Medicare Inpatient Prospective Payment System

Final Payment Rule Brief Provided by the Wisconsin Hospital Association

Program Year: FFY 2022

Overview and Resources

On August 2, 2021, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2022 payment final rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and marketbasket, this rule includes the adoption of the following policies:

- Rebasing and revising the IPPS marketbasket (MB) and the Capital Input Price Index (CIPI) based from FFY 2014 to FFY 2018;
- A rate increase amount (+0.5%) for the MACRA Coding Offset adjustment;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies including hospitals being eligible for DSH payments in FFY 2022 based on audited FFY 2018 S-10 data;
- Repealing the policy requiring hospitals to report the median payer-specific negotiated rates for inpatient services, by MS-DRG, for Medicare Advantage organizations on the Medicare cost report;
- Modification of Limitations on Redesignation by the Medicare Geographic Classification Review Board (MGCRB);
- Updates to the rules for the Value-Based Purchasing (VBP), Readmission Reduction Program (RRP) and Hospital-Acquired Condition (HAC) programs; and
- Updates to the payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive Programs.

Program changes will be effective for discharges on or after October 1, 2021 unless otherwise noted. CMS estimates the overall impact of this final rule update to be an increase of approximately $2.3 billion in aggregate payments for acute care hospitals in FFY 2022. This estimate includes operating, capital, and new technology changes as well as and increased payments as a result of the imputed floor provision.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page.

The Federal Register version of the final rule is available at https://www.federalregister.gov/public-inspection/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

Note: Text in italics is extracted from the August 13, 2021 Federal Register final rule

IPPS Payment Rates

Federal Register pages 44,794 - 44,795, 45,194 - 45,216, 45,313 – 45,317, 45,321 – 45,328, and 45,524 – 45,554

The table below lists the federal operating and capital rates adopted for FFY 2022 compared to the rates currently in effect for FFY 2021. These rates include all marketbasket increases and reductions as well as the application of annual budget neutrality factors, including CMS rebasing the MB and CIPI using FFY 2018 data. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the IQR Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

	Final FFY 2021	Final FFY 2022	Percent Change
Federal Operating Rate	**$5,961.31**	**$6,121.71** (proposed at $6,140.29)	**+2.69%** (proposed at +3.00%)
Federal Capital Rate	**$466.21**	**$472.60** (proposed at $471.89)	**+1.37%** (proposed at +1.22%)

The following table provides details for the finalized 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
Marketbasket/Capital Input Price Index update	**2.7%** (proposed at +2.5%)		**1.1%** (proposed at +1.0%)
ACA-Mandated Productivity Adjustment	**-0.7 percentage point (PPT)** (proposed at -0.2 PPT)		—
Forecast Error Adjustment	—	—	**-0.3%** (as proposed)
MACRA-Mandated Retrospective Documentation and Coding Adjustment	**+0.5%**	—	—
Wage Index Transition Adjustments	**+0.11%** (proposed at +0.13%)		**+0.47%** (proposed at +0.49%)
Annual Budget Neutrality Adjustments	**+0.07%** (proposed at +0.06%)		**+0.09%** (proposed at +0.02%)
Net Rate Update	***+2.69*** *(proposed at +3.00%)*	***+2.18%*** *(proposed at +2.5%)*	***+1.37%*** *(proposed at +1.22%)*

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** ***(Federal Register pages 45,215 and 45,524 – 45,525)***: The IQR MB penalty imposes a 25% reduction to the full MB and the EHR Meaningful Use (MU) penalty imposed a 75% reduction to the full MB; hence the entirety of 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 Marketbasket Update (2.7% MB less 0.7 PPT productivity adjustment)	**+2.0%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.7%)	—	**-0.675 PPT**	—	**-0.675 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.7%)	—	—	**-2.025 PPT**	**-2.025 PPT**
Adjusted Net Marketbasket Update (prior to other adjustments)	***+2.0%***	***+1.325%***	***-0.025%***	***-0.7%***

- **Rebasing and Revision of the Acute Care Hospital Marketbasket and Capital Input Price Index (CIPI) (*Federal Register pages 45,194 – 45,213 and 45,554):*** CMS rebases the IPPS MB and CIPI every four years by updating the costs and input price indexes used in the calculation, and may make revisions by changing the data sources for price proxies used in the input price index. The last update to the MB and CIPI was implemented in FFY 2018 using 2014 data as the base period for the construction of the costs.

  For FFY 2022, CMS will rebase the hospital marketbasket and CIPI cost weights using FFY 2018 Medicare cost

report data and the 2012 Benchmark Input-Output (I-O) "Use Tables/Before Redefinitions/Purchaser Value" tables published by the Bureau of Economic Analysis (BEA) which are available publicly at https://www.bea.gov/industry/io_annual.htm. Data taken from the BEA file are derived from the 2012 Economic Census, and will be inflated to 2018 values by CMS. In addition, CMS will revise several of the price proxies using Bureau of Labor Statistics (BLS) data.

As a result, CMS is adopting a marketbasket update of 2.7% and a CIPI of 1.1% for FFY 2022, which CMS states would be the same if rebasing was not done.

- **Retrospective Coding Adjustment** ***(Federal Register pages 44,794 – 44,795 and 45,533)*****:** CMS is adopting 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 initial coding offset rate increase was authorized as part of ATRA, which required inpatient payments to be reduced by $11 billion over a 4-year period, resulting in a cumulative rate offset of approximately -3.2%.

- **Outlier Payments** ***(Federal Register pages 45,533 – 45,544)*****:** 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 upcoming fiscal year. Therefore, for FFY 2022, CMS is finalizing 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 5.12% (proposed at 5.11%) of total IPPS payments; CMS is finalizing an outlier threshold of $30,088 (proposed at $30,967) for FFY 2022. This finalized threshold is 3.52% higher than the current (FFY 2021) outlier threshold of $29,064.

