CALIFORNIA HOSPITAL ASSOCIATION

Federal Regulatory Summary

from the California Hospital Association

SUMMARY OF PROPOSED RULE — JUNE 2020

FFY 2021 Medicare Inpatient Prospective Payment System

Overview

In the May 29 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule addressing rate updates and policy changes to the Medicare inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) prospective payment system (PPS) for federal fiscal year (FFY) 2021. The policy and payment provisions would generally be effective for FFY 2021 discharges, beginning October 1.

CMS states that, due to the COVID-19 public health emergency (PHE), the agency has limited annual rulemaking required by statute to focus primarily on essential policies and proposals that reduce provider burden and may help providers in the COVID-19 response. In addition, though the final rule is typically published around August 1, CMS has waived its typical 60-day timeline between publication and effective date of the final rule due to the COVID-19 PHE, and will provide as few as 30 days between the publishing of the final rule and its effective date. As a result, the final rule could be published as late as September 1.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. Payment and policy changes proposed for the FFY 2021 LTCH PPS are addressed in a separate summary.

For Additional Information

Questions about this summary should be directed to Megan Howard, senior policy analyst, at (202) 488-3742 or mhoward@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analytics coordinator, at areth@calhospital.org.

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Proposed FFY 2021 Payment Changes

The table below lists the federal operating and capital rates proposed for FFY 2021 compared to the rates currently in effect for FFY 2020. These rates include all market basket increases and reductions, as well as the application of an annual budget neutrality factor. These rates do not reflect hospital-specific adjustments, such as penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program or Electronic Health Record (EHR) Meaningful Use Program, quality penalties/payments, disproportionate share hospitals (DSH), etc.

	Final FFY 2020	Proposed FFY 2021	Percent Change
Federal Operating Rate	$5,796.63	$5,979.74	+3.16%
Federal Capital Rate	$462.33	$468.36	+1.30%

The table below provides details for proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2021.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Market Basket Update/Capital Input Price Index	+3.0%		+1.5%
ACA-Mandated Reductions 0.4 percentage point (PPT) productivity reduction	-0.4 PPT		—
MACRA-Mandated **Retrospective** Documentation and Coding Adjustment	+0.5%	—	—
Budget Neutrality Adjustments Related to FFY 2020 Wage Index Changes	-0.11%		+0.25%
Annual Budget Neutrality Adjustment	+0.15%		-0.44%
Proposed Net Rate Update	*+3.16%*	*+2.66%*	*+1.30%*

Retrospective Coding Adjustment

CMS proposes to apply a retrospective coding adjustment of 0.5% to the federal operating rate in FFY 2021 as part of the fourth year (of six) of rate increases tied to the American Taxpayer Relief Act (ATRA). The coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by $11 billion over a four-year period, resulting in a cumulative rate offset of approximately negative 3.2%.

Effects of the IQR and EHR Incentive Programs

Beginning in FFY 2015, the IQR market basket penalty changed from negative two percentage points to a 25% reduction to the full market basket. The same year, the EHR meaningful use penalty began its three-year phase-in, starting at 25% of the full market basket; beginning with FFY 2017, the EHR meaningful use penalty is capped at 75%. As a result of the two penalty programs, the full market basket update is at risk. The following table displays the various update scenarios for FFY 2021.

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3% Market Basket minus 0.4 PPT productivity)	+2.6%			
Penalty for Failure to Submit IQR Quality Data (25% of the base Market Basket Update of 3%)	—	-0.75%	—	-0.75%
Penalty for Failure to be a Meaningful User of EHR (75% of the base Market Basket Update of 3%)	—	—	-2.25%	-2.25%
Adjusted Net Market Basket Update (prior to other adjustments)	*+2.6%*	*+1.85%*	*-0.35%*	*-0.4%*

CMS estimates certain hospitals will not receive the full market basket rate-of-increase, including 54 that failed the quality data submission process or chose not to participate in the IQR Program, and 67 that are not meaningful EHR users. CMS also estimates 14 hospitals will be subject to both reductions.

Impact Analysis

The CHA DataSuite analysis estimates that California hospitals will experience an increase of 3.5% in overall Medicare hospital inpatient payments in FFY 2021, as compared to FFY 2020. However, the impact will vary.

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2020 IPPS Payments	**$11,561,561,300**		**$866,784,500**		**$12,428,346,400**	
Provider Type Changes	($230,800)	0.0%	$0	0.0%	($230,800)	0.0%
Marketbasket Update (Includes Budget Neutrality)	$338,293,300	2.9%	$9,152,500	1.1%	$347,445,400	2.8%
ACA-Mandated Marketbasket Reductions	($44,552,100)	-0.4%	*Not Applicable*		($44,552,100)	-0.4%
MACRA-Mandated Coding Adjustment	$56,119,200	0.5%	*Not Applicable*		$56,119,200	0.5%
Wage Index/GAF (Wage Data and Reclassification)	($331,100)	0.0%	($508,100)	-0.1%	($839,200)	0.0%
Wage Index/GAF (Other Changes)	$5,364,300	0.0%	$2,799,100	0.3%	$8,163,300	0.1%
> Expiration of FFY 2020 5% Stop Loss Transition	$11,720,500	0.1%	$1,061,700	0.1%	$12,783,300	0.1%
> Increasing Bottom Quartile Wage Index Values	$3,993,300	0.0%	$1,470,300	0.2%	$5,464,200	0.0%
> Application of FFY 2021 5% Stop Loss Transition	($10,349,100)	-0.1%	$266,300	0.0%	($10,082,500)	-0.1%
Change in Urban/Rural Status	$0	0.0%	$14,118,300	0.3%	$14,118,300	0.1%
DSH: UCC Payment Changes [1]	$13,275,900	0.1%			$13,275,900	0.1%
> DSH UCC Distribution Factor Change	$45,823,500	0.4%	*Not Applicable*		$45,823,500	0.4%
Change in Hospital Specific Rate	$0	0.0%			$0	0.0%
MS-DRG Updates	$23,986,000	0.2%	$1,864,300	0.2%	$25,851,100	0.2%
Quality Based Payment Adjustments [2]	$13,423,400	0.1%	$286,900	0.0%	$13,710,400	0.1%
Net Change due to Low Volume Adjustment	$2,234,000	0.0%	$107,100	0.0%	$2,341,300	0.0%
Estimated FFY 2021 IPPS Payments	**$11,969,147,200**		**$894,603,800**		**$12,863,751,300**	
Total Estimated Change FFY 2020 to FFY 2021¥	***$407,585,900***	***3.5%*** ▲	***$27,819,300***	***3.2%*** ▲	***$435,404,800***	***3.5%*** ▲

¥ The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2030. As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress eliminated the 2% sequester on Medicare payments from May 1, 2020 through December 31, 2020. It is estimated that sequestration for FFY 2021 IPPS-specific payments will be: -$192,957,300.

CMS' detailed impact estimates are displayed in Table I of Appendix A of the proposed rule (page 32394), which is partially reproduced below.

Hospital Type	All Proposed Rule Changes
All Hospitals	2.5%
Urban	2.5%
Urban – Pacific Region	2.7%
Rural	2.3%
Rural – Pacific Region	2.3%

Outlier Payments

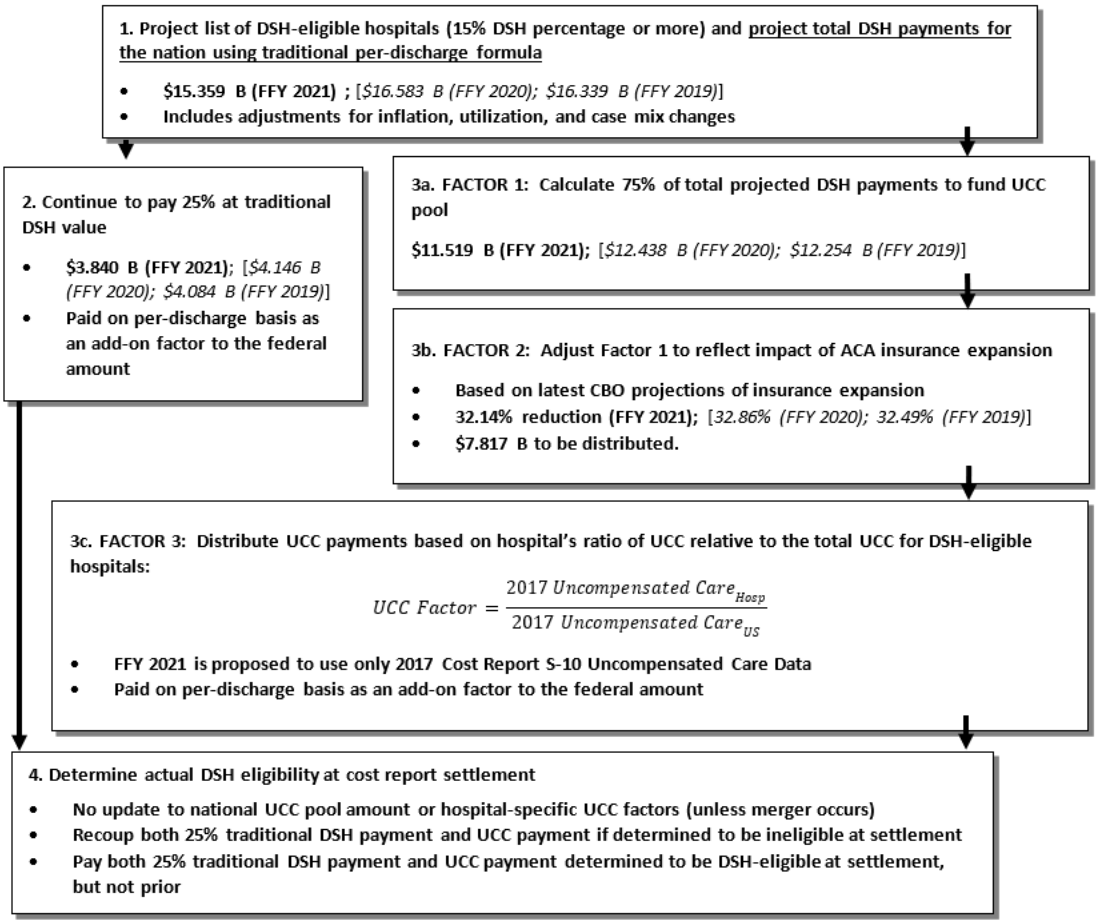
Due to prior concerns over CMS' decision not to consider outlier reconciliation in the outlier threshold development for a given fiscal year, CMS now believes incorporating historic cost report outlier reconciliations when developing the threshold is a reasonable approach and would provide a better predictor for the upcoming fiscal year. Therefore, for FFY 2021, CMS will incorporate total outlier reconciliation dollars from the FFY 2015 cost reports into the outlier model.

To maintain outlier payments at 5.1% of total IPPS payments, CMS proposes an outlier threshold of $30,006 for FFY 2021. The proposed threshold is 13.35% higher than the FFY 2020 outlier threshold of $36,473.

Medicare DSH

The Affordable Care Act (ACA) mandates the implementation of new Medicare DSH calculations and payments to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75%, referred to as the uncompensated care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This pool is to be distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

The following schematic describes the DSH payment methodology mandated by the ACA, along with proposed changes for FFY 2021 compared to FFY 2020. More details and background information follow.



Background

Medicare makes DSH and UCC payments to IPPS hospitals that serve a number of low-income patients above a certain threshold. Low-income is defined as Medicare-eligible patients also receiving supplemental security income (SSI), and Medicaid patients not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC, the proportion of inpatient days for each of these subsets of patients is used.

Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the ACA required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would be made under Section 1886(d)(5)(F) without application of the ACA
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the Secretary's estimates of the factors used to determine and distribute UCC. UCC payments are made only to hospitals eligible to receive DSH payments that are paid using the national standardized amount: sole community hospitals (SCHs) paid

on the basis of hospital-specific rates, hospitals not paid under the IPPS, and hospitals in Maryland paid under a waiver are ineligible to receive DSH and, therefore, UCC payments.

