estimated amount

Provision Description	Description of Costs, Transfers, Savings, and Benefits
	available for value-based incentive payments for FY 2023 discharges is **approximately $1.8 billion.**
Changes to the HAC Reduction Program	For the FY 2023 program year, CMS is finalizing its proposal to suppress all six measures in the HAC Reduction Program. CMS is not finalizing its proposal to not calculate or report CMS PSI 90 measure results for the FY 2023 HAC Reduction Program. Although CMS will not use the calculated scores for the CMS PSI 90 measure results to implement the HAC Reduction Program for the program year CMS will still calculate and report CMS PSI 90 that is displayed on the main pages of the Care Compare tool hosted by HHS after confidentially reporting these results to hospitals via CMS PSI 90 specific HSRs and a 30-day preview period for the NHSN CDC HAI measures. Accordingly, for the FY 2023 HAC Reduction Program, no hospital would receive a payment reduction. As a result, for the FY 2023 program year, CMS anticipates reductions to the Medicare trust fund that is otherwise estimated at **approximately $350 million**.
Changes to the Hospital IQR Program	Across 3,150 IPPS hospitals, CMS estimates that the finalized changes for the Hospital IQR Program will result in a total information collection burden increase of 746,300 hours associated with the finalized policies, and updated burden estimates and a total cost increase of approximately **$23,437,906** across a 4-year period from the CY 2023 reporting period/FY 2025 payment determination through the CY 2026 reporting period/FY 2028 payment determination.
Changes to the Medicare Promoting Interoperability Program	Across 4,500 eligible hospitals and CAHs, CMS estimates that finalized changes for the Medicare Promoting Interoperability Program will result in a total information collection burden increase of 5,513 hours associated, and updated burden estimates and a total cost increase of approximately **$233,730** across a 2-year period from the CY 2023 EHR reporting period through the CY 2024 EHR reporting period.
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	CMS estimates that changes to the CoPs, which would require hospitals and CAHs to comply with continued COVID-19-related reporting provisions, will result in an estimated burden increase of 483,600 hours based on weekly reporting (52 weeks per year) of the required information by approximately 6,200 hospitals and CAHs and at an average response time of 1.5 hours for a registered nurse with an average hourly salary of $79. This would result in an estimated total of **$38,204,400** for weekly reporting (or approximately $6,162 per facility)..

CMS also presents its traditional cost analysis table, which follows. "The net costs to the Federal Government associated with the policies in this rule are estimated at $1.4 billion." (Page 2,072)

Category	Transfers
Annualized Monetized Transfers	$1.4 billion
From Whom to Whom	Federal Government to IPPS Medicare Providers

Comments

For many payment issues, the rule's Addendum (beginning on page 1,795) contains much concise and extremely useful payment information.

This analysis does not follow the rule's organization or heads.

I. CHANGES TO PROSPECTIVE PAYMENT RATES FOR HOSPITAL INPATIENT OPERATING COSTS FOR ACUTE CARE HOSPITALS FOR FY 2023 (Page 755 and Addendum Page 1,798)

Rate Update

For FY 2023, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the national standardized amount.

The increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users will be **3.8 percent**. This reflects a projected hospital market basket update of 4.1 percent reduced by a 0.3 percentage point multi-factor productivity (MFP) adjustment.

CMS displays four applicable percentage increases to the standardized amounts, as shown in the following table. The ***Medicare Access and CHIP Reauthorization Act*** *(*MACRA) which requires an additional requirement of a +0.5 percent increase is not reflected in the amounts below.

FY 2023 Applicable Percentage Increases for the IPPS				
FY 2023	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
Market Basket Rate-of-Increase	4.1	4.1	4.1	4.1
Adjustment for Failure to Submit Quality Data (Reduction of ¼ of market basket increase)	0	0	-1.025	-1.025
Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0	-3.075	0	-3.075
MFP Adjustment	-0.3	-0.3	-0.3	-0.3
Applicable Percentage Increase Applied to Standardized Amount	**3.8**	**0.725**	**2.775**	**-0.3**

Hospitals that do comply with the quality data submission requirements but are not meaningful EHR users would receive an update of 0.725 percent, which includes a reduction of three-quarters of the market basket update. (4.1 X (1.00-.075, or 0.25) – 0.3 = 0.725).

Hospitals that fail to comply with the quality data submission requirements but are meaningful EHR users will receive an update of 2.775 percent. This update includes a reduction of one-quarter of the market basket update for failure to submit these data. (4.1 X (1.00-0.25, or 0.75) – 0.3 = 2.775).

Furthermore, hospitals that do not comply with the quality data submission requirements and also are not meaningful EHR users would receive an update of -0.3 percent.

Current FY 2022 Standardized Payment Rates

The current FY 2022 standardized payment amounts, as corrected in the October 20, 2021, ***Federal Register***, are as follows:

Hospital Submitted Quality Data and is aMeaningful EHR User		Hospital Submitted Quality Data and isNOT a MeaningfulEHR User		Hospital Did NOT Submit Quality Dataand is a Meaningful EHR User		Hospital Did NOT Submit Quality Dataand is NOT a Meaningful EHR User	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$4,138.24	**$1,983.41**	$4,056.08	$1,944.03	$4,110.85	$1,970.28	$4,028.70	$1,930.91
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,795.42	**$2,326.23**	$3,720.07	$2,280.04	$3,770.30	$2,310.83	$3,694.96	$2,264.65

The current (FY 2022) large urban labor rate is $4,138.24 and the non-labor rate is $1,983.41 for a total of $6,121.65 The other area labor rate is $3,795.42 and the non-labor component is $2,326.23 for a total of $6,121.65.

The following table (Page 1,870) illustrates the changes from the current FY 2022 national standardized amounts to the FY 2023 national standardized amounts. These amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors, etc. as shown below resulting in a gross payment rate of $6,555.34. This amount is then further adjusted by multiplying the FY 2023 adjustments.