- **Stem Cell Acquisition Budget Neutrality Factor** (***Federal Register page 45,525 – 45,526***): CMS is finalizing not to remove the Stem Cell Acquisition budget neutrality factor from the FFY 2021 standard amount and to also not apply a new factor as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider using cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

Wage Index

Federal Register pages 45,162 – 45,194, 45,204 – 45,207, and 45,546 – 45,547

- **CBSA Delineation Updates** (**Federal Register** ***pages 45,249 – 45.253):*** CMS is adopting the revisions from the March 6, 2020 OMB Bulletin 20-01 for the FFY 2022 CBSA-based labor market area delineations under the IPPS. CMS states that the delineation changes within OMB Bulletin 20-01 would not affect the CBSA-based labor market area delineations used under the IPPS. Therefore, specific wage index updates are not necessary as a result of the updates. This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.

  Based on previously adopted regulations, hospitals in urban counties that would become rural will receive a 3-year transitional DSH adjustment. In the first year (FFY 2021), hospitals in these counties received an adjustment to DSH payments equal to 2/3rds of the difference between the prior urban DSH payments and the new rural DSH payments. In the second year (FFY 2022) following the change to rural status, these hospitals will instead receive an adjustment to their DSH payments equal to 1/3rd of the difference.

  For FFY 2021, CMS adopted a 5% cap on any decrease to a hospital's wage index. Due to the COVID-19 public health emergency (PHE), CMS had sought comment on whether the transition, set to expire at the end of FFY 2021, should be extended into FFY 2022. Based on public feedback, CMS is extending the transition period through FFY 2022 for hospitals that had received the 5% cap in 2021 (providers whose FFY 2021 wage index was less than 95% of their FFY 2020 wage index). As such, there will be a continued 5% cap on any decrease in a hospital's wage index compared to its wage index for FFY 2021 in order for providers who had received a transition adjustment for FFY 2021 to have additional time to adapt. This continued transition will be implemented in a budget neutral manner with a net budget neutrality factor of 1.001020, after backing out

the effects of the FFY 2021 adjustment.

- **Imputed Floor (*Federal Register pages 45,176 – 45,178):*** From FFY 2005 through FFY 2018, CMS had implemented a budget neutral imputed floor policy to address concerns from hospitals in all-urban states that felt disadvantaged by not having rural hospitals, and thus no wage index floor. For FFYs 2019 through 2021, hospitals in all-urban states received a wage index that was calculated without applying an imputed floor. The American Rescue Plan of 2021 established a minimum area wage index for hospitals in all-urban states for FFY 2022 and onward, not implemented in a budget neutral manner, which is applied after the application of the rural floor budget neutrality adjustment. This imputed floor is to be determined by taking the higher of two different methodologies for calculating a minimum wage index.
    - The "original" methodology was established for FFY 2005 where CMS "*…calculated the ratio of the lowest-to-highest CBSA wage index for each all-urban State as well as the average of the ratios of lowest-to-highest CBSA wage indexes of those all-urban States. …then compared the State's own ratio to the average ratio for all-urban States and whichever was higher was multiplied by the highest CBSA wage index value in the State—the product of which established the imputed floor for the State."*
    - The "alternative" methodology was established for FFY 2013 to address concerns that the "original" methodology could benefit all-urban states with multiple CBSAs but not benefit an all-urban state with only one CBSA. CMS *"…determined the average percentage difference between the post-reclassified, pre-floor area wage index and the post-reclassified, rural floor wage index (without rural floor budget neutrality applied) for all CBSAs receiving the rural floor. The lowest post-reclassified wage index assigned to a hospital in an all-urban State having a range of such values then was increased by this factor, the result of which established the State's alternative imputed floor."*

  The states that would receive an imputed floor are New Jersey, Rhode Island, Delaware, Connecticut, Puerto Rico, and Washington, D.C based on the data available for the final rule. CMS does include the imputed floor adjustment in wage index tables accompanying this final rule.

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals *(Federal Register pages 45,178 – 45,180)*:** CMS had noted that many comments from the Wage Index RFI in the FFY 2019 IPPS proposed rule reflected *"a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals."* As a result, CMS had made a variety of changes in the FFY 2020 final rule to reduce the disparity between high and low wage index hospitals.

  As adopted, this is to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years; for FFY 2022 CMS will continue to increase the wage index for low wage index hospitals. 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. CMS will continue to offset these increases in a budget neutral manner by applying a budget neutrality adjustment to the national standardized amount. For the FFY 2022 final rule, the value of the 25th percentile wage index is 0.8437 (proposed at 0.8418), and the final net budget neutrality adjustment is 1.000065 after backing out the effects of the FFY 2021 adjustment.

- **CY 2019 Occupational Mix Adjustment *(Federal Register pages 45,172– 45,175)*:** CMS adopted the use of the CY 2019 Occupational Mix Survey for the calculation of the FFY 2022 wage index. The final FFY 2022 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS finalized that the FFY 2022 occupational mix adjusted national average hourly wage will be $46.47 (proposed at $46.37).

- **Urban to Rural Reclassification *(Federal Register pages 45,184 – 45,190)*:** Based on perceived hospital behavior in cancelling rural reclassifications to manipulate the wage index floor, CMS is adopting a policy that cancellation requests must be submitted no earlier than one calendar year after a hospital's reclassification effective date. Additionally, since hospitals could still time their applications around the lock-in date for reclassification and the 120 day cancelation deadline to manipulate the State's rural wage index, CMS is also finalizing that

cancellation requests will become effective for the federal fiscal year that begins in the calendar year after the calendar year in which the cancelation request is submitted.

Additionally, as a result of the decision reached in *Bates County Memorial Hospital v. Azar*, CMS released an interim final rule with comment period (CMS-1762-IFC) with revised regulations to allow hospitals with a rural redesignation to reclassify under MGCRB using the rural reclassified area as the geographic area in which the hospital is located, effective with reclassifications beginning in FFY 2023, which are due to the MGCRB at September 1, 2021. This policy was also applied when deciding timely appeals of applications for reclassifications beginning in 2022 that were denied by the MGCRB due to the prior policy.