Proposed FFY 2021 Factor 1

CMS estimates this figure based on the most recent data available and does not adjust it at a later date based on actual data. For FFY 2021, CMS uses the Office of the Actuary's (OACT) December 2019 Medicare DSH estimates, which were based on the September 2019 update of the Healthcare Cost Report Information System (HCRIS) and the FFY 2020 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's December 2019 Medicare estimate of DSH is $15.359 billion. **The proposed Factor 1 amount is 75% of this, or $11.519 billion** — about $919 million less than the final Factor 1 for FFY 2020.

Proposed FFY 2021 Factor 2

Factor 2 adjusts Factor 1 based on the percent change in the uninsured since implementation of the ACA. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of Congressional Budget Office data as the source of change in the uninsured population. The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or the District of Columbia.

For FFY 2021, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14%; for calendar years (CYs) 2020 and 2021 that rate is estimated to be 9.5%. As required, the CMS chief actuary certified these estimates.

Using these estimates, CMS calculates the proposed Factor 2 for FFY 2021 (weighting the portion of CYs 2020 and 2021 included in FFY 2021) as follows:

Percent of individuals without insurance for CY 2013: 14%
Percent of individuals without insurance for CY 2020: 9.5%
Percent of individuals without insurance for CY 2021: 9.5%
Percent of individuals without insurance for FFY 2021 (0.25 x 0.095) + (0.75 x 0.095): 9.5%

Proposed Factor 2 = 1-|(0.095-0.14)/0.14)| = 1- 0.3214 = 0.6786 (67.86%)

CMS calculates the proposed Factor 2 for the FFY 2021 proposed rule to be 0.6786 or 67.86%, and the UCC amount for FFY 2021 to be about $7.817 billion ($11.519 billion x 0.6786) — which is about $534 million less than the FFY 2020 UCC total of about $8.351 billion, a decrease of 6.4%.

Proposed FFY 2021 Factor 3

Factor 3 equals the proportion of hospitals' aggregate UCC attributable to each IPPS hospital (including Puerto Rico hospitals). The product of Factors 1 and 2 determines the total pool available for UCC payments. This result multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

In FFY 2018, CMS began transitioning to use of Worksheet S-10 as the data source for estimating the uncompensated care attributable to a hospital. For FFY 2018, CMS used a blend of two years of low-

income patient days and one year of Worksheet S-10 data (FFY 2014). In FFY 2019, CMS continued that transition by using one year of low-income patient days and two years of Worksheet S-10 data (FFY 2014 and FFY 2015). In FFY 2020, CMS transitioned to using a single year of data — the audited FFY 2015 Worksheet S-10 cost report data in the methodology to determine Factor 3. CMS concluded that using a three-year blend — which would have included both audited and unaudited data — would have introduced unnecessary variability. In the FFY 2020 IPPS final rule, CMS noted that it had begun auditing the FFY 2017 data in July 2019 with the goal of having that data available for future rulemaking.

Proposed Use of Audited FFY 2017 Worksheet S-10 Data

CMS proposes to use a single year of Worksheet S-10 data, from the FFY 2017 cost reports, to calculate Factor 3 in the FFY 2021 methodology for all eligible hospitals except for Indian Health Service (IHS) and Tribal hospitals and Puerto Rico hospitals. CMS continues to believe that mixing audited and unaudited data for individual hospitals by averaging multiple years of data could potentially lead to a less accurate result. In addition, FFY 2017 cost reports reflect the revisions to the Worksheet S-10 instructions that were effective on October 1, 2017.

CMS notes that UCC payments to hospitals whose FFY 2017 Worksheet S-10 data have been audited represent about 65% of the proposed total uncompensated care payments for FFY 2021. CMS uses data from the HCRIS extract updated through February 19, 2020. It intends to use the March 2020 update for the FFY 2021 final rule and the respective March updates for all future final years. **CMS seeks comment on its intention to use the March update of HCRIS or whether it should consider using more recent data prior to developing the final rule for purposes of calculating the final Factor 3.**

Proposal to Use Most Recent Available Single Year of Audited Worksheet S-10 Data to Calculate Factor 3 for All Subsequent Fiscal Years

CMS proposes that, for FFY 2022 and all subsequent years, it would use the most recent single year of cost report data that have been audited for a significant number of hospitals receiving substantial Medicare UCC payments to calculate Factor 3 for all eligible hospitals, with the exception of IHS and Tribal hospitals. It believes that such a policy would give providers greater predictability for planning purposes. CMS states that it could revisit this policy through future rulemaking based on comments received.

Proposed Definition of UCC

CMS again proposes that "UCC" would be defined as the amount on line 30 of Worksheet S-10, which is the cost of charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29).

Proposed Methodological Considerations for Calculating Factor 3

CMS proposes to modify the current calculation for determining the UCC values when hospitals merge. Specifically, when the effective date of the merger occurs partway through the surviving hospital's cost reporting period, to more accurately estimate UCC for the hospitals involved in a merger, CMS proposes that it does not annualize the acquired hospital's data. Rather, CMS proposes to use only the portion of the acquired hospital's unannualized UCC data that reflects the UCC incurred prior to the merger effective date, but after the start of the surviving hospital's current cost reporting period.

CMS proposes to modify its current policy for when a hospital has a cost report that starts in one fiscal year but spans the entirety of the following fiscal year such that the hospital has no cost report starting in that subsequent fiscal year. In these situations, CMS proposes to use the annualized cost report that spans both fiscal years for purposes of calculating Factor 3 when data for the latter fiscal year are used in the Factor 3 methodology.

For FFY 2021, CMS proposes to continue its new hospital methodology such that any hospitals with a CMS certification number (CCN) created on or after October 1, 2017 — due to the lack of FFY 2017 cost report data —will not receive interim FFY 2021 DSH UCC payments. However, CMS states that the Medicare administrative contractors (MACs) will make final determinations about DSH eligibility for these hospitals at cost report settlement. If eligible, they shall receive UCC payments using Factor 3 based on their FFY 2021 cost report S-10 data as the numerator, set over the established national value for the FFY 2017 cost report S-10 data as the denominator.

All-Inclusive Rate Providers

For FFY 2021, CMS continues to believe that all-inclusive rate hospitals should be excluded from the calculation of the statewide cost-to-charge ratio (CCR) values used for the trim. However, CMS proposes to adjust the UCC trim methodology when it is applied to all-inclusive rate hospitals. When such a hospital's total FFY 2017 UCC is greater than 50% of its total operating costs (when calculated using the CCR reported on Worksheet S-10, line 1 of its FFY 2017 cost report), CMS would recalculate that UCC using the CCR of the hospital's most recent available prior year cost report that would not also result in UCC of over 50% of total operating costs.

Proposed Steps to Trim CCRs

Similar to the FFYs 2018, 2019, and 2020 process, CMS proposes the following steps for trimming CCRs in FFY 2021:

Methodology for Trimming CCRs	
Step 1	Remove Maryland hospitals and all-inclusive rate providers
Step 2	For FFY 2017 cost reports, CMS would calculate a CCR ceiling by dividing the total costs on Worksheet C, Part I, Line 202, Column 3 by the charges reported on Worksheet C, Part I, Line 202, Column 8. The ceiling is calculated as three standard deviations above the national geometric mean CCR for the applicable fiscal year. Remove all hospitals that exceed the ceiling so that these aberrant CCRs do not skew the calculation of the statewide average CCR. Based on the information currently available to CMS, this trim would remove 12 hospitals that have a CCR above the calculated ceiling of 0.937 for FFY 2017 cost reports.
Step 3	Using the CCRs for the remaining hospitals in Step 2, determine the urban and rural statewide average CCRs for FFY 2017 for hospitals within each state (including non-DSH eligible hospitals), weighted by the sum of total hospital discharges from Worksheet S-3, Part I, Line 14, Column 15.
Step 4	Assign the appropriate statewide average CCR (urban or rural) calculated in Step 3 to all hospitals, excluding all-inclusive rate providers, with a CCR greater than three standard deviations above the corresponding national geometric mean (that is, the CCR "ceiling"). Under the proposed rule, the statewide average CCR would apply to 12 hospitals, of which four have FFY 2017 Worksheet S-10 data.
Step 5	For providers that did not report a CCR on Worksheet S-10, line 1, CMS would assign them the statewide average CCR as determined in step 3.

After completing the steps above, CMS proposes to re-calculate the hospitals' UCC costs (line 30) using the trimmed CCR (the statewide average CCR (urban or rural, as applicable).

UCC Data Trim Methodology

CMS proposes to continue the trim methodology for potentially aberrant UCC as finalized in the FFY 2019 and FFY 2020 IPPS/LTCH PPS final rules. That is, if the hospital's UCC costs for FFY 2017 are an extremely high ratio (greater than 50 percent) of its total operating costs, CMS proposes that data from the FFY 2018 cost report would be used for the ratio calculation. Thus, the hospital's UCC costs for FFY 2017 would be trimmed by multiplying its FFY 2017 total operating costs by the ratio of UCC costs to total operating costs from the hospital's FFY 2018 cost report to calculate an estimate of its FFY 2017 UCC costs and determine Factor 3 for FFY 2021. For hospitals whose FFY 2017 cost report has been audited, CMS will not apply the trim methodology.

Proposals Related to the Per Discharge Amount of Interim UCC Payments

CMS calculates a per-discharge amount of interim UCC by dividing the hospital's total UCC payment amount by its three-year average of discharges. This per-discharge payment amount is used to make interim UCC payments to each projected DSH-eligible hospital. These interim payments are reconciled following the end of the year.

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flows for hospitals and MA plans, CMS proposes a voluntary process through which a hospital may submit one request to its MAC for a lower discharge interim UCC payment amount, including a reduction to zero, before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to provide documentation to support a likely significant recoupment — for example, 10% or more of the hospital's total UCC payment or at least $100,000. The only change that would be made would be to lower the per-discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This proposal does not change how the total UCC payment amount will be reconciled at cost report settlement.

Process for Notifying CMS of Merger Updates and Reporting Upload Issues

In the case of hospital mergers, CMS publishes a table on its website — in conjunction with the issuance of each fiscal year's proposed and final IPPS rules— that contains a list of known mergers and the computed UCC payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies. For FFY 2021, CMS proposes that after the publication of the FFY 2021 IPPS/LTCH PPS final rule, hospitals would have 15 business days from the date of public display to review and submit comments on the accuracy of the table and supplemental data file published in conjunction with the final rule. CMS acknowledges that this is less time compared to previous years, but states that there is a limited amount of time to review hospitals' submitted information and to implement the finalized policies before the beginning of the fiscal year. CMS believes that if there are any remaining merger updates and/or upload discrepancies after the final rule, 15 days from the date of public display should be sufficient time to make any corrections to Factor 3 calculations. In addition, CMS states that it intends to revisit whether this additional comment period after the final rule is necessary.

Updates to MS-DRGs

Each year, CMS updates the Medicare Severity-Diagnosis Related Group (MS-DRG) classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes adopted for the FFY 2021 MS-DRGs would leave the number of payable DRGs at 765. Of all DRG weights, 80% will change by a less than 5% increase or decrease, with 5% increasing or decreasing by 10% or more. The five MS-DRGs with the greatest year-to-year change in weight are:

MS-DRG	Final FFY 2020 Weight	Proposed FFY 2021 Weight	Percent Change
MS-DRG 295: DEEP VEIN THROMBOPHLEBITIS WITHOUT CC/MCC	0.5770	0.9846	+70.6%
MS-DRG 796: VAGINAL DELIVERY WITH STERILIZATION/D&C WITH MCC	1.9723	1.0671	-45.9%
MS-DRG 933: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HRS WITHOUT SKIN GRAFT	3.1402	2.2539	-28.2%
MS-DRG 215: OTHER HEART ASSIST SYSTEM IMPLANT	12.8861	9.4798	-26.4%
MS-DRG 819: OTHER ANTEPARTUM DIAGNOSES WITH O.R. PROCEDURE WITHOUT CC/MCC	0.7979	0.9963	+24.9%

When CMS reviews claims data, it applies the following criteria to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within an MS-DRG is needed. A subgroup must meet all five of these criteria to warrant being created:

- A 3% reduction in the variance of costs
- At least 5% of patients in the MS-DRG fall within the subgroup
- 500 or more cases in the subgroup
- Average costs between the subgroups show at least a 20% difference
- A $2,000 difference in average costs between subgroups

Beginning with FFY 2021, CMS proposes to expand these criteria to also include Non-CC subgroups with the belief that this would better reflect resource stratification and promote stability of MS-DRG relative weights by avoiding low volume counts for the Non-CC level MS-DRGs.

