FFY 2022 Inpatient Prospective Payment System Proposed Rule Updates Webinar

June 10, 2021

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Welcome

Jaime Welcher
Education Program Manager
California Hospital Association

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Questions

We will take questions at the end of the webinar. However, if you have a question before then, please submit that question through the Q & A box – usually located at the bottom of your screen.

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Presenters

Chad Mulvany, Vice President, Federal Policy

Chad Mulvany is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters.

Based in CHA's Washington, DC Office, Chad collaborates with colleagues including CHA's senior vice president, federal relations, CHA issue managers and national hospital associations on analysis and policy development for advocacy purposes.

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Presenters

Megan Howard, Vice President, Federal Policy

As Vice President, Federal Policy for CHA, Megan Howard is responsible for providing leadership on federal regulatory issues related to health care finance, quality and patient safety, and hospital and post-acute provider related issues.

Based in the Washington, D.C. office, Megan works with Chad, CHA issue managers and national hospital associations on analysis and policy development for advocacy purposes.

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Agenda

- Payment Update
- Medicare DSH Updates
- Area Wage Index Proposals
- IME/GME Proposals
- Organ Acquisition
- Value Based Quality Programs and Hospital Inpatient Quality Reporting Program
- Promoting Interoperability Program

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Overview

- On May 10, the Centers for Medicare & Medicaid Services (CMS) published the federal fiscal year (FFY) 2022 inpatient prospective payment system (IPPS) proposed rule
- Comments due to CMS by 2 p.m. (PT) on June 28
- Submit comments online at regulations.gov and search "CMS-1752-P"
- CHA summary is available
- GOAL: CHA draft letter in June 21 edition of *CHA News*

25070 Federal Register / Vol. 86, No. 88 / Monday, May 10, 2021 / Proposed Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 425, 455, and 495

[CMS–1752–P]

RIN 0938–AU44

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2022 and to implement certain recent legislation. In addition, we are proposing to rebase and revise the hospital market baskets for acute care hospitals, update the labor-related share, and provide the market basket update that would apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis, subject to these limits for FY 2022. We are also proposing policies relating to Medicare graduate medical education (GME) for teaching hospitals to implement certain recent legislation. The proposed rule would also update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2022. In this FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to extend New COVID–19 Treatments Add-on Payment (NCTAP) for certain eligible products through the end of the fiscal year in which the PHE ends and to discontinue the NCTAP for discharges on or after October 1, 2021 for a product that is approved for new technology add-on payments beginning

repeal the collection of market-based rate information on the Medicare cost report and the market-based MS–DRG relative weight methodology, as finalized in the FY 2021 IPPS/LTCH PPS final rule.

We are proposing to establish new requirements and revise existing requirements for eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program. We are also providing estimated and newly established performance standards for the Hospital Value-Based Purchasing (VBP) Program, and proposing updated policies for the Hospital Readmissions Reduction Program, Hospital Inpatient Quality Reporting (IQR) Program, Hospital VBP Program, Hospital-Acquired Condition (HAC) Reduction Program, and the PPS-Exempt Cancer Hospital Reporting (PCHQR) Program, and the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). Additionally, due to the impact of the COVID–19 PHE on measure data used in our value-based purchasing programs, we are proposing to suppress several measures in the Hospital VBP, HAC Reduction, and Hospital Readmissions Reduction Programs. In connection with our measure suppression proposals for the FY 2022 Hospital VBP Program, we are also proposing to revise the scoring and payment methodology for the FY 2022 program year such that hospitals will not be scored using quality measure data that are distorted by the effects of the COVID–19 public health emergency (PHE) and will not receive Total Performance Scores or adjustments to their payments as a result. Similarly, we are proposing to suppress affected measures for the FY 2022 HAC Reduction Program such that hospitals will not be scored using distorted quality measure data and will not receive Total HAC Scores based on those data. For the Hospital Readmissions Reduction Program, we are proposing to suppress one affected measure under the proposed measure suppression policy for the FY 2023 applicable period such that hospitals will not be assessed using distorted quality measure data and will not receive payment reductions based on those data.

In addition, we are proposing to change, clarify, and codify Medicare organ acquisition payment policies relative to organ procurement organizations (OPOs), transplant hospitals, and donor community hospitals. Also, we are proposing to add regulation requiring that state Medicaid agencies accept valid enrollments from

suppliers for purposes of processing claims for Medicare cost-sharing liability for services furnished to Medicare-Medicaid dually eligible individuals in order to alleviate a long-standing problem related to claiming Medicare bad debt.

Additionally, we are proposing to amend the Medicare Shared Savings Program regulations to allow eligible accountable care organizations (ACOs) participating in the BASIC track's glide path the opportunity to maintain their current level of participation for performance year (PY) 2022.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. EDT on June 28, 2021.

ADDRESSES: In commenting, please refer to file code CMS–1752–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "submit a comment" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1752–P, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1752–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRG Relative Weights, Wage Index, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate

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Payment Update

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FFY 2022 Update with EHR and IQR

	No Penalty	IQR Penalty	EHR Penalty	Both Penalties
Baseline MB Update	+2.5%			
Net of ACA Reductions	+2.3%			
IQR Penalty	-	-0.625 PPT	-	-0.625 PPT
EHR Meaningful Use Penalty	-	-	-1.875 PPT	-1.875 PPT
MB Update, less EHR/IQR	2.30%	1.675%	0.425%	-0.20%

CAHs = cost-based payment reduced by up to -1.0% due to MU

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Proposed Rate Update

	FFY 2021	FFY 2022 (Proposed)	% Change
Operating Rate	$5,961.31	$6,140.29	+3.00%
Capital Rate	$466.21	$471.89	+1.22%

	Operating Rate Adjustment
ACA-Adjusted Update (2.5% MB minus 0.2 PPT productivity adjustment)	+2.30%
MACRA-Mandated **Retrospective** Coding Adjustment	+0.50%
Wage Index Transition Adjustments	+0.13%
Annual Budget Neutrality Adjustments	+0.06%
Net Rate Change	**+3.00%**

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Estimated California Impact

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.

