CALIFORNIA HOSPITAL ASSOCIATION

Federal Regulatory Summary

from the California Hospital Association

SUMMARY OF PROPOSED RULE — MAY 2021

FFY 2022 Medicare Inpatient Prospective Payment System

Overview

In the May 10 *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) 2022. The policy and payment provisions would generally be effective for FFY 2022 discharges, beginning October 1.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. Payment and policy changes proposed for the FFY 2022 LTCH PPS are addressed in a separate summary.

To Comment

Comments are due to CMS June 28 by 2 p.m. (PT) and can be submitted electronically at www.regulations.gov; search the site for "CMS-1752-P."

Member Forum

Register for CHA's FFY 2022 IPPS proposed rule webinar at 9 a.m. (PT) on June 10 to learn more about these policies and provide input for CHA's comments. Registration is available on the CHA website.

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org. or Chad Mulvany, vice president of federal policy, at (202) 270-2143 or cmulvany@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 2022 Payment Changes

The table below lists the federal operating and capital rates proposed for FFY 2022 compared to the rates currently in effect for FFY 2021. 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 2021	Proposed FFY 2022	Percent Change
Federal Operating Rate	$5,961.31	$6,140.29	+3.00%
Federal Capital Rate	$466.21	$471.89	+1.22%

The table below provides details for proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2022.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Market Basket/Capital Input Price Index Update	+2.5%		+0.7%
ACA-Mandated Reductions 0.2 percentage point (PPT) productivity reduction	-0.2 PPT		—
MACRA-Mandated Retrospective Documentation and Coding Adjustment	+0.5%	—	—
Wage Index Transition Adjustments	+0.13%		-0.24%
Annual Budget Neutrality Adjustments	+0.06%		+0.76%
Proposed Net Rate Update	***+3.00%***	***+2.5%***	***+1.22%***

Retrospective Coding Adjustment

CMS is proposing a retrospective coding adjustment of +0.5% to the federal operating rate in FFY 2022 as part of the fifth year of rate increases (of six) 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 3.2%.

Effects of the IQR and EHR Incentive Programs

Beginning in FFY 2015, the IQR MB penalty changed from -2 percentage points to a 25% reduction to the full market basket (MB), and the EHR Meaningful Use (MU) penalty began its phase-in over three years,

starting at 25% of the full MB. Beginning with FFY 2017, the EHR MU penalty has been capped at 75% of the MB; hence the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2022 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (2.5% MB less 0.2 PPT productivity)	+2.30%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.5%)	—	-0.625 PPT	—	-0.625 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.5%)	—	—	-1.875 PPT	-1.875 PPT
Adjusted Net Market Basket Update (prior to other adjustments)	***+2.30%***	***+1.675%***	***+0.425%***	***-0.2%***

CMS estimates that 65 hospitals will not receive the full market basket rate of increase because they failed the quality data submission process or chose not to participate in IQR; 105 hospitals because they are not meaningful EHR users; and 24 hospitals are estimated to be subject to both reductions.

Impact Analysis — California

The CHA DataSuite analysis estimates that California hospitals will experience an increase of 1.9% in overall Medicare hospital inpatient payments in FFY 2022, as compared to FFY 2021. However, the impact will vary.

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2021 IPPS Payments	$12,030,980,200		$880,262,200		$12,911,240,200	
Provider Type Changes	($644,800)	0.0%	($306,600)	0.0%	($951,400)	0.0%
Marketbasket Update (Includes Budget Neutrality)	$296,566,500	2.5%	$9,064,100	1.0%	$305,630,500	2.4%
ACA-Mandated Marketbasket Reductions	($23,149,200)	-0.2%	*Not Applicable*		($23,149,200)	-0.2%
Forecast Error Adjustment	*Not Applicable*		($2,658,700)	-0.3%	($2,658,700)	0.0%
MACRA-Mandated Coding Adjustment	$58,164,900	0.5%	*Not Applicable*		$58,164,900	0.5%
Wage Index/GAF (Wage Data and Reclassification)	($18,710,300)	-0.2%	$680,800	0.1%	($18,030,700)	-0.1%
Wage Index/GAF (Other Changes)	$14,270,500	0.1%	$4,240,100	0.5%	$18,509,400	0.1%
> Expiration of FFY 2021 5% Stop Loss Transition	$13,264,700	0.1%	$3,143,000	0.4%	$16,408,000	0.1%
> Application of Imputed Floor	$0	0.0%	$0	0.0%	$0	0.0%
> Increasing Bottom Quartile Wage Index Values	$1,004,900	0.0%	$1,097,600	0.1%	$2,102,200	0.0%
Change in COLA	$0	0.0%	$0	0.0%	$0	0.0%
Transitional DSH Year-Over-Year	$0	0.0%	($950,000)	-0.1%	($950,000)	0.0%
DSH: UCC Payment Changes [1]	($67,211,700)	-0.6%			($67,211,700)	-0.5%
> DSH UCC Distribution Factor Change	($22,743,300)	-0.2%	*Not Applicable*		($22,743,300)	-0.2%
Change in Hospital Specific Rate	$2,000,000	0.0%			$2,000,000	0.0%
MS-DRG Updates	($5,202,900)	0.0%	($375,300)	0.0%	($5,577,600)	0.0%
Quality Based Payment Adjustments [2]	($14,231,200)	-0.1%	($26,400)	0.0%	($14,257,700)	-0.1%
Net Change due to Low Volume Adjustment	($22,700)	0.0%	$16,700	0.0%	($6,300)	0.0%
Estimated FFY 2022 IPPS Payments	$12,272,808,100		$889,946,400		$13,162,754,200	
Total Estimated Change FFY 2021 to FFY 2022 ¥	*$241,827,900*	*2.0%* ▲	*$9,684,200*	*1.1%* ▲	*$251,513,300*	*1.9%* ▲

¥ 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 2031. As part of the Medicare Sequester Relief Act, Congress eliminated the 2% sequester on Medicare payments from October 1, 2021 through December 31, 2021. It is estimated that sequestration for FFY 2022 IPPS-specific payments will be: -$197,441,300.

CMS' detailed impact estimates are displayed in Table I of Appendix A of the proposed rule (page 25746), which is partially reproduced below.

Hospital Type	All Proposed Rule Changes
All Hospitals	2.7%
Urban	2.7%
Urban – Pacific Region	2.9%
Rural	2.9%
Rural – Pacific Region	5.5%

Outlier Payments

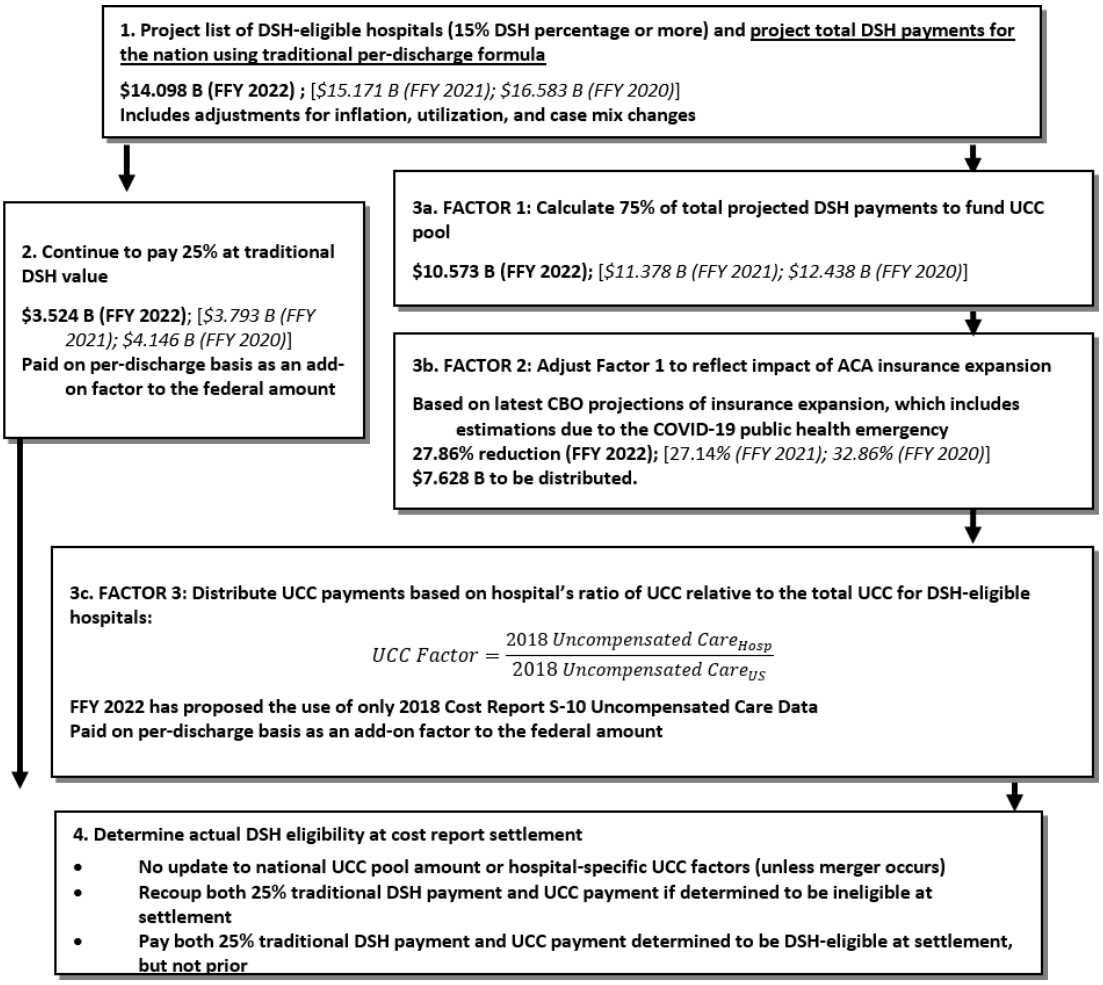
CMS continues to believe that using a methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold is a reasonable approach and would provide a better predictor for the upcoming fiscal year. Therefore, for FFY 2022, CMS is proposing to incorporate total outlier reconciliation dollars from the FFY 2016 cost reports into the outlier model using a similar methodology to FFY 2021.

Analysis done by CMS determined outlier payments at 5.11% of total IPPS payments; CMS is proposing an outlier threshold of $30,967 for FFY 2022. The proposed threshold is 6.6% higher than the current (FFY 2021) outlier threshold of $29,064. CMS is proposing to use FFY 2019 claims data (instead of FFY 2020, per normal practice) and the FFY 2019 Medicare cost reports (instead of 2019, per normal practice) to determine the fixed loss outlier threshold. CMS believes the FFY 2020 is aberrant due to the COVID-19 public health emergency (PHE).

Medicare DSH - Uncompensated Care 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 2022 compared to FFY 2021. 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 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 2022 Factor 1

CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. For FFY 2022, CMS used the Office of the Actuary's (OACT) January 2021 Medicare DSH estimates, which were based on the September 2020 update of the Healthcare Cost Report Information System (HCRIS) and the FFY 2021 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 September 2020 Medicare estimate of DSH is $14.098 billion. The proposed Factor 1 amount is 75% of this amount or $10.573 billion. The proposed Factor 1 for 2022 is about $805 million less than the final Factor 1 for FFY 2021.

Proposed FFY 2022 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 2022, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for calendar years (CYs) 2021 and 2022 is 10.2% and 10.1%, respectively. Using these estimates, CMS calculates the proposed Factor 2 for FFY 2022 (weighting the portion of calendar years 2021 and 2022 included in FFY 2022) as follows:

- Percent of individuals without insurance for CY 2013: 14%
- Percent of individuals without insurance for CY 2021: 10.2%
- Percent of individuals without insurance for CY 2021: 10.1%
- Percent of individuals without insurance for FFY 2022 (0.25 times 0.0102) +(0.75 times 0.0101): 10.1%

Proposed Factor 2 = 1-|((0.101-0.14)/0.14)| = 1- 0.2786 = 0.7214 (72.14%)

CMS calculated Factor 2 for the FFY 2022 proposed rule to be 0.7214 or 72.14 percent, and the UCC amount for FFY 2022 to be $10.573 billion x 0.7214 = $7.628 billion, which is about $662 million less than the FFY 2021 UCC payment total of about $8.290 billion; the percentage decrease is 7.99%.

Proposed FFY 2022 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.

Proposed Use of Audited FFY 2018 Worksheet S-10 Data

As in FFYs 2020 and 2021, CMS proposes to use a single year of Worksheet S-10 data from FFY 2018 cost reports to calculate Factor 3 in the FFY 2022 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 2018 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 2018 Worksheet S-10 data have been audited represent about 99.6% of the proposed total UCC payments for FFY 2022. CMS uses data from the HCRIS extract updated through February 19, 2021. It intends to use the March 2021 HCRIS update for the FFY 2022 final rule and the respective March updates for all future final years.

