Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

MAY 2021

FFY 2022 MEDICARE IPPS PROPOSED RULE – CMS-1752-P

On April 27, the Centers for Medicare & Medicaid Services (CMS) posted the unpublished version of the federal fiscal year (FFY) 2022 Inpatient Prospective Payment System (IPPS) proposed rule, effective Oct. 1, 2021 through Sept. 30, 2022. CMS will publish this proposed rule in the *Federal Register* on May 10. **CMS proposed an overall increase in IPPS payments of 2.8%.** Comments on this proposed rule are due to CMS by June 28. All page numbers in this summary refer to the unpublished version of the proposed rule.

Use of FFY 2019 Data (*pp. 50-60*): CMS typically uses the most recent full year of data available, in this case FFY 2020 data, to calculate proposed IPPS rates. However, due to the COVID-19 public health emergency (PHE), CMS proposed using the FFY 2019 data to approximate expected FFY 2022 inpatient hospital utilization. This includes FFY 2019 rather than FFY 2020 MedPAR claims data (used for, among other things, changes to MS-DRG classifications), and the FFY 2018 rather than FFY 2019 HCRIS file (used for, among other things, determining proposed MS-DRG relative rates).

IPPS Market Basket Update (*pp. 840-887, Table 1A)*: CMS proposed a 2.5% market basket update, a 0.2 percentage point Affordable Care Act-mandated productivity reduction, and a 0.5 percentage point increase to partially restore cuts made under the American Taxpayer Relief Act (ATRA) of 2012. The market basket update for hospitals that fail to submit quality data will decrease by an additional one-quarter, and hospitals that do not meet meaningful use requirements are subject to a three-quarter reduction to the initial market basket.

FFY 2022	Hospital submitted quality data and is a Meaningful EHR user	Hospital submitted quality data and is NOT a Meaningful EHR user	Hospital DID NOT submit quality data and is a Meaningful EHR user	Hospital DID NOT submit quality data and is NOT a Meaningful EHR user
Percentage increase applied to standardized amount	2.3%	0.425%	1.675%	-0.2%

National Standardized Amounts (*pp. 836-839, Tables 1A, 1B and 1D*): The table below summarizes proposed standardized amounts. For FFY 2022, CMS proposed a labor-related share of 62% for IPPS hospitals with wage index values less than or equal to 1.0000, and a labor-related share of 67.6% for IPPS hospitals with wage index values greater than 1.0000.

Wage Index	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital DID NOT Submit Quality Data and is a Meaningful EHR User	Hospital DID NOT Submit Quality Data and is NOT a Meaningful EHR User
<= 1.0000	Labor: $3806.98 Non-Labor: $2,333.31	Labor: $3,737.21 Non-Labor: $2,290.54	Labor: $3,783.72 Non-Labor: $2,319.06	Labor: $3,713.94 Non-Labor: $2,276.29
> 1.0000	Labor: $4,150.84 Non-Labor: $ 1,989.45	Labor: $4,074.76 Non-Labor: $1,952.99	Labor: $4,125.48 Non-Labor: $1,977.30	Labor: $4,049.40 Non-Labor: $1,940.83

CMS proposed a capital standard federal payment rate of $471.89.

Proposed Repeal of Market-Based MS-DRG Data Collection and Weight Calculation (*pp. 1147-1148*): CMS proposed repealing the FFY 2021 IPPS final rule requirement for hospitals to report median payer-specific negotiated charges with Medicare Advantage organizations on the Medicare cost report, as well as the subsequent policy to recalculate MS-DRG relative weights based on those data.

COVID-19 Add-On Payment (*pp. 775-777*): CMS proposed extending the New COVID-19 Treatments Add-on Payment (NCTAP) for eligible products that are not approved for new technology add-on payments (NTAPs) through the end of the FFY in which the COVID-19 PHE ends (i.e., Sept. 30 of the year in which HHS ends the PHE). CMS also proposed discontinuing the NCTAP for discharges on or after Oct. 1, 2021 for products approved for NTAPs beginning FFY 2022.

