April 28, 2021

To: Strategic Health Care Clients

From: Strategic Health Care Staff

Re: Summary of CMS' Proposed 2022 IPPS Rule

On April 27, 2021, CMS released the agency's Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital 2022 proposed rule. Please note that many of the policies will impact both short-term and long-term acute care hospitals. The 1,900+ page proposed rule is here, the fact sheet is here and the press release is here.

Comments on the proposed IPPS rule are due June 28.

Significant Policy Changes and Payment Updates:

IPPS Payment Update: CMS proposes an increase of 2.8% for 2022 or approximately $3.4 billion prior to accounting for a $.9 billion decrease in Medicare uncompensated care and Disproportionate Share Hospital (DSH) payments. For hospitals that report on quality measures and are meaningful users of EHRs, operating payments would increase by 2.8%. Among other policy changes that impact the update is a: five percent market basket increase; a ACA-mandated two percent reduction for productivity; a five percent coding adjustment increase as provided in MACRA; and, additional reductions to the market basket update for hospitals that do not successfully participate in the Hospital Inpatient Quality Reporting (IQR) program or the Promoting Interoperability program.

Medicare Uncompensated Care Payments: CMS is proposing to distribute roughly $7.6 billion in uncompensated care payments, a decrease of $660 million decrease from 2021. CMS is also proposing to: use 2019 data for rate setting in instances where FY 2020 data is significantly impacted by the COVID-19 PHE; the agency is proposing a one-year extension of NTAPs for 14 technologies which would have been discontinued in FY 2022; as authorized under the American Rescue Plan Act, proposing to reinstate the imputed floor wage index methodology for all-urban states; and, as authorized under the Consolidated Appropriations Act of 2021, proposing a five year extension of Rural Community Hospital and Frontier Community Health Integration Project (FCHIP) demo.

Table on page 32 and discussion begins on page 901.

CMS Proposed to Reverse Trump Administration Price Transparency Reporting Provision: CMS proposes to repeal the previous administration's policy requiring hospitals to report market-based payment information on Medicare cost reports starting January 1, 2021. CMS also proposes to repeal the agency's policy to begin calculating MS-DRG relative weights based on market-based rate information beginning in 2024.

The discussion of market-based payment information begins on page 1147.

COVID-19 Add-on Payments: CMS is proposing to continue New COVID-19 Treatments Add-on Payment (NCTAP) for eligible COVID-19 drugs and biologics through end of the fiscal year in which the PHE ends.

Table on page 31 and discussion begins on page 775.

Graduate Medical Education: CMS is proposing to implement several provisions related to graduate medical education (GME) as authorized under the Consolidated Appropriations Act of 2021, including: distributing an additional 1,000 graduate medical education (GME) slots, phased-in at 200 slots per year beginning in 2023, for qualifying hospitals or moreover those in rural areas health professional shortage areas and areas with shortages of healthcare professionals; and, allowing rural training hospitals participating in an accredited rural training track to receive a GME cap increase.

The discussion related to GME begins on page 1068.

Medicare Shared Savings Program (MSSP): CMS will continue its 2021 policy by allowing ACOs in the BASIC Track's glide path the option to elect to maintain their current level of risk for 2022.

Table on page 33 and discussion begins on page 1558.

MACRA's Quality-Payment Program (QPP)

COVID-19-Informed Data Policy: CMS is proposing several policies to disallow the use of data in 2022 and 2023 if the agency determines that circumstances caused by the PHE affect quality scores significantly.

Hospital Value-Based Purchasing (VBP) Program (A two percent of base DRG payment at risk): Among other VBP changes, CMS proposes to for 2022: suppress or ignore HCAHPS, the MSPB measure, five HAI measures, and, the Pneumonia 30-Day Mortality Rate measure as well as the Patient Safety and Adverse Events Composite measure for the 2023 program year. CMS also proposes not to issue a Total Performance Score to any hospital for 2022. Instead, CMS would award each hospital a payment incentive equal to the amount withheld for the fiscal year, or two percent.

The discussion for Hospital VBP begins on page 992.

Hospital Readmissions Reduction Program (HRRP) (A three percent penalty based on readmissions for AMI, CHF, pneumonia, COPD, CABG, total hip/total knee arthroplasty): CMS proposes to suppress the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization measure and exclude COVID diagnosed patients from denominators of the remaining five condition-specific readmissions measures.