Changes From FY 2022 Standardized Amounts To The FY 2023 Standardized Amounts

	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 Base Rate after removing: 1. FY 2022 Geographic Reclassification Budget Neutrality (0.986741) 2. FY 2022 Operating Outlier Offset (0.949) 3. FY 2022 Rural Demonstration Budget Neutrality Factor (0.999361) 4. FY 2022 Lowest Quartile Budget Neutrality Factor (0.998029) 5. FY 2022 Transition Budget Neutrality Factor (0.999859)	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,431.41 Nonlabor (32.4%) $2,123.93 *(Combined labor and nonlabor = $6,555.34)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,064.31 Nonlabor (38%) $2,491.03 *(Combined labor and nonlabor = $6,555.34)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,431.41 Nonlabor (32.4%) $2,123.93 *(Combined labor and nonlabor = $6,555.34)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,064.31 Nonlabor (38%) $2,491.03 *(Combined labor and nonlabor = $6,555.34)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,431.41 Nonlabor (32.4%) $2,123.93 *(Combined labor and nonlabor = $6,555.34)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,064.31 Nonlabor (38%) $2,491.03 *(Combined labor and nonlabor = $6,555.34)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,431.41 Nonlabor (32.4%) $2,123.93 *(Combined labor and nonlabor = $6,555.34)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,064.31 Nonlabor (38%) $2,491.03 *(Combined labor and nonlabor = $6,555.34)*
FY 2023 Update Factor	**1.038**	**1.00725**	**1.02775**	**0.9970**

	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 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap	1.000509	1.000509	1.000509	1.000509
FY 2023 Cap Policy MS-DRG Weight Budget Neutrality Factor	0.999764	0.999764	0.999764	0.999764
FY 2023 Wage Index Budget Neutrality Factor	1.000968	1.000968	1.000968	1.000968
FY 2023 Reclassification Budget Neutrality Factor	0.984399	0.984399	0.984399	0.984399
FY 2023 Lowest Quartile Budget Neutrality Factor	0.998146	0.998146	0.998146	0.998146
FY 2023 Cap Policy Wage Index Budget Neutrality Factor	0.999689	0.999689	0.999689	0.999689
FY 2023 RCH Demonstration Budget Neutrality Factor	0.998935	0.998935	0.998935	0.998935
FY 2023 Operating Outlier Factor	0.949000	0.949000	0.949000	0.949000
Adjustment for FY 2023 Required under Section 414 of MACRA	**1.005**	**1.005**	**1.005**	**1.005**
Totals	**$6,375.74**	**$6,186.86**	**$6,312.78**	**$6,123.91**
National Standardized Amount for FY 2022 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,310.00 Nonlabor: $2,065.74**	**Labor: $4,182.32 Nonlabor: $2,004.54**	**Labor: $4,267.44 Nonlabor: $2,045.34**	**Labor: $4,139.76 Nonlabor: $1,984.15**
National Standardized Amount for FY 2022 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $3,952.96 Nonlabor: $2,422.78**	**Labor: $3,835.85 Nonlabor: $2,351.01**	**Labor: $3,913.92 Nonlabor: $2,398.86**	**Labor: $3,796.82 Nonlabor: $2,327.09**

The change between the final FY 2022 full market-basket rate of increase amount of $6,121.65 and the FY 2023 amount of $6,375.74 is $254.09, or a net increase of approximately 4.15 percent.

These amounts are before other adjustments such as the hospital value-based purchasing program, the hospital readmission program, and the hospital acquired conditions program.

Comment (Page 1,985)

CMS says that 24 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2023 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users.

CMS says 158 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2023 because they are identified as not meaningful EHR users that do submit quality information.

CMS says 20 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2022 because they are identified as not meaningful EHR users that do not submit quality data.

Labor-Share (Pages 627 and 1,906)

On page 627 CMS says, "we are finalizing our proposals, without modification, to continue to use a labor-related share of 67.6 percent for discharges occurring on or after October 1, 2022 for all hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.0000."

On page 1,906 CMS says, "We note that the proposed labor related share of 68.2 percent, which was based on IHS Global Inc's fourth quarter 2021 forecast of the 2017-based LTCH market basket, has been updated to reflect IHS Global Inc's second quarter 2022 forecast, and that this update, resulting in a labor related share of 68.0 percent, is a slightly smaller increase over the labor share from FY 2022, which was 67.9 percent."

The FY 2023 rate tables (page 1,906) say the labor share will be unchanged from the current FY 2022 amount of 67.6 percent.

Areas with wage index values equal to or less than 1.000 will remain at 62.0, as required by current law.

Comment

Since the rate tables say the labor share is 67.6 percent, one would assume that is the correct amount.

Outlier Payments (Page 1,864)

In accordance with section 1886(d)(3)(B) of the Act, CMS will reduce the FY 2023 standardized amount by 5.1 percent to account for the projected proportion of payments paid as outliers.

CMS is finalizing an outlier fixed-loss cost threshold for FY 2023 equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible IHS/Tribal hospitals and Puerto Rico hospitals and any add-on payments for new technology, **plus $38,859.**

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2023 (Page 1,893)

CMS is finalizing a FY 2023 Federal capital rate of capital Federal rate of **$483.76** for FY 2023. The current rate is $472.60.

	FY 2022	FY 2023	Change	Percent Change
Update Factor[1]	1.0080	1.0250	1.0250	2.50
GAF/DRG Adjustment Factor[1]	1.0004	1.0012	1.0012	0.12
Quartile/Cap Adjustment Factor[2]	0.9974	0.9972	0.9998	-0.02
Outlier Adjustment Factor[3]	0.9471	0.9448	0.9976	-0.24
Capital Federal Rate	$472.59	**$483.76**	1.0236	2.36

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2023 (Pages 28 and 1,021)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

Accordingly, for FY 2023, the rate-of-increase percentage to be applied to the target amount for these hospitals will be the operating market basket update percentage increase of **4.1 percent.**

II. CHANGES TO THE HOSPITAL AREA WAGE INDEX (Page 545)

The FY 2023 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2019 (the FY 2022 wage indexes were based on data from cost reporting periods beginning during FY 2018). The FY 2023 indexes are located in Table 3 on the CMS website – Wage Index Table by CBSA—FY 2023 Final Rule.

Occupational Mix Adjustment to the FY 2023 Wage Index (Page 571)

The FY 2023 occupational mix adjustment is based on the calendar year (CY) 2019 survey.

The FY 2023 Occupational Mix *Adjusted* National Average Hourly Wage is **$47.73**. (Page 574)

The FY 2023 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows; (Page 575)

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$44.44
National LPN and Surgical Technician	$26.86
National Nurse Aide, Orderly, and Attendant	$18.54
National Medical Assistant	$19.53
National Nurse Category	$37.38

Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Budget Neutrality Adjustment

Rural Floor (Page 577)

By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS estimates that 192 hospitals would receive an increase in their FY 2023 wage index due to the application of the rural floor.