The full list of proposed FFY 2021 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at www.cms.gov/files/zip/table-5-fy-2021-proposed-ms-drgs-relative-weighting-factors-and-geometric-and-arithmetic-mean-length.zip.

For comparison, the FFY 2020 DRGs are available in Table 5 on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-FR-Table-5.zip.

CMS discusses specific changes proposed to the MS-DRGs for FFY 2021. Highlights of CMS' discussion are summarized below; more specific details are available in the proposed rule.

Chimeric Antigen Receptor (CAR) T-Cell Therapy

CAR T-cell therapy is a cell-based gene therapy in which a patient's T-cells are genetically engineered to add a chimeric antigen receptor on the T-cells that will bind to a certain protein on the patient's cancerous cells. The CAR T-cells are then administered to the patient by infusion.

In response to comments from CHA and other stakeholders who requested that CMS create an MS-DRG specifically for CAR T-cell treatments, CMS examined claims for cases reported with the two ICD-10-PCS procedure codes for CAR T-cell therapies, XW033C3 and XW043C3. CMS identified clinical trial claims as claims with the ICD-10-CM diagnosis code Z00.6 (Encounter for examination for normal comparison and control in clinical research program), which is reported only for clinical trial cases, or with standardized drug charges of less than $373,000, which is the average sales price of the two approved CAR T-cell therapies (KYMRIAH and YESCARTA). CMS agreed with commenters that, given the high cost of the CAR T-cell product, it was appropriate to distinguish cases where the CAR T-cell therapy was provided without cost as part of a clinical trial so that the analysis reflected the resources to provide CAR T-cell therapy outside of a clinical trial.

CMS now believes it is appropriate to consider development of a new MS-DRG. For FFY 2021, CMS proposes to assign cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a proposed new MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy), and to remove those codes from MS-DRG 016 and rename it "Autologous Bone Marrow Transplant with CC/MCC." As additional procedure codes for CAR T-cell therapies are created, CMS will use its established process to assign those codes to the most appropriate MS-DRG.

In some cases, the CAR T-cell therapy patients may be part of a clinical trial where the high-cost therapy product is furnished to the hospital at no cost. CMS proposes to modify its relative weight methodology for MS-DRG 018 to make its relative weight reflective of the typical costs of providing CAR T-cell therapies by excluding clinical trial claims from the calculation of the average cost. CMS also proposes to exclude CAR T-cell cases with less than $373,000 in drug costs — the average sales price of KYMRIAH and YESCARTA — from the relative weight calculation.

As providers do not typically pay for the cost of a drug for clinical trials, CMS proposes to apply an adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018. CMS proposes to apply an adjustment of 0.15 to the payment amount for clinical trial cases that would both group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or contain standardized drug charges of less than $373,000. Furthermore, CMS proposes to update the adjustment based on more recent data with the final rule.

Hip and Knee Joint Replacements

CMS has noted that clinically effective treatment of patients undergoing hip replacement following hip fracture tends to have greater resource requirements than those without hip fracture. This is in addition to increased complexity associated with hip fracture patients that can be attributed to other factors related to replacement due to bone fracture, as well as potentially being frailer on average than those requiring hip replacement because of degenerative joint disease.
As a result, for FFY 2021, CMS proposes to create two new MS-DRGs for hip replacement with a principal diagnosis of hip fracture:

- MS-DRG 521: Hip Replacement with Principal Diagnosis of Hip Fracture with MCC

- MS-DRG 522: Hip Replacement with Principal Diagnosis of Hip Fracture without MCC

CMS also notes that the Comprehensive Care for Joint Replacement (CJR) model includes episodes triggered by MS-DRG 469 with hip fracture and MS-DRG 470 with hip fracture. **CMS seeks comment on the effect that the proposal would have on the CJR model and whether to incorporate the proposed new MS-DRGs, if finalized, into the CJR model's proposed extension to December 31, 2023. Comments on the CJR proposed rule are due June 23, 2020.**

New Technology Payments

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. CMS proposes policies to:

- Discontinue add-on payments for eight medical services/technologies
- Continue new technology add-on payments for 10 technologies

CMS also seeks public comment on the implementation of new technology add-on payments for a number of additional medical services/technology outlined in the proposed rule.

Additionally, in FFY 2020, CMS adopted an alternative pathway for new technology add-on payments related to antimicrobial products that have been designated as a Qualified Infectious Disease Product (QIDP) by the FDA. For FFY 2022 and subsequent years, CMS proposes to expand this pathway to products that have been approved, and for the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) as well. Finally, CMS proposes to create a process to grant conditional approval for new technology add-on payments for those that meet the new technology add-on payment criteria under the alternative pathway for QIDPs, or for the LDAP pathway as proposed, even if it has not received FDA marketing authorization by July 1 of the fiscal year for which the applicant is applying for the add-on payments.

Post-Acute Care Transfer and Special Payment MS-DRGs

When a patient is transferred from an acute care facility to a post-acute care or hospice setting, the transferring hospital receives a per diem payment, with a total payment capped at the full MS-DRG amount. For MS-DRGs subject to the post-acute care transfer policy that CMS deems to be high cost, CMS applies a special payment methodology so that the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with total payment capped at the full MS-DRG amount. Each year CMS, using established criteria, reviews the lists of MS-DRGs subject to the post-acute care transfer policy and special payment policy status.

For FFY 2021, CMS proposes changes to several MS-DRGs affected by these policies. Specifically, CMS proposes to:

- Reassign procedure codes from MS-DRG 16 (Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy) to create new MS-DRG 18 (Chimeric Antigen Receptor [CAR] T-cell Immunotherapy) for cases reporting the administration of CAR T-cell therapy
- Create new MS-DRG 019 (Simultaneous Pancreas and Kidney Transplant with Hemodialysis)
- Reassign procedures involving head, face, neck, ear, nose, mouth, or throat by creating six new MS-DRGs 140-142 (Major Head and Neck Procedures with MCC, with CC, and without CC/MCC, respectively) and 143-145 (Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) and deleting MS-DRGs 129-130 (Major Head and Neck

Procedures with CC/MCC or Major Device, and without CC/MCC, respectively, MS-DRGs 131-132 (Cranial and Facial Procedures with CC/MCC and without CC/MCC, respectively) and MS-DRGs 133-134 (Other Ear, Nose, Mouth and Throat O.R. Procedures with CC/MCC and without CC/MCC, respectively)

- Reassign procedure codes from MS-DRGs 469-470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement, and without MCC, respectively) and create two new MS-DRGs, 521 and 522 (Hip Replacement with Principal Diagnosis of Hip Fracture with MCC and without MCC, respectively) for cases reporting a hip replacement procedure with a principal diagnosis of a hip fracture
- Reassign procedure codes from MS-DRG 652 (Kidney Transplant) into two new MS-DRGs, 650 and 651 (Kidney Transplant with Hemodialysis with MCC and without MCC, respectively) for cases reporting hemodialysis with a kidney transplant during the same admission
- Add MS-DRGs 521 and 522 to the list of post-acute care transfer policy MS-DRGs as well as to the list subject to the MS-DRG special payment methodology

Market-Based MS-DRG Relative Weight Proposed Data Collection and Potential Change in Methodology for Calculating MS-DRG Relative Weights

In June 2019, the President issued an executive order (EO) instructing federal agencies to take a number of steps to promote price transparency and competition in health care markets. CMS cites the EO as the reason it promulgated the Hospital Price Transparency final rule as part of the CY 2020 outpatient prospective payment system rulemaking cycle. Under that final rule – beginning January 1, 2021 – hospitals are required to make public a machine-readable file online that includes all standard charges (including gross charges, discounted cash prices, payer-specific negotiated rates [but defined as charges in the final rule], and de-identified minimum and maximum negotiated rates) for all hospital items and services. In addition, hospitals must publicly post discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum negotiated rates for at least 300 "shoppable" services (70 CMS-specified and 230 hospital-selected) that are displayed and packaged in a consumer-friendly manner.

In the proposed rule, CMS reviews the history of cost-based payment for hospital services, the IPPS, and the use of charges reduced to cost to set the relative weights and make outlier payments. CMS expresses concerns that chargemaster rates rarely reflect the true market costs and sets a goal of Medicare reducing its reliance on the hospital chargemaster and adjusting Medicare payment rates so that they reflect the relative market value for inpatient items and services. In addition, CMS cites an October 2019 EO that requires a report to identify approaches to modify Medicare fee-for-service (FFS) payments to more closely reflect prices paid for services in Medicare Advantage (MA) and other commercial plans, as well as a separate study on recommending approaches to transition "toward true market-based pricing" for Medicare FFS payments.

To reduce the Medicare program's reliance on the hospital chargemaster, CMS proposes that hospitals would be required to report:

- The median payer-specific negotiated charge that the hospital has negotiated with all its MA plans, by MS-DRG
- The median payer-specific negotiated charge the hospital has negotiated with all its third-party payers, which would include MA plans, by MS-DRG

Hospitals would be required to report this information on their Medicare cost report for cost reporting periods ending on or after January 1, 2021, to be used in potentially setting the IPPS MS-DRG relative weights beginning in FY 2024. As hospitals are currently required to publicly report payer-specific negotiated charges, CMS believes that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals.

For third-party payers that do not negotiate rates by MS-DRG, the hospital would determine and report the median payer-specific negotiated charges by MS-DRG using its payer-specific negotiated charges for the same or similar package of services that can be cross walked to an MS-DRG. CMS believes that use of these data in the MS-DRG relative weight setting methodology would represent a significant and important step in reducing the Medicare program's reliance on hospital chargemasters, and would better reflect relative market-based pricing in Medicare FFS inpatient reimbursements.

Proposed Market-Based Data Collection

CMS proposes that the data collected be furnished through the Medicare hospital cost reports. If CMS were to finalize its proposal, all the data would become publicly accessible on the HCRIS dataset in a de-identified manner and would be usable for analysis by third parties.

The Hospital Price Transparency Final Rule requires that hospitals make standard charges for all items and services publicly available via a single machine-readable file and a consumer-friendly list of standard charges for at least 300 shoppable services. CMS proposes that hospitals would calculate the median payer-specific negotiated charge by MS-DRG using the payer-specific negotiated charge data by MS-DRG from the single machine-readable file for all items and services.

To determine the median payer-specific negotiated charge for MA organizations for a given MS-DRG, a hospital would list, by MS-DRG, each discharge in its cost reporting period that was paid for by an MA organization and the corresponding payer-specific negotiated charge. Once each discharge and its corresponding MA negotiated rate is arrayed, the hospital would calculate and report the median MA negotiated rate on its cost report. CMS would separately require the same process for all for other (non-MA) third-party payer median negotiated charges.

CMS proposes to use the same definitions of "payer specific negotiated charge" and "items and services" that it used in the Hospital Price Transparency Final Rule. CMS explains that an MS-DRG is a type of service package consisting of items and services based on patient diagnosis and other characteristics. CMS proposes this definition of items and services because it captures the types of items and services, including service packages, that a hospital uses to calculate and report the median payer-specific negotiated charges.

CMS proposes to use the established definition of an MA organization – a public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. CMS proposes to define "third-party payer" as an entity that is – by statute, contract, or agreement – legally responsible for payment of a claim for a health care item or service.

CMS recognizes that hospitals may negotiate rates with third-party payers as a percent discount off chargemaster rates, on a per diem basis, or by MS-DRG or other similar DRG system. There may be hospitals that do not negotiate charges for service packages by MS-DRG or for service packages that could be cross walked to an MS-DRG. Given the variety of negotiated payment arrangements, **CMS seeks comments on whether and how to use data to determine the relative weights where data are not collected by MS-DRGs, as well as alternative ways to capture market-based information for potential use in Medicare FFS payments**.