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 continue its policy to treat hospitals that merge after the development of the final rule similarly to new hospitals. Consistent with its policy adopted in the FFY 2015 IPPS/LTCH PPS final rule, CMS proposes that the newly merged hospital's final UCC payment would be determined at cost report settlement where the numerator of the newly merged hospital's Factor 3 would be based on the cost report of only the surviving hospital (that is, the newly merged hospital's cost report) for the current fiscal year. If the hospital's cost reporting period is less than 12 months, CMS would annualize its data for purposes of the Factor 3 calculation. Interim UCC payments for the newly merged hospital would be based only on the data (FFY 2018 cost report) for the surviving hospital's CMS certification number (CCN) available at the time of the development of the final rule. At cost report settlement, CMS would determine the newly merged hospital's final UCC payment based on the uncompensated care costs reported on its FFY 2022 cost report.

For FFY 2022, CMS proposes to continue its new hospital methodology first adopted in FFY 2020. Any hospitals with a CCN created on or after October 1, 2018 — due to the lack of FFY 2018 cost report data — will not receive interim FFY 2022 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 will receive UCC payments using Factor 3 based on their FFY 2022 cost report S-10 data as the numerator, set over the same denominator that is determined prospectively for purposes of determining Factor 3 for all DSH-eligible hospitals, with the exception of Puerto Rico hospitals and IHS and Tribal hospitals.

All-Inclusive Rate Providers

In the FFY 2021 IPPS/LTCH PPS final rule, CMS also modified the potentially aberrant UCC trim methodology when it is applied to all-inclusive rate providers (AIRPs). Under this modified trim methodology, when an AIRP's total UCC is greater than 50% of its total operating costs when calculated using the cost-to-charge ratio (CCR) included on its FFY 2017 cost report, CMS will recalculate the AIRP's UCC using the CCR reported on Worksheet S-10, line 1 of the hospital's most recent available prior year cost report that does not result in UCC of over 50% of total operating costs. CMS proposes to continue to apply this policy in 2022.

Proposed Steps to Trim CCRs

Similar to the FFY 2021 process, CMS proposes the following steps for trimming CCRs in FFY 2022:

Methodology for Trimming CCRs	
Step 1	Remove Maryland hospitals and all-inclusive rate providers
Step 2	For FFY 2018 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.
Step 3	Using the CCRs for the remaining hospitals in Step 2, determine the urban and rural statewide average CCRs for FFY 2018 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 10 hospitals, of which three have FFY 2018 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 previously finalized. If the hospital's UCC costs for FFY 2018 are an extremely high ratio (greater than 50%) of its total operating costs, CMS proposes that data from the FFY 2019 cost report would be used for the ratio calculation. Thus, the hospital's UCC costs for FFY 2018 would be trimmed by multiplying its FFY 2018 total operating costs by the ratio of UCC costs to total operating costs from the hospital's FFY 2019 cost report, to calculate an estimate of its FFY 2018 UCC costs and determine Factor 3 for FFY 2022. For hospitals whose FFY 2018 cost report has been audited, CMS will not apply the trim methodology.

Additionally, for FFY 2022, CMS proposes that for certain rare cases — hospitals that are not currently projected to be DSH-eligible and that do not have audited UCC data — when such a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care (line 23 column 2) to total UCC costs (line 30) is greater than 60% (rounded from 58%), it would exclude the hospital from the prospective Factor 3 calculation. This proposed trim would only impact hospitals that are not currently projected to be DSH eligible. If the hospital is ultimately determined to be DSH eligible at cost report settlement, then the MAC would calculate the Factor 3 after reviewing the reported UCC information.

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. CMS proposes to modify this calculation for FFY 2022 to be based on the average of FFY 2018 and FFY 2019 historical discharge data, rather than a three-year average that includes data from FFYs 2018, 2019, and 2020. It believes that using a three-year average would underestimate discharges, due to the decrease in discharges during the pandemic.

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flows for hospitals and Medicare Advantage (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 2022, CMS again proposes that after the publication of the FFY 2022 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 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. Comments about issues that are specific to data and supplemental data files for this proposed rule can be submitted to Section3133DSH@cms.hhs.gov. Any changes to distribution amounts will be posted on the CMS website prior to October 1, 2021.

1115 Waiver Days in the Medicaid Fraction for Medicare Disproportionate Care

Some states extend medical coverage benefits under a section 1115(a) demonstration project (also referred to as a section 1115 waiver) to populations that could not have been made eligible for medical assistance under the Medicaid state plan. The proposed rule states that CMS' intent has been to include patient days of those populations who, under a demonstration project, receive benefits, including inpatient hospital coverage benefits, that are similar to the benefits provided to traditional Medicaid beneficiaries. This would **not** include circumstances where states extended coverage only for specific services (such as family planning) and that do not include insurance coverage for hospital care.

Due to a number of court decisions on the inclusion of patient days in the numerator of the Medicaid fraction when calculating a hospital's disproportionate patient percentage, CMS is proposing that for a patient day to be included in the numerator, the patient must be eligible for inpatient hospital services under an approved state Medicaid plan that includes coverage for inpatient hospital care on that day, or directly receive inpatient hospital coverage on that day under an authorized waiver.

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. For FFY 2022, CMS would typically use the 2020 Medicare Provider Analysis and Review (MedPAR) claims data file for IPPS rate setting and FFY 2019 Hospital Cost Report data. However, CMS is proposing to use the FFY 2019 MedPAR claims data and FFY 2018 Hospital Cost Report data, as utilization patterns in the FFY 2020 MedPAR data were significantly impacted by COVID-19 PHE.

CMS is proposing that the total number of payable DRGs would be held constant at 765, with 98% of DRG weights changing by less than +/- 5%, and 0.5% changing by +/- 10% or more. The five MS-DRGs with the greatest year-to-year change in weight are:

MS-DRG	Final FFY 2021 Weight	Proposed FFY 2022 Weight	Percent Change
MS-DRG 218: CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITHOUT CC/MCC	5.1432	6.1165	+18.9%
MS-DRG 014: ALLOGENEIC BONE MARROW TRANSPLANT	12.7788	10.6726	-16.5%
MS-DRG 228: OTHER CARDIOTHORACIC PROCEDURES WITH MCC	6.2153	5.3326	-14.2%
MS-DRG 229: OTHER CARDIOTHORACIC PROCEDURES WITHOUT MCC	3.988	3.4422	-13.7%
MS-DRG 293: HEART FAILURE AND SHOCK WITHOUT CC/MCC	0.6526	0.5900	-9.6%

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 in FFY 2021, CMS expanded 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. In this proposed rule, CMS found that applying this criterion to all MS-DRGs currently split into three severity levels for FFY 2022 would result in the deletion of 96 MS-DRGs (32 MS-DRGS multiplied by three severity levels) and the creation of 58 new MS-DRGs. These updates would also have an impact on relative weights and payments rates proposed for FFY 2022. Due to the PHE and concerns about the impact that implementing this many MS-DRG changes at one time, CMS is proposing to delay the application of the non-CC subgroup criterion for these MS-DRGs until FFY 2023 and, in the meantime, maintain the current structure for FFY 2022.

The full list of proposed FFY 2022 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/fy2022-ipps-nprm-table-5.zip. For comparison purposes, the FFY 2021 DRGs are available in Table 5 on the CMS website at www.cms.gov/files/zip/fy-2021-ipps-fr-table-5.zip.

CMS discusses specific changes proposed to the MS-DRGs for FFY 2022. 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 treatments have been eligible for new technology add-on payments since FFY 2020. There had been a request to create a new MS-DRG specifically for CAR T-cell treatments; however, CMS has not made any changes due to the limited number of cases in which they are used, and as a result would have made the creation of a CAR T-cell therapy-specific MS-DRG appear premature.

In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy). As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign them to the most appropriate MS-DRG. For FFY 2022, the proposed new codes assigned to MS-DRG 018 can be found in Table 6B. CMS is also proposing to revise the title of MS-DRG 018 to "Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies" to better reflect other immunotherapies that would be assigned to this MS-DRG.

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, similarly to FFY 2021. The proposed adjustment of 0.17 would be applied 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, contain standardized drug charges of less than $373,000, or when there is expanded access use of immunotherapy. As in the past, CMS would not apply this payment adjustment to cases where a CAR T-cell therapy product is purchased but the case involves a clinical trial of a different product, as well as where there is expanded us of immunotherapy.

Proposed Changes to the MS-DRG Diagnosis Codes

Under the IPPS MS-DRG classification, CMS developed a standard list of diagnoses that are considered CCs. In the FFY 2020 proposed and final rule, CMS proposed but ultimately postponed adoption of the proposed comprehensive changes in the severity level designations to allow further opportunity to provide additional information to the public on the methodology utilized and clinical rationale for its proposals.

For FFY 2022, as an interval step in the comprehensive review of severity level designations, CMS is considering changing the severity level diagnosis of all "unspecified" diagnosis codes to a non-CC where there are other codes available in that code subcategory that further specify the anatomic site. CMS states that the use of these "unspecified" diagnosis codes may contribute to less reliable data for researching clinical outcomes, and more robust claims data would inform its decision making in determining the most appropriate CC subclass assignment. The table below, reproduced from the proposed rule, summarizes the potential MCC/CC severity level changes.

Potential MCC/CC Subclass Modifications						
Severity Level-CC Subclass	Version 38.1 Severity Level Number of Codes	Potential Version 39 Severity Level Number of Codes	Percent Change	Potential Version 39 Change to MCC Subclass, Number of Codes	Potential Version 39 Change to CC Subclass, Number of Codes	Potential Version 39 Change to Non-CC Subclass, Number of Codes
MCC	3,278	2,771	-15.5%	N/A	0	507
CC	14,679	11,696	-20.3	0	N/A	2,983
Non-CC	54,664	58,154	6.4	0	0	N/A
Total	**72,621**	**72,621**	**N/A**	**0**	**0**	**3,490**

To understand how each chapter of ICD-10-CM might be affected by this proposal, CMS also compared the Version 38.1 to the potential Version 39 ICD-10 MS-DRG severity level list by each of the 22 chapters of the ICD-10-CM classification. The Diseases of the Musculoskeletal System and Connective Tissue (M00-M99) chapter of ICD-10-CM would have the largest percentage reduction (29.2%) in codes. The diagnosis codes impacted by this proposed change in severity level designation are shown in Table 6P.21 of the proposed rule.

CMS solicits comments on adopting a change to the severity level designation of the 3,490 "unspecified" diagnosis codes currently designated as either CC or MCC, where there are other codes available in the code subcategory that further specify the anatomic site, to a non-CC for FFY 2022. CMS is also interested in comments about whether this modification might present operational challenges and how CMS might foster reporting of the most specific diagnosis codes supported by the available medical record documentation.

New Technology Payments

Due to the circumstances around FFY 2022 rate setting and the COVID-19 PHE, CMS is proposing to make a one-time exception to continue add-on payments for all technologies approved for payment in FFY 2021 but would otherwise be discontinued in FFY 2022 due to the technologies no longer being considered new. A table of these 14 technologies can be found on pages 25213-25216 of the proposed rule.

CMS finalized in FFY 2021 that, beginning with applications submitted for new technology add-on payments for FFY 2022, CMS could 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 Qualified Infectious Disease Products (QIDPs) or Limited Population Pathway for Antibacterial and Antifungal Drugs (LPADs), even if it has not yet received Food and Drug Administration (FDA) marketing authorization by July 1 (the existing deadline by which it must be granted FDA marketing authorization to be eligible for new technology add-on payment) of the fiscal year for which the applicant is applying

for the add-on payments. CMS seeks public comment on the implementation of 21 new technology add-on payments under the traditional pathway and 16 under the alternative pathway.

Proposal to Extend the New COVID-19 Treatments Add-on Payment Through the End of the FFY in which the PHE Ends for Certain Products

CMS previously established the New COVID-19 Treatments Add-on Payment (NCTAP) to increase the current IPPS payment amount for drugs and biologicals authorized for emergency use for the treatment of COVID-19 in the inpatient setting. Specifically, beginning for discharges on or after November 2, 2020, through the end of the PHE, hospitals will be paid the lesser of 65% of the operating outlier threshold for the claim or 65% of the amount for which the cost of the case exceeds the standard DRG payment, including the relative weight CARES Act adjustment.

In this rule, CMS is proposing that any discharges that qualify for NCTAP should remain eligible for the add-on for the remainder of the fiscal year following the end of the PHE in order to minimize payment disruption. The extension of NCTAP is also being proposed through the end of the fiscal year when the PHE ends, for eligible products that are not otherwise approved for new technology add-on. If an eligible product is approved for the new technology add-on for FFY 2022, the NCTAP will be discontinued.