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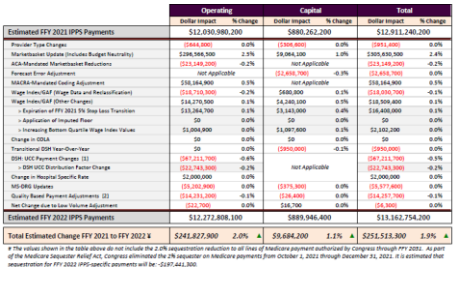
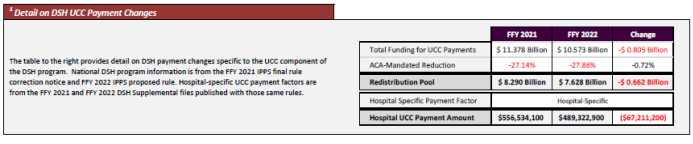
DataSuite IPPS Analysis

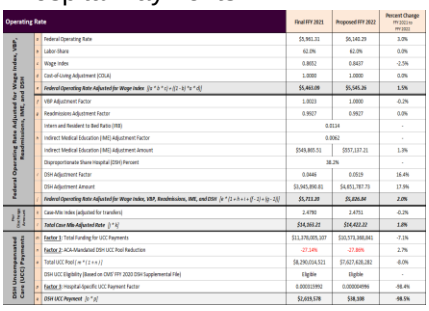
Hospital Report



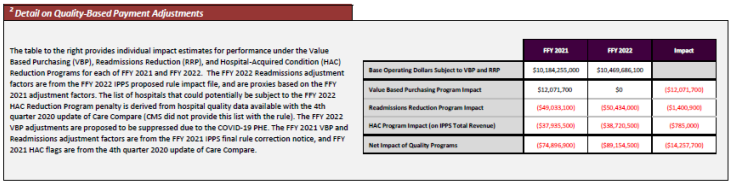
DSH Breakout



Hospital Payments



Quality Breakout



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Data Source for MS-DRG Classifications and Relative Weights

- CMS typically uses the following data when calculating rates for the fiscal year under study:
  - ✓ Medicare Provider Analysis and Review (MedPAR) claims from 2 years prior (FFY 2020 data for FFY 2022 rule)
  - ✓ Hospital Cost Reports beginning 3 years prior (FFY 2019 data for FFY 2022 rule)
- CMS has determined that these data have been significantly impacted by the COVID-19 Public Health Emergency (PHE)
- Proposing to instead use FFY 2019 MedPAR data and FFY 2018 Cost Report data for FFY 2022 rate setting
  - ✓ This data would be used where utilization patterns in the FFY 2020 MedPAR file were significantly affected
  - ✓ Extends to most other calculations that would use either of these data sources
  - ✓ Invites public comment on alternatively using FFY 2020 MedPAR claims and FFY 2019 Cost Report data

Uncompensated Care (UC) Medicare Disproportionate Share Hospital (DSH)

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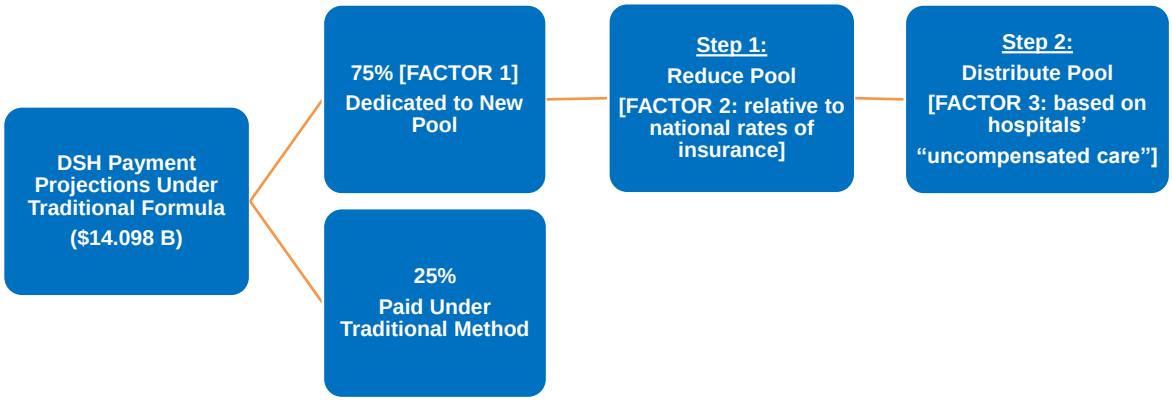
Medicare DSH



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Uncompensated Care DSH

A significant decrease in Factor 1 drives a reduction in the total UC DSH pool. CMS proposes to continue using one year of audited S-3 data – FFY 2018 for Factor 3.