As an alternative, CMS considered requiring hospitals to submit a median of the actual payments received rather than just the median of the negotiated rates. CMS provides an example where the payer-specific negotiated charge is $30,000 with a third-party payer for major joint replacement paid under the All Patient Refined (APR)-DRG system (equivalent to MS-DRG 470). The hospital and payer have agreed to additional payment above a stop loss threshold ($150,000) based on 50% of charges, as well as 60% of the cost of implanted hardware.

In this example, the hospital's payer-specific negotiated charge for a major joint replacement (MS-DRG 470 equivalent) is $30,000. However, the resulting payment per discharge will vary, depending on whether the patient's cost exceeded the stop-loss threshold, or the patient received implanted hardware. Under CMS' proposal, the hospital would only consider the $30,000 negotiated rate in determining the median. Under the alternative proposal, the hospital would consider the additional payments above the stop-loss threshold and for implantable equipment when considering the median payment to report. **CMS requests comment on this alternative approach as well as the potential burden of calculating and submitting a median negotiated reimbursement relative to a median negotiated charge.**

CMS proposes that this policy would apply to IPPS hospitals in the 50 states, DC, and Puerto Rico. The policy would exclude critical access hospitals (CAHs) that are not paid based on negotiated rates and hospitals in Maryland, which are currently paid under the Maryland Total Cost of Care Model. Federally owned and operated hospitals, as well as hospitals operated under the Indian Health Care Improvement Act that do not receive payment based on negotiated rates, would also be excluded.

Potential Market-Based MS-DRG Relative Weight Methodology Beginning in FFY 2024

CMS seeks comments on whether to use the data it is proposing that hospitals report (or any of the alternatives that are being considered or arise as a result of the public comment process) beginning with cost reporting ending in FFY 2021, for determining the MS-DRG relative weights, beginning in FFY 2024. If CMS adopts this idea, it will propose further details in the FFY 2021 IPPS/LTCH PPS final rule. The proposed rule outlines the following steps for incorporating these data into the relative weight calculation:

- Step One: Standardize the median MA organizations' payer-specific negotiated charges by removing the effects of differences in area wage levels, and cost-of living adjustments for hospital claims from Alaska and Hawaii, in the same manner as under the current MS-DRG relative weight calculation for those effects.
- Step Two: Create a single weighted average standardized median MA organization payer-specific negotiated charge by MS-DRG across hospitals. For each MS-DRG, CMS would use each hospital's transfer-adjusted case count to weight the standardized payer-specific negotiated charge as it does under the current MS-DRG relative weight methodology. CMS would further

consider whether to use unadjusted Medicare case counts, or other alternative approaches based on the review of public comments.

- Step Three: CMS would create a single national weighted average across MS-DRGs of the results of Step Two, where the weights are the national Medicare transfer adjusted case counts by MS-DRG (or the unadjusted case counts if that is what is used for Step Two).
- Step Four: For each MS-DRG, the result from Step Two for each MS-DRG would be divided by the result from Step Three across all MS-DRGs to create each MS-DRG's relative weight.
- Step Five: As under the current cost-based MS-DRG relative weight methodology, the market-based relative weights would be normalized by an adjustment factor so that the average case weight after recalibration would be equal to the average case weight before recalibration such that aggregate payments neither increase nor decrease.

CMS requests comments on the above methodology, including alternatives and suggested refinements, as well as:

- Whether CMS should continue to estimate and publicly provide the MS-DRG relative weights using the current cost-based estimation methodology, as well as the revised methodology
- Whether to provide a transition to any new market-based MS-DRG methodology, and on the appropriate design of any such transition
- Other ways to further reduce the role of hospital chargemasters in Medicare IPPS payments and further reflect market-based approaches in Medicare FFS payments

FFY 2021 Area Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index (AWI). Additional details about this methodology can be found in the regulation. Proposed rule wage index tables 2, 3, and 4 can be found at www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-proposed-rule-home-page.

Proposed Core-Based Statistical Areas (CBSAs) for the FFY 2021 Hospital Wage Index

Hospitals are assigned to labor market areas, and the wage index reflects the weighted average hourly wage reported on Medicare cost reports. CMS uses Office of Management and Budget (OMB) CBSA delineations as labor market areas. CMS is currently using OMB delineations from 2015 (based on the 2010 census) updated by OMB Bulletin numbers 13-01, 15-01, and 17-01. Typically, OMB bulletins issued between decennial censuses have only minor modifications to labor market delineations. However, the April 10, 2018, OMB Bulletin No. 18-03 and the September 14, 2018, OMB Bulletin No. 18-04 included more modifications to the labor market areas than are typical between decennial censuses. CMS proposes to use the revised delineations as described in the September 14, 2018, OMB Bulletin No. 18-04 beginning with the FFY 2021 IPPS wage index. The new delineations have implications for the wage index and geographic reclassification, including 34 urban counties becoming rural, 47 rural counties becoming urban, and counties moving to a different CBSA. No counties in California are impacted. In some cases, the revised OMB delineations changed a CBSA's name or number only but not any of its constituent counties, which is why it may be listed differently than in prior years.
CMS proposes to mitigate any negative impact on hospitals as a result of the CBSA delineation changes by applying a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index from the prior fiscal year. Consistent with the application of the 5% cap in FFY 2020, the proposed FFY 2021 5% cap on wage index decreases would be applied to all hospitals that have a decrease in their wage indexes, regardless of the circumstance causing the decline, so that a hospital's final wage index

for FFY 2021 will not be less than 95% of its final wage index for FY 2020. CMS will also apply a proposed budget neutrality adjustment of 0.99858 to the IPPS operating rate for FFY 2021.

Worksheet S-3 Wage Data

CMS indicates that it has received appeals on how physician compensation is accounted for in the calculation of the wage index. Compensation of physician time spent in Part A activities is allowable for the wage index while compensation for Part B billable activities is not. Physician activities, such as funded research, that are not paid under either Part A or Part B of Medicare are reported in a non-reimbursable cost center. The proposed rule describes the documentation requirements (such as physician allocation agreements and time studies) for costs to be included in the wage index. The rule indicates that the MAC makes the final determination on the adequacy of the records maintained for the allocation of physicians' compensation.

CMS calculates the FFY 2021 wage index based on wage data of 3,196 hospitals. CMS states that the data file used to construct the final wage index includes FFY 2017 data submitted to CMS as of February 7, 2019. General wage index policies are unchanged from prior years, although CMS notes it proposes to exclude 84 providers due to aberrant data. However, if data elements for some of these providers are corrected, CMS intends to include data from those providers in the final FFY 2021 wage index.

Occupational Mix Adjustment

Section 1886(d)(3)(E) of the Act requires CMS to collect data every three years on the occupational mix of employees for each Medicare-participating short-term, acute care hospital to construct an occupational mix adjustment to the wage index. The current occupational mix survey data from 2016 are used for the occupational mix adjustment applied to the FFY 2019 through FFY 2021 IPPS wage indexes. CMS reports having occupational mix data for 97% of hospitals (3,113 of 3,196) used to determine the FFY 2021 wage index. The FFY 2021 national average hourly wage, unadjusted for occupational mix, is $45.11. The occupational mix adjusted national average hourly wage is $45.07. Hospitals are required to submit completed 2019 occupational mix surveys to their MACs (not directly to CMS), on the Excel hospital reporting form – by August 3, 2020 – via email attachment or overnight delivery. This deadline was extended from July 1 due to the COVID-19 PHE.

Rural Floor

The rural floor is a provision of statute that prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates that the rural floor will increase the FFY 2021 wage index for 225 hospitals. CMS calculates a national rural floor budget neutrality adjustment factor of 0.993991 (negative 0.6%), applied to hospital wage indexes.

Frontier Floor Wage Index

The ACA requires a wage index floor for hospitals in the low population density states of Montana, Nevada, North Dakota, South Dakota, and Wyoming. CMS indicates that 45 hospitals will receive the frontier floor value of 1.0000 for FFY 2020. This provision is not budget neutral, and CMS estimates an increase of approximately $70 million in IPPS operating payments.

Revisions to the Wage Index Based on Hospital Reclassifications

Geographic reclassification describes a process where hospitals apply to use another area's wage index. To do so, the applying hospital must be within a specified distance and have wages comparable to that

area. The Medicare Geographic Classification Review Board (MGCRB) decides whether hospitals meet the criteria to receive the wage index of another hospital. CMS did not propose any changes to the geographic reclassification criteria.

Geographic Reclassifications

The MGCRB approved 435 hospitals for a geographic reclassification starting in FFY 2021. Because reclassifications are effective for three years, a total of 957 hospitals are in a reclassification status for FFY 2021, including those initially approved by the MGCRB for FFY 2019 (244 hospitals) and FFY 2020 (279 hospitals). **The deadline for withdrawing or terminating a wage index reclassification for FFY 2021 approved by the MGCRB is July 13, 2020.** Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process were incorporated into the final FFY 2021 wage index values.

Hospitals with One or Two Years of Wage Data Seeking MGCRB Reclassification

CMS proposes to modify 42 CFR §412.230(d)(2)(ii)(A) to clarify that a hospital may qualify for an individual wage index reclassification if the hospital has only one or two years of wage data. The regulations currently state that a three-year average hourly wage is used to support the reclassification application. The proposed revision will clarify that the hospital may use one or two years of data in such circumstances, as when a hospital is new and does not have three years of data. This policy also applies to a change of hospital ownership where the new owner does not accept the provider agreement of the prior owner.

Revised OMB Labor Market Area Delineations on Reclassified Hospitals

As summarized above, CMS proposes to adopt revised labor market area delineations as described in the September 14, 2018, OMB Bulletin No. 18-04 beginning with the FFY 2021 IPPS wage index. CMS encourages hospitals with current reclassifications to verify they remain reclassified to an area with a higher wage index. If not, hospitals may withdraw or terminate their FFY 2021 reclassifications by July 13, 2020, using the procedure outlined in 42 CFR §412.273(c). Hospitals with an FFY 2019 or FFY 2020 reclassification that may continue into FFY 2021, as well as new reclassification beginning with FFY 2021, may withdraw the more recent reclassification in favor of a prior one. CMS proposes a process – following past practice – to determine the best alternative location to reassign current reclassifications for the remaining three years when the OMB delineations affect geographic reclassification, and it is not possible for the reclassification to continue seamlessly. CMS also cites the proposed 5% cap on wage index reductions intended to mitigate any adverse financial impacts that result from the revisions to a hospital's wage index from the revised OMB delineations and geographic reclassification policies.

Lugar Hospitals and Counties

A "Lugar" hospital is located in a rural county adjacent to one or more urban areas that is automatically reclassified to the urban area where the highest number of its workers commute. The out-migration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Out-migration adjustments are fixed for three years. A hospital can either be reclassified or receive the out-migration adjustment, but not both. Lugar status is automatic and must be declined through an urban to rural reclassification application for the hospital to receive an out-migration adjustment to its home area wage index.

Of the 47 rural counties that will become urban under the new OMB delineations, 23 are currently deemed urban Lugar counties. These counties will no longer be deemed urban under the new OMB delineations, and hospitals within these counties would no longer be Lugar hospitals. CMS includes an unnumbered table that lists the counties that would no longer be deemed urban.

CMS revises the list of Lugar counties once every 10 years based on information on commuting patterns from the decennial census. In past years, CMS did not revise eligibility for Lugar status between decennial censuses. However, CMS proposes to revise the list of Lugar counties based on the revised OMB delineations for FFY 2021 because the revised OMB delineations will make some hospitals rural that are currently urban. As an urban wage index is generally higher than a rural wage index, CMS believes revising the list of Lugar hospitals may benefit hospitals with a status changing from urban to rural as a result of the new OMB delineations.

Out-Migration Adjustment

CMS proposes to use the same policies, procedures, and computation that were used for the FFY 2012 out-migration adjustment and estimates increased payments of approximately $46 million in FFY 2021 for 203 hospitals receiving the out-migration adjustment. This provision is not budget neutral.