Market-Based MS-DRG Relative Weight Proposed Policy Change

In FFY 2021, CMS finalized a policy that required hospitals to use the Medicare cost report to report *"the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations … payers, by MS-DRG*" for cost reporting periods ending on or after January 1, 2021, as well as a new market-based methodology for estimating the MS-DRG relative weights, beginning in FFY 2024, which would be based on the median payer-specific negotiated charge information collected on the Medicare cost report. Due to comments received on the 60-day Paperwork Reduction Act revision request published on November 19, 2020, CMS is proposing to repeal both of the aforementioned policies while comments and alternative approaches are considered.

FFY 2022 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. A complete list of the proposed wage indexes for payments in FFY 2022 is available on Table 2 on the CMS website.

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, 17-01, and 18-04. On March 6, 2020, OMB issued Bulletin No. 20-01. CMS proposes to incorporate the changes from Bulletin No. 20-01 into

the FFY 2022 labor market areas and wage indexes but notes that the updates would not affect any hospital's geographic area for purposes of the wage index calculation for FFY 2022.

CMS indicates that OMB Bulletin 18-04 that it used for determining the labor market areas and hospital wage index in FFY 2021 had a significant impact. CMS adopted a policy cap and decrease in a hospital's wage index of 5% for FFY 2021 only. Due to the COVID-19 PHE, CMS seeks comment on whether the transition, set to expire at the end of FFY 2021, should be extended into FFY 2022 in a budget-neutral manner.

Worksheet S-3 Wage Data

CMS calculates wage index values based on data from FFY 2018-submitted cost reports. Categories of included and excluded costs from prior years are unchanged from FFY 2021. CMS calculates the FFY 2022 wage index using wage data from 3,159 hospitals. The data file used to construct the final wage index includes FFY 2018 data submitted to CMS as of February 5, 2021. General wage index policies are unchanged from prior years, although CMS notes that it proposed to exclude 86 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 2022 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. Data from the 2019 CMS occupational mix survey will be used in the FFY 2022 IPPS wage indexes. CMS reports having occupational mix data for 94% of hospitals (2,955 of 3,159) used to determine the FFY 2022 wage index. The FFY 2022 national average hourly wage, unadjusted for occupational mix, is $46.42. The occupational mix adjusted national average hourly wage is $46.37.

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 2022 wage index for 287 urban hospitals, requiring a budget neutrality adjustment factor of 0.993988 (-0.60%) applied to hospital wage indexes. CMS proposes to continue a policy adopted in FFY 2020 to not include the wage data of a hospital that is reclassifying from urban to rural in calculating the rural floor for a state. Such a hospital's wage data will be used to calculate the rural wage index but not the rural floor wage index that applies to hospitals that are not treated as rural for IPPS payment purposes.

Imputed Floor

The rural floor cannot apply in all urban states, as there is no rural area wage index upon which to determine the floor. CMS adopted an imputed floor for all urban states beginning in FFY 2005 (benefiting only New Jersey hospitals) and in FFY 2013 adopted an alternative methodology benefiting hospitals in all urban states (hospitals in Delaware and Rhode Island) that did not benefit from the original methodology. Both methodologies were applied in a budget-neutral manner — necessitating a

reduction in payments to all hospitals to offset the cost. CMS allowed both imputed floor methodologies to expire after FFY 2018.

Section 9831 of the American Rescue Plan Act (ARPA) enacted by Congress on March 11, 2021, re-established the imputed floor. However, the provision was exempted from IPPS budget neutrality requirements, eliminating the need for a reduction in payment to hospitals to offset its cost. In addition to states that previously benefited from the imputed floor, the ARPA provision will apply in Washington DC, Puerto Rico, and in states that have rural areas but no hospitals that are being paid using a rural wage index (only Connecticut at the time of the proposed rule).

The ARPA was enacted too late for CMS to incorporate the imputed floor wage index into the proposed rule. The final rule wage index will reflect the calculation of the imputed floor.

Frontier Floor Wage Index

The Affordable Care Act 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 44 hospitals will receive the frontier floor value of 1.0 for FFY 2022. All hospitals in Nevada have a wage index of over 1.0. Therefore, the provision will have no effect on Nevada hospitals. This provision is not budget neutral.

Revisions to the Wage Index Based on Hospital Reclassifications

CMS did not propose any changes to the geographic reclassification rules. However, it did simultaneously release a separate interim final rule that changes reclassification policy for urban hospitals that have reclassified to rural areas under § 412.103 beginning in FFY 2022. In response to a court ruling against the agency in *Bates County Memorial Hospital v. Azar*, an urban hospital that has been reclassified as rural under § 412.103 may qualify for a subsequent Medicare Geographic Classification Review Board (MGCRB) reclassification if its average hourly wage is 106% of the average hourly wage of hospitals located in the rural area of its state, rather than other urban hospitals located in its same geographic area. This revised policy is effective for MGCRB reclassifications beginning on October 1, 2022. If a hospital was rejected for an MGCRB reclassification beginning on October 1, 2021, but would have qualified were this rule in effect, the denial of the hospital's geographic reclassification may be reversed for FFY 2022.

Geographic Reclassifications

The MGCRB approved 496 hospitals for wage index reclassifications starting in FFY 2022. Because reclassifications are effective for three years, a total of 1,058 are in a reclassification status for FFY 2022. These include those initially approved by the MCGRB in FFY 2020 (245 hospitals) and FFY 2021 (317). The deadline for withdrawing or terminating a wage index reclassification for FY 2022 approved by the MGCRB is June 24, 2021. Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process will be incorporated into the final FFY 2022 wage index values.

Allowing Electronic Appeals of MGCRB Decisions

In the FFY 2021 IPPS/LTCH rule, CMS revised the regulations to allow electronic submissions of appeals of MGCRB decisions and require electronic copies to CMS' Hospital and Ambulatory Policy Group. CMS further revises this in the FFY 2022 IPPS/LTCH proposed rule, specifying that a hospital's request for review must be in writing and sent to the Administrator, in care of the Office of the Attorney Advisor, in the manner directed by the Office of the Attorney Advisor.

Tolling the Administrator's Review for Good Cause

Currently the CMS Administrator has 90 calendar days following a party's request for review of an MGCRB decision to issue a decision. The Administrator has 105 days from the date of the MGCRB's decision to issue a decision if the Administrator initiates a review. The 90-day timeframe to issue a decision can be tolled for good cause, but there is no comparable provision that allows the 105-day timeframe to be tolled. CMS is proposing that the Administrator can also toll the 105-day deadline for good cause.

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. A Lugar hospital must decline its reclassification using the same process as other hospitals to receive the outmigration adjustment (e.g., notify CMS within 45 days of proposed rule publication that it is declining is Lugar reclassification).

The proposed rule restates the following policies for how Lugar hospitals may decline their urban status to receive the out-migration adjustment:

- Waiving Lugar status (deemed urban) results in the hospital being treated as rural for all IPPS purposes.
- Waiving Lugar status can be done once for the three-year period that the outmigration adjustment is effective.
- If a Lugar hospital waives its reclassification for three years, it must notify CMS to reinstate its Lugar status within 45 days of proposed publication for the following fiscal year. Reinstatement requests may be sent electronically to wageindex@cms.hhs.gov.
- If a Lugar hospital declines its urban reclassification to receive an out-migration adjustment that it would no longer qualify for once it is reclassified as rural, CMS will decline the Lugar hospital's request and continue to assign it a higher urban wage index.

Out-Migration Adjustment

CMS proposes to use the same policies for the FFY 2022 out-migration adjustment that it has been using since FFY 2012. Estimates of increased payments are $40 million in FFY 2022 to 184 hospitals. 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.

Proposed Changes to Urban to Rural Cancellation Requirements

CMS revisits concerns first raised in the FFY 2020 IPPS/LTCH final rule about relatively low-wage hospitals timing an urban to rural reclassification to become effective after the lock-in date to avoid reducing their state's rural wage index. These hospitals then cancel their rural reclassifications effective for the next fiscal year and reapply to become rural again after the lock-in date. The proposed rule notes that at least 21 hospitals in one state and five hospitals in another state engaged in this practice in FFY 2020.

To address this practice, CMS proposes that requests to cancel rural reclassifications must be submitted to the CMS Regional Office not earlier than one calendar year after the reclassification effective date. If finalized, as an example, a hospital approved to receive a rural reclassification effective October 1, 2021, would not be eligible to request cancellation until October 1, 2022. Further, CMS is proposing to make cancellation requests effective for the federal fiscal year that begins in the calendar year after the calendar year in which the cancellation request is submitted.

For example, if finalized, a cancellation request submitted on December 31, 2021, would be effective October 1, 2022. However, a cancellation request submitted on January 1, 2022, would not become effective until October 1, 2023. CMS' proposed policy will ensure that a hospital approved for rural reclassification (and that does not receive an additional reclassification) would have its data included in the calculation of the rural wage index for at least one FFY before the rural reclassification status could be canceled. The policy would apply to all written requests submitted by hospitals on or after October 1, 2021, to cancel rural reclassifications.

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. 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 at least 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 1.0, its IPPS payments will be higher with a labor-related share of 62%. If a hospital has a wage index that is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 67.6%. As a result of its proposal to rebase and revise the hospital market basket from 2014 to 2018, CMS proposes to use a revised national labor-related share of 67.6%for FFY 2022. CMS is applying budget neutrality for the change to the labor-related share from 68.3% to 67.6% but not applying budget neutrality when applying the 62% labor share.

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 2022, 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 2022, the 25th percentile wage index value across all hospitals is 0.8418. CMS proposes to apply a budget neutrality adjustment of -0.19% 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

Rebasing and Revising of Hospital Market Baskets

CMS is proposing to rebase the hospital MB that is used in the annual update to IPPS operating costs and the update to target amounts for facilities excluded from the IPPS and the capital input price index (CIPI) used to annually update capital IPPS payments. The current MB and CIPI use 2014 data for the base year. CMS proposes to use 2018 data to rebase both factors.

The below table illustrates the impact of changing to a 2018-based IPPS market basket. In no year would the change be more than 0.1 percentage point, and the average for the historical and projected period is unchanged.

FFY	2014-Based IPPS Market Basket % Change	2018-Based IPPS Market Basket % Change
Historical Data		
FFY 2017	2.6	2.5
FFY 2018	2.5	2.5
FFY 2019	2.4	2.4
FFY 2020	2.0	2.0
Average: FFY 2017 – FFY 2020	**2.4**	**2.4**
Forecast		
FFY 2021	2.4	2.4
FFY 2022	2.5	2.5
FFY 2023	2.8	2.7
FFY 2024	3.0	3.0
Average FFY 2021 – FFY 2024	**2.7**	**2.7**

The below table illustrates the impact from changing to a 2018-based CIPI. In no year would the change be more than 0.1 percentage point, and the average for the historical and projected period is unchanged.

FFY	2014-Based IPPS Market Basket % Change	2018-Based IPPS Market Basket % Change
Historical Data		
FFY 2017	1.1	1.0
FFY 2018	1.2	1.1
FFY 2019	1.4	1.3
FFY 2020	1.2	1.2
Average: FFY 2017 – FFY 2020	**1.2**	**1.2**
Forecast		
FFY 2021	1.0	0.9
FFY 2022	1.0	1.0
FFY 2023	1.2	1.1
FFY 2024	1.3	1.2
Average FFY 2021 – FFY 2024	**1.1**	**1.1**

Proposed Payments for Indirect and Direct Graduated Medical Education Costs

The Consolidated Appropriations Act (CAA) of 2021 contained three provisions, each in a different section, affecting direct graduate medical education (GME) and indirect medical education (IME) payments that CMS is proposing to implement.

Distribution Additional Residency Positions (Section 126 of the CAA)

CMS is proposing to add 200 GME-funded full-time equivalents (FTEs) to the program in FFY 2023, with an additional 200 added in each subsequent year until a total of 1,000 FTEs have been added. Hospitals are proposed to be limited to at most 1.0 FTE position per hospital per year, with no hospital receiving more than 25 FTEs over the course of the program. Priority for these positions is given in four statutorily specified categories, with each category receiving at least 10% of the aggregate of the total residency positions:

- Hospitals located in a rural area or treated as such
- Training more residents than the FTE cap
- States with new medical schools or additional locations/branch campuses (this includes California)
- Hospitals that serve areas designated Health Professional Shortage Areas (HPSA). At least 50% of the resident's training time over the duration of the program must occur within the HPSA. For this category, CMS proposes to use geographic HPSAs rather than facility HPSAs.