CMS estimates that 275 hospitals will receive an increase due to the application of the rural floor. (Page 583)

Imputed Floor (Page 583 & 2,000)

The following States -- New Jersey, Rhode Island, Delaware, Connecticut, and Washington, D.C.—will be all-urban States as defined in section 1886(d)(3)(E)(iv)(IV) of the Act, and thus hospitals in such States will be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2023. The imputed floor adjustment is estimated to increase IPPS operating payments by approximately $124 million. There are an estimated 66 providers in Connecticut, Delaware, Washington D.C., New Jersey, and Rhode Island that will receive the imputed floor wage index

State Frontier Floor (Page 588)

For FY 2023, 44 hospitals will receive the frontier floor value of 1.0000 for their FY 2023 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming. CMS notes that while Nevada meets the criteria of a frontier State, all hospitals within the State currently receive a

wage index value greater than 1.0000. Overall, this provision is not budget neutral and is estimated to increase IPPS operating payments by approximately $64 million.

Continuation of the Low Wage Index Hospital Policy, Budget Neutrality Adjustment (Page 589)

The low wage index increases the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals (the low wage index hospital policy).

For purposes of the low wage index hospital policy, based on the data for this rule, the 25th percentile wage index value across all hospitals for FY 2023 is **0.8427.** The current amount is 0.8437.

The FY 2020 low wage index hospital policy and the related budget neutrality adjustment are the subject of pending litigation, Bridgeport Hospital, et al., v. Becerra, No. 1:20-cv-01574 (D.D.C.).

CMS says it disagrees with the district court's and notes that its decision remains subject to potential appeal.

CMS is finalizing as proposed, to continue the low wage index hospital policy and the related budget neutrality adjustment for FY 2023. (Page 595)

Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications (Page 596)

The MGCRB has completed its review of FY 2023 reclassification requests. Based on such reviews, there are **383** hospitals approved for wage index reclassifications by the MGCRB starting in FY 2023.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2023, hospitals reclassified beginning in FY 2021 or FY 2022 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period.

There were **311** hospitals approved for wage index reclassifications in FY 2021, and **315** hospitals approved in FY 2022.

Of all the hospitals approved for reclassification for FY 2021, FY 2022 and FY 2023, 1,009 hospitals are in a MGCRB reclassification status for FY 2023 (with 166 of these hospitals reclassified back to their geographic location).

Applications for FY 2024 reclassifications are due to the MGCRB by September 1, 2022.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 608)

Table 2 includes the out-migration adjustments for the FY 2023 wage index. In addition, Table 4A, ''List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act'' consists of the following: A list of counties that are eligible for the outmigration adjustment for FY 2023 identified by FIPS county code, the FY 2023 out-migration adjustment, and the number of years the adjustment will be in effect.

Reclassification from Urban to Rural Under Section 1886(d)(8)(E) of the Act Implemented at 42 CFR 412.103 (Page 610)

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB.

Specifically, section 1886(d)(8)(E) of the Act provides that, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital that satisfies certain criteria, the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

Permanent Cap on Wage Index Decreases (Page 627)

CMS is adopting a permanent approach to smooth year-to-year decreases in hospitals' wage indexes. CMS is applying a 5.0-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.
CMS says there will be 126 hospitals receiving the cap in FY 2023. (Page 638)

Comment

Note, the final rule has this item listed as subhead "N." However, the CMS table of contents does not include such reference.

III. OTHER DECISIONS AND CHANGES to the IPPS OPERATING SYSTEM (Page 777)

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 761)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Case-mix

Rural hospitals with fewer than 275 beds can qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2022 must have a CMI value for FY 2021 that is at least—**1.8262** (national--all urban); or the median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region	Case-MixIndex Value
1. New England (CT, ME, MA, NH, RI, VT)	1.4961
2. Middle Atlantic (PA, NJ, NY)	1.59995
3. East North Central (IL, IN, MI, OH, WI)	1.7062
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7709
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.68745
6. East South Central (AL, KY, MS, TN)	1.6754

Region	Case-MixIndex Value
7. West South Central (AR, LA, OK, TX)	1.8756
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.8960
9. Pacific (AK, CA, HI, OR, WA)	1.8547

A hospital must also have the number of discharges for its cost reporting period that began during FY 2020 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Pages 767, 1,721 & 2,015)

Beginning with FY 2023, the low-volume hospital qualifying criteria and payment adjustment will revert to a hospital located more than 25 road miles from another subsection (d) hospital and that has less than 200 discharges, Medicare and non-Medicare, during the fiscal year.

Currently, the low-volume hospital qualifying criteria provide that a hospital must have fewer then 3,800 total discharges during the fiscal year, and the hospital must be located more than 15 road miles from the nearest "subsection (d)" hospital.

For FY 2023, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2022, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2022. If a hospital's written request for low-volume hospital status for FY 2023 is received after September 1, 2022, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC would apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2023 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

Comment

CMS says that "effective for FY 2023 and subsequent years, under current policy at § 412.101(b), in order to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than **200** discharges (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2023 and subsequent years, the statute specifies that a low-volume hospital must have less than **800** discharges during the fiscal year."

Therefore, "effective for FY 2023 and subsequent years, under current policy at § 412.101(b), in order to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than 200 discharges during the fiscal year." (Page 1,721)

Just another inconsistency/ misleading error.

Based upon the best available data at this time, CMS estimates the expiration of the temporary changes to the low-volume hospital payment policy will decrease aggregate low-volume hospital payments by

$437 million in FY 2023 as compared to FY 2022. These payment estimates were determined based on the estimated payments for the 632 providers that are expected to no longer qualify under the criteria that will apply in FY 2023, and were calculated using the same methodology.

Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (Page 780)

Because section 50205 of the ***Bipartisan Budget Act*** extended the MDH program through FY 2022 only, beginning October 1, 2022, the MDH program will no longer be in effect.

A hospitals that previously qualified for MDH status will be paid based on the IPPS Federal rate.

Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105) (Page 785)

The IME formula multiplier remains unchanged at 1.35.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Pages 786 & 2,025)

CMS is finalizing two proposed changes to its GME policies.

First, after reviewing the statutory language regarding the direct GME full-time equivalent (FTE) cap and the court's opinion in *Milton S. Hershey Medical Center, et al. v. Becerra*, CMS is finalizing a modified policy to be applied prospectively for all teaching hospitals, as well as retrospectively for certain providers and cost years. The modified policy addresses situations for applying 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. Specifically, effective for cost reporting periods beginning on or after October 1, 2022, if the hospital's unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds that FTE cap, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the 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.