Factors 1 and 2: Comparison of FFYs 2022 vs. 2021

Factor	FFY 2022	FFY 2021	Change from Prior Year
1: Base Funding	$10.573 B	$11.378 B	-$.81 B
2: Available Pool	$7.628 B (27.86% reduction)	$8.290 B (27.14% reduction)	-$.662 B

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Uncompensated Care DSH – Factor 1

Decreases in projected Medicare discharges and the "other" factor are driving the decrease in Factor 1.

UC DSH Factor 1 Comparison: Proposed FFY 2022 to Final FFY 2021

	Update	Discharge	Case Mix	Other	Total	Est DSH Pmt, $ Billions
2019	0.0000	0.0040	0.0000	(0.0025)	0.0018	(0.8010)
2020	0.0000	(0.0380)	(0.0010)	(0.0173)	(0.0581)	(1.6026)
2021	0.0000	(0.0680)	0.0150	(0.0206)	(0.0741)	(2.6300)

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Factor Determination, UCC Per Discharge and Other

- Similarly, to FFY 2021, CMS is proposing to use Worksheet S-10 uncompensated care data (UCC) from audited FFY 2018 Hospital Cost Reports to calculate Factor 3.
- Proposal to use a hospital's 2-year average discharges to estimate interim UCC payments per discharge rather than the previous policy using a 3-year average due to the possibility that FFY 2020's discharges may cause UCC to be underrepresented.
  - ✓ Years proposed to be used would be FFY 2018 and 2019
  - ✓ Would be reconciled at cost report settlement as in past years

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Factor Determination, UCC Per Discharge and Other (cont.)

- Hospitals are proposed to have 60 days from the public display of the FFY 2022 IPPS proposed rule and 15 business days from public display of the FFY 2022 final rule to determine accuracy of the DSH data table. Any changes would be posted to the CMS website prior to 10/1/2021.
- Comments regarding data issues for this proposed rule can be submitted to Section3133DSH@cms.hhs.gov.
- Section 1115 Waiver Days: CMS is proposing to update the numerator of the Medicaid fraction (used to calculate a hospital's disproportionate patient percentage) so that for a patient day to be included, the patient must have been eligible for inpatient services under an approved state Medicaid plan on that day, or received an authorized waiver.

Area Wage Index Proposals

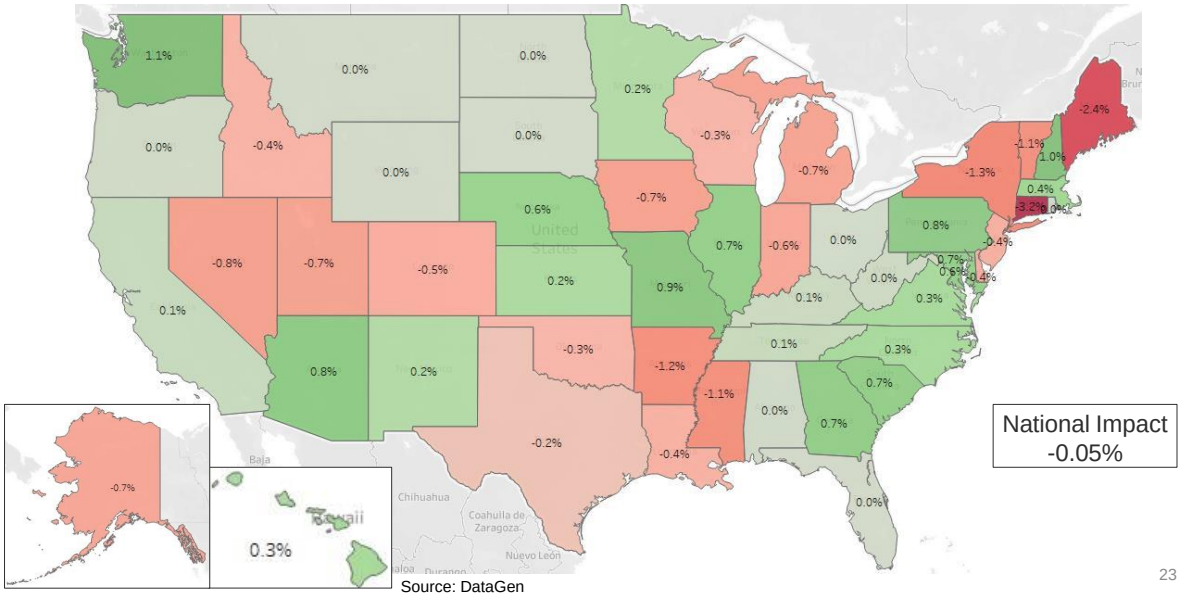
CBSA Changes

- CMS proposes to adopt revisions from the March 6, 2020 OMB Bulletin 20-01, however there would be no effect on core-based statistical areas (CBSAs) with this update.
- CMS adopted in FFY 2021 that hospitals in counties that became rural would receive an add-on to their traditional DSH adjustment equal to 1/3 of the difference between the urban-and rural-calculated adjustments for FFY 2022, compared to their FFY 2020 designation.
- This transition started in FFY 2021 at 2/3 and will be phased out in FFY 2023.