- **Labor-Related Share** ***(Federal Register pages 45,193 – 45,194 and 45,204 – 45,207)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2022, CMS will apply a labor-related share of 67.6% (as proposed) for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.
- **Cost-of-Living Adjustment Updates** ***(Federal Register pages 45,546 – 45,547)***: For inpatient facilities in Alaska and Hawaii, the IPPS provides a cost-of-living adjustment (COLA). The COLA is applied by multiplying the non-labor-related portion of the facility standardized amount by the applicable COLA factor. Under the IPPS COLA policy, the COLA amounts are revised every four years, when the IPPS market basket is rebased. As the IPPS COLA factors were last updated in FFY 2018, they are now due to be updated for FFY 2022. The adopted IPPS COLA factors, in effect for FFYs 2022 – 2025, for Alaska and Hawaii are shown below:

Area	FFYs 2018 -2021	Final FFYs 2022 - 2025
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.25	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.25	1.22
City of Juneau and 80-kilometer (50-mile) radius by foot	1.25	1.22
Rest of Alaska	1.25	1.24
Hawaii:		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.21	1.22
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

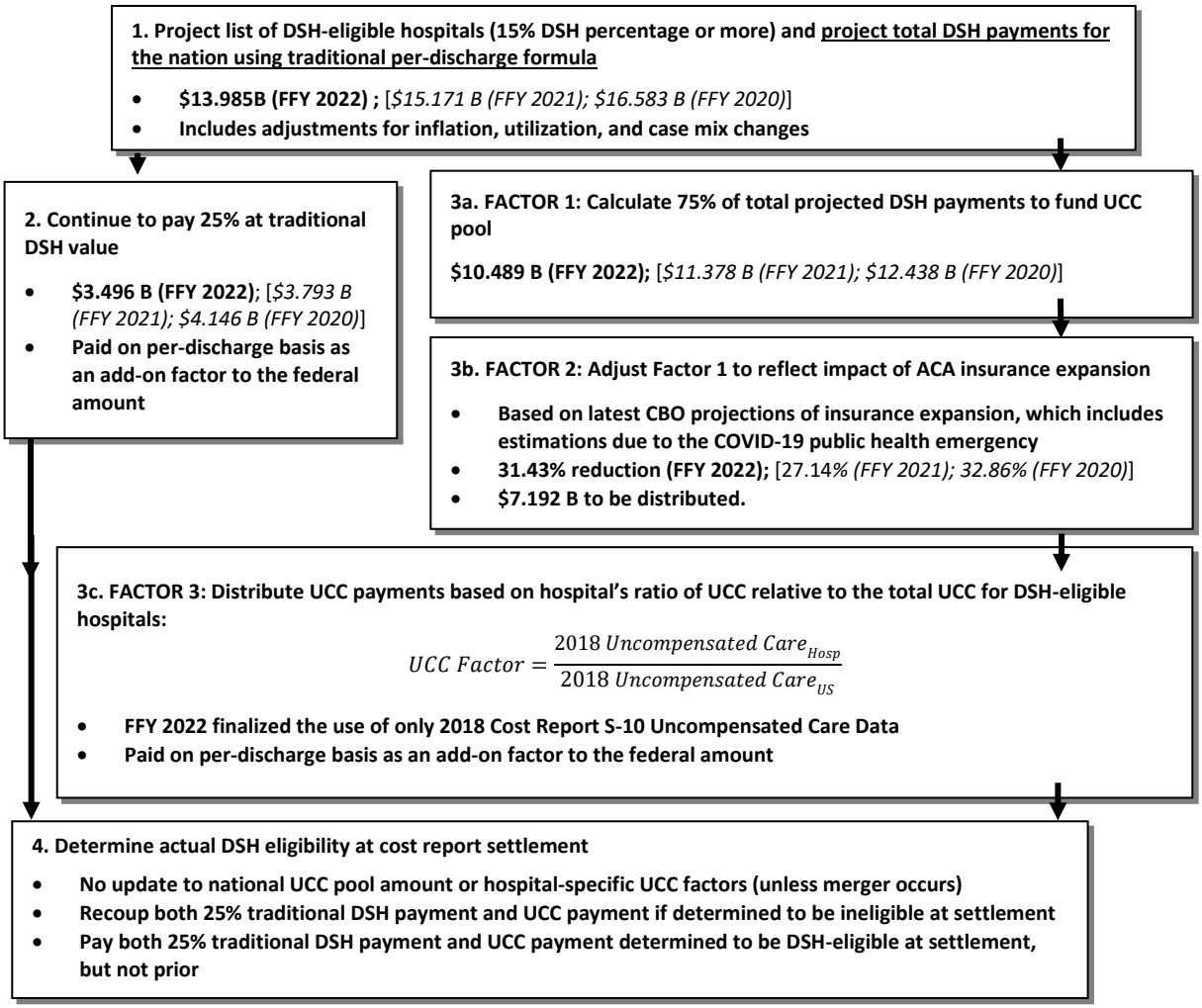
A complete list of the finalized wage indexes for payments in FFY 2022 is available on Table 2 on the CMS Web site at https://www.cms.gov/files/zip/fy-2022-ipps-final-rule-tables-2-3-and-4a-and-4b-wage-index-tables.zip

DSH Payments

Federal Register pages 45,221 – 45,249, and 45,585 – 45,589

The ACA mandates the implementation of Medicare DSH calculations and payments in order 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% of the funds, referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2022** ***(Federal Register pages 45,221 –45,248)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program has been finalized to change from FFY 2021 to FFY 2022:



The DSH dollars available to hospitals under the ACA's payment formula would decrease by $1.098 billion in FFY 2022 relative to FFY 2021 due to a decrease in the pool from projected DSH payments.