Second, the law requires caps on the number of FTE residents that each teaching hospital may include in its indirect medical education (IME) adjustment and direct GME payment formulas. To provide flexibility to teaching hospitals that cross-train residents, CMS allows teaching hospitals to enter into "Medicare GME affiliation agreements" to share and redistribute those cap slots to accommodate the actual rotations of their residents. The law also includes a provision allowing additional cap slots for urban hospitals that establish "rural training tracks" with rural hospitals, now called Rural Training Programs (RTPs). CMS' current regulations do not allow GME affiliation agreements for RTPs. Stakeholders have requested that RTPs be afforded the same flexibility as other teaching hospitals to share their RTP cap slots via special RTP affiliation agreements. With this final rule, CMS is allowing an urban and a rural hospital participating in the same RTP to enter into an "RTP Medicare GME affiliation agreement" effective for the academic year beginning July 1, 2023.

CMS has estimated the impact of this change for FY 2023 to be $170 million.

IV. PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHs) FOR FY 2023 (§ 412.106) (Page 641)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75 percent of uncompensated care payment is the product of three factors.

The 3 factors in determining the amount of such payments are as follows.

Calculation of Factor 1 for FY 2023 (Page 652)

This factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The Office of the Actuary's June 2022 estimate of Medicare DSH payments for FY 2023 is approximately $13.949 billion. Therefore, $3.487 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2023).

Therefore, Factor 1 for FY 2023 will be **$10,461,731,029.40** which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2023 ($13,948,974,705.87 minus $3,487,243,676.47).

Calculation of Factor 2 for FY 2023 (Page 670)

"The projected rates of uninsurance for CY 2021 and 2022 reflect the estimated impact of the COVID–19 pandemic. As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates."

- Percent of individuals without insurance for CY 2013: 14.0 percent.
- Percent of individuals without insurance for CY 2022: 8.9 percent.
- Percent of individuals without insurance for CY 2023: 9.3 percent.
- Percent of individuals without insurance for FY 2023 (0.25 times 0.089) + (0.75 times 0.093)= 9.2 percent.
- 1- |((0.092-0.14)/0.14)| = 1-0.3429= 0.6571 (65.71 percent).
- Therefore, the final Factor 2 for FY 2023 will be **65.71 percent**.

- The FY 2023 uncompensated care amount is **$10,461,731,029.40***0.6571 = ***$6,874,403,459.42***

The following shows the 75 percent yearly amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" was $8.273 billion
- The FY 2020 "pool" was $8.351 billion
- The FY 2021 "pool" was $8.290 billion
- The FY 2022 "pool" is $7.192 billion
- The FY 2023 "pool" will be $6.874 billion

The pool amount for FY 2023 will be $318 million less than the current FY 2022 amount.

Calculation of Factor 3 for FY 2023 (Page 677)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

CMS is using the average of the audited FY 2018 and audited FY 2019 reports for calculating factor 3. CMS says that FY 2024 will be the first year that three years of audited data will be available at the time of rulemaking.

Medicare Disproportionate Share Hospital (DSH) Payments: Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction (§ 412.106) (Page 739)

CMS is not finalizing its proposal to revise its regulations at § 412.106(b)(4) to explicitly reflect its interpretation of the language "regarded as" "eligible for medical assistance under a State plan approved under title XIX" in section 1886(d)(5)(F)(vi) of the Act.

V. CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 50)

Comment

This is an extensive and detailed section regarding MS-DRGs and coding. The section, including new technologies is nearly 500 pages. The material that follows is but a guide for the items being addressed. To fully comprehend the changes requires an in-depth review of the changes being adopted. CMS did not propose any new MS-DRGs for FY 2023, which means the number of MS-DRGs is maintained at 767 for FY 2023.

FY 2023 MS-DRG Documentation and Coding Adjustment (Page 51)

CMS is implementing a positive 0.5 percentage point adjustment to the standardized payment amounts for FY 2023. This will constitute a permanent and final adjustment to payment rates for coding and documentation as prescribed by section 414 of the MACRA.

Changes to Specific MS-DRG Classifications (Page 55)

Listed below are the specific MS-DRG items CMS is addressing in this final rule.

1. Pre-MDC: MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies (Page 69)

2. MDC 01 (Diseases and Disorders of the Nervous System)

   a. Laser Interstitial Thermal Therapy (LITT) (Page 78)

   b. Vagus Nerve Stimulation (Page 107)

Comment

<u>The proposed rule did not have a number 3. There is no number 3 in this final rule either.</u>

4. MDC 02 (Diseases and Disorders of the Eye): Retinal Artery Occlusion (Page 122)

5. MDC 04 (Diseases and Disorders of the Respiratory System): Acute Respiratory Distress Syndrome (ARDS) (Page 133)

6. MDC 05 (Diseases and Disorders of the Circulatory System)

a. Percutaneous Transluminal Coronary Angioplasty (PTCA) Logic (Page 136)

b. Neuromodulation Device Implant for Heart Failure (Barostim™ Baroreflex Activation Therapy) (Page 138)

c. Cardiac Mapping (Page 152)

d. Surgical Ablation (Page 159)

7. MDC 06 (Diseases and Disorders of the Digestive System): Appendicitis (Page 172)

8. MDC 07 (Diseases and Disorders of the Hepatobiliary System and Pancreas): Laparoscopic Cholecystectomy with Common Bile Duct Exploration (Page 177)
9. MDC 10 (Diseases and Disorders of the Endocrine System): Eladocagene Exuparvovec Gene Therapy (Page 183)

10. (Endocrine, Nutritional and Metabolic Diseases and Disorders) and to MS–DRGs 987, 988, and 989 (Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without MCC/CC, respectively) (Page 186)

11. Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (Page 192)

a. Embolization of Portal and Hepatic Veins (Page 193)
b. Percutaneous Excision of Hip Muscle (Page 197)

12. Operating Room (O.R.) and Non-O.R. Issues (Page 202)

Changes to the MS-DRG Diagnosis Codes for FY 2023 (Page 213)

The following tables identify the additions and deletions to the diagnosis code MCC severity levels list and the additions and deletions to the diagnosis code CC severity levels list for FY 2023 and are available at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

- Table 6A.—New Diagnosis Codes–FY 2023
- Table 6B.—New Procedure Codes–FY 2023
- Table 6C.—Invalid Diagnosis Codes–FY 2023
- Table 6D.—Invalid Procedure Codes–FY 2023● Table 6E.—Revised Diagnosis Code Titles–FY 2023
- Table 6G.1.— Secondary Diagnosis Order Additions to the CC Exclusions List–FY 2023
- Table 6G.2.— Principal Diagnosis Order Additions to the CC Exclusions List–FY 2023
- Table 6H.1.— Secondary Diagnosis Order Deletions to the CC Exclusions List–FY 2023
- Table 6H.2.— Principal Diagnosis Order Deletions to the CC Exclusions List—FY 2023
- Table 6I.– Complete MCC List- FY 2023
- Table 6I.1.— Additions to the MCC List–FY 2023
- Table 6I.2.– Deletions to the MCC List–FY 2023
- Table 6J.— Complete CC List–FY 2023

- Table 6J.1.— Additions to the CC List–FY 2023
- Table 6J.2.– Deletions to the CC List–FY 2023
- Table 6K.– Complete List of CC Exclusions–FY 2023.