Wage Index Reclassifications

- CMS is proposing that requests for cancelling rural reclassifications requests must be submitted no earlier than one calendar year after a hospital's reclassification effective date, and these requests would be effective for the FFY that begins in the calendar year after the calendar year in which the request was submitted.
- In addition to the IPPS proposed rule, CMS released an interim final rule (CMS-1762-IFC) with provisions to allow urban hospitals that have been granted a redesignation as rural under §412.103 to reclassify under Medicare Geographic Classification Review Board using the rural reclassified area as the geographic area.
  - ✓ Effective for reclassifications beginning FFY 2023
  - ✓ Also applied when deciding timely appeals for applications beginning in FFY 2022 that were denied due to the prior policy

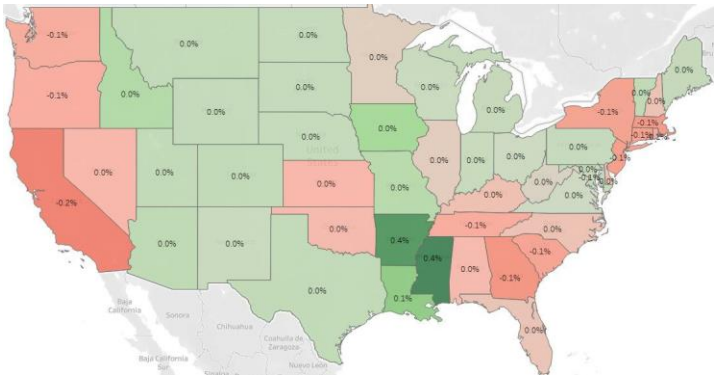
Impact of Standard Wage Index Changes



Area Wage Index – Low AWI Policy

CMS proposes to continue its low area wage index policy resulting in a negative budget neutrality adjustment.

Impact of Bottom Quartile Change



Key Details of Proposed Policy

- FFY 2022 bottom quartile of the wage index is <.8418
- Proposed budget neutrality adjustment is -.19%

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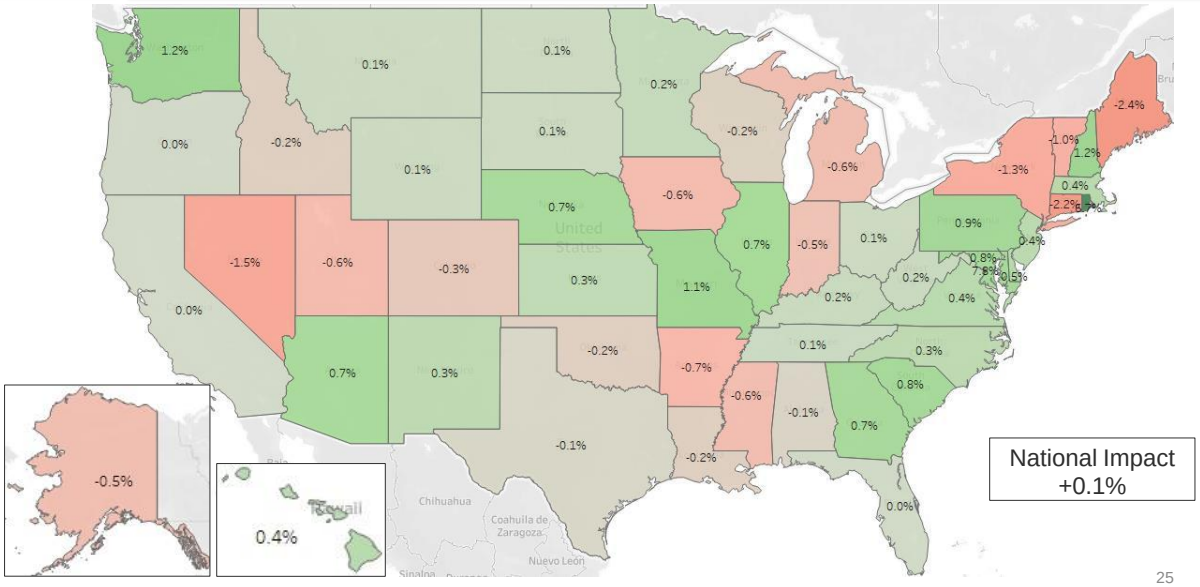
All Newly Proposed Wage Index Changes



Source: DataGen

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Labor Related Share

- Change in the labor-related share to 67.6% for hospitals with wage index of more than 1.0.
- Hospitals with a wage index less than or equal to 1.0 will continue to have a labor- related share of 62.0%

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Labor Related Share (cont.)

CMS is proposing to decrease the labor related share as part of its quadrennial rebasing process.

Comparison of 2014-Based Labor Related Share and Proposed 2018-Based Labor Related Share

	2014-Based IPPS Market Basket Cost Weights	Proposed 2018-Based IPPS Market Basket Cost Weights	Difference
Wages and Salaries	43.4	41.2	-2.2
Employee Benefits	12.4	11.7	-0.7
Professional Fees: Labor-Related	6.8	8.6	1.8
Administrative and Facilities Support Services	1.0	1.1	0.1
Installation, Maintenance, and Repair Services	2.4	2.4	0
All Other: Labor-Related Services	2.3	2.6	0.3
Total Labor-Related Share	**68.3**	**67.6**	**-0.7**

Note: Details may not add to total due to rounding

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Wage Index Reduction Transition - RFC

For FFY 2021, CMS adopted a transition period for wage index reductions.

- A hospital's FFY 2021 wage index would be no less than 95% of its final FFY 2020 wage index
  - ✓ "5% stop-loss-adjustment"

Due to the COVID-19 PHE, CMS is seeking comment on whether to extend this policy into FFY 2022 in a budget neutral manner.

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Indirect Medical Education (IME)
Graduate Medical Education (GME)

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IME/GME – New Residency Slots: Overview

CMS proposes to distribute 200 new residency slots created by Section 126 of the Consolidated Appropriations Act (CAA) of 2021 over five years (1,000 total).