- **Eligibility for FFY 2021 DSH Payments** ***(Federal Register pages 45,222 – 45,224 and 45,585 – 45,589)*****:** CMS is projecting that 2,366 hospitals will be eligible for DSH payments in FFY 2022 based on audited FFY 2018 S-10 data. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2022. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file is available at https://www.cms.gov/files/zip/fy-2022-ipps-final-rule-medicare-dsh-supplemental-data-file.zip.

- **Adjustment to Factor 3 Determination** ***(Federal Register pages 45,232 – 45,249)*****:** CMS is adopting the continued use of the most recent single year of cost report data that has been audited for a significant number of hospitals receiving substantial Medicare uncompensated care payments to calculate Factor 3 for all eligible hospitals, with the exception of hospitals located in Puerto Rico and Indian Health Service (IHS) and Tribal hospitals.

  Similar to the FFY 2021 methodology, for FFY 2022 CMS is finalizing the use of Worksheet S–10 data from the audited FFY 2018 cost reports to calculate Factor 3.

  For the values provided with the FFY 2022 IPPS final rule, CMS utilized the March 2021 update of HCRIS (extract updated through June 30, 2021), except where report upload discrepancies by CMS or the MACs have

been corrected. CMS intends to use the March update for all future final rules but may consider using more recent data if appropriate.

Regarding hospitals for which CMS has elected to not use S-10 data in the past:

- **UCC Distributions for Indian Health Service (IHS) and Tribal Hospitals:** As in prior years**,** CMS is finalizing its intent to not utilize Worksheet S-10 for the calculation of Factor 3 for IHS/Tribal hospitals. Instead, Factor 3 amounts for these providers would be calculated by utilizing the FFY 2013 data for Medicaid days, due to the effects of Medicaid expansion on data reported for FFYs 2014 and 2015, which would then combined with the most recent update of the SSI days. The denominator for these hospitals' Factor 3 determination would continue to be based on low-income patient days.
- **UCC Distributions for Puerto Rico Hospitals:** For FY 2022, CMS adopted the use of the same methodology finalized in FFY 2021 to determine Factor 3 for Puerto Rico hospitals based on FFY 2013 Medicaid days and the most recent update of SSI days, with a denominator based on low-income patient days. In addition, as residents of Puerto Rico are not eligible for SSI benefits, CMS also finalized the continued use of a proxy for SSI days for Puerto Rico hospitals, consisting of 14 percent of a hospital's Medicaid days.

CMS is adopting its modification to the use of a hospital's three-year average discharge number to estimate their uncompensated care payment per discharge. CMS believes that using a three-year average which includes FFY 2020 discharge data would underestimate discharges due to the COVID-19 pandemic affecting number of discharges. Instead, CMS is adopting the use of a two-year average of discharges to calculate interim payments (FFY 2018 and FFY 2019). As in past years, interim payments made using this value will be reconciled at cost report settlement to equal the uncompensated care pool distribution amount that will be published with the FFY 2022 IPPS final rule.

For FY 2022, CMS finalized its proposal that hospitals will have 15 business days from the date of public display of the FFY 2022 IPPS PPS final rule to review and submit comments on the accuracy of the table and supplemental data file published along with the rule. Comments regarding issues that are specific to data and supplemental data files for this final 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.

- **Counting Days Associated with Section 1115 Demonstration Projects in the Medicaid Fraction** ***(Federal Register page 45,249):*** Due to a number of court decisions regarding the inclusion of patient days in the numerator of the Medicaid fraction when calculating a hospitals disproportionate patient percentage, CMS had proposed 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 receives inpatient hospital coverage on that day under an authorized waiver. CMS will continue to review and is planning to release a document separate from this final rule to address the large numbers of comments they received relating to this proposal.

GME Payments

Federal Register pages 44,776, 45,221, and 45,310 – 45,313

The Consolidated Appropriations Act (CAA) of 2021 contained 3 provisions affecting direct Graduate Medical Education (GME) and indirect (IME) payments, which CMS had proposed to implement. In this final rule, CMS is not elaborating on comments received related to these provisions, and is planning to address public comments in future rulemaking. For more information, please refer to the proposed rule on pages 25,502 – 25,524 of the May 10, 2021 *Federal Register*.

CMS is finalizing their proposal that for cost report periods beginning on or after October 1, 2021, GME and IME FTE counts on the submitted Intern and Resident Information System (IRIS) diskette must match the total FTE counts reported on the cost report.

The Indirect Medical Education adjustment factor will continue to remain at 1.35 for FFY 2022.

Updates to the MS-DRGs

Federal Register pages 44,789 – 44,794, 44,795 – 45,162, 45,317 – 45,320 and 45,529

Each year CMS updates the 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 IPPS rate-setting, CMS typically uses the MedPAR claims data file that contains claims from discharges 2 years prior to the fiscal year that is the subject of rulemaking. For Hospital Cost Report data, CMS traditionally uses the dataset containing cost reports beginning 3 years prior to the fiscal year under study. CMS evaluated whether this method is still applicable for FFY 2022, and determined that both the FFY 2020 MedPAR claims data and the FFY 2019 Hospital Cost Report data have been significantly impacted by the COVID-19 PHE. Therefore, CMS finalized the use of FFY 2019 MedPAR claims data and FFY 2018 Hospital Cost Report data in situations where the utilization patterns in the FFY 2020 MedPAR data were significantly impacted by COVID-19 PHE for the FFY 2022 IPPS rate setting.