Table on page 32 and discussion begins on page 958.

Hospital-Acquired Condition (HAC) Reduction Program (A one percent reduction of all inpatient payment for quartile of hospitals with highest HACs): CMS proposes to suppress the third and fourth quarters of 2020 for both the 2022 and 2023 program years for the following measures: CDC National Healthcare Safety Network Healthcare-Associated Infection (HAI); and, CMS PSI 90 data. CMS also proposes extend suppressing date from the first half of 2020 to the entire year.

The discussion on the HAC Reduction Program begins on page 1048.

Hospital Inpatient Quality Reporting Program (For hospitals that fail to successfully report, one-fourth reduction in the annual market basket): In the proposed rule CMS will add five new measures to the IQR program: Maternal Morbidity Structural Measure (beginning with a shortened reporting period of October 1-December 1, 2021); Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (voluntary reporting would begin July 1, 2022); COVID-19 Vaccination Coverage Among Health Care Personnel (beginning with a shortened reporting period of October 1-December 1, 2021); Hospital Harm-Severe Hypoglycemia eCQM; and, Hospital Harm-Severe Hyperglycemia eCQM. CMS proposes to remove these five measures: Death Among Surgical Inpatients with Serious Treatable Complications; Exclusive Breast Milk Feeding; Admit Decision Time to ED Departure Time for Admitted Patients; Anticoagulation Therapy for Atrial Fibrillation/Flutter eCQM; and, Discharged on Statin Medication eCQM. CMS proposes to require hospitals to use certified technology updated with the 2015 Edition Cures Update and must support reporting requirements for all available eCQMs.

Table on page 33 and discussion begins on page 1261.

Promoting Interoperability (For hospitals that fail to successfully report, three-fourth reduction in the annual market basket): CMS proposes several changes to the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals, including: increasing the minimum required score for the objectives and measures from 50 points to 60 points (out of 100 points) to be considered a meaningful EHR user; continuing the EHR reporting period of a minimum of any continuous 90-day period and increase reporting period to any continuous 180-day period for CY 2024; maintaining the Electronic Prescribing Objective's Query of PDMP measure as optional while increasing its available bonus from 5 points to 10 points; adding a new Health Information Exchange (HIE) Bi-Directional Exchange measure as an optional alternative to the two existing measures beginning in CY 2022; requiring attestation on four of the existing Public Health and Clinical Data Exchange Objective measures; and, adopting two new eCQMs to the measure set beginning in CY 2023 and removing four eCQMs in CY 2024.

Table on page 33 and discussion begins on page 1431.

Health Equity: Contained within the proposed rule is an RFI titled, "Closing the Health Equity Gap in CMS Hospital Quality Programs – Request For Information," i.e., CMS is seeking comments on how the agency can better address health disparities and social determinants of health.

The discussion on Health Equity begins on page 1239.

Long Term Care Hospitals: For FY 2022, CMS expects LTCH-PPS payments to increase by approximately 1.4 percent or $52 million. LTCH PPS payments for FY 2022 for discharges paid the site neutral payment rate are expected to increase by 3 percent, these discharges are expected to represent approximately 25 percent of all LTCH cases and 10 percent of all LTCH PPS payments in FY 2022. Click here for the LTCH PPS tables for this FY 2022 proposed rule are available through the Internet on the CMS website, under the list item for Regulation Number CMS-1752-P.

CMS proposes to propose to adopt one new measure beginning with the FY 2023 LTCH QRP, the COVID-19 Vaccination Coverage among Healthcare Personnel. CMS also proposes to update the denominator for one measure, the Transfer of Health Information to the Patient–Post-Acute Care measure to exclude patients discharged home under the care of an organized home health service or hospice.

The discussion of LTCHs start on page 1175.

Organ Acquisition Payment Policies for Transplant Hospitals and Organ Procurement Organizations: CMS proposes to change, clarify, and codify Medicare organ acquisition payment policies relative to organ procurement organizations (OPOs), transplant hospitals, and donor community

hospitals by proposing to count only organs transplanted into Medicare beneficiaries so that Medicare more accurately records and pays its share of organ acquisition costs.

The discussion of the new organ policies begins on page 1498.

If you have comments or questions, please contact David Introcaso at david.introcaso@shcare.net or at 202.907.7426 or Devon Seibert-Bailey at devon.seibert-bailey@shcare.net or at 202.302.7918.

Thank you.