NTAPs (*pp. 286-777*): Because CMS proposed using FFY 2019 data in developing FFY 2022 relative weights, it also proposed a one-year extension of NTAPs for 14 technologies for which the NTAP would otherwise be discontinued in FFY 2022. These technologies include: Azedra®, Cablivi®, Elzonris™, AndexXa™, Spravato®, Zemdri®, T2 Bacteria® Panel, ContaCT, Eluvia™ Drug-Eluting Vascular Stent System, Hemospray®, IMFINZI®/TECENTRIQ®, NUZYRA®, SpineJack® System and Xospata® (*pp. 309-213*).

Changes to MS-DRG Diagnosis Codes (*pp. 224-234*): CMS proposed changing the severity level designation for all unspecified diagnosis codes to Non-Complication/Comorbidity (Non-CC) if there are other codes available in the relevant code subcategory that further specify the anatomic site. Effective FFY 2022, this would result in 3,490 unspecified diagnosis codes currently designated as CC or Major CC (MCC) being reclassified as Non-CC. A list of the 3,490 codes is in Table 6P.2a, available on the CMS website. If finalized, this would change the severity level of 4.8% of ICD-10-CM diagnosis codes (there are currently 72,621 diagnosis codes in the ICD-10-CM classification).

Wage Index (*pp. 778-839, Table 3*): In the FFY 2021 IPPS final rule, CMS adopted a policy placing a 5% cap on any decrease in a hospital's wage index from the hospital's final wage index in FFY 2020 in response to the adoption of Office of Management and Budget Bulletin No. 18-04. The intent of this policy was to ensure that a hospital's final wage index for FFY 2021 would not be less than 95% of its final wage index for FFY 2020 (see IHA's FFY 2021 IPPS summary for more information). This cap is set to expire at the end of FFY 2021; however, CMS proposed extending

this policy through FFY 2022 in response to the COVID-19 PHE. CMS requested comments on how to extend this policy and whether it should be budget neutral.

CMS also proposed to continue the FFY 2020 low-wage-index hospital policy. This budget neutral policy increases the wage index for hospitals with a wage index value below the 25th percentile. CMS increases the wage index for such hospitals by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile value for all hospitals.

The table below displays FFY 2022 proposed wage index information for Illinois hospitals:

Core Based Statistical Area	Wage Index	Geographic Adjustment Factor	Reclassified Wage Index	Reclassified Geographic Adjustment Factor	State Rural Floor	FFY 2022 Average Hourly Wage
Bloomington	0.9138	0.9401	0.8782	0.9149		42.6338
Cape Girardeau	0.8450	0.8911				38.1614
Carbondale	0.8450	0.8911				37.8778
Champaign-Urbana	0.8817	0.9174	0.8817	0.9174		40.9007
Chicago-Naperville-Evanston	1.0364	1.0248	1.0236	1.0161		48.3478
Danville	0.9560	0.9697	0.9453	0.9622		44.5996
Decatur	0.8498	0.8945				39.6438
Elgin	1.0527	1.0358	1.0527	1.0358		47.5970
Kankakee	0.8870	0.9212	0.8703	0.9093		41.3794
Lake County	1.0109	1.0075				47.1570
Peoria	0.8523	0.8963	0.8523	0.8963		39.6804
Rock Island	0.8450	0.8911	0.8450	0.8911		38.6297
Rockford	0.9970	0.9979	0.9827	0.9881		46.5109
St. Louis	0.9449	0.9619	0.9449	0.9619		44.0808
Springfield	0.9054	0.9342	0.8881	0.9219		42.2428
Rural	0.8450	0.8911	0.8450	0.8911	0.8450	39.4154

Finally, CMS proposed permanently reinstating a minimum area wage index for hospitals in all-urban states per Section 9831 of the American Rescue Plan Act of 2021. This "imputed rural floor" increases the wage index for the all-urban states of Connecticut, Delaware, the District of Columbia, Rhode Island and New Jersey. This reinstated policy would not be budget neutral, and thus would not require reductions to the standardized amount.

Disproportionate Share Hospital (DSH) Payment Changes (*pp. 901-957*): For FFY 2022, CMS estimated the 75% pool for DSH hospitals to be approximately $10.57 billion. After adjusting the pool for uninsured individuals (estimated at 10.1% for FFY 2022), CMS estimated the uncompensated care amount to be approximately $7.63 billion, a decrease of about $660 million compared to FFY 2021.

Consistent with the FFY 2021 IPPS final rule, CMS proposed using a single year of uncompensated care data from Medicare cost report worksheet S-10 to determine the

distribution of DSH uncompensated care payments for FFY 2022. The most recent audited S-10 data are from FFY 2018 cost reports.