Changes to the Medicare Code Editor (MCE) (Page 242)

The Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

Changes to Surgical Hierarchies (Page 258)

CMS is maintaining the existing surgical hierarchy for FY 2023.

Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems (Page 261)

The official list of ICD-10-CM and ICD-10-PCS codes can be found on the CMS website at: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

For FY 2023, there are 73,639 ICD-10-CM codes and 78,496 ICD-10-PCS codes. (Page 272)

Replaced Devices Offered without Cost or with a Credit (Page 272)

The existing MS-DRGs currently subject to the replaced device policy is displayed in the rule's table on page 273.

Add-On Payments for New Services and Technologies for FY 2023 (Page 318)

New COVID-19 Treatments Add-On Payment (NCTAP)

Effective for discharges occurring on or after November 2, 2020 and until the end of the public health emergency (PHE) for COVID–19, CMS established the NCTAP to pay hospitals the lesser of (1) 65 percent of the operating outlier threshold for the claim or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment, including the adjustment to the relative weight under section 3710 of the ***Coronavirus Aid, Relief, and Economic Security*** (CARES) ***Act***, for certain cases that include the use of a drug or biological product currently authorized for emergency use or approved for treating COVID–19.

FY 2023 Status of Technologies Receiving New Technology Add-On Payments for FY 2022 (Page 336)

CMS provided a 1-year extension of new technology add-on payments for FY 2022 for 13 technologies for which the new technology add-on payment would otherwise have been discontinued beginning in FY 2022.

The following table lists the technologies for which CMS will discontinue making new technology add-on payments for FY 2023 because they are no longer "new" for purposes of new technology add-on payments. This table also presents the newness start date, new technology add-on payment start date, the 3-year anniversary date of the product's entry onto the U.S. market, relevant final rule citations from prior fiscal years, and coding assignments for each technology.

Discontinuation of Technologies Approved for FY 2022 New Technology Add-on Payments No Longer Considered New for FY 2023 Because 3-year Anniversary Date Will Occur Prior to April 1, 2023 (Page 355)

	Technology	FDA/Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US Market
1	*Balversa™*	04/12/2019	10/19/2019	4/12/2022
2	*Jakafi®*	05/24/2019	10/1/2019	5/24/2022
3	*BAROSTIM NEO™ System*	08/16/2019	10/1/2020	08/16/2022
4	*Optimizer® System*	10/23/2019	10/1/2020	10/23/2022
5	*RECARBRIO™ (cUTI/ cIAI)*	07/16/2019 commercially available in US 1/6/20	10/1/2020	1/6/2023
6	*Soliris®*	06/27/2019	10/1/2020	6/27/2022
7	*XENLETA™*	08/19/2019 commercially available in US 9/10/19	10/1/2020	9/10/2022
8	*ZERBAXA®*	06/03/2019	10/1/2020	6/03/2022
9	*Azedra®*	05/21/2019	10/1/2019	5/21/2022
10	*EXALT™ Model D*	12/13/2019	10/1/2021	12/13/2022
11	*Fetroja® (Cefiderocol)* (cUTI)	11/19/2019 Commercially available in US 2/24/2020	10/1/2020	2/24/2023

The table below lists the technologies for which CMS will continue making new technology add-on payments for FY 2023 because they are still considered "new" for purposes of new technology add-on payments.

Continuation of Technologies Approved for FY 2022 New Technology Add-On Payments Still Considered New for FY 2023 Because 3-Year Anniversary Date Will Occur on or After April 1, 2023 (Page 349)

	Technology	FDA/Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US Market	Maximum NTAP Amount for FY 2023	Coding Used to IdentifyCases Eligible for NTAP
1	*Rybrevant™*	05/21/2021	10/1/2021	5/21/2024	$6,405.89	XW033B7 or XW043B7
2	*Cosela™*	02/12/2021	10/1/2021	2/12/2024	$5,612.10	XW03377 or XW04377
3	*ABECMA®*	03/26/2021	10/1/2021	3/26/2024	$289,532.75	XW033K7 or XW043K7
4	*StrataGraft®*	06/15/2021	10/1/2021	6/15/2024	$44,200.00	XHRPXF7
5	*TECARTUS®*	07/4/2020	10/1/2021	7/4/2023	$259,350.00	XW033M7 or XW043M7
6	*VEKLURY®*	07/1/2020*	10/1/2021	7/1/2023*	$2,028.00	XW033E5 or XW043E5
7	*Zepzelca™*	06/15/2020	10/1/2021	6/15/2023	$9,145.50	XW03387 or XW04387

	Technology	FDA/Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US Market	Maximum NTAP Amount for FY 2023	Coding Used to IdentifyCases Eligible for NTAP
8	*aprevo® Intervertebral Body Fusion Device*	12/03/2020 (ALIF and LLIF) 6/30/2021(TLIF)	10/1/2021	12/03/2023 (ALIF and LLIF) 6/30/2024 (TLIF)	$40,950.00	XRGA0R7 or XRGA3R7 or XRGA4R7 or XRGB0R7 or XRGB3R7 or XRGB4R7 or XRGC0R7 or XRGC3R7 or XRGC4R7 or XRGD0R7 or XRGD3R7 or XRGD4R7
9	*aScope® Duodeno*	07/17/2020	10/1/2021	7/17/2023	$1,296.75	XFJB8A7 or XFJD8A7
10	*Caption Guidance™*	09/15/2020	10/1/2021	9/15/2023	$1,868.10	X2JAX47
11	*Harmony™ Transcatheter Pulmonary Valve (TPV) System*	03/26/2021	10/1/2021	3/26/2024	$26,975.00	02RH38M
12	*Intercept® (PRCFC)*	05/05/2021	10/1/2021	5/05/2024	$2,535.00	30233D1 or 30243D1 in combination with one of the following D62, D65, D68.2,D68.4 or D68.9
13	*ShockWave C2 Intravascular Lithotripsy (IVL) System*	02/12/2021	10/1/2021	2/12/2024	$3,666.00	02F03ZZ or 02F13ZZ or 02F23ZZ or 02F33ZZ
14	*Fetroja ® (HABP/ VABP)*	09/25/2020	10/1/2021	9/25/2023	$8,579.84	XW033A6 or XW043A6 in combination with ICD-10-CM code Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, J15.8, or J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, or B96.89
15	Recarbrio™ (HABP/VABP)	06/04/2020	10/1/2021	6/04/2023	$9,576.51	XW033U5 or XW043U5 in combination with ICD-10-CM code Y95 and one of the following: J14, J15.0, J15.1, J15.5, J15.6, J15.8, or J95.851 and one of the following: B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, or B96.89

CMS allowed for a 1-year extension of new technology add-on payments for FY 2022 for 13 technologies (see table below) for which the new technology add-on payment would have otherwise been discontinued beginning with FY 2022.