Reclassification from Urban to Rural

A qualifying IPPS hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Not later than 60 days after the receipt of an application from an IPPS hospital that satisfies the statutory criteria, CMS must treat the hospital as being in the rural area of the state in which the hospital is located.

Allowing Electronic Appeals of MGCRB Decisions

Current regulations require that appeals of MGCRB applications must be mailed to the Administrator in care of the Office of the Attorney Advisor with a hard copy to CMS' Hospital and Ambulatory Policy Group. Appeals may be not submitted by facsimile or other electronic means. CMS proposes to revise the regulation to remove the prohibition on electronic or facsimile submissions. CMS would also require that copies be sent to the Hospital and Ambulatory Policy Group via email to wageindex@cms.hhs.gov.

Canceling a Rural Reclassification

An urban hospital can reclassify as rural to become a Rural Referral Center (RRC) if it has over 275 beds or meets specific case mix and discharge criteria announced in the annual IPPS rule. CMS is aware of confusion regarding qualification for urban to rural reclassification based on discharge and case mix criteria. The confusion is over whether the criteria must be met using (1) the criteria in effect on the filing date of the hospital's application or (2) the criteria that would be in effect during the fiscal year that any RRC classification would become effective.

CMS is clarifying that the criteria that must be met for the hospital to reclassify as rural are those in effect as of the filing date for RRC status. However, for purposes of qualifying for RRC status, the hospital must meet the discharge and case mix criteria in effect at the start of its next cost reporting period when it becomes an RRC. CMS indicates that this differential policy for reclassifying as rural and qualifying for RRC status is appropriate because an urban to rural reclassification can happen at any time, while applications for RRC status must be submitted during the last quarter of a hospital's cost reporting period.

Process for Requests for Wage Index Data Corrections

CMS details its established multistep, 15-month process for the review and correction of the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes.

CMS posts the wage index timetable on its website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2021-Wage-Index-Home-Page. This website also includes all the public use files that CMS has made available during the wage index development process.

Labor-Related Share

The Secretary is required to update the labor-related share from time to time, but no less often than every three years. CMS is currently using a national labor-related share of 68.3%. If a hospital has a wage index of less than one, its IPPS payments will be higher with a labor-related share of 62%. If a hospital a wage index that is higher than 1, its IPPS payments will be higher using the national labor-related share. CMS proposes to continue using a national labor-related share of 68.3% for FFY 2021.

Continuation of the Low Wage Index Hospital Policy

Despite opposition from CHA and other stakeholders, in the FFY 2020 IPPS final rule CMS adopted a policy intended to address concerns that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. CMS finalized the policies to be effective for a minimum of four years to be properly reflected in the Medicare cost report for future years. For FFY 2021, CMS proposes to continue the following specific policies:

- Hospitals with a wage index value in the bottom quartile of the nation would have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals. For FFY 2021, the 25th percentile wage index value across all hospitals is 0.8420. CMS proposes to apply a budget neutrality adjustment of -0.18 percent for this policy.
- Remove the wage data from urban hospitals reclassifying as rural from the calculation of the rural floor wage index.
- Not apply a floor on a county's wage index based on the rural area wage index that results from a hospital in that county reclassifying from urban to rural
- Limit reductions in a hospital's wage index for any reason to 5% in a single year. For FFY 2021, the budget neutrality adjustment for this policy will be -0.026%.

Graduate Medical Education Payments

Teaching hospitals receive payments from Medicare to compensate them for their indirect medical education (IME) and direct graduate medical education (DGME) costs. These payments are based on the number of full-time equivalent (FTE) residents trained by the hospital subject to a cap based on the number of residents the hospital claimed for IME and DGME payment in 1996.

CMS includes provisions in the regulations that allow for temporary modification of a hospital's FTE cap when a residency program or a teaching hospital closes. Under current regulations, for an individual

resident to be considered displaced and a hospital eligible for a cap adjustment for continuing to train the resident, the resident must be physically present at the hospital training on the day prior to or the day of the hospital or program closure. To address the needs of residents attempting to find alternative hospitals to complete their training as well as to facilitate seamless Medicare IME and direct GME funding for originating and receiving hospitals, CMS is proposing to make two policy changes.

First, CMS proposes that the key day for linking temporary Medicare funding would be the day that the hospital/residency program closure was publicly announced, allowing residents time to find a new facility at which to complete their training while the residency program of the originating hospital winds down. Second, CMS proposes to allow funding to be transferred temporarily for residents who are not physically present at the closing hospital/closing program, but had intended to train at (or return to training at, in the case of residents on rotation) the closing hospital program.

To apply for the temporary Medicare resident cap increase, the receiving hospital must submit a letter to its MAC within 60 days of beginning the training of the displaced residents. However, CMS is proposing to require only the last four digits of each resident's Social Security number to reduce the amount of personally identifiable information included in the letter.

The IME adjustment factor is proposed to remain at 1.35 for FFY 2021.

Low-Volume Hospital Adjustment

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the adjustment amounts. The Bipartisan Budget Act of 2018 extended the relaxed low-volume adjustment criteria (>15-mile/ <1,600 Medicare discharges) through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-22 and changed the discharge criteria to require that a hospital have fewer than 3,800 total discharges, rather than 1,600 Medicare discharges. The new payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} * \frac{Total\ Discharges}{13{,}200}$$

Beginning in FFY 2023, the criteria for the low-volume hospital adjustment will return to more restrictive levels. At that point, to receive a low-volume adjustment, subsection (d) hospitals would need to:

- Be located more than 25 road miles from another subsection (d) hospital
- Have fewer than 200 total discharges (all payer) during the fiscal year

For a hospital to acquire low-volume status for FFY 2021, CMS will require — consistent with historical practice — that a hospital have submitted a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that it meets the applicable mileage and discharge criteria. The MAC must have received a written request by September 1, 2020, for the adjustment to be applied to payments for discharges beginning on or after October 1, 2020. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Under this process, a hospital receiving the adjustment for FFY 2020 will continue to receive it by providing its MAC with a verification statement that it continues to meet the mileage criteria and provide information for the discharge criteria from its most recently submitted cost report.

RRC: Annual Updates to Case-Mix Index and Discharge Criteria

CMS provides updated criteria for determining RRC status, including updated minimum national and regional case-mix index (CMI) values and updated minimum national and regional numbers of discharges. To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2020, CMS proposes that a rural hospital with fewer than 275 beds available for use meet specific geographic criteria, and:

- Have a CMI value for FFY 2019 that is at least 1.70435 (national—all urban) or the median CMI value (not transfer-adjusted) for urban hospitals, excluding those with approved teaching programs, calculated by CMS for the census region in which the hospital is located
- Have at least 5,000 discharges for the cost reporting period that began during FFY 2018; for osteopathic hospitals, this threshold is 3,000

A hospital seeking to qualify as an RRC should obtain its hospital-specific (not transfer-adjusted) CMI value from its MAC.

For hospitals seeking to qualify for initial RRC status, CMS proposes to amend the RRC regulations in order annualize the total number of discharges to determine a hospital's RRC eligibility if that hospital's most recent cost reporting period is not equal to 12 months. Additionally, if a hospital has multiple cost reports beginning in the same fiscal year and none are equal to 12 months, the hospital's number of discharges from the longest cost report beginning in that fiscal year would be annualized to estimate the total number of discharges.

Short Cost Reporting Periods and Sole Community Hospitals (SCHs)

To be classified as an SCH, a hospital must draw a certain percentage of inpatients from its service area, which CMS defines as the area from which a hospital draws at least 75 percent of its inpatients during its most recent 12-month cost reporting period ending before the hospital applies for classification as an SCH. CMS is aware of situations where a hospital's most recent cost reporting period prior to seeking SCH classification is less than 12 months in length. To address this, CMS proposes to clarify its policy to reflect that when a hospital's cost reporting period ending prior to it applying for SCH status is for less than 12 months, the hospital's next, most recent, 12-month or longer cost reporting period prior to the short period would be used.

Allogeneic Hematopoietic Stem Cell Acquisition Costs

Allogeneic hematopoietic stem cell transplants involve collecting or acquiring stem cells from a healthy donor's bone marrow, peripheral blood, or cord blood for intravenous infusion to the recipient. Currently, acquisition costs associated with these services are included in the operating costs of inpatient hospital services. IPPS payments for such acquisition services are included in the MS-DRG payments for the allogeneic hematopoietic stem cell transplants when the transplants occurred in the inpatient setting.

CMS proposes changes to reflect the requirement of the Further Consolidated Appropriations Act of 2020 that, for cost reporting periods beginning on or after October 1, 2020, payment to inpatient

hospitals for hematopoietic stem cell acquisition would be made on a reasonable cost basis, rather than be included in operating costs. CMS also proposes to apply a budget neutrality adjustment to the standardized amount to account for these payments, as required by the statute.

CMS also proposes that these hospitals be required to formulate a standard acquisition charge for these services. The standard acquisition charge does not represent the cost of acquiring stem cells for an individual transplant; instead, it approximates the hospital's average cost of acquiring hematopoietic stem cells. The standard acquisition charge would be billed and paid on an interim payment basis as a "pass-through" item using the corresponding ancillary cost-to-charge ratios. At cost report settlement, a determination would reconcile the actual cost incurred compared to the interim payments made to the hospital.

CMS also proposes to require that hospitals maintain an itemized statement that identifies the services furnished in collecting hematopoietic stem cells. The itemized statement would identify standard charges, the name of the donor and prospective recipient and the recipient's health insurance number. CMS proposes that the hospital's Medicare share of the hematopoietic stem cell acquisition costs are based on the ratio of the number of its allogeneic hematopoietic stem cell transplants furnished to Medicare beneficiaries to the total number of its allogeneic hematopoietic stem cell transplants furnished to all patients, regardless of payer, applied to reasonable cost.

Hospitals with High Percentage of End Stage Renal Disease (ESRD) Discharges

CMS provides additional payment to hospitals for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during an inpatient stay, if the hospital has established that ESRD beneficiary discharges (excluding discharges with MS-DRGs 652, 682, 683, 684, and 685) where the beneficiary received dialysis services, make up at least 10% of its total Medicare discharges.

CMS proposes to exclude the following newly proposed MS-DRGs from the total ESRD discharges used to determine a hospital's eligibility for the high ESRD discharge percentage payment:

- MS-DRG 019: Simultaneous Pancreas/Kidney Transplant with Hemodialysis
- MS-DRG 650: Kidney Transplant with Hemodialysis with MCC
- MS-DRG 651: Kidney Transplant with Hemodialysis without MCC

In addition, CMS proposes to remove the following MS-DRGs from the exclusion list:

- MS-DRG 652: Kidney Transplant
- MS-DRG 685: Admit for Renal Dialysis

Submission of Electronic Patient Records to Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs)

Currently, QIOs are authorized to have access to the records of providers, suppliers, and practitioners under Medicare, and health care providers that submit Medicare claims must cooperate with QIO reviews. Providers must provide patient care and other pertinent data to the QIO when review information is being collected. Beginning FFY 2021, CMS proposes to require that providers and practitioners submit patient records to BFCC-QIOs in an electronic format. Specifically, CMS proposes to:

- Define "patient record" as all patient care data and other pertinent data or information (whether or not part of the medical record) relating to care or services provided to an individual

patient, in the possession of the provider or practitioner, as requested by a QIO for the purpose of performing one or more QIO functions.

- Require patient records be delivered in electronic format, unless a QIO approves a waiver. Initial waiver requests by providers that are required to execute a written agreement with the QIO would be expected to be made at the time of the written agreement, although the waiver could be requested later if necessary. Other providers and practitioners who are not required to execute a written agreement with a QIO would request a waiver by giving the QIO notice of their lack of capability to submit patient records in electronic format.
- Establish reimbursement rates of $3.00 per patient record that are submitted to the QIO in electronic format and $0.15 per page for requested patient records submitted by facsimile or by photocopying and mailing (plus the cost of first-class postage for mailed photocopies), after a waiver is approved by the QIO. Only one reimbursement would be provided by the QIO for each patient record submitted, per request, even if a particular patient record is submitted to the QIO using multiple different formats, in fragments, or more than once in response to a particular request.