CMS proposes to further prioritize residency programs that treat underserved populations in population-based HPSAs and will use HPSA scores to award resident slots. CMS would pro-rate residents in the above prioritization categories only in the event that the number of qualifying hospitals under the first category or the highest HPSA score under the second category exceed the number of residency positions available. Hospitals applying for residency positions for programs that do not serve HPSAs are not categorically excluded, but those applications would have the lowest priority. CMS proposes that the application deadline for these positions for a fiscal year be January 31 of the prior fiscal year, starting with January 31, 2022, for positions for FFY 2023.

Promoting Rural Hospital GME Funding Opportunity (Section 127 of CAA)

Rural Training Tracks (RTTs) are GME programs that are specifically designed to train residents to practice in rural areas. CMS describes RTTs as "hub (urban hospital) and spoke (rural hospital)" programs. Under current policy, an urban hub may be an existing medical residency training program and neither the urban nor rural hospital would qualify for a cap adjustment when a new spoke is added.

Cap Adjustment for Urban and Rural Hospitals Participating in Rural Training Track Programs

To implement section 127 of the CAA, CMS proposes that each time an urban hospital adds a new spoke, the urban and rural hospital would qualify for a cap adjustment. While CMS proposes allowing cap adjustments when new spokes are added to an existing RTT, CMS is not proposing to allow expansion of existing RTT programs when a new spoke is not added. CMS describes this limitation as being consistent with the statute's direction that allows it to prescribe rules for adjustments to FTE caps while considering that Congress established caps to limit the number of residents subsidized by Medicare in the aggregate nationally. Further, CMS notes that the statute authorizes the Secretary to "adjust in an appropriate manner" the FTE cap for hospitals participating in RTTs.

CMS notes that the slots associated with the RTT FTE limitation are fungible. Urban and rural hospitals

with multiple RTT "spokes" may reduce the number of FTE residents training between the hub and spokes in order to accommodate an increase in training at the hub or another spoke, subject to the proviso that 50% of the training must continue to occur in rural areas. Further, urban and rural hospitals can receive cap adjustments for new RTT programs in different specialties.

Removal of Requirement that Rural Track Must Be "Separately Accredited"

Section 127 of the CAA removes the requirement that the rural track be "separately accredited." CMS proposes that — effective for cost reporting periods beginning on or after October 1, 2022, so long as the program in its entirety is accredited by the ACGME, regardless of the specialty — it may qualify as an RTT and urban and/or rural hospitals receive rural track FTE cap adjustments assuming all other requirements are met. CMS, consistent with the language of section 127 of the CAA, proposes to allow any specialty program where more than 50% of the training occurs in a rural area to qualify as an RTT.

Exemption from the Three-Year Rolling Average During the Five-Year Rural Track FTE Limitation Window

Consistent with section 127 of the CAA, CMS is proposing that, during the five-year cap growth window for RTTs, the FTE residents participating in the RTT either at the urban hospital or a rural hospital would not be included in a hospital's three-year rolling average calculation effective for RTTs started in cost reporting periods beginning on or after October 1, 2022.

Addressing Adjustment of Low Per-Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals (Section 131 of the CAA)

Section 131 of the CAA provides CMS with the opportunity to reset the low or zero direct GME per-resident amount (PRA) and to reset the low direct GME and IME FTE resident caps of hospitals that hosted a small number of residents for a short duration. The statute classifies two categories of hospitals that CMS refers to as "category A" and "category B."

- Category A: A hospital that, as of December 27, 2020, has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997
- Category B: A hospital that, as of December 27, 2020, has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before December 27, 2020

Hospitals Qualifying to Reset their PRAs

The CAA allows the PRA to be reset if the hospital trains at least 1.0 FTE (in the case of a category A hospital) or more than 3.0 FTEs (in the case of a category B hospital). CMS will not round up to determine whether a hospital qualifies for a recalculated PRA. The recalculation period begins on December 27, 2020, and ends five years later. To redetermine the PRA, CMS proposes that the training occurring at a category A hospital or a category B hospital need not necessarily be in a new program. Residents may be in either an approved program that is "new" for Medicare direct GME and IME purposes, or may be in an existing approved program.

The relevant factor in determining when to reset PRAs is if and when the hospital trains the requisite number of FTE residents in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and before December 26, 2025 (five years from enactment). Once reset, in the absence of additional legislation, the PRAs for either a category A hospital or a category B hospital are permanent, subject to annual inflation updates.

Calculating the Revised PRA and Cost Reporting Requirements

CMS will calculate the revised PRA under the normal existing rules as the lower of:

- The hospital's actual cost per resident incurred in connection with the GME program(s), based on the cost and resident data from the hospital's replacement base year cost reporting period
- The updated weighted mean value of per-resident amounts of all hospitals located in the same geographic wage area, calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals

CMS is proposing to establish a PRA for instances where a hospital trains less than 1.0 FTE and that hospital entered into a GME affiliation agreement for that training. If a hospital did not enter into such an agreement, a PRA will only be established if at least 1.0 FTE is trained. Additionally, CMS proposes that all hospitals, even those not classifying as category A or B, enter FTE counts on Worksheets E, Part A and E-4 of the CMS-Form-2552-10, for cost reporting periods on or after December 27, 2020, during which the hospital trains at least 1.0 FTE and provide the information required by the Interns and Residents Information System (IRIS), regardless of whether the hospital incurs costs or is a program sponsor.

Hospitals Qualifying to Reset their FTE Resident Caps

To qualify for resetting the FTE cap, the statute states the Secretary shall adjust the FTE resident caps in the manner applicable to a new program if the hospital "begins training" the requisite number of FTE residents (1.0 or 3.0 depending on whether the hospital is category A or B). To reset a PRA, a training program does not necessarily need to be new. However, the statute requires a training program to be new for the hospital to qualify to have its FTE cap reset. CMS proposes that "begins training" means future training in a new program for the first time on or after December 27, 2020.

Calculating Replacement FTE Resident Caps

CMS proposes to use its existing regulations to calculate each qualifying hospital's FTE cap (e.g., the cap would be determined in the fifth year of the new program based on the number of residents in training at that time). The proposed rule further indicates that CMS proposes not to set an FTE cap for any hospital that has trained fewer than 1.0 FTE resident in a cost reporting period beginning on or after December 27, 2020. For all hospitals that do not yet have caps triggered, CMS proposes that a cap will only be triggered in a GME-naïve hospital as of December 27, 2020, when the hospital trains at least 1.0 FTE in a new medical residency training program.

Intern and Resident Information System (IRIS)

IRIS is an audit tool used to determine whether hospitals that jointly train residents are not counting any single resident as more than 1.0 FTE. The regulations currently require an IRIS "diskette" to be provided to the hospital's MAC with its cost report. CMS proposes to change the regulations to only requires IRIS "data." CMS is currently in the process of upgrading IRIS to an XML format, which CMS proposes to require hospitals to use for all cost reports with cost reporting periods beginning on or after October 1, 2021. CMS also proposes that the FTE count on IRIS must match the counts the hospital claims on its cost report worksheets. CMS is proposing that the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and of IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the hospital's cost report, or the cost report will be rejected for lack of supporting documentation.

The IME adjustment factor is proposed to remain at 1.35 for FFY 2022.

Low-Volume Hospital Adjustment

Legislative action by Congress over the past several years has 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 2022, CMS will require — consistent with historical practice — it to 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, 2021, for the adjustment to be applied to payments for discharges beginning on or after October 1, 2021. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

A hospital receiving the low-volume hospital payment adjustment for FFY 2021 may continue to receive a low-volume hospital payment adjustment in FFY 2022 by providing its MAC with a verification

statement that it continues to meet the mileage criterion and provide information for the discharge criterion 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. While the latest data used for these purposes would normally be FFY 2020 CMI values and FFY 2019 Medicare cost reports, CMS proposes to continue using FFY 2019 CMI values and FFY 2018 cost reports due to the COVID-19 PHE.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2021, CMS proposes that a rural hospital with fewer than 275 beds available for use must 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 (Pacific Census Region – 1.6913) 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.

Proposed Quality Measure Suppression Policy in Response to the COVID-19 PHE

In response to the COVID-19 PHE, CMS proposes to adopt a policy that would permit the agency to suppress certain measures in its value-based programs if it determines the PHE has significantly impacted performance on the measure. CMS proposes to adopt the following Measure Suppression Factors for the Hospital Readmissions Reduction Program, the Hospital Value-Based Purchasing (VBP) Program, the Hospital Acquired Conditions (HAC) Reduction Program, the Skilled Nursing Facility VBP program, and the End-Stage Renal Disease Quality Incentive Program:

1. Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or worse compared to historical performance during the immediately preceding program years
2. Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the COVID-19 PHE
3. Rapid or unprecedented changes in:
    i. Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials

   ii. The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin
4. Significant national shortages or rapid or unprecedented changes in
   i. Health care personnel
   ii. Medical supplies, equipment, or diagnostic tools or materials
   iii. Patient case volumes or facility-level case mix

In addition, CMS seeks comments on the development of a measure suppression policy for future PHEs, if that policy could be activated without notice-and-comment rulemaking, and if CMS should consider a regional adjustment in the measure suppression policy.

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.

The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio (ERR) to the median 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, see CHA's FFY 2018 IPPS final rule summary.

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

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). However, CMS proposes to apply its proposed Measure Suppression policy for the pneumonia readmission measure for the FFY 2023 program, as well as changes to the other measure denominators to exclude COVID-19 diagnosed patients, as described below.

CMS proposes no changes to the factors used by CMS in removing measures, the use of sub-regulatory processes to make non-substantive changes to measures and other program features, or the methodology for calculating the payment adjustment.

CHA DataSuite analysis estimates that the HRRP will result in an overall Medicare payment reduction for California hospitals of approximately $50.4 million for FFY 2022.

Proposed Measure Suppression: Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization (NQF #0506)

CMS proposes to suppress the HRRP's pneumonia readmission measure for the FFY 2023 program year citing Measure Suppression Factor 2, clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the COVID-19 PHE. CMS proposes to calculate the measure's rate for the relevant program year but then suppress the use of that rate to make hospital payment changes by weighting the suppressed measure at 0% in the HRRP scoring methodology. CMS would continue to provide hospitals with confidential reports of their rates as calculated without suppression.

CMS believes this is necessary to suppress this measure because the SARS-CoV-2 virus is primarily a respiratory pathogen and often causes pneumonia, and patients with COVID-19 readmitted for pneumonia are a distinct, severely ill subset for whom appropriate risk adjustment may not be readily accomplished. CMS states that it conducted simulations of suppressing the pneumonia readmission measure for FFY 2023 and found that the number of hospitals whose payments would fall due to their HRRP performances was reduced by about 5%.

CMS notes that much of the applicable period for this measure for FFY 2023 falls within the time frame of the declared PHE. For the FFY 2022 program year, CMS does not propose to suppress the measure because after accounting for the nationwide extraordinary circumstance exception (ECE) that excluded all Q1 and Q2 2020 claims data from quality reporting and subsequent calculations, the entirety of the applicable period falls outside of the declared PHE.

Exclusion of COVID-19 Diagnosis from Remaining HRRP Measures

CMS analyzed the five remaining readmission measure conditions and found a less severe impact of COVID-19 on data validity than the pneumonia readmission measure. CMS says that it found that it could address the impact of the PHE on these measures by excluding patients having secondary diagnoses of COVID-19 from their measure cohorts. CMS will use its established subregulatory process for HRRP technical measure specification updates to remove patients having secondary diagnoses of COVID-19 from the denominators of these five readmission measures.

Proposed Use of MedPAR Files in the HRRP

For FFY 2022, CMS proposes to use MedPAR claims data corresponding to the HRRP applicable period in the calculation of aggregate payments made to hospitals for excess readmissions. Specifically, the annual March MedPAR file update would be used as the data source. Until now, CMS has adopted

nearly identical policies for MedPAR data usage annually during HRRP rulemaking. CMS proposes to adopt a policy to automatically use MedPAR data corresponding to the applicable period for HRRP calculations beginning with FFY 2023 and all subsequent program years. Under this proposal, for all subsequent years, CMS would advance this three-year period by one year unless otherwise specified by the Secretary in notice-and-comment rulemaking. CMS also proposes to automatically adopt the use of the update of the MedPAR file for each FFY, which is updated six months after the end of each FFY within the applicable period, as its data source, and to similarly advance it by one year from the previous program fiscal year.