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	Final FFY 2022 Weight	Percent Change
MS-DRG 218: CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITHOUT CC/MCC	5.1432	6.1093	+18.78%
MS-DRG 014: ALLOGENEIC BONE MARROW TRANSPLANT	12.7788	10.6770	-16.45%
MS-DRG 228: OTHER CARDIOTHORACIC PROCEDURES WITH MCC	6.2153	5.3303	-14.24%
MS-DRG 229: OTHER CARDIOTHORACIC PROCEDURES WITHOUT MCC	3.988	3.4412	-13.71%
MS-DRG 293: HEART FAILURE AND SHOCK WITHOUT CC/MCC	0.6526	0.5899	-9.61%

When CMS reviews claims data, they apply 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 criteria in order 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 are in the subgroup;
- average costs between the subgroups show at least a 20-percent difference; and
- there is 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 the proposed rule, CMS found that applying this criteria 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 3 severity levels) and the creation of 58 new MS-DRGs. These updates would also have an impact on relative weights and payments rates for FFY 2022. Due to the PHE and concerns about the impact that implementing this many MS-DRG changes at one time, CMS is finalizing the delay of the application of the Non-CC subgroup criteria for these MS-DRGs until FFY 2023 and, in the meantime, maintain the current structure for FFY 2022.

The full list of the final 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 https://www.cms.gov/files/zip/fy2022-ipps-fr-table-5-fy-2022-ms-drgs-relative-weighting-factors-and-geometric-and-arithmetic-mean.zip. For comparison purposes, the

FFY 2021 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy-2021-ipps-fr-table-5.zip.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapies** ***(Federal Register pages 44,798 – 44,806, 44,963 – 44,965, 45,319 – 45,320, and 45,525 – 45,526)*****:** CAR T-cell treatments are 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 these procedure codes to the most appropriate MS-DRG. For FFY 2022, the adopted new codes assigned to MS-DRG 018 can be found in Table 6B. – New Procedure Codes available at https://www.cms.gov/files/zip/fy2022-ipps-nprm-tables-6a-6j.zip. CMS also finalized the revision of 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 is adopting an adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018, similarly to FFY 2021. The adjustment of 0.17 will 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.

- **New Technology** ***(Federal Register pages 44,967 – 45,162)***: CMS states that numerous new medical services or technologies are potentially eligible for add-on payments outside the PPS. Due to the circumstances around FFY 2022 rate setting and the COVID-19 PHE, CMS adopted a one-time exception to continue add-on payments for certain 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 the 13 technologies approved can be found on Federal Register pages 44,974– 44,975.

  In FFY 2021, CMS adopted a policy 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 QIDPs or LDAP, even if it has not yet received 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 considered the implementation of 16 new technology add-on payments under the traditional pathway, of which 7 were approved; and 12 under alternative pathways, of which 9 were approved and one of which (CONTEPO) was approved conditionally.

  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 which the cost of the case exceed the standard DRG payment, including the relative weight Coronavirus Aid, Relief, and Economic Security Act adjustment.

  In this rule, CMS is finalizing its proposal, with modification, that any discharges which qualify for NCTAP shall 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 adopted for eligible products that are not otherwise approved for new technology add-on through the end of the fiscal year in which the PHE ends.

CMS did not finalize a discontinuation of the NCTAP for eligible products approved for the new technology add-on for FFY 2022, but instead the NCTAP will also be extended through the end of the fiscal year that the PHE ends. CMS is also finalizing the proposal to reduce the NCTAP for an eligible case by the amount of any new technology add-on payment so there is no financial incentives in choosing technologies eligible for both NCTAP and new technology add-on payments.

- **Market-Based MS-DRG Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights - Repeal** ***(Federal Register pages 45,317 – 45,319)***: In FFY 2021, CMS adopted 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 finalizing its repeal of both of the aforementioned policies and is not currently finalizing an alternative approach.

Low-Volume Hospital Adjustment

Federal Register pages 45,219 – 45,221

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Bipartisan Budget Act of 2018 had extended the relaxed low volume adjustment criteria (>15-road miles/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 total discharges (rather than 1,600 Medicare discharges). The current 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 with FFY 2023, the criteria for the low-volume hospital adjustment will return to the more restrictive levels. At that point, in order to receive a low-volume adjustment, subsection (d) hospitals would need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status for FFY 2022, consistent with historical practice, a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria. The MAC must receive a written request by September 1, 2021 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2021. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Under this process, a hospital receiving the adjustment for FFY 2021 may continue to receive it without reapplying if it continues to meet the mileage and discharge criteria.

RRC Status

Federal Register pages 45,216 – 45,219

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of 3 optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the

minimum 275 bed criteria). The finalized FFY 2022 minimum case-mix and discharge values are available on the pages listed above.

CMS notes that the CMI values calculated using FFY 2019 data differ greatly from those calculated using FFY 2020. As such, CMS is adopting the calculation of CMI values for FFY 2022 using discharge data from FFY 2019 and bills posted to CMS' records through March 2020.

Organ Acquisition Payment

Federal Register page 44,776

Organ acquisition costs are excluded from the MS-DRGs and instead are paid based on reasonable and necessary costs. According to the Medicare reasonable cost principles and the prohibition of cross-subsidization, the cost of services for organ acquisition costs must be borne by the appropriate payer.

In the IPPS proposed rule, CMS stated that in order for Medicare to more accurately pay its share of organ acquisition costs, they believed it was necessary to require that transplant hospitals (THs)/hospital based organ procurement organizations (HOPOs) keep track of organs and the identity of the organ recipient, and whether that recipient is a Medicare beneficiary. CMS had proposed that, beginning FFY 2022, THs/HOPOs must accurately count and report Medicare usable organs and kidneys and total usable organs/kidneys on their Medicare hospital costs reports. CMS also proposed that instead the donor community hospital must bill the OPO its customary charges that are 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 also requested information on the physician effort and resources required to procure a cadaveric kidney for transplantation to assist with future proposals related to physician fee payment for organ retrieval from cadaveric donors.

In this final rule, CMS is not elaborating on comments received and is planning to address public comments in future rulemaking. For more information please refer to the proposed rule on pages 25,656 – 25,676 of the May 10, 2021 *Federal Register*.

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

Federal Register pages 45,498 – 45,502

For FFY 2022 and subsequent years, CMS is finalizing a policy that, for the purposes of determining Medicare cost-sharing obligations, state Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers as long as the provider or supplier meets all Federal Medicaid enrollment requirements. CMS noted with this policy that states are not required to recognize or enroll additional provider types for purposes other than submission and adjudication of cost sharing claims or issuance of a Medicaid remittance advice. Compliance with this policy will be enforced beginning January 1, 2023 and CMS will propose enforcement penalties, if necessary, in future rulemaking.