Electronic Filing of Provider Review Reimbursement Board (PRRB) Appeals

The PRRB is an independent forum for resolving payment disputes typically arising from certain Medicare Part A final determinations (usually cost report audit appeals). Staff support is provided to the PRRB by the Office of Hearings (OH). On August 16, 2018, the OH and the Board released the OH Case and Document Management System (OH CDMS), a web-based portal where providers can file appeals and the PRRB can release outgoing electronic correspondence and Board decisions with immediate system notification of an action. This system is already in use by all MACs and many others that have appeals before the PRRB. CMS proposes a number of technical changes to regulations consistent with use of the OH CDMS electronic system.

CMS states that as early as FFY 2021, the PRRB may require that all new submissions be filed electronically using OH CDMS, which can be accessed on the Electronic Filing webpage. The OH recommends that parties to PRRB appeals, who have not already done so, sign up for and begin using OH CDMS as soon as possible to allow time to become familiar with the system and avoid any issues that may arise if signing up for the system is delayed until after use of the system becomes mandatory.

Medicare Bad Debt Policy

CMS states that it is proposing a number of changes to Medicare bad debt policies to clarify certain policies that have been the subject of litigation and generated interest and questions from stakeholders over the past several years. Under current regulations at §413.89, Medicare pays some of the uncollectible deductible and coinsurance amounts to certain providers, suppliers, and other entities eligible to receive reimbursement for bad debt of Medicare beneficiaries. To be an allowable Medicare bad debt, the debt must meet all the following criteria (see §413.89(e) and Provider Reimbursement Manual (PRM), Chapter 3, Section 308):

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was uncollectible when claimed as worthless.

- Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS proposes to make many of these changes effective both retroactively and prospectively. In other circumstances, CMS proposes prospective changes to the regulations effective for cost reporting periods beginning on or after October 1, 2020.

Reasonable Collection Efforts

CMS proposes revisions to §413.89(e)(2), which currently only states that "the provider must be able to establish that reasonable collection efforts were made." However, CMS notes that more detailed requirements exist in the PRM. Specifically, CMS proposes to add the following to this section of the regulations.

Non-Indigent Beneficiaries

Reasonable collection efforts are only required from non-indigent beneficiaries. CMS proposes to add §413.89(e)(2)(i) , which states: "A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes." CMS indicates this policy is not new and has existed since the promulgation of Medicare bad debt policy. Later in the proposed rule – summarized below – CMS provides further detail on determining indigency by the provider when the beneficiary is not eligible for Medicaid.

Issuance of a Bill

CMS proposes to codify requirements currently in the Provider Reimbursement Manual into §413.89(e)(2) to include:

- The collection effort must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.
- For cost reporting periods beginning before October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.
- For cost reporting periods beginning on or after October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following:
    - The date of the Medicare remittance advice
    - The date of the remittance advice from the beneficiary's secondary payer, if any
- The collection effort must also include other actions such as subsequent billings, collection letters, and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

CMS proposes to make the above requirements effective retroactively except for the provisions that have an effective date of cost reporting periods beginning on or after October 1, 2020. For cost reporting periods beginning prior to October 1, 2020, providers are required to issue a bill only "shortly after discharge or the death of the beneficiary." For cost reporting periods beginning on or after October 1, 2020, the requirement is to issue a bill on or before 120 days after the latter of the date of the Medicare remittance advice or the date of remittance advance from the beneficiary's secondary payer, if any.

120-day Collection Effort and Reporting Period for Writing Off Bad Debts

CMS proposes two changes in this section of the rule. First, CMS proposes to add a requirement to §413.89(e)(2) that a bill cannot be considered uncollectible until at least 120 days have passed since the provider first attempted to receive payment. If the provider receives partial payment, the 120-day period restarts. This policy will be effective retroactively as CMS states that it merely codifies in regulation what was an established policy in the PRM. CMS indicates that the requirement to restart the 120 days upon receiving a partial payment is a clarification of a policy CMS established in response to inquiries.

Second, CMS proposes to revise an existing provision of the regulations (§413.89(f)) to clarify that any payment on the account made by the beneficiary, or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report. If the collection is made in a cost reporting period after the debt has been written off as uncollectible, the recovered amount must be used to reduce the provider's reimbursable costs in the period in which the amount is recovered. However, the amount of such reduction in the period of recovery must not exceed the actual amount reimbursed by the program for the related bad debt in the applicable prior cost reporting period. CMS proposes this policy would be effective retroactively.

Similar Collection Effort and Collection Agency Fees

As indicated above, CMS proposes to add a provision that "the collection effort must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients." CMS again states that the provision is proposed to codify existing requirements in the PRM. CMS states that similar collection efforts mean that the provider must take the same actions to collect Medicare and non-Medicare debts alike. For example, if a provider elects to refer its non-Medicare accounts to a collection agency, the provider must similarly refer Medicare accounts of "like amount" without regard to class of patient. The collection agency's effort to collect the debt must also be similar between Medicare and non-Medicare patients. This means that for comparable amounts, the collection agency must use similar collection practices for both accounts. The effort must constitute a genuine, rather than a token, collection effort. Collection accounts that remain at a collection agency cannot be claimed by the provider as a Medicare bad debt. Furthermore, a fee charged by a collection agency can be considered an allowable administrative expense but cannot be written off to bad debt. CMS proposes to make this policy effective retroactively.

Documentation of Reasonable Collection Efforts

CMS proposes to add §413.89(e)(2)(A)(i)(6) to codify long-standing provisions of the Provider Reimbursement Manual related to documentation of reasonable collection efforts. CMS proposes that the provider must maintain and, upon request, furnish to the Medicare contractor documentation of the provider's collection effort, whether the provider performs the collection effort in house or whether the provider uses a collection agency to perform the required collection effort on the provider's behalf. The documentation of the collection effort must include: the provider's bad debt collection policy that describes the collection process for Medicare and non-Medicare patients; the patient account history documents that show the dates of various collection actions such as the issuance of bills, follow-up collection letters, reports of telephone calls and personal contact, etc. CMS proposes to make this policy effective retroactively.

Determining Indigency

For beneficiaries who are not Medicaid eligible, CMS indicates that the Provider Reimbursement Manual requires that the beneficiary's total resources be considered when a provider evaluates their indigence. CMS proposes that new paragraph (e)(2)(ii)(A) that provides detailed specifications for how a provider is to determine indigence for beneficiaries who are not Medicaid eligible. CMS proposes to make this policy effective retroactively.

Dual Eligible Beneficiaries

To satisfy the reasonable collection effort, a provider that has furnished services to a dual eligible beneficiary must determine whether Medicaid (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible and/or coinsurance amounts. A provider satisfies this requirement: by (1) billing the state Medicaid program to determine that no source other than the patient would be legally responsible for the patient's medical bill; for example, Title XIX, local welfare agency, and guardian (the "must bill requirement"); and (2) obtain and submit to the MAC, a Medicaid remittance advice (RA) from the state Medicaid program (the "RA requirement"). If a provider does not bill the state and submit the Medicaid RA to Medicare with its claim for bad debt reimbursement for dual eligible beneficiaries, the result is that unpaid deductible and coinsurance amounts cannot be included as an allowable Medicare bad debt.

CMS proposes to codify this policy in §413.89(e)(2). Any amount that the state is obligated to pay, either by statute or under the terms of its approved Medicaid state plan, will not be included as an allowable Medicare bad debt, regardless of whether the state actually pays its obligated amount to the provider or provides the Medicaid RA indicating that it has no obligation to pay. However, the Medicare deductible and/or coinsurance amount, or any portion thereof that the state is not obligated to pay, can be included as an allowable Medicare bad debt. Unpaid deductible and coinsurance without collection effort documentation will not be considered as allowable bad debts. CMS proposes to make this policy effective retroactively.

Accounting Standard Update (ASU) Topic 606 and Accounting for Medicare Bad Debt

The Financial Accounting Standards Board's (FASB) ASU 2014-09, Revenue from Contracts with Customers (Topic 606), was published in May 2014 with the first implementation period in 2018. Under the ASU Topic 606, an amount representing a bad debt would generally no longer be reported separately as an operating expense in the provider's financial statements, but will be treated as an "implicit price concession," and included as a reduction in patient revenue. Topic 606 makes other related changes.

To implement Topic 606, CMS proposes to modify the regulations to add that, effective for cost reporting periods beginning on or after October 1, 2020, "bad debts, also known as 'implicit price concessions' are amounts considered to be uncollectible from accounts that were created or acquired in providing services" and "bad debts, also known as 'implicit price concessions,' charity, and courtesy allowances represent reductions in revenue."

In addition, CMS indicates that many providers are incorrectly writing off Medicare-Medicaid crossover bad debts to a contractual allowance account because they are unable to bill the beneficiary for the difference between the billed amount and the Medicaid claim payment amount. CMS says that other

providers are writing these amounts off to a contractual allowance account because the Medicaid remittance advice referenced the unpaid amount as a "Medicaid contractual allowance."

These Medicare-Medicaid crossover claims amounts do not meet the classification requirements for a Medicare bad debt because the amounts were written off to a contractual adjustment or allowance account instead of a bad debt expense account. CMS proposes to add paragraph (c)(3) to §413.89(c) to clarify that, effective for cost reporting periods beginning on or after October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debt or implicit price concession).

Hospital IQR Program

CMS proposes changes to the hospital IQR Program to gradually increase the number of cases for which electronic clinical quality measure (eCQM) must be submitted, begin public reporting of hospital performance on eCQMs on *Hospital Compare*, and modify the IQR data validation program.

CMS does not propose any changes to the IQR Program measure set or policies about the retention, removal, addition, or updating of measures. CMS also maintains current data submission requirements and deadlines, sampling and case thresholds, data accuracy and completeness acknowledgement, reconsideration and appeals, and the Extraordinary Circumstances Exception policy. Table 1 in the appendix to this summary shows the previously adopted and finalized measure sets for FFY 2020 through FFY 2024. Technical specifications for hospital IQR Program measures are available from the CMS QualityNet website at www.qualitynet.org and for eCQMs at http://ecqi.healthit.gov/.

Reporting and Submission Requirements for eCQMs

Currently, hospitals are required to report one self-selected calendar quarter of data for four self-selected eCQMs from the list of eight available eCQMs. In the FFY 2020 IPPS final rule, CMS finalized that beginning with the CY 2022 reporting period (FFY 2024 payment determination), hospitals must report on Safe Use of Opioids – Concurrent Prescribing eCQM and three self-selected eCQMs.

CMS proposes to maintain requirements that hospitals submit data on four self-selected eCQMs for the CY 2021 reporting period, and three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM beginning with the CY 2022 reporting period. However, CMS proposes to increase the number of quarters for which hospitals must report eCQMs. Specifically, CMS proposes:

- For FFY 2023 payment (CY 2021 reporting) hospitals would report data for two self-selected calendar quarters.
- For FFY 2024 payment (CY 2022 reporting) hospitals would report data for three self-selected calendar quarters.
- For FFY 2025 payment (CY 2023 reporting) and subsequent years, hospitals would report data for all four calendar quarters.

CMS believes that this proposal would produce more comprehensive and reliable quality measure data for patients and providers because a single quarter of data is not enough to capture trends in performance over time. CMS reminds readers that the current policy of reporting data for only one calendar quarter was established in response to stakeholder feedback about challenges in reporting eCQM data and was intended to provide hospitals with time to upgrade systems and undergo training to support eCQM reporting. CMS believes the proposal to gradually increase the amount of data to be

reported for eCQMs would provide hospitals and vendors time to plan and build on investments already made in EHR infrastructure.

CMS proposes a modification to the file identification elements for eCQM reporting by proposing to add EHR Submitter ID as a fifth key element for file identification beginning with reporting for FFY 2023 payment. Hospitals are currently required to submit eCQM data using the Quality Reporting Document Architecture (QRDA) I file format, which CMS expects to contain four elements for file identification: (1) CMS Certification Number (CCN); (2) CMS Program Name; (3) EHR Patient ID; and (4) Reporting period specified in the Reporting Parameters Section of the CMS Implementation Guide for the applicable reporting year (see https://ecqi.healthit.gov/qrda). The EHR Submitter ID would prevent a file previously submitted by another vendor – in situations where a hospital uses multiple vendors to submit QRDA files – from being overwritten. The EHR Submitter ID for hospitals is the CCN.