ECE Policy Clarifications

CMS describes several exceptions granted to participants in the Medicare quality reporting and value-based programs to address the COVID-19 PHE, including the agency's March 2020 guidance memorandum and September 2020 COVID-19 interim final rule with comment period. CMS clarifies that the nationwide exceptions will result in the exclusion of CY Q1 and Q2 2020 data from HRRP calculations of hospitals' performances on readmission measures for FFYs 2022, 2023, and 2024. CMS notes that participating hospitals are not exempted from submitting claims for care delivered during the excepted periods. Rather, the exceptions granted relate only to claims data usage by the program and not to payment reductions under the program based on nonexcepted data. In addition, CMS clarifies that the impact of the two quarters of data (2020 Q1 and Q2) that were excluded from the HRRP due to the nationwide COVID-19 ECE on payment adjustment factor components will be addressed through the established sub-regulatory process.

Request for Comment: Stratifying Future Results for Condition-Specific Readmission Measures by Race and Ethnicity

CMS requests comments on several specific policies intended to support providers in quality improvement activities to reduce health inequities, make more informed decisions, and promote provider accountability for health care disparities. Specifically, CMS seeks comments on the possible future stratification of condition and procedure-specific readmission measure results by race and ethnicity, public reporting of those stratified results on *Care Compare*, and the collection of additional social risk factors (e.g., language preference, disability status). In addition, CMS suggests that it could provide confidential hospital specific reports for the six readmission measures stratified by both dual eligible status (as done currently) and race and ethnicity in Spring 2022, with public reporting of the of the results in Spring 2023.

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 DRG payments to all participating hospitals. CMS calculates a VBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. The adjustment factor may be positive, negative, or result in no change in the payment rate that would apply absent the program.

Due to proposed measure suppression policies described below, CMS will apply an overall budget neutral VBP adjustment for all hospitals. In FFY 2021 California hospitals, in aggregate, received a positive VBP adjustment. Because in FFY 2022 California hospitals will receive a budget neutral ($0) adjustment, **CHA estimates that FFY 2022 VBP payments to California hospitals will decrease by approximately $12 million compared to FFY 2021.**

In general, the previously adopted measures, domain weights (25% each across the four domains), case minimums, and payment adjustment methodologies would be continued. However, CMS proposes several policies related to its measure suppression policy to address the impact of the COVID-19 PHE. In addition, CMS proposes to permanently remove the Patient Safety and Adverse Events Composite (PSI-90) measure (NQF #0531) from the VBP Program beginning with FFY 2023. Table 2 in the appendix of this summary lists previously adopted measures for the program.

Proposed Hospital VBP Program Measure Suppression Policy in Response to the COVID-19 PHE

As described earlier in this summary, CMS proposes a measure suppression policy to address concerns that VBP payments may become inequitable due to COVID-19 impacts, especially for hospitals treating large numbers of COVID-19 patients.

For the FFY 2022 payment year, CMS proposes to suppress all of the measures in three of the four program domains — Person and Community Engagement, Safety, and Efficiency and Cost — and to adopt a special scoring and payment rule. Under the special rule, CMS would calculate a domain score for the remaining Clinical Outcomes Domain, whose measures CMS proposes not to suppress. However, since that domain score would be the only one available and as that domain's weight is only 25%, CMS would not calculate TPS for hospitals. CMS would continue to make the statutory 2%reduction to each hospital's base operating DRG payment amount. However, absent the availability of TPS, each hospital would be assigned a budget-neutral, value-based incentive payment percentage, returning to the hospital the amount lost through the DRG payment rate reduction (i.e., the hospital's base operating DRG payment would remain unchanged for FFY 2022). CHA refers readers to the proposed rule for CMS' discussion of payment details should the measure suppression policy not be finalized.

CMS would continue to provide confidential reports to hospitals that contain performance results as if no measures had been suppressed. CMS notes that these reports may be delayed due to operational constraints but anticipates delivering them before the end of CY 2021. CMS proposes to publicly display Q3 and Q4 2020 hospital data accompanied by information about performance impairment due to COVID-19 effects.

For FFY 2023, CMS proposes to suppress the Hospital 30-Day, All Cause, Risk Standardized Mortality Rate Following Pneumonia (PN) Hospitalization (NQF #0468) measure, noting many patients with COVID-19 as a secondary diagnosis within the measure cohort had higher mortality rates. Under its proposed measure suppression policy, CMS would calculate a hospital's performance on the measure —

and continue to provide confidential feedback reports — but would not use the measure rates to generate achievement or improvement points. CMS does not propose to make any changes to the FFY 2023 scoring methodology as a result of its proposed suppression of the pneumonia mortality measure.

Proposed Removal of the CMS Patient Safety and Adverse Events Composite (PSI-90) for FFY 2023

CMS proposes to remove CMS Patient Safety and Adverse Events Composite (PSI-90) (NQF #0531) from the hospital VBP Program measure set beginning with the FFY 2023 payment year. CMS notes that this measure was adopted in the FFY 2018 IPPS/LTCH final rule but reporting for the measure is not required until FFY 2023 and has not yet begun. CMS notes that the measure is already in use in the HAC Reduction Program and including the measure in both programs increases burden on hospitals and the agency. CMS acknowledges that the hospital VBP Program currently uses five other patient safety measures that are included in the HAC Program (CAUTI, CLABSI, CDI, MRSA, and SSI) but believes there is still opportunity to encourage improvement in patient safety through both programs and is not removing these measures from the hospital VBP Program.

Updates to the Specifications Beginning with the FFY 2023 Program Year to Exclude Patients Diagnosed with COVID-19

CMS will use its established sub-regulatory process to update the following four condition-specific mortality measures and one procedure-specific complication measure to exclude patients with either principal or secondary diagnosis of COVID-19 from the measure denominators beginning with the FFY 2023 program year:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (NQF #0229)
- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)

CMS says that it does not believe it needs to update the measure specifications for the FFY 2022 program year because the only data that would have been affected by the PHE for COVID-19 are from Q1 and Q2 of CY 2020, which are excluded under the nationwide ECE granted in response to the PHE.

Proposed and Previously Adopted Performance and Baseline Periods

CMS has previously established baseline and performance periods for hospital VBP measures for FFYs 2023 through 2027, which vary in length by measure, ranging from one to three years. CMS reassessed these periods for potential impacts of the nationwide ECE policy in response to COVID-19, which excludes data from Q1 and Q2 of 2020 from use in hospital VBP Program scoring. CMS determined that

it will propose changes for measures with a one-year baseline or performance period that would otherwise include data from the excepted quarters. Specifically, CMS proposes to revise the FFY 2024 performance periods for the HCAHPS, MSPB, and all five Patient Safety Domain measures to include baseline periods from CY 2019 rather than CY 2020. In addition, CMS notes that, while baseline periods for some FFY 2027 measures will be shortened by the exclusion of the excepted quarters, the periods remain 30 or more months in length, which CMS judges as sufficient for data reliability.

CHA refers readers to Tables V.H-6 through V.H-10 in the proposed rule for lists of the baseline and performance periods by measure for FFYs 2023 through 2027 as previously established and without change by this rule, or as proposed in this rule.

Proposed Previously Adopted Performance Standards

CMS notes that it had previously established performance standards for the hospital VBP Program payment years FFYs 2022 through 2026 in prior regulations. CMS proposes several policies in the proposed rule that would impact those previously established standards, such as the suppression of measures in FFYs 2022 and 2023, the removal of PSI-90, and changes to the baseline periods to account for the exclusion of Q1 and Q2 2020 data. CHA refers readers to Tables V.H-11 through V.H-15 in the proposed rule for additional details.

Hospital-Acquired Conditions (HAC) Reduction Program

Under the HAC 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 or scoring methodology for the HAC Reduction Program. However, CMS proposes measure suppression policies to address the impact of the COVID-19 PHE on measures. Table 3 in the appendix of this summary lists previously adopted measures for the HAC Reduction Program.

CHA DataSuite analysis estimates that overall California hospitals will lose approximately $38.7 million under this program for FFY 2021.

Proposed HAC Reduction Program Measure Suppression Policy in Response to COVID-19 PHE

In response to concerns that HAC Reduction Program payments may become inequitable due to COVID-19 impacts, especially for hospitals treating large numbers of COVID-19 patients, CMS proposes to suppress measure data from all HAC Reduction Program measures (the five CDC NHSN HAI measures and PSI-90) for Q3 and Q4 of 2020 for the FFY 2022 and 2023 payment years. After accounting for the previously finalized ECE policies that exclude Q1 and Q2 of 2020, the FFY 2022 and 2023 HAC Reduction Program would include the following performance periods:

- **CMS PSI-90 for FFY 2022:** July 1, 2018, through December 31, 2019 (18 months)
- **CMS PSI-90 for FFY 2023:** July 1, 2019, through December 31, 2019, plus January 1, 2021, through June 30, 2021

- **CDC NHSN HAI measures for FFY 2022:** January 1, 2019, through December 31, 2019 (12 months)
- **CDC NHSN HAI measures for FFY 2023:** January 1, 2021, through December 31, 2021 (12 months)

CMS says its analysis indicates that using data from the proposed performance periods would provide sufficiently reliable data to evaluate hospital performance under the HAC Reduction Program for FFYs 2022 and 2023. Under its proposed measure suppression policy, hospitals would continue to report data from Q3 and Q4 of 2020, and CMS would continue to provide confidential feedback reports to hospitals using the suppressed data. CMS also proposes to publicly report the data accompanied by notes describing the limitations of the measure results and total HAC scores due to suppression.

Hospital IQR Program

The hospital IQR program is a pay-for-reporting program under which hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update. Additional information on the IQR measures and reporting processes is available online.

CMS proposes several changes to the IQR program, including the addition of five new measures, the removal of five existing measures, and revisions to the current electronic health record (EHR) certification requirements. Table 1 in the appendix to this summary shows the proposed and previously adopted measure sets for FFY 2021 through FFY 2026.

Proposals to Adopt New Measures into the Hospital IQR Measure Set

CMS proposes to adopt five new measures to the IQR program, including one structural measure, one hybrid measure, two electronic clinical quality measures (eCQMs), and a measure to assess the percentage of health care personnel vaccinated for COVID-19.

Maternal Morbidity Structural Measure

CMS proposes to adopt one new structural measure to determine the number of hospitals currently participating in a structured state or national Perinatal Quality Improvement (QI) Collaborative and whether participating hospitals are implementing the safety practices or bundles embedded in these QI initiatives beginning with the FFY 2023 payment year. CMS proposes to define a state or national Perinatal QI Collaborative as a statewide or a multi-state network working to improve women's health and maternal health outcomes by addressing the quality and safety of maternity care. The measure would require attestation in response to a two-part question:

> Question. "Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care (part 1), and has implemented patient

> safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis (part 2)?"
>
> Responses. (A) "Yes"; (B) "No"; or (C) "N/A (our hospital does not provide inpatient labor/delivery care)".

CMS clarifies that a "Yes" response requires an affirmative answer to both parts of the measure's question. Full measure specifications are available on the CMS website.

CMS proposes to begin reporting with a shortened period of October 1 through December 31, 2021, for the FFY 2023 payment determination. Beginning with FFY 2024 and subsequent payment years, the reporting period would be the 12-month calendar year occurring two years prior to the payment year (e.g., calendar year 2022 reporting for FFY 2024 payment). The measure's submission period would follow the current policy — April 1, 2022, through May 16, 2022 — for the first year, and April 1 through the deadline as for Q4 chart-abstracted measures in subsequent years. Hospitals would submit data using a CMS-approved web-based data collection tool available on the CMS Quality Net website.

Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure with Claims and Electronic Health Record Data (NQF #3502) (Hybrid HWM Measure)

CMS proposes to adopt one new hybrid measure (based on both claims and electronically submitted clinical data) to more comprehensively measure the mortality rates of hospitals and to improve its ability to measure mortality rates in smaller volume hospitals beginning with IQR Program FFY 2026 payment year. The measure's core clinical data elements are intended to reflect patient clinical status at admission. Mortality data are subdivided into 15 mutually exclusive service line divisions, six surgical (e.g., orthopedic), and nine non-surgical (e.g., pulmonary), and the measure is expressed as a ratio: the number of deaths within 30 days of admission as predicted by the hospital's observed case mix and service mix divided by deaths expected using nationwide data for similar case and service mixes. The measure includes Medicare FFS beneficiaries ages 65-94 years, and some high-risk major trauma diagnoses (e.g., burns) are excluded.

More detailed information about this measure is found in the Core Clinical Data Elements and Hybrid Measures folder, available for download on the CMS website. CMS would update the measure specifications annually for changes in diagnosis codes and clinical laboratory value sets.

For this and other hybrid measures combining clinical (EHR) data with claims data, CMS performs the measure calculations and reports results back to data submitters. CMS says that calculation of reliable results for the Hybrid HWM measure would require hospitals to report the core clinical data element vital signs for at least 90% of the Medicare FFS aged beneficiary discharges, and the laboratory test results for at least 90% of non-surgical patients. CMS notes that the clinical elements and lab tests were chosen from those nearly universally collected by hospitals at or soon after admissions.