Medicare Shared Savings Program

Federal Register pages 45,502 – 45,506

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 finalizing its proposal 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 the same level which it participated during PY 2021. This is similar to the provision granted to ACOs in the May 2020 COVID-19 IFC.

For PY 2023, an ACO that opted for a PY 2022 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 Federal Register page 45,504 shows the different glide path scenarios for each if an ACO elected to maintain their levels.

Quality-Based Payment Adjustments

Federal Register pages 45,249 – 45,310

For FFY 2022, IPPS payments to hospitals will be adjusted for quality performance under the Readmissions Reduction Program (RRP) and the Hospital-Acquired Conditions (HAC) Reduction Program. Detail on the FFY 2022 programs and payment adjustment factors are below (future program year program changes are addressed in the next section of this brief):

- **Value Based Purchasing (VBP) Adjustment** ***(Federal Register pages 45,266 – 45,300)*****:** Due to the COVID-19 PHE, CMS is suppressing all Person and Community Engagement, Safety, and Efficiency and Cost Reduction measures and therefore not adjusting hospital payments for the FFY 2022 program year.

  CMS will still provide FFY 2022 confidential feedback reports to hospitals to allow review of changes in performance rates that CMS has observed. CMS also will still publically report Q3 and Q4 2020 data noting the limitations of the data.

  In the August 25th COVID-19 interim final rule with comment period (IFC), CMS updated the extraordinary circumstances exception policy in response to the public health emergency so that no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the VBP Program. This was **not** extended for Q3 and Q4 of 2020.

  Details and information on the program currently in place for FFY 2020 and FFY 2021 program are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

- **Readmissions Reduction Program (RRP)** ***(Federal Register pages 45,249 – 45,266)*****:** The FFY 2022 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

  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 RRP. Therefore, the FFY 2022 RRP will only use data from July 1, 2017 - December 31, 2019 for calculations. This was **not** extended for Q3 and Q4 of 2020.
  Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare Fee-For-Service and Medicare Advantage patients during the same 3-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the 6 measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

  The data applicable to the FFY 2022 RRP program is still being reviewed and corrected by hospitals, and therefore CMS did not yet post factors for the FFY 2022 program in Table 15. CMS expects to release the final FFY 2022 RRP factors in the fall of 2021.

  Details and information on the RRP currently are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.

- **HAC Reduction Program** ***(Federal Register pages 45,300 – 45,310)*****:** The FFY 2022 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC

measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates , and Clostridium difficile (C.diff.) rates. The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

Adopted in the August 25th COVID-19 IFC, no claims and chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the HAC Reduction Program. Some data reporting has been made optional as well. Please refer to CMS-3401-IFC for details. In this final rule, CMS adopted the extension of this policy for Q3 and Q4 of 2020 for HAC. This results in the following FFY 2022 performance periods:

- FFY 2022: PSI-90 from July 1, 2018 – December 31, 2019, HAI from January 1, 2019 – December 31, 2019.

CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166.

Quality-Based Payment Policies—FFYs 2023 and Beyond

For FFYs 2023 and beyond, CMS is adopting new policies for its quality-based payment programs.

For all of the quality-based payment programs, CMS is adopting the following measure suppression factors to determine whether to suppress a measure in the program for one or more years that overlap with the COVID-19 PHE:

- *"Significant deviation in national performance on the measure during the PHE for COVID-19, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years.*
- *Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.*
- *Rapid or unprecedented changes in: (i) clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or (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.*
- *Significant national shortages or rapid or unprecedented changes in: (i) healthcare personnel; (ii) medical supplies, equipment, or diagnostic tools or materials; or (iii) patient case volumes or facility-level case mix."*

Additionally for all programs, CMS requested comment on the creation of a measure suppression policy in preparation for a future national PHE and if such policy should have the flexibility to suppress certain measures outside of the rulemaking process. CMS is also asked for feedback on whether a regional adjustment should be included in the measure suppression policy. Public comment can be found on Federal Register pages 45,252 – 45,253 for RRP, 45,303 – 45,304 for VBP, and 45,303 – 45,304 for HAC.

- **VBP Program** ***(Federal Register pages 45,266 – 45,300)*****:** CMS had already adopted VBP program rules through FFY 2022 and some program policies and rules beyond FFY 2022. CMS is adopting further program updates through FFY 2027, which include:
  - National performance standards for a subset of the FFYs 2024 and 2027 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking).

  Due to the impact of the COVID-19 PHE, CMS is implementing the following:

- Omit 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 for FFY 2022 that calculates measure rates for all measures, but only achievement/improvement/domain scores for the Clinical Outcomes domain. These scores are solely for information purposes as all hospitals will be given a value-based incentive payment amount that leaves base operating DRG payments unchanged for FFY 2022;
- Omit the MORT-30-PN measure for the FFY 2023 program;
- Exclude COVID-19 diagnosed patients from the denominators for the Clinical Outcomes domain measures beginning with the FFY 2023 program; and
- Update baseline periods for the FFY 2024 program for Person and Community Engagement, Safety, and Efficiency and Cost Reduction domains from Calendar Year (CY) 2020 to CY 2019.

Separately, CMS is finalizing the removal of the Patient Safety and Adverse Events Composite (PSI-90) measure (NQF #0531) measure from the VBP program beginning with FFY 2023 (and therefore the measure would no longer be added into the program) due to the cost associated with the measure outweighing the benefit of its use in the program.

- **Readmissions Reduction Program** ***(Federal Register pages 45,249 – 45,266)*****:** CMS is finalizing an automatic adoption of the use of MedPAR data for the measure 3-year performance period beginning FFY 2023 and for all subsequent program years, unless otherwise specified.