Data Submission and Reporting of Hybrid Measures

CMS currently allows voluntary reporting of the Hybrid Hospital-Wide Readmission (HWR) measure, and mandatory reporting of the measure will be required beginning with the FFY 2025 payment determination. Hospitals are required to use EHR technology certified to the 2015 Edition, and to submit the required data elements using the QRDA I file format. In this rule, CMS proposes that the requirements for using the 2015 Edition and QRDA I file format would also apply to any future hybrid measure adopted for the IQR Program.

Proposed Changes to IQR Validation Requirements

CMS proposes to combine the validation processes for chart-abstracted data and eCQM data over time. CMS notes that only one clinical process of care measure subject to chart abstracted data validation (the sepsis measure) remains in the IQR Program for the 2021 reporting period (FFY 2023 payment). The proposal includes the following seven elements:

(1) *Modify data submission quarters.* The quarters of data used for both chart-abstracted and eCQM data validation would be aligned over time. For the FFY 2023 payment determination, instead of requiring that hospitals selected for data validation provide samples for four quarters (Q3 2020 – Q2 2021), CMS proposes to require data for chart abstracted measure be provided only for Q3 and Q4 of 2020. CMS proposes no change would to quarters for data validation of the eCQMs; for these measures, hospitals provide data for a sample of charts for the self-selected calendar quarter of 2020 for which the hospital has elected to report the eCQMs. For the FFY 2024 payment determination, CMS proposes to require that the quarters of data validation for chart-abstracted measures be Q1-Q4 of 2021.

(2) *Expand targeting criteria to include hospital selection for eCQMs.* Beginning with the FFY 2024 payment determination, CMS proposes to incorporate eCQMs into the data validation process established for chart-abstracted measures. A single pool of hospitals would be selected for validation, and a selected hospital would submit data for both chart-abstracted measures and eCQMs. The current criteria for targeted validation would continue to apply. CMS clarifies that a hospital that has been granted an Extraordinary Circumstances Exception under the IQR Program could still be selected for validation under the targeting criteria.

(3) *Reduce validation pool from 800 to 400 hospitals.* Beginning with data validation for FFY 2024 payment, CMS proposes to reduce the number of hospitals randomly selected for

validation from the current 400 hospitals to as few as 200 hospitals. The number of hospitals selected for targeted validation would remain at 200, for a total of up to 400 hospitals.

(4) *Remove exclusions for eCQM validation selection.* CMS proposes to remove current exclusion criteria before random selection of up to 200 hospitals for eCQM validation beginning the FFY 2024 payment determination. Final adoption of this proposal is contingent on CMS finalizing the combination of the validation pools for eCQMs and chart-abstracted measures.

(5) *Require electronic file submissions for chart-abstracted measure validation data.* CMS proposes that beginning with data validation for the FFY 2024 payment determination (Q1 2021 data submissions), hospitals submitting medical records for validation of IQR Program measures would be required to submit PDF copies of medical records using direct electronic files submission via a CMS-approved secure file transmission process. Hospitals could no longer submit the required records via paper copies, DVDs, CDs, or flash drives. CMS would reimburse hospitals at $3.00 per chart, consistent with current reimbursement for electronic submissions of charts.

(6) *Align the eCQM and chart-abstracted data validation scoring processes.* CMS proposes to combine the validation scoring for chart-abstracted measures and eCQMs into a single score. However, because eCQM validation does not currently assess the accuracy of the eCQMs reported by the hospital, the combined score would weigh the chart-abstracted measure agreement rate at 100%. Hospitals would still be required provide at least 75% of the requested medical records for eCQM validation.

(7) *Update the educational review process to address eCQM validation results.* CMS proposes to adapt the process under which a hospital may request an educational review if they believe they have been scored incorrectly or have questions about the validation results to include eCQM validation. A hospital would have 30 days after receiving eCQM validation results to contact the Validation Support Contractor and request a written review. CMS proposes that this would be provided to the requesting hospital through a CMS-approved secure file transmission process.

CMS proposes no changes to the number of cases that hospitals selected for data validation are required to submit. However, CMS notes that elsewhere in this proposed rule it would expand the number of quarters for which hospitals must report eCQMs under the IQR Program. Should those proposals be finalized, hospitals selected for data validation would have to submit validation data for each quarter for which eCQM data were submitted. For example, for validation affecting the FFY 2024 payment determination, hospitals would report a total of 16 requested cases from two calendar quarters of data (eight cases x two quarters). This would increase to 32 requested cases (eight cases x four quarters) for validation affecting the FFY 2026 payment determination and for subsequent years.

Public Display of eCQM Data

Currently, hospital performance on eCQMs is not publicly reported on *Hospital Compare*. CMS has analyzed eCQM validation data from the 2017 and 2018 reporting periods and concluded that eCQM data are accurate enough to be publicly reported in the aggregate. CMS proposes to begin public reporting of eCQM data for the 2021 reporting period/FFY 2023 payment determination. CMS would publicly post the data as early as the fall of 2022.

Hospital Value-Based Purchasing (VBP) Program

As required by law, the available funding pool for the hospital VBP Program is equal to 2% of the base operating diagnosis-related group (DRG) payments to all participating hospitals. CMS estimates the total amount available for VBP payments to be $1.9 billion. In FFY 2021, CHA estimates that, overall, California hospitals will earn approximately $17.4 million in hospital VBP payments, with some hospitals seeing a positive and others a negative impact.

CMS proposes no changes to the hospital VBP Program for FFY 2021. The previously adopted measures, domain weights (25% each across the four domains), case minimums, and payment adjustment methodologies would be continued. Table 2 in the appendix of this summary lists previously adopted measures for the program.

Previously Adopted Performance and Baseline Periods

CMS did not propose changes to previously adopted performance and baseline periods for the program measures, the specific time periods of which are automatically updated each year. The proposed rule includes tables, on pages 32772-32775, that display the baseline and performance periods for each fiscal year from 2023 through 2026.

Previously Adopted Performance Standards

The final rule includes a series of tables that display the previously and newly proposed numeric performance standards for VBP program measures for FFYs 2023-25. The tables are listed on pages 32776-32779 of the proposed rule.

Hospital-Acquired Conditions (HACs) Reduction Program

Under the HACs Reduction Program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. CMS does not propose any changes to the measure set for the HACs Reduction Program. Table 3 in the appendix of this summary lists previously adopted measures for the HACs Reduction Program. In the proposed rule, CMS proposes automatic adoption of applicable periods beginning with FFY 2023, and changes to data validation procedures to align with the hospital IQR Program. CMS establishes factors for removal of program measures, establishes the data collection period for the FFY 2022 program year, clarifies certain data validation and data collection policies finalized in the FFY 2019 IPPS final rule, and updates regulatory text to reflect previously adopted policies effective with the FFY 2020 payment year.

CMS estimates that 780 hospitals will fall into the worst-performing quartile and be penalized in FFY 2021 under the program. However, CMS provides no aggregate dollar amount of the penalties in its impact analysis. CHA DataSuite analysis estimates that California hospitals will lose approximately $47 million under this program for FFY 2021.

Automatic Adoption of Applicable Periods for FFY 2023 and Subsequent Years

CMS has previously finalized a 24-month “applicable period,” or performance period, for the HACs reduction program. The applicable period has been adopted annually in the IPPS/LTCH final rule. For example, the applicable period previously adopted for FFY 2022 is the 24-month period from July 1, 2018, through June 30, 2020, for the Patient Safety Indicators (PSI)90 measure, and January 1, 2019, through December 31, 2020, for the National Healthcare Safety Network (NHSN) measures.

In this rule, CMS proposes the automatic adoption of applicable periods for FFY 2023 and all subsequent program years. Specifically, beginning in FFY 2023, the applicable period for both the CMS PSI 90 and Centers for Disease Control and Prevention (CDC) NHSN HAI measures would be the 24-month period beginning one year after the start of the applicable period for the previous program year. For example, for FFY 2023, the applicable period for the CMS PSI 90 measure would be the 24-month period from July 1, 2019, through June 30, 2021, and the applicable period for CDC NHSN HAI measures would be the 24-month period from January 1, 2020, through December 31, 2021. All subsequent years would advance the 24-month periods by one year, and any changes to the policy would be made through notice and comment rulemaking.

HACs Reduction Program Data Validation

CMS proposes changes to the data validation process for the HACs Reduction Program to align with proposed changes to the hospital IQR Program measure validation process, which is summarized earlier in this summary. Specifically, CMS proposes to align data submission quarters across the two programs, and align hospital selection for validation – under which the total pool would be reduced from up to 600 (up to 400 randomly selected and up to 200 targeted hospitals) to 400 (up to 200 randomly selected and up to 200 targeted hospitals). CMS also proposes to require digital submission of medical record files for validation beginning in FFY 2023.

Specifically, hospitals would be required to submit PDF copies of medical records using direct electronic files submission via a CMS-approved secure file transmission process. Currently, hospitals have a choice of submitting paper copies of medical records or submitting electronic versions through secure transmission. Submission via secure transmission can entail downloading or copying the digital image of the patient chart onto CD, DVD, or flash drive, or submission of PDFs using a CMS-approved secured file transfer system. Under the proposal, CMS would only accept PDF copies submitted through a CMS-approved secured file transfer system, and would no longer accept CD, DVD, or flash drives containing digital images of patient charts or paper charts, beginning with Q1 2021 data submissions for FFY 2024 program year validation. CMS would continue to reimburse hospitals at $3.00 per chart, consistent with current reimbursement for electronic submissions of charts.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program (HRRP) reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor between 1 (no reduction) and 0.9700, for the greatest possible reduction of 3% of base operating DRG payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

CMS retains the six previously adopted readmissions measures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA), chronic obstructive pulmonary disease (COPD), and coronary artery bypass grafting (CABG). CMS proposes no changes to the factors used by CMS in removing measures, the use of subregulatory processes to make nonsubstantive changes to measures and other program features, or the methodology for calculating the payment adjustment.

CMS estimates that 2,583 hospitals will be penalized under the HRRP in FFY 2021. CHA DataSuite analysis estimates that the HRRP will result in a Medicare payment reduction for California hospitals of approximately $44 million for FFY 2021.

Automatic Adoption of Applicable Periods for FFY 2023 and Subsequent Years

CMS proposes to automatically adopt the applicable three-year period for which data will be collected for calculating the readmission payment adjustment factor. Previously, the applicable period has been adopted through rulemaking each year. Consistent with previously adopted periods, CMS proposes that – beginning in FFY 2023 – the applicable period for the HRRP would be the three-year period beginning one year advanced from the start of the applicable period for the previous program fiscal. That is, for FFY 2023, the applicable period for HRRP measures and for determining dual eligibility would be the three-year period from July 1, 2018, through June 30, 2021. The same rules would apply for all subsequent years, and any future change to the policy would occur through notice and comment rulemaking.

Previously adopted applicable periods for payment years 2020–2022 are listed in the table below:

HRRP Applicable Period	
Payment Year	**Discharge Dates**
FFY 2020	July 1, 2015-June 30, 2018
FFY 2021	July 1, 2016-June 30, 2019
FFY 2022	July 1, 2017-June 30, 2020

Payment Adjustment Methodology

CMS proposes no changes to its previously finalized methodology for calculating the HRRP payment adjustment. Using Medicare Provider Analysis and Review (MedPAR) data for the three-year applicable period, hospitals will be grouped by quintiles (five peer groups) based on their proportion of dually eligible patients. The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio (ERR) to the median excess ERR for the hospital's peer group. "Payment" refers to base operating DRG payments, "dx" refers to an HRRP condition (i.e., AMI, HF, PN, COPD, THA/TKA or CABG), and "NMM" is a budget neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions. For additional information on the methodology, CHA refers readers to our FFY 2018 IPPS final rule summary.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

Confidential Reporting of Stratified Readmissions Data

As stated in its FFY 2020 IPPS final rule, CMS says that in spring of 2020, it will include — in confidential hospital-specific reports — data on the six readmissions measures stratified by patient dual eligible status. Results will be provided using two disparity methodologies: the within-hospital disparity method compares readmissions rates for dual eligible and other beneficiaries, and the dual eligible outcome

measure compares performance in care for dual eligible across hospitals. These methods differ from the HRRP stratification and will not be used for any payment calculations. CMS is providing the data because it believes that they allow for a more meaningful comparison and will provide additional perspectives on health care equity.