At least 10% of Residency Slots Must be Allocated to the Following Categories:

1) Hospitals located in rural areas or treated as rural for IPPS purposes
2) Hospitals that are training more residents than their full-time equivalent (FTE) cap
3) Hospitals in states with new medical schools or additional locations and branches of existing medical schools
4) Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)

IME/GME – New Residency Slots: Additional Details

Hospitals may only receive one additional FTE per year and must demonstrate they can use the slot within five years.

Proposed and Alternative Criteria

1) Proposed Scoring Criteria: CMS proposes to prioritize allocation by primary care and mental health HPSA score.
2) Alternative Scoring Criteria: Hospitals that qualify in more than one of the four statutory eligibility categories would be given priority. Hospitals qualifying in all four categories would receive top priority.

Other Details

1) Demonstrated Likelihood: Hospitals must fill the slots made available within the first five training years from the date the increase would be effective.
2) Application Deadline: the application deadline will be January 31 of the FFY prior to the fiscal year the increase in FTEs becomes effective. For increases that are effective July 1, 2023, the application deadline is January 31, 2022.

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IME/GME – New Residency Slots: Criteria Comparison

CMS' proposed criteria would use Health Professional Shortage Area (HPSA) scores to rank applicants in each category.

Proposed: Prioritization by HPSA Score
0 = Low shortage, 25 – High Shortage

Hospital Group	HPSA Score	FTEs Awarded per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	25	1	50	225
50 hosps	24	1	50	225
50 hosps	21	1	50	225
80 hosps	19	0.625	50	125
Total (230 Hosps)			200	800

The alternative awards slots using the number of categories applicants qualify for.

Alternative: Prioritization by Number of Qualifying Categories

Hospital Group	Total Score	FTEs Awarded per Hospital	Number of FTEs Awarded	FTEs Remaining
50 hosps	4	1	50	225
50 hosps	3	1	50	225
50 hosps	2	1	50	225
80 hosps	1	0.625	50	125
Total (230 Hosps)			200	800

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IME/GME – Rural Training Track (RTT) Cap Expansion

Section 127 of the CAA provides for adjustments to FTE caps for both urban and rural hospitals that "established or establishes" a RTT for cost reporting periods beginning on or after October 1, 2022.

CMS Proposes the Following to Implement the RTT Provisions:

1) Separate "1-2 format" accreditation not required regardless of specialty.
2) 50% of training must occur in rural areas.
3) Urban and rural hospitals are exempt from the FTE 3-year rolling average during the 5-year growth window for FTE residents participating in rural tracks.
4) During the 5-year cap growth window for RTTs, the residents participating either at the urban hospital or a rural hospital would not be included in a hospital's 3-year rolling average calculation effective for RTTs started in cost reporting periods beginning on or after October 1, 2022.

IME/GME – Rural Training Track (RTT) Cap Expansion (cont.)

Based on the proposed rule urban "hub" and rural "spoke" hospitals may expand their FTE cap in the situations described below.

Can the Hospital Count New FTEs in a RTT?

Hospital	New Spoke Added	New Program Added to Existing Spoke	Existing Program Expanded
Urban "Hub"	Yes	Yes	No
Rural "Spoke"	Yes	Yes	No

IME/GME – Low Resident Count Reset

Section 131 of the CAA allows certain hospitals that have low FTE caps to establish new per resident amounts and teaching caps.

Hospitals Qualifying for a PRA/Cap Reset

Hospital Category	Requirement as of December 27, 2020
Category A	• A hospital that has an intern and resident count of **less than 1.0 FTE** in any cost reporting period beginning before **October 1, 1997**. • Reset occurs after hospital trains at least 1.0 FTE on after 12/27/2020 and before 12/26/2025.
Category B	• A hospital that has an intern and resident count of **no more than 3.0 FTEs** in any cost reporting period beginning on or after October 1, 1997, and before **December 27, 2020**. • Reset after hospital trains at least 3.0 FTEs on after 12/27/2020 and before 12/26/2025.

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IME/GME – Low Resident Count: Updating PRA

For qualifying hospitals, CMS proposes the following related to resetting the PRA.

CMS Proposes the Following to Calculate a New PRA:

1) Calculation will occur in the first year the hospital trains more than 1 (category A) or 3 (category B) residents during a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025.
2) PRA calculated based on the existing methodology – lesser of hospital actual GME cost in the new base year or geographic mean.
3) Hospitals with GME affiliation agreements will have PRA established when less than 1.0 is trained.
4) Residents may be in either an approved program that is "new" or may be in an existing approved program.

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IME/GME – Low Resident Count: Updating FTE Count

For qualifying hospitals, CMS proposes the following related to resetting their FTE cap.

CMS Proposes the Following to Calculate a New FTE Cap:

1) Calculation will occur in the first year the hospital trains more than 1 (category A) or 3 (category B) residents during a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025.
2) FTE cap calculated using existing methodology – determined in the 5th year of the new program based on the number of residents in training at that time.
3) 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.
4) Residents must be in a new program.

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IME/GME – IRIS

CMS makes two proposals related to the Intern and Resident Information System (IRIS).

Proposed IRIS Changes:

1) Providers will be required to use the new XML IRIS format for all cost reports with cost reporting periods beginning on or after October 1, 2021.
2) Cost reports will be rejected for lack of supporting documentation if they do not contain the same resident counts (unweighted and weighted) as the IRIS data submitted.