Indirect and Direct Medicare Graduate Medical Education (IME/GME) (*pp. 39-41*): CMS implemented certain GME-related policies established under the Consolidated Appropriations Act of 2021 (CAA) through the FFY 2022 IPPS rule making process. Under the CAA, the Secretary of HHS is required to add 1,000 Medicare-funded residency positions. Beginning FFY 2023, CMS will distribute up to 200 additional residency positions per year. At least 10% of new residency positions must go to hospitals that fall into one of the following categories:

1. Located in or treated as located in rural areas;
2. Where the reference resident level of the hospital is greater than the otherwise applicable resident limit;
3. In states with new medical schools or additional locations and branches of existing medical schools; and
4. Serving Health Professional Shortage Areas (HPSAs).

Additionally, non-rural hospitals that establish such programs in rural areas may receive an adjustment to their full-time equivalent (FTE) resident limit. Similarly, each rural hospital participating in such training may also receive an adjustment to its FTE resident limit.

Finally, certain hospitals may reset or establish new per resident amounts (PRAs) if the hospital has extremely low or $0 PRAs. Eligible hospitals much meet certain criteria, including that resident training began in a cost reporting period beginning on or after Dec. 27, 2020 and before Dec. 26, 2025. There is also an opportunity for certain hospitals with very small FTE resident caps to replace those caps if the Secretary determines the hospital begins training residents between Dec. 27, 2020 and Dec. 26, 2025.

Medicare Promoting Interoperability Program (*pp. 1431-1491*): CMS proposed several changes to the Medicare Promoting Interoperability Program.

CMS proposed continuing the minimum 90-day electronic health record (EHR) reporting period for calendar year (CY) 2023 Medicare Promoting Interoperability Program for new and returning eligible hospitals and Critical Access Hospitals (CAHs). However, for CY 2024 CMS proposed a minimum 180-day EHR reporting period for new and returning hospitals and CAHs.

For the CY 2022 reporting period CMS proposed maintaining the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional, but increasing the associated bonus points from 5 to 10. CMS also requested comments on several Query of PDMP measure issues, including the readiness of eligible hospitals and CAHs to transition to a performance-based version of the measure and the interaction between the measure and HL7® Fast Healthcare Interoperability Resources (FHIR®) technology, among other technical considerations.

CMS proposed modifying the Provide Patients Electronic Access to Their Health Information measure to require all eligible hospitals and CAHs to ensure patients, or their representatives, have indefinite access to patient health information. This access would be via any application the patient chooses beginning with EHR reporting period CY 2022, and include claims and clinical

data with dates of service on or after Jan. 1, 2016. CMS stated this proposal aligns with requirements placed on payers and health plans under the Patient Access and Interoperability final rule.

Citing COVID-19, CMS proposed adding the Health Information Exchange (HIE) Bi-Directional Exchange measure to the Health Information Exchange Objective under the Medicare Promoting Interoperability Program. This measure would be an optional alternative to two existing measures: the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure. The new HIE measure would be worth 40 points.

CMS also proposed several changes to the Public Health and Clinical Data Exchange Objective, including expanding the number of required measures from two to four and increasing the minimum required score for the objective from 50 points to 60 points (out of 100 points) to be considered a meaningful EHR user.

Proposed objectives and measures for the CY 2022 Medicare Promoting Interoperability Program are in Table IX.F.-02 on *pp. 1471-1475*. Finalized and proposed performance-based scoring methodology for the CY 2022 EHR reporting period are in Table IX.F.-04 on *pp. 1478-1479*.

CMS also requested information on several issues that would further the exchange of data across different programs and entities, including:

- Adoption of FHIR®-based application programming interface (API) solutions;
- Changes to the Medicare Promoting Interoperability Program that would better target patient access outcomes related to use of patient portals or third-party application(s);
- Potential changes to OpenNotes that would ensure clinical notes are widely available to patients; and
- The development of, or support and adoption of, designating high performing hospitals in the context of EHR excellence.

Health Equity and Hospital Quality Programs (*pp. 1239-1261*): CMS requested information on potential policies meant to better measure, account for, and address issues of health equity through its quality programs. Specifically, CMS seeks feedback on the following:

- Potential future stratification of quality measure results by race and ethnicity;
- Improving demographic data collection, including the possible collection of a minimum set of demographic data elements; and
- Potential creation of a confidential Hospital Equity Score to synthesize results across multiple social risk factors and disparity measures that would inform interventions hospitals could use to improve their performance in certain domains specific to health equity.