PPS-Exempt Cancer Hospital (PCH) Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a quality reporting program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting Program follows many of the policies established for the hospital IQR program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking. Five initial measures were adopted for FFY 2014, and subsequent rulemaking has added and removed measures. Table 4 of the Appendix of this summary lists the 15 previously adopted measures for the program.

Proposed Modification and Public Display for CLABSI and CAUTI Measures

CMS proposes to modify the central-line associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures to adopt updated measure specifications from the CDC. The revised measures were endorsed by the National Quality Forum in October 2019. The revisions employ a new risk adjustment methodology that calculates measure rates that are stratified by patient locations within hospitals, including oncology units. If the proposal to adopt the revised CLABSI and CAUTI measures is finalized, CMS proposes to publicly display the measures beginning in the fall of 2022 using data reported from 2021.

Medicare and Medicaid Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction of 2.25% in the update factor for FFY 2021, and would receive an update of 0.35%. A hospital that fails to meet both the meaningful use and IQR Program requirements would receive an update factor of -0.4%.

Reporting Periods for 2022

CMS previously adopted a continuous 90-day reporting period for the Medicare and Medicaid Promoting Interoperability Program through 2021. CMS proposes to extend this continuous 90-day reporting period for 2022. CMS also reminds hospitals that under current law, the Medicaid Promoting Interoperability will end in 2021.

Voluntary Reporting of Query of Prescription Drug Monitoring Program (PDMP) Measure

The Query of PDMP measure assesses the number of Schedule II opioid prescriptions for which Certified EHR Technology (CEHRT) data are used to conduct a query of a PDMP for prescription drug history (except where prohibited and in accordance with applicable law) as a percentage of the number of all Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or CAH during the EHR reporting period. CMS previously finalized this as an optional measure for the 2019 and 2020 policies, and mandatory beginning in 2021. CMS notes that a recent assessment of PDMPs by the Office of the National Coordinator for Health Information Technology (ONC) found that less than half of hospitals reported integration of PDMP queries into the EHR workflow. In response to comments from stakeholders, CMS proposes to continue the Query of PDMP measure as a voluntary measure for EHR

reporting periods in 2021. Hospitals electing to report this measure report "yes" if for least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH used data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law. Hospitals that voluntarily report the measure would receive five bonus points under the proposed 2021 Promoting Interoperability Program scoring methodology.

Change in Health Information Exchange Measure Name

CMS proposes to change the name of the Health Information Exchange Objective measure "Support Electronic Referral Loops by Receiving and Incorporating Health Information" to "Support Electronic Referral Loops by Receiving and Reconciling Health Information." CMS believes that the word "reconciling" better reflects the actions required by the measure.

Scoring Methodology for 2021 Reporting Period

As previously finalized, to be considered a meaningful user of EHR technology, an eligible hospital or CAH must:

- Report on all the required measures across all four objectives, unless an exclusion applies
- Report "yes" on all required yes/no measures, unless an exclusion applies
- Attest to completing the actions included in the Security Risk Analysis measure
- Achieve a total score of at least 50 points

Failure to meet any of the first three requirements results in an automatic score of zero. CMS proposes the following scoring methodology for the 2021 reporting period:

Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in 2021

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Query of Prescription Drug Monitoring Program (PDMP)	5 points (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Choose any two of the following: Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

Currently, hospitals participating in the Medicare and Medicaid Promoting Interoperability Programs must report on four self-selected measures (from an available eight) for one self-selected quarter of data during the calendar year. The list of available eCQMs is included in Table 1 of the Appendix to this summary.

In alignment with proposals for the IQR program, CMS proposes to maintain requirements that hospitals submit data on four self-selected eCQMs for the CY 2021 reporting period, and three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM beginning with the CY 2022 reporting period. However, CMS proposes to increase the number of quarters for which hospitals must report eCQMs. Specifically, CMS proposes:

- For FFY 2023 payment (CY 2021 reporting) hospitals would report data for two self-selected calendar quarters.
- For FFY 2024 payment (CY 2022 reporting) hospitals would report data for three self-selected calendar quarters.
- For FFY 2025 payment (CY 2023 reporting) and subsequent years, hospitals would report data for all four calendar quarters.

CMS proposes that the data submission period would continue to be the two months following the end of the respective calendar year.

Consistent with the IQR Program, CMS proposes that eCQM data would be publicly reported beginning with reporting year 2021/FFY 2023 payment determination data. These data would be publicly posted as early as the fall of 2022. Along with other IQR Program measures, eCQM data would be available for hospitals to review during the 30-day preview period.

Appendix — Quality Reporting Program Tables

Table 1

IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2020	2021	2022	2023	2024
Chart-Abstracted Process of Care Measures					
VTE-6 Incidence of potentially preventable VTE	X	Removed			
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X	X
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF #0495)	X	Removed			
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)	X	X	Removed		
IMM-2 Immunization for influenza (NQF #1659)	X	Removed			
PC-01 Elective delivery < 39 weeks gestation (NQF#0469)	X	X	X	X	X
Healthcare-Associated Infection Measures					
Central Line Associated Bloodstream Infection (CLABSI)	X	X	Removed		
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	Removed		
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	Removed		
MRSA Bacteremia	X	X	Removed		
Clostridium Difficile (C. Diff)	X	X	Removed		
Healthcare Personnel Influenza Vaccination	X	X	X	X	X
Claims-Based Measures					
Mortality					
Acute Myocardial Infarction (AMI) 30-day mortality rate	Removed				
Heart Failure (HF) 30-day mortality rate	Removed				
Pneumonia 30-day mortality rate	X	Removed			
Stroke 30-day mortality rate	X	X	X	X	X
COPD 30-day mortality rate	X	Removed			
CABG 30-day mortality rate	X	X	Remove		
Readmission/ Coordination of Care					
AMI 30-day risk standardized readmission	Removed				

Heart Failure 30-day risk standardized readmission	Removed				
Pneumonia 30-day risk standardized readmission	Removed				
TKA/THA 30-day risk standardized readmission	Removed				
Hospital-wide all-cause unplanned readmission	X	X	X	X	X**
Stroke 30-day risk standardized readmission	Removed				
COPD 30-day risk standardized readmission	Removed				
CABG 30-day risk standardized readmission	Removed				
Hybrid (claims+EHR) hospital-wide readmission	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary**
Excess days in acute care after hospitalization for AMI	X	X	X	X	X
Excess days in acute care after hospitalization for HF	X	X	X	X	X
Excess days in acute care after hospitalization for PN	X	X	X	X	X

Patient Safety

PSI90 Patient safety composite (NQF #0531)	Removed				
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X	X
THA/TKA complications	X	X	X	Removed	

Efficiency/Payment

Medicare Spending per Beneficiary	Removed				
AMI payment per 30-day episode of care	X	X	X	X	X
Heart Failure payment per 30-day episode of care	X	X	X	X	X
Pneumonia payment per 30-day episode of care	X	X	X	X	X
THA/TKA payment per 30-day episode of care	X	X	X	X	X
Kidney/UTI clinical episode-based payment	Removed				
Cellulitis clinical episode-based payment	Removed				
Gastrointestinal hemorrhage clinical episode-based payment	Removed				
Aortic Aneurysm Procedure clinical episode-based payment	Removed				
Cholecystectomy/Common Duct Exploration episode-based payment	Removed				

Spinal Fusion clinical episode-based payment	Removed				
Patient Experience of Care					
HCAHPS survey + 3-item Care Transition Measure	X	X	X	X	X
Structural Measures					
Safe Surgery Checklist Use	Removed				
Hospital Survey on Patient Safety Culture	Removed				

Electronic Clinical Quality Measures

Measure	Payment Years		
	2019-2021	2022	2023-2024
STK-2 Antithrombotic therapy for ischemic stroke	Report 4 of the following 15 eCQMs: AMI-8a CAC-3 ED-1 ED-2 EHDI-1a PC-01 PC-05 STK-02 STK-03 STK-05 STK-06 STK-08 STK-10 VTE-1	Report 4 of the following 8 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2	Report 4 of the following 9 eCQMs ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 Safe use of Opioids*
STK-3 Anticoagulation therapy for Afib/flutter			
STK-5 Antithrombotic therapy by end of hospital			
STK-6 Discharged on statin (NQF #0439)			
STK-8 Stroke education			
STK-10 Assessed for rehabilitation services (NQF #0441)			
VTE-1 VTE prophylaxis (NQF #0371)			
VTE-2 ICU VTE prophylaxis (NQF #0372)			
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) (NQF #0163)			
CAC- 3 Children's asthma care – 3			
ED-1 Median time from ED arrival to departure from the emergency room for			
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)			
EDHI-1a Hearing screening prior to hospital discharge			
PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469)			
PC-05 Exclusive breast milk feeding (NQF #0480)			

*Beginning with the FFY 2024 payment determination, hospitals will be required to report this eCQM and three other self-selected eCQMs

**Beginning with the FFY 2026 payment determination, this measure will be removed and mandatory reporting of the Hybrid HWR measure will be required

Table 2

VBP-1 Program Measures and Domains by Payment Year					
Measure	**2018**	**2019/2020**	**2021**	**2022**	**2023/2024**
Clinical Outcomes					
Acute Myocardial Infarction (AMI) 30-day mortality rate	X	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty		X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate			X	X	X
CABG 30-day mortality rate				X	X
Safety					
PSI90 Patient safety composite (NQF #0531)	X	Removed			
Patient Safety and Adverse Events composite					X
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X	X	X
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
MRSA Bacteremia	X	X	X	X	X
Clostridium Difficile (C. Diff)	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation	X	X	Removed		
Patient and Caregiver Centered Experience of Care/Care Coordination (Person and Community Engagement)					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Management (before 2018)* Communication about Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital 3-Item Care Transition measure	X	X	X	X	X
Efficiency and Cost Reduction					
Medicare Spending per Beneficiary	X	X	X	X	X
AMI Payment per 30-day episode			Removed		
HF Payment per 30-day episode			Removed		
PN Payment per 30-day episode				Removed	

*The pain management component of HCAHPS was removed beginning with the FFY 2018 payment determination.

Table 3

HAC Reduction Program Measures and Performance Periods for Payment Determination in FFYs 2019-2021			
Measure	**FFY 2019**	**FFY 2020**	**FFY 2021**
Domain 1			
PSI90 Patient Safety & Adverse Events Composite	X	X	X
Performance Period	10/1/15-6/30/17	7/1/16-6/30/18	7/1/17-6/30/19
Domain 2			
NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	X
NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X
NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X
NHSN Methicillin-Resistant Staphylococcus Aureus Bacteremia (MRSA) Outcome Measure (NQF #1716)	X	X	X
Colon/Abdominal Hysterectomy Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753)	X	X	X
Performance Period	1/1/16-12/31/17	1/1/17-12/31/18	1/1/18-12/31/19

Table 4

PCH QRP Measures	
Measure	**Public Display**
Safety and Healthcare-Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	X
NHSN CDI (NQF #1717)	X
NSHN MRSA bacteremia (NQF #1716)	X
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	X
NHSN CLABSI (NQF #0139)	Proposed Beginning 2022
NHSN CAUTI (NQF #0138)	Proposed Beginning 2022
Clinical Process/Oncology Care	
Oncology: Plan of Care for Pain (NQF #0383)	X
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)	
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	
Patient Experience of Care	
HCAHPS (NQF #0166)**	X
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	X
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	
Proposed: Surgical Treatment Complications for Localized Prostate Cancer	

** Beginning with October 1, 2018, discharges, responses to the pain management questions will not be public.