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Other Proposals

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Market-Based DRG Weights Data Collection Repeal

- In the FFY 2021 final rule, CMS adopted two DRG related policies that are being proposed for repeal:
  - ✓ For cost reports ending on or after January 1, 2021, non-excluded hospitals are required to report the median payer-specific negotiated charge for Medicare Advantage (MA) payers by MS-DRG on the Medicare Cost Report .
  - ✓ Beginning in FFY 2024, a new market-based methodology for estimating MS-DRG relative weights based on median payer-specific negotiated charge information.
- CMS is seeking comment on the repeal of these two policies as well as alternatives.

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Additional Proposals

- Adjustments to CAR T-Cell Therapy MS-DRG payments and coding
- Option to “freeze” risk level for certain ACOs at performance year (PY) 2021
- Updated policies for Organ Acquisition Payments
- Use of FFY 2019 discharge data and CMS records through March 2020 for RRC eligibility
- Extension of the following add-on payments
  - ✓ New technology payments for technologies approved for payment in FFY 2021
  - ✓ NCTAP payments through the fiscal year following the end of the COVID-19 pandemic
- Delay of the application of the Non-CC subgroup criteria for several MS-DRGs until 2023
- Updates to the IQR and Promoting Interoperability Programs

Organ Acquisition

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Counting Organs for Medicare Cost Allocation: Overview

CMS proposes to change the definition of a "Medicare organ" for reimbursement purposes. This change is estimated to reduce organ acquisition reimbursement by $4.15 billion nationally.

- **Background**: Medicare calculates organ acquisition costs using the percentage of usable "Medicare organs" (numerator) to total usable organs a hospital transplants and excises (denominator).
- **Denominator**: Total usable organs.
- **Current Numerator**: "Medicare usable organs" are those transplanted into Medicare beneficiaries and those excised and sent to either another transplant hospital or an OPO.
- **Proposed Numerator**: Beginning on October 1, 2021, "Medicare usable organs" include *only organs transplanted* into Medicare beneficiaries.

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Counting Organs for Medicare Cost Allocation: Overview

Historically, hospitals and OPOs have not had the ability to track the recipient of excised organs. CMS believes this is possible and can capture data identifying the recipient's insurance coverage.

CMS Asserts in Proposed Rule:

- OPTN policy requires OPOs use organ tracking capability.
- Some transplant hospitals voluntarily use tracking capabilities.
- Transplant hospitals that do not use tracking capabilities can acquire this data manually.

Impact on Medicare Share of Organ Acquisition Costs

Organ	2018 SRTR[1] Share	2018 Medicare Share	Percentage Point Difference
Kidney	58.60%	67.80%	-9.20%
Heart	33.00%	42.80%	-9.80%
Liver	29.20%	38.60%	-9.40%
Lung	45.70%	46.60%	-0.90%
Pancreas	45.80%	58.00%	-12.20%
Intestine	15.40%	14.90%	0.50%

1) Scientific Registry of Transplant Recipients (SRTR)

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Donor Community Hospitals: Overview

CMS proposes to limit what "Donor Community Hospitals" may charge for harvesting organs.

- 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 excises organ(s) from a cadaveric donor it bills the OPO its customary charges or a negotiated rate.
- CMS is concerned that some donor community hospitals are charging OPOs amounts that are in excess of reasonable costs.
- CMS proposes that beginning on October 1, 2021, donor community hospitals must bill the OPO its customary charges, reduced to cost.

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Codifying Existing Policy: Overview & Discussion

CMS is proposing to "codify" existing sub-regulatory guidance.

Area	PRM Citation	Concern
Living Donor/Cadaveric Standard Acquisition Charge[1]	3101/3102	Limited. Proposed rule details how acquisition costs are set in subsequent years, PRM does not.
Included Costs for Calculating Organ Acquisition Costs	3101/3102	Currently None.
Costs Related to Living Donor Complications[1]	3105B	Concern raised that complications are not considered organ acquisition costs after discharge.
Provisions Related to Pancreata Used for Pancreatic Islet Cell Transplants[1]	3110	Limited. Language related to "charge" varies slightly (full vs. standard charge) from rule to PRM
Principle of Intent to Transplant	3111	Currently None.
Counting and Cost Allocation of En Bloc Organs	3115	Currently None.
Counting and Cost Allocation of Research Organs	3115	Currently None.
Counting and Cost Allocation of Discarded Organs	3111/3116	Currently None.
Acquisition Costs for Medicare Secondary Payer Organs	3104	Currently None.
Acquisition Charges for Paired Kidney Exchange	3106	Currently None.

[1] See appendix for additional details.

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Surgeon Fees for Cadaveric Donor Kidney Excisions

CMS solicits data to determine the appropriateness of surgeon fees for cadaveric donor kidney excisions.

- Medicare's payment is limited to $1,250 for excising a cadaveric donor kidney.
- CMS indicates that cost report data from 48 OPOs showed average surgeon fee costs per local kidney of $745.
- CMS is soliciting data on surgical time, dry runs, travel and wait times, as well as the incremental time required for extended criteria donors and donors after cardiac death.
- Additionally, the proposed rule seeks resource information to determine the difference in procuring one kidney or a pair of kidneys from a single donor.

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Value-Based Quality Payment Programs: Hospital VBP Program, Hospital Readmissions Reduction Program, HAC Reduction Program

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COVID-19 PHE Measure Suppression Policy

- 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. Proposed factors include:
  - ✓ Significant performance deviation
  - ✓ Clinical proximity of measure to COVID-19
  - ✓ Rapid/unprecedented changes in care delivery, treatments, understanding of disease, etc.
  - ✓ National shortages or unprecedented changes in personnel, supplies, patient mix, etc.
- In accordance with the August 25th COVID-19 IFC, no claims data reflecting services provided January 1, 2020-June 30, 2020 will be used in calculations for the 3 quality programs.