Similar to its approach for the similar hybrid hospital readmission measure (Hospital HWR, NQF # 2879), CMS proposes an initial voluntary reporting period for the Hybrid HWM measure to run from July 1, 2022, through June 30, 2023. Mandatory reporting would begin July 1, 2023, through June 30, 2024, to be used for the FFY 2026 payment determination, with a similar timeline for subsequent payment years. In keeping with established policies, hospitals would be required to submit the clinical data elements and their associated linking variables no later than the first business day three months following the end of the reporting period. Hospitals would be required to submit data to CMS using Quality Reporting Data Architecture Category I (QRDA I) files.

CMS notes that the six linking variables should be submitted for 100% of discharges in the measurement period, but hospitals will meet IQR Program requirements if they submit linking variables on 95% or more of discharges with a Medicare FFS claim for the same hospitalization during the measurement period. During the voluntary data collection period, hospitals that fail to meet the proposed data submission requirements would not be penalized, but once the Hybrid HWM measure becomes mandatory, failing to meet the requirements would result in the hospital receiving the IQR Program update penalty. CMS expects to begin publicly reporting the measure as part of the July 2025 *Care Compare* website refresh.

COVID-19 Vaccination Coverage Among Health Care Personnel Measure

CMS proposes to add a new process measure to the Hospital IQR Program beginning with the FFY 2023 payment year to track the percentage of health care personnel (HCP) who receive a complete COVID-19 vaccination course, calculated as:

> Numerator: The cumulative number of HCP eligible to work in the health care facility for at least one day in the submission period and who received a complete vaccination course against SARS-CoV-2
> Denominator: The cumulative number of HCP eligible to work in the health care facility for at least one day during the submission period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC

CMS proposes an initial data reporting period of October 1, 2021, through December 31, 2021, for the FFY 2023 payment year. For FFY 2024 and subsequently, CMS proposes a full calendar year reporting period (e.g., all 12 months of CY 2022 data would be reported for use in the FFY 2024 payment year).

Data submission would be required quarterly, and data would be submitted through the CDC National Health Safety Network (NHSN) web-based surveillance system for at least one week each month; if a hospital were to report more than one week per month, the most recent week of data would be used. If finalized, CMS would publicly report the CDC-calculated vaccination coverage rates on a quarterly basis on *Care Compare.* Full measure specifications are available on the CDC website.

Hospital Harm – Severe Hypoglycemia Electronic Clinical Quality Measure (eCQM) (NQF #3503e)

CMS proposes to add a new eCQM to the Hospital IQR Program beginning with the FFY 2025 payment year to track the rate at which severe hypoglycemia events occur after hospital administration of antihyperglycemic medications. The measure is calculated as:

> Numerator: The number of hospitalized patients with a blood glucose test result of less than 40 mg/dL (indicating severe hypoglycemia) with no repeat glucose test result greater than 80 mg/dL within five minutes of the initial low glucose test, and where an antihyperglycemic medication was administered within 24 hours prior to the low glucose result
> Denominator: All inpatients aged 18 years or older discharged and to whom at least one dose of an antihyperglycemic medication was administered during the index admission

There are no additional inclusion or exclusion criteria. Measure specifications are available online.

Hospital Harm – Severe Hyperglycemia Electronic Clinical Quality Measure (eCQM) (NQF #3533e)

CMS proposes to add a new eCQM to the Hospital IQR Program beginning with the FFY 2025 payment year that would track the frequency of severe hyperglycemic events among hospitalized diabetic patients. The measure is calculated as:

> Numerator: The total number of severe hyperglycemic events across inpatient hospitalizations
> Denominator: The total number of eligible hospital days across inpatient hospitalizations of patients aged 18 years or older who have one or more of the following: a diagnosis of diabetes that starts before or during the index admission; administration of at least one dose of insulin or any antidiabetic medication during the index admission; or presence of at least one blood glucose value greater than 200 mg/dL at any time during the index admission

There are no additional inclusion or exclusion criteria. Measure specifications are available online.

Proposals to Remove Measures from the Hospital IQR Measure Set

CMS proposes to remove five measures from the hospital IQR Program for the FFYs 2023 through 2026 payment determinations, in accordance with its previously established measure removal factors:

- Deaths Among Surgical Inpatients with Serious Treatable Complications: CMS says that the proposed new Hybrid HWM measure applies to a much broader set of patients and conditions and aligns with the IQR Program goal to increase use of EHR data.
- Exclusive Breast Milk Feeding eCQM: CMS states that the proposed new Maternal Mortality measure is a more holistic assessment of the quality of maternal care.
- Admit Decision Time to Emergency Department departure (ED-2) eCQM: CMS notes that recent studies show that this measure of ED boarding time is inconsistently reported and not strongly associated with adverse outcomes.

- Anticoagulation Rx for Atrial Fibrillation/Flutter eCQM: CMS reports that hospitals seldom choose to report this measure, and the patients are captured in stroke measure STK-02 eCQM.
- Discharged on Statin Medication eCQM: CMS notes that current guidelines emphasize antiplatelet therapy over use of statins.

Future Measures for Consideration

CMS seeks comments on several possible future IQR measures, including the development of a hospital-level measure of all-cause mortality for Medicare beneficiaries admitted with COVID-19, inclusion of the Hospital-Level, Risk-Standardized Patient Reported Outcomes (PRO) Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) performance measure currently available for voluntary reporting for hospitals in the Comprehensive Care for Joint Replacement (CJR) payment model, and the development of a structural measure to assess the degree of hospital leadership engagement in health equity performance data.

In addition, CMS seeks comment on the potential to provide confidential hospital-specific reports with results stratified using indirectly estimated race and ethnicity, dual eligibility status, and potentially by disability status, for the HWR claims-only measure, using both of CMS' disparity methods (within and across hospitals). In addition, CMS seeks comments on publicly reporting such stratified data on *Care Compare* after at least one year of confidential reporting on the measure.

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 2021 IPPS final rule, CMS finalized a progressive increase, over a three-year period beginning with CY 2021, to the number of quarters for which hospitals are required to report eCQM data, up to four quarters of data. CMS also requires that beginning with the CY 2022 reporting period, hospitals report on three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM.

The revised eCQM reporting requirements as finalized in the FFY 2021 final rule are:

- For FFY 2023 payment (CY 2021 reporting) hospitals must report data on four self-selected eCQMs for two self-selected calendar quarters.
- For FFY 2024 payment (CY 2022 reporting) hospitals must report data for three self-selected eCQMs and the Safe Use of Opioids eCQM for three self-selected calendar quarters.
- For FFY 2025 payment (CY 2023 reporting) and subsequent years, hospitals must report data for three self-selected eCQMs and the Safe Use of Opioids eCQM for all four calendar quarters.

CMS proposes to require hospitals to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for the IQR program, beginning CY 2023 reporting period/FFY 2025 payment determination.

Data Submission and Reporting of Hybrid Measures

In alignment with its proposal for eCQM reporting, CMS proposes to require hospitals to use only certified technology consistent with the 2015 Edition Cures Update beginning with CY 2023 reporting/FFY 2025 payment determinations. CMS proposes no changes to previously adopted file formats or reporting deadlines.

Proposed Changes to IQR Validation Requirements

In the FFY 2021 IPPS final rule, CMS finalized policies to combine the validation process for chart-abstracted measure data and eCQM data using an incremental approach, which included updating the educational review process to address eCQM validation results. CMS notes that until now it could only make hospital score corrections for chart-abstracted measures after data validation education reviews for the first three quarters of the data validation period. CMS can now calculate the confidence interval for all four validation quarters of chart-abstracted measures. The agency proposes to extend the effects of the education review process policy beginning with validations affecting the FFY 2024 payment determination so that scores can be corrected for all four quarters of validation.

PPS-Exempt Cancer Hospital 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.

CMS proposes to remove one measure, adopt one new measure, and other minor administrative updates to codification of PCHQR Program requirements. CMS proposes no changes to policies for updating technical specifications, data submission procedural requirements, exceptional circumstances exceptions, or public data reporting via the CMS Provider Data Catalog. Table 4 of the Appendix of this summary lists the 16 proposed and previously adopted measures for the program.

Proposed Removal of the Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology Measure (PCH-15) (NQF # 0383)

CMS proposes to remove PCH-15 from the PCHQR Program's measure set beginning with the FFY 2024 program year, because it is no longer feasible to implement the measure specifications. CMS states that the measure steward is reverting to a prior measure version and will no longer maintain the specifications for the measure version used for PCHQR Program reporting. CMS further notes that removal of this chart-abstracted measure would also reduce provider reporting burden and that the measure is approaching "topped out" status.

Proposed Adoption of the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure

CMS proposes to adopt the COVID-19 Vaccination Coverage HCP measure — as previously described for the hospital IQR Program — for the PCHQR Program beginning with the FFY 2023 program year. The proposed data reporting, submission, and public display requirements are also taken from the hospital IQR Program measure (e.g., initial reporting period of October 1, 2021, through December 31, 2021, for PCHQR Program year FFY 2023).

Proposed Procedural Requirement Update and Codifications

CMS proposes to replace the terms "QualityNet Administrator" with "QualityNet security official" to align with other CMS quality programs. The identified individual's responsibilities would not change. CMS clarifies that failure to maintain an active security official after a PCH successfully registers to participate in the PCHRQ Program will not result in a finding that the PCH did not successfully participate in the program.

CMS also proposes to codify PCHQR Program requirements in new § 412.24 titled "Requirements under the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program." CMS also proposes a new paragraph § 412.23(f) that would require cancer hospitals that participate in the PCHQR Program to follow all the requirements listed at § 412.24.

Medicare 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 equal to three quarters of the market basket and would receive an update of 0.425% for FFY 2022. A hospital that fails to meet both the meaningful use and IQR Program requirements would receive an update factor of -0.2%.

Proposed Reporting Periods for 2023 and 2024

CMS previously adopted a continuous 90-day reporting period for the Medicare Promoting Interoperability Program through 2022. CMS proposes to extend this continuous 90-day reporting period for 2023. However, beginning with the 2024, CMS proposes to increase the reporting period to a minimum of any continuous 180-day period for new and returning participants.

CMS reminds readers that under the statute, the Medicaid Promoting Interoperability Program will end in 2021 and that December 31, 2021, is the last date states may make Medicaid PIP payments to Medicaid-eligible hospitals.

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 critical access hospital (CAH) during the EHR reporting period. CMS previously finalized this as an optional measure for the 2019 through 2021 programs, with mandatory reporting in 2022. In this rule, CMS proposes to extend voluntary reporting of this measure to reporting periods in 2022. Consistent with its policies for physicians under the Merit-based Incentive Payment System (MIPS), CMS proposes to increase the bonus points for this optional measure from five to 10, resulting in an increase to 20 in the maximum total points available for the Electronic Prescribing Objective for 2022.

Provide Patients Electronic Access to Their Health Information Measure Under the Provider-to-Patient Exchange Objective

Beginning with the 2022 EHR reporting period, CMS proposes to modify the "Provide Patients Electronic Access to Their Health Information" measure to require eligible hospitals and CAHs to ensure that patient health information remains available to the patient (or patient-authorized representative) to access indefinitely and using any application of their choice that is configured to meet the technical specifications of the API in the eligible hospital or CAH's CEHRT. This would include all patient health information from encounters on or after January 1, 2016.

CMS notes the proposed January 1, 2016, encounter start date aligns with the date of service finalized under the Patient Access and Interoperability final rule for MA organizations, Medicaid fee-for-service (FFS) programs, Medicaid managed care plans, Children's Health Insurance Plan (CHIP) FFS programs, CHIP managed care entities, and qualified health plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs) to make available to beneficiaries and enrollees certain claims and clinical data that they maintain through a Patient Access API.

Health Information Exchange Objective: Engagement in Bi-Directional Exchange Through Health Information Exchange (HIE)

CMS proposes a new optional measure for the Health Information Exchange objective, intended to incentivize participation in HIEs that support bi-directional exchange and contribute to a longitudinal care record for the patient, facilitating enhanced care coordination across settings. The proposed measure "Health Information Exchange (HIE) Bi-Directional Exchange" would serve as an alternative to the two existing measures under the objective: Support Electronic Referral Loops by Sending Health Information, and Support Electronic Referral Loops by Receiving and Reconciling Health Information (worth 20 points each). The proposed measure would be worth 40 points, and hospitals would report by attestation, which would require a yes/no response. Eligible hospitals or CAHs would attest to the following:

- Participating in an HIE in order to enable secure, bi-directional exchange of information to occur for **all** unique patients admitted to or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and **all** unique patient records stored or maintained in the EHR for these departments, during the EHR reporting period in accordance with applicable law and policy

- Participating in an HIE that is capable of exchanging information across a broad network of unaffiliated exchange partners, including those using disparate EHRs, and not engaging in exclusionary behavior when determining exchange partners
- Using the functions of CEHRT to support bi-directional exchange with an HIE

CMS notes the proposed new measure is broader than the existing measures, as the other two measures under the objective only apply to new patients and known transitions or referrals. The bi-directional engagement would have to be enabled for all unique patients admitted to or discharged from the eligible hospital or CAH inpatient or emergency department and all unique patient records stored or maintained in the EHR for those departments during the EHR reporting period. There would be no exclusions, exceptions, or allowances made for partial credit.