  Due to the impact of the COVID-19 PHE, CMS is finalizing the following:

  - Omit the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506) from the FFY 2023 program (measure would be weighted at 0%); and
  - Exclude COVID-19 diagnosed patients from the measure denominators for the remaining 5 conditions beginning with the FFY 2023 program. In the final rule, CMS clarified that this includes patients with a primary or secondary diagnosis present on admission of COVID-19 from both index admissions and readmissions.

  In addition, CMS made several clarifications for the current Extraordinary Circumstance Exception (ECE) Policy which can be found on Federal Register pages 45,260 – 45,262.

  Lastly, CMS requested comment on possible future stratification of condition/procedure-specific readmission measure results by race/ethnicity, and the collection of additional social risk factors (ex. Language preference, disability status). Specifically, CMS suggested providing confidential hospital specific reports for the 6 readmission measures stratified by both dual eligible (as done previously) and race/ethnicity in Spring 2022, with publication of the results in Spring 2023. CMS also sought comment on mechanisms for incorporating other demographic characteristics to address and advance health equity, including the potential to include administrative and self-reported data to measure co-occurring disability status. Comments can be found on Federal Register pages 45,263 – 45,266.

- **HAC Reduction Program** ***(Federal Register pages 45,300 – 45,310)*****:** CMS is suppressing 3Q2020 and 4Q2020 (July 1, 2020 through December 31, 2020) PSI-90 and CDC NHSN HAI measure data from the HAC program for FFY 2022, FFY 2023, and FFY 2024 due to the COVID-19 PHE. Therefore, with the previously finalized omission of January 1, 2020 - June 30, 2020 data from the program, this would result in the following performance periods:

  - FFY 2022: PSI-90 from July 1, 2018 – December 31, 2019, HAI from January 1, 2019 – December 31, 2019;
  - FFY 2023: PSI-90 from July 1, 2019 – December 31, 2019 and January 1, 2021 – June 30, 2021, HAI from January 1, 2021 – December 31, 2021; and
  - FFY 2024: PSI-90 from January 1, 2021 – June 30, 2022 and HAI from January 1, 2021 – December 31, 2022.

Hospitals will still be required to submit 3Q2020 and 4Q2020 data and data would still be publically reported. CMS will also still include 3Q and 4Q 2020 in feedback reports to hospitals for information purposes.

Separately, CMS is making several clarifications for the current ECE Policy listed on Federal Register pages 45,308 – 45,310.

Updates to the IQR Program and Electronic Reporting Under the Program

Federal Register pages 45,360 – 45,426

CMS is adopting five new measures into the IQR program:

- Maternal Morbidity Structural Measure for CY 2021 reporting period/FFY 2023 payment determination beginning with a shortened reporting period from October 1, 2021 - December 31, 2021;
- Hybrid Hospital-Wide All-Cause Risk Standard Mortality (Hybrid HWM) - beginning with a voluntary submission period which would run from July 1, 2022 - June 30, 2023 followed by mandatory reporting for the FFY 2026 payment determination beginning with July 1, 2023 - June 30, 2024;
- COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) for CY 2021 reporting period/FFY 2023 payment determination beginning with a shortened reporting period from October 1, 2021 - December 31, 2021;
- Hospital Harm-Severe Hypoglycemia eCQM beginning with the CY 2023 reporting period/FFY 2025 payment determination; and
- Hospital Harm-Severe Hyperglycemia eCQM beginning with the CY 2023 reporting period/FFY 2025 payment determination.

CMS also finalized, with modification, to begin reporting the COVID-19 Vaccination measure on Care Compare with the September 2022 refresh, or as soon as feasible. Instead of adding one additional quarter of data during each advancing refresh as proposed, CMS will only report the most recent quarter of data.

CMS is not adopting its proposal to remove one measure from IQR beginning with the CY 2021 reporting period/FFY 2023 payment determination:

- Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI-04).

CMS is also finalizing the removal of three measures from IQR beginning with the CY 2024 reporting period/FFY 2026 payment determination:

- Exclusive Breast Milk Feeding (PC-05) (NQF #0480);
- Admit Decision Time to ED Departure Time for Admitted Patients (ED-2); and
- Discharged on Statin Medication (STK-06).

CMS is not finalizing the removal of Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) for the CY 2024 reporting period/FFY 2026 payment determination.

In the proposed rule CMS sought comment on the potential of the following new measures for the IQR program. The measures and corresponding comment Federal Register pages are as follows:

- 30-Day, All-Cause Mortality Measure for Patients Admitted With COVID-19 Infection (Federal Register page 45,407); and
- Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (Federal Register pages 45,411 – 45,414).

In addition, CMS has identified several opportunities in which the IQR program could address the gap in existing health inequities including the stratification of HWR measure data by both dual eligibility and race/ethnicity as well as the inclusion of a structural measure assessing the degree of hospital leadership engagement in health equity performance data. Comments can be found on Federal Register pages 45,415 – 45,416.

In the FFY 2021 final rule, CMS finalized a progressive increase, over a 3-year period, to the number of quarters for which hospitals are required to report eCQM data up to four quarters of data. Until hospitals are required to

submit 4 calendar quarters of self-selected data, the quarters chosen can either be consecutive or nonconsecutive. The transition is outlined below.

Reporting Period/Payment Determination	Finalized # of Self-Selected Calendar Quarters Required	Finalized # of Self-Selected eCQMs required
CY 2021 reporting period/FFY 2023 payment determination	2	4
CY 2022 reporting period/FFY 2024 payment determination	3	3 and Safe Use of Opioids eCQM
CY 2023 reporting period/FFY 2025 payment determination	4	

In the CY 2021 Payment Policies Under the Physician Fee Schedule Final Rule, CMS expanded flexibility under Hospital IQR Program by allowing hospitals to use either technology certified to the 2015 Edition criteria for CEHRT as was previously finalized for reporting eCQMs and for reporting hybrid measures, or technology certified to the 2015 Edition Cures Update standards. In this rule, CMS is finalizing a proposal that hospitals only use 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. CMS is clarifying that certified technology must support the reporting requirements for all available eCQMs.