FFY 2022 Hospital Value-Based Purchasing (VBP) Program

Due to the impact of COVID-19, CMS proposes to:

- Suppress all measures in the Person and Community Engagement, Safety, and Efficiency and Cost Reduction Domains for FFY 2022
- Adopt a special scoring and payment rule to account for the suppression of most measures for FFY 2022, under which CMS would not calculate a hospital's total performance score (TPS)
  - ✓ CMS would continue to make the statutory 2 percent reduction to each hospital's base operating DRG payment amount
  - ✓ Absent the availability of TPSs, 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)

FFY 2023 Hospital VBP Program

CMS proposes several policies to address the impact of COVID-19 but does not propose a neutral scoring methodology:

- ✓ CMS would suppress the pneumonia 30-day mortality measure from the Clinical Outcomes domain
- ✓ CMS would exclude patients with COVID-19 diagnosis from the Clinical Outcomes domain measures beginning with FFY 2023
- ✓ CMS would update baseline periods for the FFY 2024 program for Person and Community Engagement, Safety, and Efficiency and Cost Reduction domains from CY 2020 to CY 2019

CMS also proposes to permanently remove PSI-90 beginning with FFY 2023.

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Hospital Readmissions Reduction Program (HRRP)

- For FFY 2022, CMS proposes to only use data from July 1, 2017 – December 31, 2019 for HRRP calculations (excludes data from Q1 and Q2 of 2020 due to nationwide COVID-19 extraordinary circumstances exception (ECE))
- For FFY 2023, CMS proposes to:
  - ✓ Suppress Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506)
  - ✓ Exclude COVID-19 diagnosed patients from the measure denominators for the remaining 5 conditions.

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Hospital-Acquired Conditions (HAC) Reduction Program

- In addition to the exclusion of Q1 and Q2 2020 data due to the nationwide COVID-19 ECE, CMS proposes to suppress measure data for all HAC Reduction Program measures (the five CDC NHSN HAI measure and PSI-90) for Q3 and Q4 of 2020 for the FFY 2022 and 2023 payment years.
- CMS' proposal results in the following performance periods:

Measure	FFY 2022 Proposed Performance Period	FFY 2023 Proposed Performance Period
CDC NHSN HAIs	Jan. 1, 2019 – Dec. 31, 2019	Jan. 1, 2021 – Dec. 31, 2021
PSI-90	July 1, 2018 – Dec. 31, 2019	July 1, 2019 – Dec. 31, 2019 **PLUS** Jan. 1, 2021 – June 30, 2021

Hospital Inpatient Quality Reporting (IQR) Program

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Proposed Changes to Inpatient Quality Reporting (IQR) Program Measure Set

FFY Payment Determination	Proposed New Measures	FFY Payment Determination	Proposed Measure Removals
FFY 2023	COVID-19 Vaccination Among Healthcare Personnel (HCP)	FFY 2023	Deaths Among Surgical Inpatients with Serious Treatable Complications
	Maternal Morbidity Structural Measure	FFY 2026	Exclusive Breast Milk Feeding (eCQM)
FFY 2025	Hospital Harm – Severe Hypoglycemia Electronic Clinical Quality Measure (eCQM) (NQF # 3503e)		Admit Decision Time to Emergency Department departure (ED-2) (eCQM)
	Hospital Harm – Severe Hyperglycemia Electronic Clinical Quality Measure (eCQM) (NQF # 3533e)		Anticoagulation Rx for Atrial Fibrillation/Flutter (eCQM)
FFY 2026 (mandatory)	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure with Claims and Electronic Health Record Data (NQF #3502)		Discharged on Statin Medication (eCQM)

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COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure

- Proposed measure would track the percentage of healthcare personnel (HCP) who receive a complete COVID-19 vaccination
  - ✓ Detailed measure specifications available on CDC's website
  - ✓ HCP is defined to include all employees who receive a paycheck from the facility, licensed independent practitioners affiliated with – but not employed – by the facility, adult students, trainees and volunteers
- Hospitals would submit measure data using NHSN's standard data submission requirements via the CDC/NHSN web-based surveillance system.
- CMS proposes an initial data submission period of October 1, 2021 – December 31, 2021 (for the FFY 2023 IQR program), with full calendar year submissions required beginning with calendar year 2022 (FFY 2024 IQR program).
- CMS proposes to publicly report the measure quarterly on *Care Compare* beginning with the October 2022 refresh for data submitted in the 4th quarter of 2021

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Electronic Clinical Quality Measure (eCQM) Reporting

- 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**.
- Revisions to Current EHR Certification Requirements
  - ✓ Beginning with FFY 2025 payment (CY 2023 reporting), hospitals would be required to report the eCQMs using certified EHR technology consistent with 2015 Edition Cures Update as finalized in the ONC's 21st Century Cures Act final rule

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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
  - ✓ Development of a structural measure to assess the degree of hospital leadership engagement in health equity performance data
- 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).
  - ✓ CMS also seeks comments on publicly reporting such stratified data on *Care Compare* after at least one year of confidential reporting on the measure

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RFI: Closing the Health Equity Gap in Hospital Quality Programs

- CMS seeks comments on how to revise CMS 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:
  - ✓ Additional measure stratification – similar to current dual-eligible measure stratification – to include race/ethnicity, initially using indirect estimation methods, with possible public reporting
  - ✓ Expanded and standardized demographic data collection - such as the collection of a minimum set of standardized demographic data elements collected using certified EHR technology
  - ✓ Development of a Hospital Equity Score measure similar to Health Equity Summary Score used for Medicare Advantage contracts/plans