CMS is proposing to discontinue new technology add on payments for these 13 technologies in FY 2023.

Discontinuation of Technologies which Received a One Year Extension for New Technology Add-On Payment In FY 2022 Because 3-Year Anniversary Date Occurred Before The Second Half of FY 2022 (Page 360)

Technology		FDA/Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US Market
1	*Cablivi®*	02/06/2019	10/01/2019	02/06/2022
2	*Elzonris™*	12/21/2018	10/01/2019	12/21/2021
3	*AndexXa™*	05/03/2018	10/01/2018	05/03/2021
4	*Spravato®*	3/5/2019	10/01/2019	3/5/2022
5	*Zemdri®*	6/25/2018	10/01/2018	6/25/2021
6	*T2 Bacteria® Panel*	05/24/2018	10/01/2019	05/24/2021
7	*ContaCT*	02/13/2018 (commercially available 10/01/2018)	10/01/2020	10/01/2021
8	*Eluvia™ Drug-Eluting Vascular Stent System*	09/18/2018 commercially available in US 10/04/2018	10/01/2020	10/04/2021
9	*Hemospray®*	05/07/2018 (commercially available 07/01/2018)	10/01/2020	07/01/2021
10	*IMFINZI®/ TECENTRIQ®*	Imfinzi: 03/27/2020 Tecentriq: 03/18/2019 Newness date is 3/18/2019 for both	10/01/2020	03/18/2022
11	*NUZYRA®*	10/02/2018 (commercially available 02/01/2019)	10/01/2020	2/01/2022
12	*SpineJack® System*	08/30/2018 (commercially available 10/11/2018)	10/01/2020	10/11/2021
13	Xospata®	11/28/2018	10/01/2019	11/28/2021

FY 2023 Applications for New Technology Add-On Payments (Traditional Pathway) (Page 362)

CMS received 18 applications for new technology add-on payments for FY 2023 under the traditional new technology add-on payment pathway. In accordance with the regulations under § 412.87(e), applicants for new technology add-on payments must have received FDA approval or clearance by July 1 of the year prior to the beginning of the fiscal year for which the application is being considered. Five applicants withdrew their applications prior to the issuance of the proposed rule. Seven others

subsequently withdrew their applications leaving the 5 below. Four have been approved and one not approved.

A. *CARVYKTI™ (ciltacabtagene autoleucel). The maximum new technology add-on payment for a case involving the use of CARVYKTI™ or ABECMA® is $289,532.75 for FY 2023.* (Page 362)

B. *DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj).* The maximum new technology add-on payment for a case involving the use of DARZALEX FASPRO® is $5,159.41 for FY 2023. (Page 377)

C. *Hemolung Respiratory Assist System (Hemolung RAS). The maximum new technology add-on payment for a case involving the use of Hemolung RAS is $6,500 for FY 2023.* (Page 403)

D. *LIVTENCITY™ (maribavir). The maximum new technology add-on payment for a case involving the use of LIVTENCITY™ is $32,500 for FY 2023.* (Page 438)

E. *UPLIZNA® (inebilizumab-cdon).* CMS is not approving new technology add-on payments for UPLIZNA® for FY 2023. (Page 453)

FY 2023 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 473)

CMS received 19 applications for new technology add-on payments for FY 2023 under the alternative pathways. Six applicants withdrew applications prior to the issuance of the proposed rule. Five more withdrew prior to this final rule. Two did not receive FDA approval prior to July 1, 2022.
The remaining 6 applications received a Breakthrough Device designation from FDA, 1 has a pending Breakthrough Device designation from FDA, and the remaining application was designated as a QIDP by FDA and is also requesting approval under the LPAD pathway from FDA.

A. *CERAMENT® G The maximum new technology add-on payment for a case involving the use of CERAMENT® G is $4,918.55 for FY 2023* (Page 475)

B. *GORE® TAG® Thoracic Branch Endoprosthesis . The maximum new technology add-on payment for a case involving the use of the GORE® TAG® TBE is $27,807 for FY 2023* (Page 484)

C. *iFuse Bedrock Granite Implant System. The maximum new technology add-on payment for a case involving the use of the iFuse Bedrock Granite Implant System is $9,828 for FY 2023* (Page 492)

D. *Thoraflex™ Hybrid Device. The maximum new technology add-on payment for a case involving the use of the Thoraflex™ Hybrid Device is $22,750 for FY 2023 (* (Page 499)

E. *ViviStim® Paired VNS System. The maximum new technology add-on payment for a case involving the use of the ViviStim® Paired VNS System would be $23,400 for FY 2023* (Page 504)

CMS says in total, 25 technologies are eligible to receive add-on payments for FY 2023. CMS estimates that FY 2023 Medicare spending on new technology add-on payments will be approximately $784 million.

Alternative Pathways for Qualified Infectious Disease Products (QIDPs) (Page 509)

- *DefenCath™ (solution of taurolidine (13.5 mg/mL) and heparin (1000 USP Units/mL))*

CMS is granting a conditional approval for DefenCath™ for new technology add-on payments for FY 2023, subject to the technology receiving FDA marketing authorization by July 1, 2023. The maximum new technology add-on payment for a case involving the use of DefenCath™ will be for $4,387.50 for FY 2023.

VI HOSPITAL READMISSIONS REDUCTION PROGRAM: UPDATES AND CHANGES (§§ 412.150 THROUGH 412.154) (Page 837)

The Hospital Readmissions Reduction Program currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery program.

CMS is finalizing that beginning in FY 2024 the Pneumonia Readmission Measure (NQF #0506) will no longer be suppressed under the Hospital Readmissions Reduction Program.