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. In this rule, CMS is finalizing 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.

Tables in the final rule on Federal Register pages 45,399 – 45,406 outline the previously adopted and newly finalized Hospital IQR Program measure set for the FFYs 2023 – 2026 payment determination and subsequent years.

In the CY 2021 OPPS/ASC final rule, CMS adopted modifications to the methodology used to calculate the Overall Hospital Quality Star Rating. The Overall Star Rating will continue to use data collected on hospital inpatient and outpatient measures that are publicly reported on Care Compare through CMS quality programs, including data from the Hospital IQR Program.

Request for Information – Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

Federal Register pages 45,342 – 45,349

CMS aims to move to fully digital quality measurement in quality reporting and value-based purchasing programs by 2025. CMS has heard from stakeholders about the technological challenges and burden of reporting eCQM data and therefore is currently working to convert current eCQMs to FHIR. CMS specifically asked for feedback on its potential use of FHIR, a free and open source standards framework, to define digital quality measures (dQMs) within hospital quality programs. Comments can be found on Federal Register pages 45,347 – 45,349.

Request for Information – Closing the Health Equity Gap in CMS Hospital Quality Programs

Federal Register pages 45,349 – 45,360

CMS requested public comment on potential expansion of current disparity methods in hospital quality programs. CMS states it is committed to achieving equity in health care outcomes and supporting providers in quality

improvement activities to reduce health inequities. Comments on the topic can be found on Federal Register pages 45,356 – 45,360.

Promoting Interoperability Program

Federal Register pages 45,460 – 45,498

The Medicaid Promoting Interoperability Program is ending CY 2021 and therefore December 31, 2021 is the last date that States can make program incentive payments to Medicaid eligible hospitals (other than pursuant to a successful appeal related to 2021 or a prior year).

For the Medicare Promoting Interoperability Program, CMS will continue an EHR reporting period minimum of any continuous 90-day period for CY 2023 for new and returning participants. For CY 2024, CMS is adopting an increase to the EHR reporting period minimum to any continuous 180-day period for new and returning participants. CMs states this would minimally increase burden and the additional data would help to further improve the program.

CMS is finalizing that the Query of Prescription Drug Monitoring Program (PDMP) measure remain optional but is worth 10 bonus points, instead of 5, beginning with CY 2022 reporting. This will increase maximum Electronic Prescribing points to 20 for CY 2022. With this, CMS also requested feedback on requiring the Query of PDMP measure in the near future. Comments are on Federal Register pages 45,463 – 45,464.

Separately, beginning with CY 2022 reporting, CMS is adopting the Health Information Exchange (HIE) Bi-Directional Exchange measure as an optional alternative to the two existing Health Information Exchange measures (listed below). Hospitals and CAHs will either need to report the two existing measures OR the new bi-directional exchange measure. The new measure will be worth 40 points. CMS is hoping this optional measure incentivizes eligible hospitals and CAHs *"to participate in HIEs while establishing a high performance standard for sharing information with other health care providers."*

CMS is also adopting its proposal to begin requiring the following four measures of the Public Health and Clinical Data Exchange objective, beginning with CY 2022 reporting, in order to allow nationwide syndromic surveillance for early warning of emerging outbreaks and threats:

- Syndromic Surveillance Reporting ;
- Immunization Registry Reporting;
- Electronic Case Reporting; and
- Electronic Reportable Laboratory Result Reporting.

An eligible hospital or CAH will receive 10 points for the objective if they report a "yes" response for each of the 4 required measures. If a hospital does not report "yes" for each of the 4 measures, the hospital will need to claim applicable exclusions for which they quality for the remaining measures. Otherwise, they will receive 0 points. If the hospital or CAH claims applicable exclusions for all four measures, CMS will redistribute the points associated with the Provider to Patient Exchange objective.

As for the two other measures in the Provider to Patient Exchange objective, CMS is making them optional and available for 5 bonus points if they report a "yes" for either of the measures.

Lastly, CMS is adopting a new SAFER Guides measure to the Protect Patient Health Information objective beginning with CY 2022 EHR reporting with a "yes/no" response that will not impact the score of the Medicare Promoting Interoperability Program but is required.

Adopted Performance-Based Scoring Methodology Beginning with the CY 2022 EHR Reporting Period		
Objectives	**Measures**	**2022: Maximum Points**
Electronic Prescribing	e-Prescribing	10 points
	Query of Prescription Drug Monitoring Program (PDMP)	10 points (bonus) ***(adopted)***

Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	20 points
	OR	
	Health Information Exchange (HIE) Bi-Directional Exchange measure	40 points (optional instead of previous 2 measures) ***(adopted)***
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	**Finalized** as Required with yes/no response Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Electronic Reportable Laboratory Result Reporting	10 points ***(adopted)***
	Finalized as optional to report one of the following Public Health Registry Reporting Clinical Data Registry Reporting	5 points (bonus) ***(adopted)***

With regards to the scoring methodology, CMS is finalizing an increase to the minimum scoring threshold from 50 points to 60 points (out of 100 points) beginning with CY 2022.

In addition, CMS is not adopting its proposal to modify the Provide Patients Electronic Access to Their Health Information measure beginning with the CY 2022 reporting period to add a data availability requirement.

Beginning with CY 2022 reporting, CMS will eliminate 2 of the 3 attestation statements that require a hospital demonstrates that the hospital has not knowingly and willfully taken action to limit or restrict the compatibility or interoperability of the certified EHR technology.

Consistent with the Hospital IQR program, CMS is removing three eCQMs (proposed to remove four eCQMs) and is adopting two new eCQMs from the Hospital IQR programs measure set. These are listed in the IQR section of this brief.

Also to align with the changes to IQR, CMS will now require hospitals to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for eCQMs, beginning CY 2023 reporting period.

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