To successfully attest to the new measure, the eligible hospital or CAH must use the capabilities defined for CEHRT to engage in bi-directional exchange via the HIE, which includes capabilities that support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI). CMS clarifies that an eligible hospital or CAH attesting to the three statements would not be required to use all the relevant certified health IT modules to support their connection with an HIE, nor must a connection with an HIE be solely based on certified health IT modules. For instance, a provider's EHR could generate a C-CDA using a certified health IT module, and subsequently transmit that document to an HIE using technology that is not part of a certified health IT module. CMS notes that none of the actions required to attest to the new measure are intended to conflict with a patient's rights or a covered entity's requirements and responsibilities under the HIPAA Privacy Rule.

Proposed Modifications to the Public Health and Clinical Data Exchange Objective

Beginning with the 2022 EHR reporting period, CMS proposes to require reporting on the following four measures under the Public Health and Clinical Data Exchange Objective: Syndromic Surveillance Reporting; Immunization Registry Reporting; Electronic Case Reporting; and Electronic Reportable Laboratory Result Reporting. The agency believes its proposal will better support public health agencies for future health threats and a long-term COVID-19 pandemic recovery. Currently, hospitals are required to report on two of the six measures finalized under the objective.

Syndromic Surveillance Reporting

Beginning with the 2022 EHR reporting period, CMS proposes to change the setting for which data are required to be submitted from urgent care to the emergency department (POS 23). It would make a technical change to the first exclusion to the measure by eliminating a reference to urgent care.

CMS believes requiring this measure will expand coverage of syndromic surveillance to every region in the United States, help health care facilities and public health agencies better prepare for emerging health events, and provide critical national early warning capabilities necessary for swift response and

control of COVID-19 outbreaks. It does not believe this requirement would pose a significant burden on hospitals, as 49 states already participate in the National Syndromic Surveillance Program.

Immunization Registry Reporting

CMS does not propose any changes to the description of the measure or to any of the exclusions. It believes that requiring this measure is critical for the COVID-19 vaccination response and to understanding vaccine coverage nationwide and at the jurisdictional level.

Electronic Case Reporting

CMS does not propose any changes to the description of the measure and notes that all the exclusions previously finalized remain available. CMS is concerned by the uneven adoption of electronic case reporting. It believes requiring this measure would accelerate the development of electronic case reporting capabilities in EHR systems, reduce health care administrative burden of complying with state-mandated disease reporting requirements, provide regulatory clarity for EHR vendors, and improve the timeliness, completeness, and utility of case report data for public health agencies.

Electronic Reportable Laboratory Result Reporting

CMS does not propose any changes to the description of the measure or to any of the exclusions. It notes that electronic laboratory reporting by hospitals lags in comparison to larger commercial and clinical laboratories. The agency believes that requiring this measure would spur hospital laboratories to adopt this capability, increase the timeliness and completeness of laboratory reporting to public health agencies, strengthen the effectiveness of prevention and control measures, and reduce the burden of reporting by laboratory staff.

Proposed Scoring of the Public Health and Clinical Data Exchange Objective

Beginning with the 2022 EHR reporting period, eligible hospitals and CAHs would receive 10 points for this objective if they report a "yes" response for each of the four required measures. If an exclusion is claimed for three or fewer of the required measures, the hospital would receive 10 points for the objective if they report a "yes" response for one or more of these measures and claim applicable exclusions for which they qualify for the remaining measures. Failure to report on any of the four measures or reporting a "no" response for one or more of those measures, would result in a score of zero for the objective and a total score of zero for the Medicare PIP. If applicable exclusions are claimed for all four measures, CMS proposes to redistribute the 10 points for the objective to the Provider to Patient Exchange objective.

CMS proposes to make the remaining two measures (Public Health Registry Reporting and Clinical Data Registry Reporting) optional and available for a total of five bonus points if a "yes" response is reported for either of the two optional measures. Because these measures would be optional, CMS proposes to eliminate the exclusions previously available for them.

Safety Assurance Factors for EHR Resilience (SAFER) Guides

The Office of the National Coordinator for Health IT (ONC) developed and released the Safety Assurance Factors for EHR Resilience (SAFER) Guides in 2014 (updated in 2016). Three of these guides (the foundational, infrastructure, and clinical process guides) support the ability of health care providers and organizations to address EHR safety by conducting self-assessments to optimize the safety and safe use of EHRs.

CMS proposes to add a new SAFER Guides measure to the Protect Patient Health Information objective beginning with the 2022 EHR reporting period. Following the completion of an initial self-assessment, an eligible hospital or CAH would have to attest to having conducted an annual self-assessment of all nine SAFER guides at any point during the calendar year in which the EHR reporting period occurs. Attestation would consist of one "yes/no" attestation statement accounting for a complete self-assessment using all nine guides. The measure would be required, but it would not be scored. CMS notes that a self-assessment does not require an organization to confirm that it has implemented "fully in all areas" each practice described in a particular SAFER guide, and the organization would not be scored on how many of the practices it has fully implemented.

Proposed Changes to Information Blocking Attestations

Currently under the promoting interoperability program, hospitals must report on three statements to support that the hospital does not engage in information blocking. CMS notes that the ONC's 21st Century Cures Act final rule finalized a definition of information blocking for health care providers and established exceptions for actions that would not be considered information blocking. As a result, CMS proposes to no longer require the second and third attestation statements. Hospitals would continue to attest to the following statement: "Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology."

Proposed Scoring Methodology for 2022 Reporting Period

CMS notes that performance results for 2019 showed that 3,776 of 3,828 participating eligible hospitals and CAHs met the minimum threshold score of 50 points to be considered a meaningful user of EHR technology. For the 2022 EHR reporting period, CMS proposes to raise the minimum threshold score to 60 points.

After accounting for the proposals described above, to be considered a meaningful user of EHR technology, an eligible hospital or CAH would be required to:

- 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 60 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 2022 reporting period:

Proposed Performance-Based Scoring Methodology for EHR Reporting Periods in CY 2022		
Objectives	**Measures**	**Maximum Points**
e-Prescribing	e-Prescribing	10 points
	Query of Prescription Drug Monitoring Program (PDMP)	10 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
	OR	
	Health Information Exchange (HIE) Bi-Directional Exchange measure	40 points (optional instead of previous 2 measures)
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Proposed as required with yes/no response: Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Electronic Reportable Laboratory Result Reporting	10 points
	Proposed as optional to report one of the following: Public Health Registry Reporting Clinical Data Registry Reporting	5 points (bonus)

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

In alignment with proposals for the IQR program, CMS maintains the previously finalized reporting requirement for eCQMs:

- 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 eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM for three self-selected calendar quarters.
- For FFY 2025 payment (CY 2023 reporting) and subsequent years, hospitals would report data for three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM for all four calendar quarters.

Consistent with the IQR program, CMS proposes to adopt two new eCQMs for the PIP program beginning with the 2023 reporting period/FFY 2025 payment determination: Hospital Harm - Severe Hypoglycemia (NQF #3503e) and Hospital Harm - Severe Hyperglycemia (NQF #3533e). CMS also proposes to remove four eCQMs beginning with the 2024 reporting period/FFY 2026 payment determination: STK-03 Anticoagulation Therapy for Atrial Fibrillation/Flutter (NQF #0436), STK-06

Discharged on Statin Medication (NQF #0439), PC-05 Exclusive Breast Milk Feeding (NQF #0480), and ED-2 Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497). In addition, CMS proposes to require eligible hospitals and CAHs to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for eCQMs, beginning with the 2023 reporting period.

Requests for Information

CMS includes two specific requests for information (RFI) across its quality programs. Specifically, the agency seeks comments on adopting a digital measurement approach and strategies to close the health equity gap in its hospital quality and value-based programs.

RFI on Advancing to Digital Quality Measurement

CMS requests input into the agency's planning for transformation to a fully digital quality enterprise by 2025, posing numerous questions grouped into three categories: definition of digital quality measures, use of Fast Healthcare Interoperability Resources (FHIR) for current eCQMs, and other changes under consideration to advance digital quality measures.

As part of its discussion, CMS offers a definition for digital quality measures (dQMs): "quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems." CMS notes that a dQM score includes a calculation that processes digital data. The agency also lists multiple examples of dQM data sources (e.g., electronic health records, wearable medical devices). CMS also discusses the potential role of FHIR-based standards for efficient exchange of clinical information across clinical settings through APIs. CMS says it is actively studying the use of FHIR-based APIs to access quality data it already collects as well as transitioning to FHIR-based quality reporting through APIs for eCQMs already adopted into several of the agency's quality reporting and value-based programs. CHA refers readers to pages 25549-25554 of the proposed rule for the full set of questions posed in each category.

RFI on Closing the Health Equity Gap in CMS Hospital Quality Programs

CMS seeks comments on how it could revise the CMS hospital quality programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for hospitals, providers, and patients. CMS explores three potential major, near-term initiatives and poses multiple questions specifically applicable to each initiative.

For much of the RFI, CMS focuses discussion on the potential for expanding use of CMS Disparity Within-Hospital and Across-Hospital methods — currently provided to hospitals for certain measures stratified by dual eligible status — to include race and ethnicity stratification. CMS notes the availability of several tools for capturing race and ethnicity and compares them to the gold-standard of self-reported data. CMS also discusses its work on indirect estimation methods applicable to race and ethnicity and its experience using those methods.

CMS also reviews collection and standardization of a minimum demographic data set, using electronic definitions and related aspects of the CEHRT currently required for use by hospitals under the Medicare Promoting Interoperability Program to improve the robustness of disparity method results. CMS concludes its discussion by exploring the potential development of a Hospital Equity Score (HES) for hospitals based on prior work from which a Health Equity Summary Score was developed for use in Medicare Advantage contracts and plans. HES would be provided confidentially to hospitals, and any public reporting of scores would be subject to notice-and-comment rulemaking.

Specifically, CMS seeks comments on:

- The possibility of expanding the agency's current disparities methods to include reporting by race and ethnicity using indirect estimation.
    - What would be appropriate privacy safeguards for the data produced through indirect estimation?
    - What are data elements beyond race and ethnicity that would be feasible to collect and be useful for stratification within quality measures?
- The possibility of hospital collection of standardized demographic information for the purposes of potentially incorporating into measure specifications to permit more robust equity measurement.
    - What are the feasibility and utility for collection by hospitals, at the time of admissions, of a minimum set of demographic data elements using electronic data definitions that permit nationwide, interoperable health information exchange?
- The design of a Hospital Equity Score for calculating results across multiple social risk factors and measures, including race/ethnicity and dual eligibility.
- What are potential interventions by hospitals to improve low equity scores?

Medicaid Enrollment of Medicare Providers and Suppliers for Process of Processing Claims for Cost Sharing for Services Furnished to Dually Eligible Beneficiaries

State Medicaid programs are required to pay providers for Medicare cost-sharing on behalf of certain Medicare enrollees who are also enrolled in Medicaid ("dually eligible") regardless of whether those items or services are covered under a state's Medicaid program. However, Medicaid programs may limit their payments for Medicare cost sharing to the amount equal to what the state would have paid for that item or service under the Medicaid program. The provider is prohibited from charging the beneficiary the difference between the Medicaid payment amount and their Medicare payment amount but may claim those amounts as reimbursable Medicare "bad debt."

In order for a provider to claim unpaid amounts are bad debt, they need to receive a remittance advice (RA) from the state that the claim processing has been completed and that identifies the state's cost sharing liability. In some states where the Medicaid program does not recognize a particular service or provider type, the providers have been unable to enroll in the Medicaid program nor receive an RA from the state program and, therefore, are unable to incorporate those costs as bad debt. To address this

problem, CMS proposes that a state Medicaid agency would be required to allow enrollment of all Medicare-enrolled providers and suppliers for purposes of processing claims to determine Medicare cost-sharing if the providers or suppliers meet all Medicaid enrollment requirements, even if the Medicare-enrolled provider or supplier is of a type not recognized by the state Medicaid agency.

Organ Acquisition Payment

CMS proposes to codify into the Medicare regulations longstanding Medicare organ acquisition payment policies, with clarifications where necessary, and to codify some new organ acquisition payment policies.