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RFI: Advancing Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

- 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 (dQMs) as, *"quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems."*
  - ✓ Potential role of FHIR-based standards for efficient exchange of clinical information across clinical settings through APIs, including transitioning to FHIR-based quality reporting through APIs for existing eCQMs
  - ✓ Other changes under consideration to advance digital quality measures, such as how dQMs could support alignment across public and private quality measurement efforts

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Promoting Interoperability Program Proposals

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Proposed Increase to Reporting Period and Minimum Scoring Threshold

- 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
  - ✓ Beginning in 2024, CMS proposes to increase the reporting period to a minimum of **any continuous 180-day period** for new and returning participants
- CMS proposes to raise the minimum scoring threshold to be considered a meaningful user of certified EHR technology from 50 points to **60 points.**

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Proposed Changes to Objectives and Measures

- ePrescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) Measure
  - ✓ CMS proposes to maintain as an optional measure for CY 2022 reporting, but seeks comments on the future direction of the measure
- Health Information Exchange (HIE) Objective
  - ✓ Beginning with FY 2022, CMS proposes to add a new, attestation-based, optional measure "Engagement in Bi-Directional Exchange Through Health Information Exchange (HIE)" that could be reported in place of the existing measures in the objective
- Provider to Patient Exchange Objective: Provide Patients Electronic Access to their Health Information Measure
  - ✓ CMS proposes to modify measure to require eligible hospitals and CAHs to ensure that patient health information remains available **indefinitely** and using **any application of the patient's choice**

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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
  - ✓ Electronic Reportable Laboratory Result Reporting
- CMS maintains current measure definitions and exclusions
  - ✓ Failure to report on any of the four measures (or reporting a "no" response for one or more of the measures) would result in a score of zero for the objective and a total score of zero for the PI program.
  - ✓ If exclusions claimed for all four measures, points to be redistributed to the Provider to Patient Exchange objective

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SAFER Guides and Information Blocking Attestation Statements

- Under the Protect Patient Health Information Objective, CMS proposes to add a new SAFER Guides measure beginning with the 2022 EHR reporting period.
  - ✓ 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.
- Due to the promulgation of information blocking regulations by ONC, CMS proposes to no longer require two of the three current information blocking 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."*

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Proposed Scoring Methodology for 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)

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eCQM Reporting Requirements

- 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 three self-selected eCQMs plus the Safe Use of Opioids – Concurrent Prescribing eCQM for all four calendar quarters
- CMS proposes to add and remove new eCQMs in alignment with IQR program proposals

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Closing Comments/Next Steps

Comments on the proposed rule are due to CMS by 2 p.m. (PT) on June 28, 2021 and can be submitted electronically at http://www.regulations.gov.

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Questions

We will take questions at the end of the webinar. However, if you have a question before then, please submit that question through the Q & A box – usually located at the bottom of your screen.

Contact

For questions, please contact us!

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Appendix – Selected Comparisons of the Proposed Rule to the Provider Reimbursement Manual

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Living Donor/Cadaveric Standard Acquisition Charge

CMS is proposing to codify the language below which is currently not found in sections 3110A or B in the Provider Reimbursement Manual.

> *"A TH calculates its subsequent living donor SAC for each living organ type by using the transplant hospital's actual organ acquisition costs for the living donor organ type from the prior year's MCR, adjusted for any changes in the current year. The TH divides these costs by the actual number of usable living organs procured by the TH during that prior cost reporting period. Currently, when a TH/HOPO provides an organ to another transplant hospital or OPO, it must bill the receiving TH or OPO its SAC, by organ type, or the hospital's standard departmental charges that are reduced to cost."*

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Living Donor Complications

Concern has been raised that costs related to living donor complications are not considered organ acquisition costs after the donor is discharged.

PRM 3105B

*"Expenses incurred for complications that arise with respect to the donor are covered only if they are directly **attributable to the organ donation**. Complications that arise after the date of the donor's discharge are billed under the recipient's health insurance claim number. This is true of both facility costs and physician services. "*

FFY 2022 IPPS Proposed Rule[1]

*"Medicare covers costs incurred for living kidney donor complications only if they are directly **attributable to the kidney donation**. Costs incurred for complications arising after the kidney donor's discharge date are billed under the Medicare transplant recipient's MBI, including facility costs and physician services. The contractor reviews costs for kidney donor complications billed under the transplant recipient's MBI."*

1) Page 1520 Display Copy FFY 2022 IPPS Proposed Rule

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Provisions Related to Pancreata Used for Pancreatic Islet Cell Transplants

The language related to pancreata procurement costs is modified in the proposed rule.

PRM 3110

*"The pancreata procured for islet cell transplants require the same quality and care to procure as pancreata procured for solid organ transplants. Accordingly, pancreata procured for islet cell transplants must be assigned **a full charge** and treated as solid organs for procurement purposes."*

FFY 2022 IPPS Proposed Rule[1]

*"The pancreata procured for islet cell transplants require the same quality and care to procure as pancreata procured for solid organ transplants. Accordingly, pancreata procured for islet cell transplants are treated as solid organs for procurement purposes, and pancreata procured for covered islet cell transplants must be assigned **a full standard acquisition charge**."*

1) Page 1521 Display Copy FFY 2022 IPPS Proposed Rule

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Thank you

Thank you for participating in today's webinar.

For education questions, contact:
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