Digital Quality Measurement and use of FHIR® in Hospital Quality Programs (*pp. 1222-1239*): CMS requested information on policies meant to move further toward its goal of fully digitizing quality measurement by 2025. Specifically, CMS seeks feedback on the following:

- A proposed definition of digital quality measures (dQMs) as quality measures calculated using digital data from one or more sources of data including, but not limited to, administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments, patient portals or applications, health information exchanges or registries; where dQMs are intended to improve the patient experience including quality of care, improve the health of populations, and/or reduce costs;
- Use of FHIR® as a framework for measure structure and data submission for current electronic clinical quality measures (eCQMs); and
- Feedback on a number of data issues, including how to align across programs, the importance of data standardization, and collaboration opportunities, in an effort to move further toward measurement digitization and interoperability.

Hospital Quality Reporting Measure Suppression Policy (*pp. 964-965, 996-997, and 1053-1054*): In response to the potential impact of the COVID-19 PHE on quality reporting measures, CMS developed measure suppression factors for use in the Hospital Value-Based Purchasing (VBP), Hospital-Acquired Condition (HAC) Reduction, Hospital Readmissions Reduction (HRRP), Skilled Nursing Facility VBP, and End-Stage Renal Disease (ESRD) Quality Incentive programs. The proposed measure suppression factors are meant to help CMS evaluate whether it should suppress (i.e., not use) certain measure data it believes the COVID-19 PHE has significantly impacted and would, by extension, significantly impact hospital payments. The proposed factors include:

1. 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.
2. Clinical proximity of the measure's focus to the relevant disease, pathogen, or health impacts of the PHE for COVID-19.
3. Rapid or unprecedented changes in:
    a. Clinical guidelines, care delivery or practice, treatments, drugs, or related protocols, or equipment or diagnostic tools or materials; or
    b. The generally accepted scientific understanding of the nature or biological pathway of the disease or pathogen, particularly for a novel disease or pathogen of unknown origin.
4. Significant national shortages or rapid or unprecedented changes in healthcare personnel; medical supplies, equipment, or diagnostic tools or materials; or patient case volumes or facility-level case mix.

Details specific to the Hospital-Acquired Condition (HAC) Reduction Program, Hospital Readmissions Reduction Program (RRP), and Hospital Value-Based Purchasing (VBP) Program follow.

HAC (*pp. 1048-1067*): CMS proposed suppressing performance data from the third and fourth quarters of 2020 when calculating HAC performance for FFYs 2022 and 2023. Instead, CMS would base Total HAC scores for FFYs 2022 and 2023 on the following applicable periods:

- FFY 2022 CMS PSI 90 measure: 18-month period from July 1, 2018 through December 31, 2019;
- FFY 2022 CDC NHSN HAI measures: 12-month period from January 1, 2019 through December 31, 2019;
- FY 2023 CMS PSI 90 measure: 12-month period from July 1, 2019 through December 31, 2019 and January 1, 2021 through June 30, 2021;
- FFY 2023 CDC NHSN HAI measures: 12-month period from January 1, 2021 through December 31, 2021.

RRP (*pp. 958-991*): CMS proposed suppressing the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (National Quality Forum (NQF) #0506) for the FFY 2023 program year. CMS also proposed excluding COVID-19 diagnosed patients from the measure denominators for the following RRP measures:

- Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0505);
- Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2515);
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891);
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure Hospitalization (NQF #0330); and
- Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551).

VBP (*pp. 992-1047*): CMS proposed suppressing all measures in the Person and Community Engagement, Safety, and Efficiency and Cost Reduction Domains for the FFY 2022 program year.

CMS will adopt a special scoring and payment rule for the FFY 2022 program year, calculating measure rates for all measures, including the measures it proposed to suppress, but only calculating achievement and improvement scores for the measures in the Clinical Outcomes Domain, which CMS did not propose suppressing. As the Clinical Outcomes Domain is only 25% of the total performance score (TPS), CMS will not calculate TPSs for hospitals. Instead, payment adjustments will be neutral for hospitals in the FFY 2022 program year.