Definitions

The proposed rule clarifies the distinction between a transplant hospital and a transplant program and the meaning of "freestanding:"

- *Transplant Hospital (TH)* means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.
- *Transplant Program* means an organ-specific transplant program within a transplant hospital.
- *Freestanding* means independent organ procurement organization (IOPO). For an organ procurement organization (OPO) to be an IOPO, it must file a Medicare cost report separate from the hospital.

This terminology is intended to establish consistent use of the above terms in place of "transplantation center," which meant a "transplant program," and "certified transplant center," which meant a transplant hospital.

The definition of "organ" is different for payment purposes than it is for OPO conditions for coverage (CfCs). For the CfCs, a pancreas used for research or islet cell transplantation may be considered an organ. For payment purposes, the definition of "organ" does not include a pancreas that is only used for research purposes.

Medical Complications

In the proposed rule, CMS clarifies that living kidney donor complications related to the surgery to remove a kidney and occurring after the date of discharge are not considered kidney acquisition costs. Living kidney donor complications are statutorily authorized to be paid under Part A or Part B in section 1881(d) of the Act, with no liability for deductibles or coinsurance. Medicare covers costs incurred for living kidney donor complications only if they are directly attributable to the kidney donation.

Medicare Organs

Medicare organ acquisition payment policy includes the presumption that some organs are transplanted into Medicare beneficiaries, despite the category name "Medicare usable organs" or "Medicare kidneys." As a result, through unintended consequences, Medicare currently shares in the organ acquisition costs for some organs that are not actually transplanted into Medicare beneficiaries.

Medicare's decades-old presumption that most kidney transplant recipients are Medicare beneficiaries

was also applied to non-renal organs due to a lack of organ tracking capabilities and has led Medicare to reimburse THs and OPOs for organ acquisition costs for organs that were not actually transplanted into Medicare beneficiaries. CMS now believes that organ tracking capabilities allow THs and OPOs to discern organ recipients' health insurance payer information so that organ acquisition costs can be more appropriately assigned to the Medicare program for organs transplanted into Medicare beneficiaries.

For these reasons, CMS is proposing that Medicare usable organs include only organs transplanted into Medicare beneficiaries (including kidneys for Medicare Advantage beneficiaries with dates of service after January 1, 2021), organs for which Medicare has a secondary payer liability for the organ transplant, and pancreata procured for the purpose of acquiring pancreatic islet cells acquired for transplantation for Medicare beneficiaries participating in a National Institute of Diabetes and Digestive and Kidney Diseases clinical trial. If finalized as proposed, the requirement would be effective for cost reports beginning on or after October 1, 2021. Other provisions of the regulations for determining Medicare's share are unchanged.

Donor Community Hospitals

Medicare-certified hospitals that are not transplant hospitals but collaborate with OPOs to procure organs from cadaveric donors for transplantation are referred to as "donor community hospitals." Currently, when a donor community hospital incurs costs for services provided to the cadaveric donor, as authorized by the OPO following the declaration of death and consent to donate, it bills the OPO its customary charges (not reduced to cost) or a negotiated rate.

The proposed rule states CMS is aware that some donor community hospitals are charging OPOs amounts that are in excess of reasonable costs for harvesting organs from cadavers, resulting in Medicare paying more than reasonable costs for the acquisition of these organs. CMS proposes that for cost reporting periods beginning on or after October 1, 2021, when a donor community hospital incurs costs for services furnished to a cadaveric donor, as authorized by the OPO, the donor community hospital must bill the OPO its customary charges, reduced to cost by applying its most recently available hospital-specific cost-to-charge ratio for the period in which the service was rendered.

CMS is also aware that some donor community hospitals are improperly billing OPOs for services provided to cadaveric donors prior to the declaration of death and consent to donate. CMS proposes that a donor community hospital (a Medicare-certified non-transplant hospital) incurs organ acquisition costs for donor organ procurement services authorized by the OPO following declaration of death and consent to donate.

Medicare Shared Savings Program

Due to the COVID-19 PHE and concerns about lack of predictability and disrupted population health activities brought forth by Accountable Care Organizations (ACOs) participating in the BASIC track, CMS is proposing that those participating ACOs may elect to maintain or "freeze" their risk level under the BASIC track's glide path for performance year (PY) 2022 at its PY 2021 performance level. This is similar

to the provision granted to ACOs in the May 2020 COVID-19 interim final rule with comment period (IFC).

For PY 2023, an ACO that opted for this advancement deferral would automatically advance to the level of the track's glide path it would have participated in for PY 2023 if it had advanced normally in PY 2022 (unless the ACO elects to advance more quickly before the start of PY 2023). ACOs that participated in the freeze for PY 2021 and PY 2022 would be similarly advanced for PY 2023. The table on DISPLAY page 1,564 shows the different glide path scenarios for each if an ACO elected to maintain its levels.

Appendix — Quality Reporting Program Tables

Table 1

Summary Table: IQR Program Measures by Payment Determination Year FFY 2021 X= Mandatory Measure, V= Voluntary Reporting						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Chart-Abstracted Process of Care Measures						
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X	X	X
PC-01 Elective delivery < 39 weeks gestation (NQF#0469)	X	X	X	X	X	X
ED-1 Time from ED arrival to departure for admitted patients (NQF#0495)	Removed					
ED-2 Time from admit decision to ED departure for admitted patients (NQF #0497)**	X	Removed				
IMM-2 Immunization for influenza (NQF #1659)	Removed					
VTE-6 Incidence of potentially preventable VTE	Removed					
Electronic Clinical Quality Measures						
AMI-8a Primary PCI w/in 90 minutes arrival CAC-3 Home Mgmt Plan Document to Caregiver STK-2 Antithrombotic therapy for ischemic stroke (NQF #0435) STK-3 Anticoagulation therapy for Afib/flutter (NQF #0436)*** STK-5 Antithrombotic therapy by end of hospital day 2 (NQF #0438) 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) ED-1 Time from ED arrival to departure for admitted patients (NQF#0495) ED-2 Time from admit decision to ED departure for admitted patients (NQF #0497)*** EDHI-1a Hearing Screening Pre-Hospital Discharge PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469) PC-05 Exclusive breast milk feeding (NQF #0480) *** Safe Use of Opioids – Concurrent Prescribing (NQF #3316c)	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 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	Report 4 of the following 11 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 HH-01 HH-02 Safe Use of Opioids	Report Safe Use of Opioids AND 3 of the following 7 eCQMs: STK-02 STK-05 VTE-1 VTE-2 HH-01 HH-02	Report Safe Use of Opioids AND 3 of the following 7 eCQMs: STK-02 STK-05 VTE-1 VTE-2 HH-01 HH-02	Report Safe Use of Opioids AND 3 of the following 7 eCQMs: STK-02 STK-05 VTE-1 VTE-2 HH-01 HH-02

Summary Table: IQR Program Measures by Payment Determination Year FFY 2021 X= Mandatory Measure, V= Voluntary Reporting						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Hospital Harm-Severe Hypoglycemia (NQF #3503e)* Hospital Harm-Severe Hyperglycemia (NQF #3533e)*						
Health Care-Associated Infection Measures						
Central Line Associated Bloodstream Infection (CLABSI)	X	Removed				
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	Removed				
Catheter-Associated Urinary Tract Infection (CAUTI)	X	Removed				
MRSA Bacteremia	X	Removed				
Clostridium Difficile Infection (CDI)	X	Removed				
Healthcare Personnel Influenza Vaccination (NQF #0431)	X	X	X	X	X	X
Healthcare Personnel COVID-19 Vaccination*			X	X	X	X
Claims-Based Measures						
Mortality						
Pneumonia 30-day mortality rate	Removed					
Stroke 30-day mortality rate	X	X	X	X	X	X
COPD 30-day mortality rate	Removed					
CABG 30-day mortality rate	X	Removed				
Readmission/Coordination of Care						
Hospital-wide all-cause unplanned readmission (NQF #1789)**	X	X	X	X	X	Removed
Excess days in acute care after hospitalization for AMI (NQF #2881)	X	X	X	X	X	X
Excess days in acute care after hospitalization for HF (NQF #2880)	X	X	X	X	X	X
Excess days in acute care after hospitalization for PN (NQF #2882)	X	X	X	X	X	X
Claims and Electronic Data Measures (Hybrid)						
Hybrid HWR (all-cause readmission) (NQF #2879)				V		X
Hybrid HWM (all-cause mortality)*					V	**X**
Patient Safety						
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)***	X	X	Removed			
THA/TKA complications	X	X	Removed			
Efficiency/Payment						
AMI payment per 30-day episode of care (NQF #2431)	X	X	X	X	X	X
Heart Failure payment per 30-day episode of care (NQF # 2436)	X	X	X	X	X	X

Summary Table: IQR Program Measures by Payment Determination Year FFY 2021 X= Mandatory Measure, V= Voluntary Reporting						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Pneumonia payment per 30-day episode of care (NQF #2579)	X	X	X	X	X	X
THA/TKA payment per 30-day episode of care	X	X	X	X	X	X
Patient Experience of Care						
HCAHPS survey (NQF #0166)	X	X	X	X	X	X
Structural Measures						
Maternal Mortality*			X	X	X	X

*Measure proposed for adoption in FFY 22 rule
** Measure replaced by Hybrid HWR measure for FFY 26
*** Proposed for removal in this rule
*** Proposed for removal effective FFY 26

Table 2

Summary Table VBP-1: Measures and Domains by Payment Year					
Measure	**NQF #**	**2021**	**2022**	**2023/ 2024**	**2025 2026**
Clinical Outcomes Domain					
Acute Myocardial Infarction (AMI) 30-day mortality rate	0230	X	X	X	X
Heart Failure (HF) 30-day mortality rate	0229	X	X	X	X
Pneumonia (PN) 30-day mortality rate	0468	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty	1550	X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate	1893	X	X	X	X
CABG 30-day mortality rate	2558		X	X	X
Safety Domain					
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)*	0531			Removed	
Central Line Associated Blood Stream Infection (CLABSI)	0139	X	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	0138	X	X	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X	X	X	X
Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X	X	X	X
Clostridium Difficile Infection (CDI)	1717	X	X	X	X
Perinatal Care: elective delivery < 39 weeks gestation	0469	Removed			
Person and Community Engagement Domain					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital	0166	X	X	X	X
3-Item Care Transition measure (CTM)	0228				
Efficiency and Cost Reduction Domain					
Medicare Spending per Beneficiary	2158	X	X	X	X

*The predecessor measure, the AHRQ PSI–90 patient safety composite, was removed beginning with FFY 2019. Reporting of the successor measure was to start with FFY 2023 but is instead proposed for removal in FFY 2023 in this rule.

Table 3

HAC Reduction Program Measures and Performance Periods for Payment Years 2020-2023					
	NQF #	**FFY 2020**	**FFY 2021**	**FFY 2022***	**FFY 2023***
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531	X	X	X	X
Applicable (Performance) Period		*7/1/16-6/30/18*	*7/1/17-6/30/19*	*7/1/18 - 12/31/19*	*7/1/19 - 12/31/19 plus 1/1/21 - 6/30/21*
CDC NSHN Measures					
Central Line-associated Blood Stream Infection (CLABSI)	0139	X	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	0138	X	X	X	XX
Colon and Abdominal Hysterectomy Surgical Site Infections	0753	X	X	X	X
Methicillin-resistant staphylococcus aureus (MRSA)	1716	X	X	X	X
Clostridium difficile (CDI)	1717	X	X	X	X
Applicable (Performance) Period CDC NHSN Measures		*1/1/17-12/31/18*	*1/1/18-12/31/19*	*1/1/2019-12/31/19*	*1/1/21 - 12/31/21*

* Proposed Adjustments to Applicable Periods Due to COVID-19 Impacts

Table 4

PCHQR Program Measures for FY 2023 and Subsequent Years	
Measure	**Public Display Began**
Safety and Healthcare Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	2019
NHSN CDI (NQF #1717)	2019
NHSN MRSA bacteremia (NQF #1716)	2019
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	2019
NHSN COVID-19 vaccination coverage among health care personnel	Proposed for program addition FFY 2023
NHSN CLABSI (NQF #0139)	Deferred until 2022
NHSN CAUTI (NQF #0138)	Deferred until 2022
Clinical Process/Oncology Care	
Oncology: Plan of Care for Pain (NQF #0383)	2016; Proposed for program removal FFY 2024
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210)	Not Displayed
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	Not Displayed
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	Not Displayed
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	Not Displayed
Patient Experience of Care	
HCAHPS (NQF #0166)	2016
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	2020 Finalized for program removal FFY 2022
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	Not Displayed
Surgical Treatment Complications for Localized Prostate Cancer	Not Displayed