A hospital subject to the Hospital Readmissions Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

CMS estimates that 2,273 hospitals, representing 79.78 percent of all hospitals will be penalized in FY 2023. (Page 2,020)

VII. HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: POLICY CHANGES (Pages 879 & 2,022)

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating MS-DRG payments each fiscal year by 2.0 percent and redistributing the entire amount back to the hospitals as value-based incentive payments.

CMS is:

- Pausing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and five Hospital Acquired Infection (HAI) measures, for the purposes of scoring and payment for the FY 2023 program year.

- CMS is not awarding hospitals a Total Performance Score (TPS), and will instead award hospitals a payment incentive multiplier that results in a value-based incentive payment amount that is equal to the amount withheld for the fiscal year (2.0 percent). That is, each hospital will receive a 2.0 percent reduction to its base operating DRG payment amount for each FY 2023 discharge and will then receive a value-based incentive payment percentage that will result in a value-based incentive payment amount that is equal to the 2.0 percent withheld. The impact for every hospital under the Hospital VBP Program will be a net percentage payment adjustment of zero.

VIII. HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM: UPDATES AND CHANGES (42 CFR 412.170) (Pages 947 & 2,022)

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to reduce payment by 1.0 percent for "applicable hospitals," which are subsection (d) hospitals that rank in the worst performing quartile on select measures of hospital-acquired conditions.

CMS is:

- Pausing the Patient Safety and Adverse Events measure (CMS PSI 90 measure) and the five CDC NHSN Healthcare-Associated Infection (HAI) measures from the calculation of measure scores and the Total HAC Score, thereby not penalizing any hospital under the HAC Reduction Program FY 2023 program year;
- Publicly and confidentially (through Hospital Specific Report) reporting CDC NHSN HAI measure results;
- Calculating and publicly reporting the CMS PSI 90 measure displayed on the main pages of the Care Compare tool hosted by HHS after confidentially reporting these results to hospitals with a 30-day preview period;
- Pausing CY 2021 CDC NHSN HAI measures data from the FY 2024 HAC Reduction Program Year;
- Making a technical update to the measure specification to adjust the minimum volume threshold for the CMS PSI 90 measure beginning with the FY 2023 program year;
- Making a technical update to the CMS PSI 90 measure specifications to risk-adjust for history of COVID-19 diagnosis beginning with the FY 2024 program year;
- Updating the NHSN CDC HAI data submission requirements for newly opened hospitals beginning with the FY 2024 HAC program year; and
- Clarifying the removal of the no mapped location policy beginning with the FY 2023 program year.

IX. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (Page 1,101)

Hospital Inpatient Quality Reporting (IQR) Program (Page 1,177)

CMS is adopting 10 new measures, including four electronic clinical quality measures (eCQMs):

1) Hospital Commitment to Health Equity Measure Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination and for Subsequent Years; (Page 1,180)

2) Adoption of Two Social Drivers of Health Measures Beginning with Voluntary Reporting in the CY 2023 Reporting Period and Mandatory Reporting Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years; (Page 1,207)

3) Screen Positive Rate for Social Drivers of Health measure, beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 1,246)

4) Cesarean Birth eCQM Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination with Mandatory Reporting Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years; (Page 1,262)

5) Severe Obstetric Complications eCQM Beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination with Mandatory Reporting Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years; (Page 1,283)

6) Hospital-Harm—Opioid-Related Adverse Events eCQM (NQF #3501e) Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years; (Page 1,303)

7) Global Malnutrition Composite Score eCQM (NQF #3592e) Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination and for Subsequent Years; (Page 1,320)

8) Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #3559), Beginning with Two Voluntary Reporting Periods in CYs 2025 and 2026, Followed by Mandatory Reporting for Eligible Elective Procedures Occurring July 1, 2025 through June 30, 2026, Impacting the FY 2028 Payment Determination and for Subsequent Years; (Page 1,340)

9) Medicare Spending Per Beneficiary (MSPB) Hospital Measure (NQF #2158) Beginning with the FY 2024 Payment Determination; and (Page 1,373)

10) Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF # 1550) Beginning with the FY 2024 Payment Determination. (Page 1,183)

CMS is refining two measures currently in the Hospital IQR Program measure set— (1) Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA and/or TKA (Page 1,407) and (2) Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)—beginning with the FY 2024 payment determination. (Page 1,414)

CMS presents tables reflecting Summaries of Previously Finalized Hospital IQR Program Measures from FY 2024 through 2028. (Page 1,422)

Comment

The hospital IOR extends more than 400 pages.

Updates to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
(Page 1,522)

The PCHQR Program is a voluntary quality reporting program for the eleven cancer hospitals that are statutorily exempt from the IPPS. CMS collects and publishes data from PCHs on applicable quality measures.

CMS is:

- Finalizing that it will begin public display of the 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);
- Adopting and codifying a patient safety exception into the measure removal policy; and
- Acknowledging comments received from stakeholders on the request for information in the proposed rule regarding the potential future adoption of two digital National Healthcare Safety Network (NHSN) measures: the NHSN Healthcare-associated *Clostridioides difficile* Infection Outcome measure and NHSN Hospital-Onset Bacteremia & Fungemia Outcome measure.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (Page 1,533)

LTCHs that do not meet LTCH QRP reporting requirements are subject to a two-percentage points reduction in their annual percentage unit.

There are no proposals for new measures for the LTCH QRP.

X. CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM (Page 1,547)

The following is from a CMS fact sheet.

In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs for eligible hospitals and critical access hospitals (CAHs)) to encourage eligible professionals, eligible hospitals, and CAHs to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT).

With this rule CMS is finalizing the following changes to the Medicare Promoting Interoperability Program for eligible hospitals and CAHs:

- Make mandatory the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure, adding a third exclusion; expand the measure to include not only Schedule II opioids, but also Schedule III and IV drugs, and maintain the associated points at 10 points;
- Add a new Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure under the Health Information Exchange (HIE) Objective as a yes/no attestation measure, beginning with the EHR reporting period in CY 2023, as an optional alternative to the three existing measures under the HIE Objective;
- Add a new Antimicrobial Use and Resistance (AUR) Surveillance measure and require its reporting under the Public Health and Clinical Data Exchange Objective, beginning with the CY 2024 EHR reporting period;
- Beginning with the CY 2023 EHR reporting period, reduce the active engagement options for the Public Health and Clinical Data Exchange Objective from three to two options;
- Beginning with the CY 2023 EHR reporting period, require submission of the level of active engagement, in addition to submitting the measures for the Public Health and Clinical Data Exchange Objective;
- Beginning with the CY 2024 EHR reporting period, require eligible hospitals and CAHs to limit the duration of their time on level of active engagement option one to a single EHR reporting period.
- Institute public reporting of certain Medicare Promoting Interoperability Program data beginning with the CY 2023 EHR reporting period;
- Beginning with CY 2023 EHR reporting period, CMS will increase the Public Health and Clinical Data Exchange Objective from 10 to 25 points, increase the points associated with the Electronic Prescribing Objective from 10 to 20, reduce the points associated with the Health Information Exchange Objective from the current 40 points to 30 points, and reduce the points associated with the Provide Patients Electronic Access to Their Health Information from the current 40 to 25 points;
- Adopt two new eCQMs to the Medicare Promoting Interoperability Program's eCQM measure set beginning with the CY 2023 reporting period, and two new eCQMs beginning with the CY 2024 reporting period, in alignment with the Hospital IQR Program;
- Modify the eCQM reporting and submission requirements to increase eCQM reporting from four eCQMs (one mandatory and three self-selected) to six eCQMs (three mandatory and three self-selected) beginning with the CY 2024 reporting period in alignment with the Hospital IQR Program.

XI. CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2023 (Page 964)

Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2023 (Page 1,087)

CMS is updating to the LTCH PPS standard Federal payment rate by 3.8 percent (that is, the most recent estimate of the LTCH PPS market basket increase of 4.1 percent less the productivity adjustment of 0.3 percentage point). (Page 1596)

The LTCH PPS standard Federal payment rate for FY 2023 is **$46,432.77**. The current rate is $44,713.67. (Calculated as $44,713.67 x 1.038 x the area wage level budget neutrality factor rate of 1.0004304). (Page 2,042)

For LTCHs that fail to submit quality reporting data for FY 2023, in accordance with the requirements of the LTCH QRP under section 1866(m)(5) of the Act, CMS is establishing an LTCH PPS standard Federal payment rate of $45,538.11 (calculated as $44,713.67 x 1.018 (1.038-1.02) x 1.0004304) for FY 2023. (Page 2,042)

Beginning with FY 2023, CMS will apply a permanent 5.0 percent cap on any decrease to an LTCH's wage index from its wage index in the prior year.

The FY 2023 wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS web site.

The proposed labor related share of 68.2 percent, which was based on IHS Global Inc's fourth quarter 2021 forecast of the 2017-based LTCH market basket, has been updated to reflect IHS Global Inc's second quarter 2022 forecast, and that this update, resulting in a labor related share of **68.0 percent**, is a slightly smaller increase over the labor share from FY 2022, which was 67.9 percent. (Page 1,907)

Adjustment for High-Cost Outlier (HCO) Cases (Page 1,929)

CMS is proposing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2023 of **$38,518** that would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2023 payments for such cases. (Page 1,943)

The current amount for FY 2022 is **$33,015**

High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Approximately 75 percent of LTCH cases were paid the LTCH PPS standard Federal payment rate and approximately 25 percent of LTCH cases were paid the site neutral payment rate for discharges occurring in FY 2019.

CMS is setting a fixed-loss amount for site neutral payment rate cases of **$38,859**, which is the same as the FY 2023 IPPS fixed-loss amount. The current amount is $30,998.

TABLES (Page 1,957)

The following IPPS tables for this rule are generally available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2023 IPPS Final Rule Home Page" or "Acute Inpatient-Files- for Download."

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Table 6P.	ICD-10-CM and ICD-10-PCS Codes for MS-DRG Change—FY 2023 (Table 6P contains multiple tables, 6P.1a. through 6P.6c, that include the ICD-10-CM and ICD-10-PCS code lists relating specific MS-DRG changes).
Table 8A.	FY 2023 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
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The following LTCH PPS tables are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1771-F:

Table 8C.	FY 2023 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
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FINAL COMMENTS

There are just too many items that can be covered in this analysis. This analysis has not discussed a number of issues relating to eCQMs, timing reporting, validations, changes to conditions of participation and deferred compensation plans.

In the proposed rule, CMS solicited a number of requests for information. In this final rule CMS does acknowledge receipt of comments, but basically says such information will be used in future rulemaking.

One can appreciate the need and the burden to carefully review these rules. However, the increasing size of the material every year makes it more and more difficult. Too much old and unnecessary history are creating this excessive material.

We note that CMS is increasing its referrals to readers to older ***Federal Register*** cites for additional information. While this is an excellent way to help reduce printed historical information. The process is cumbersome. The CMS cites are not web linked. You cannot simply click on the reference *to* find the material.

CMS says its goal is to produce payments reflecting quality. Indeed, a noble goal. However, before CMS keeps adding statistical data to mimic quality, it needs to address its own rulemaking. This rule, as are most, is "careless." It contains numerous errors, has much, too much redundancy, is not concise and to the point in making changes and the case for such changes.

Finally, CMS is not helpful in providing easier access to pertinent section. Yes, this rule does have a limited table of contents, but it is incomplete and does not contain vital page numbering. If I can assemble such, why can't CMS?

DRG WEIGHTS

Since case-mix is a major determinant for payment purposes, the table below is intended to reflect changes in case-mix for the MS-DRGs with the most discharges.

CMS appears to no longer include its Table 7 which contained the number of discharges by DRG. Therefore, the table below contains the FY 2022 MS-DRGs with more than 100,000 discharges, but reflects the FY 2023 weighting factors.

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS)					
RELATIVE WEIGHTING FACTORS					
MS-DRG	MS-DRG Title	Discharges	Final FY 2023 Weights	Final FY 2022 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	85,224	1.0164	1.0200	-0.35%
177	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	429,413	1.7799	1.8491	-3.74%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	82,558	1.2070	1.2261	-1.56%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	59,542	1.0855	1.1251	-3.52%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	79,877	1.2987	1.3120	-1.01%
194	SIMPLE PNEUMONIA & PLEURISY W CC	38,868	0.8402	0.8639	-2.74%
291	HEART FAILURE & SHOCK W MCC	345,861	1.2798	1.2683	0.91%
378	G.I. HEMORRHAGE W CC	96,394	0.9850	0.9935	-0.86%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	92,274	0.7876	0.7658	2.85%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	118,659	1.9119	1.9003	0.61%
682	Renal FAILURE W MCC	83,783	1.4866	1.4727	0.94%
683	RENAL FAILURE W CC	84,236	0.8949	0.8793	1.77%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	85,590	0.7956	0.7940	0.20%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	554,839	1.9572	1.8722	4.54%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	110,909	1.0280	1.0263	0.17%

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