For the FFY 2023 program year, CMS proposed suppressing the Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate Following Pneumonia (PN) Hospitalization measure (MORT-30-PN). CMS also proposed removing the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) measure (NQF #0531) from the VBP, stating the costs associated with the measure outweigh the measure's benefits.

Finally, starting FFY 2023, CMS proposed excluding COVID-19 diagnosed patients from the denominators for the following measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230);

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

Assuming CMS finalizes these proposed changes, Table V.H-4 summarizes the FFY 2022 VBP measures (*pp. 1022-1023*) and Table V.H-5 summarizes VBP measures for FFY 2023, 2024 and 2025 (*pp. 1023-1024*). Proposed changes to baseline and performance periods due to COVID-19 are in Table V.H-6 through V.H-10 (FFYs 2023-2027, *pp. 1028-1032*).

Inpatient Quality Reporting (IQR) Program (*pp. 1261-1372*): CMS proposed adding five measures to the IQR, including:

- Maternal Morbidity Structural Measure (*pp. 1264-1273*);
- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality with Claims and Electronic Health Record Data (NQF #3502) measure (*pp. 1273-1292*);
- COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure (*pp. 1293-1303*);
- Hospital Harm-Severe Hypoglycemia eCQM (NQF #3503e) (*pp. 1303-1311*); and
- Hospital Harm-Severe Hyperglycemia eCQM (NQF #3533e) (*pp. 1311-1317*).

CMS also proposed removing five hospital IQR measures, including:

- Death Among Surgical Inpatients with Serious Treatable Conditions (CMS PSI-40) (*pp. 1317-1319*);
- Exclusive Breast Milk Feeding (PC-05) (NQF #0480) (*pp. 1319-1320*);
- Admit Decision Time to ED Departure Time for Admitted Patients (ED-2) (*pp. 1321-1323*);
- Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) (*pp. 1323-1327*); and
- Discharged on Statin Medication (STK-06) (*pp. 1324-1327*).

Finalized and newly proposed measures for FFYs 2023-2026 payment determinations are on *pp. 1327-1330*.

CMS also requested comment on two potential future hospital-level measures: All-cause Mortality for Medicare Beneficiaries Admitted with COVID-19; and Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty.

Finally, CMS proposed, beginning with the CY 2023 reporting period/FFY 2025 payment determination, that hospitals must use only certified technology updated to be consistent with the 2015 Edition Cures Update to submit data for the Hospital IQR Program.

Clarification of Extraordinary Circumstances Exceptions (ECE) Policy due to Public Health Emergency (*pp. 981-987*): On March 22, 2020, CMS announced it was excluding data for the first and second quarters of CY 2020 from the Medicare quality reporting and VBP programs due to

COVID-19. In this proposed rule, CMS clarified that an approved ECE does not "except" a facility from the quality program, but instead "excepts" the facility from reporting data for the approved data-reporting period. Additionally, referencing the FFY 2020 IPPS/LTCH PPS final rule, CMS clarified that it would use sub-regulatory updates to address the impact of the two quarters of data excepted under the ECE. CMS referred readers to the Hospital Specific Report User Guide on QualityNet for such sub-regulatory updates.

Interim Final Rule with Comment (*p. 827*): In tandem with this IPPS proposed rule, CMS issued an interim final rule with comment period (IFC) to modify limitations on redesignation by the Medicare Geographic Classification Review Board (MGCRB) to comply with the decision in *Bates County Memorial Hospital v. Azar*, 464 F. Supp. 3d 43 (D.D.C. 2020) (CMS-1762-IFC). The IFC revised regulation at Social Security Act § 412.230, allowing hospitals with rural redesignation under Section 1886(d)(8)(E) to reclassify under the MGCRB using the rural reclassified area as the geographic area in which the hospital is located effective with reclassifications beginning with FFY 2023.

Further, prior to this IFC, hospitals with rural redesignations were not permitted to use the rural area's wage data for purposes of reclassifying under the MGCRB. Beginning with FFY 2022 applications that were denied due to this previous policy, CMS will now apply the new IFC policy and allow such hospitals to apply for redesignation using the rural area's wage data.

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Sources:

Centers for Medicare & Medicaid Services. 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. May 10, 2021. Available from: https://www.federalregister.gov/public-inspection/2021-08888/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Accessed April 29, 2021.

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