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AHA Summary of CMS' Hospital Inpatient PPS Proposed Rule for Fiscal Year 2022

The Centers for Medicare & Medicaid Services (CMS) April 27 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS proposed rule for fiscal year (FY) 2022. In addition to proposing a 2.8% increase in inpatient PPS payments for 2022 and other policies, the rule would repeal the requirement to report certain payer-negotiated rates and make changes to the Graduate Medical Education (GME) program and related payments, and quality measurement and value programs. Highlights of the proposals related to the LTCH PPS are covered in a separate Special Bulletin.

AHA Take: We are very pleased CMS is proposing to repeal the requirement that hospitals and health systems disclose privately negotiated contract terms with payers on the Medicare cost report. We have long said that privately negotiated rates take into account any number of unique circumstances between a private payer and a hospital and their disclosure will not further CMS' goal of paying market rates that reflect the cost of delivering care. We once again urge the agency to focus on transparency efforts that help patients access their specific financial information based on their coverage and care. **See AHA's full statement that was shared with the media here.**

Highlights of the inpatient PPS rule follow.

Key Takeaways

CMS proposes policies to:

- Increase inpatient PPS payments by 2.8% in FY 2022.
- Repeal the requirement to report the median payer-specific negotiated rates for inpatient services, by Medicare Severity-Diagnosis-related Group (MS-DRG), for Medicare Advantage organizations.
- Use data from Worksheet S-10 in the FY 2018 cost report to determine the distribution of FY 2022 DSH uncompensated care payments.
- Extend New COVID-19 Treatments Add-on Payments for eligible COVID-19 products through the end of the fiscal year in which the public health emergency (PHE) ends.
- Implement changes to the GME program and related payments, as required in the Consolidated Appropriations Act, 2021.
- Change the Promoting Interoperability Program, including by requiring a 180-day reporting period for CY 2024 and increasing the minimum required score to be considered a meaningful EHR user.
- Suppress certain measures in hospital quality reporting and value programs, applying neutral payment adjustments under hospital value-based purchasing (VBP) for FY 2022, to account for the impact of the COVID-19 PHE.
- Add five new measures for the inpatient quality reporting (IQR) program.

Inpatient PPS Payment Update. The proposed rule would increase inpatient PPS rates by a net of 2.8% in FY 2022, compared to FY 2021, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.5%, less 0.2 percentage points for productivity required by the Affordable Care Act (ACA), and plus 0.5 percentage points to partially restore cuts made as a result of the American Taxpayer Relief Act (ATRA) of 2012. Table 1 below details the factors CMS includes in its estimate.

Table 1: Impacts of FY 2022 CMS Proposed Policies

Policy	Average Impact on Payments
Market-basket update	+ 2.5%
Productivity cut mandated by the ACA	- 0.2%
Partial restoration of documentation and coding cut mandated by ATRA	+ 0.5%
Total	**+ 2.8%**

The ACA and ATRA adjustments would be applied to all hospitals. Additionally, hospitals not submitting quality data would be subject to a one-quarter reduction of the initial market basket and, thus, would receive an update of 2.18%. Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2019 would be subject to a three-quarter reduction of the initial market basket and, thus, would receive an update of 0.93%. Hospitals that fail to meet both of these requirements would be subject to a full reduction of the initial market-basket rate and receive an update of 0.30%.

In light of the COVID-19 PHE, CMS proposes to use FY 2019 data in approximating expected FY 2022 inpatient hospital utilization for rate-setting purposes.

Price Transparency: Market-based MS-DRG Data Collection and Weight Calculation. CMS proposes to repeal the requirement that hospitals report the median payer-specific negotiated rates for inpatient services, by MS-DRG, for Medicare Advantage organizations on the Medicare cost report. In addition, CMS proposes to repeal the market-based MS-DRG relative weight methodology it had planned to implement in FY 2024; instead, it would continue using its existing cost-based methodology. The agency solicits public comments on alternative approaches or data sources for rate setting for FY 2024 and subsequent fiscal years.

Disproportionate Share Hospital (DSH) Payment Changes. Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is updated as the percentage of uninsured individuals changes and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. For FY 2022, CMS estimates the 75% pool to be approximately $10.57 billion. After adjusting this pool for the percent of individuals without insurance, CMS estimates the uncompensated

care amount to be approximately $7.63 billion, a decrease of roughly $660 million compared to FY 2021.

The agency proposes again to use a single year of uncompensated care data from Worksheet S-10 to determine the distribution of DSH uncompensated care payments for FY 2022. Specifically, CMS proposes using S-10 data from FY 2018 cost reports, which the agency has recently audited.

Complication/Comorbidity and Major Complication/Comorbidity Analysis. CMS is soliciting comments on adopting a change to the severity level designation of the 3,490 "unspecified" diagnosis codes currently designated as either complication/comorbidity (CC) or major complication/comorbidity (MCC), where there are other codes available in that code subcategory that further specify the anatomic site, to a Non-CC for FY 2022. If approved, the change would affect the severity level assignment for 4.8% of the ICD-10-CM diagnosis codes.

New Technology Add-on Payment (NTAP). The inpatient PPS provides additional payments, known as NTAPs, for cases with relatively high costs involving eligible new medical services or technologies. For FY 2022, in connection with CMS' proposal to use FY 2019 instead of FY 2020 data for rate setting, CMS is proposing a one-year extension of NTAPs for 14 technologies for which payments would otherwise be discontinued beginning FY 2022.

New COVID-19 Treatments Add-on Payment (NCTAP). In response to the pandemic, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) for eligible discharges during the PHE. CMS proposes to extend the NCTAP payments for eligible COVID-19 products through the end of the fiscal year in which the PHE ends.

Area Wage Index. CMS makes several proposals in the rule around the area wage index, which adjusts payments to reflect differences in labor costs across geographic areas. First, the agency proposes to continue its low-wage-index hospital policy as established in the FY 2020 final rule. Specifically, for hospitals with a wage index value below the 25th percentile, the agency would continue to increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. As it has done previously, the agency would reduce the FY 2022 standardized amount for all hospitals to make this policy budget neutral.

Second, as required by the American Rescue Plan Act, CMS proposes to permanently reinstate a minimum area wage index for hospitals in all-urban states, known as an "imputed rural floor." Previously, for FYs 2019 – 2021, hospitals in all-urban states received a wage index without the application of an imputed floor. Per the law, this reinstated policy is not budget neutral and would not require reductions to the standardized amount.

Finally, concurrent with this proposed rule, CMS issued an interim final rule that would make technical amendments to current regulations related to how certain hospitals can be reclassified through the Medicare Geographic Classification Review Board.

Indirect and Direct Medicare Graduate Medical Education. CMS proposes to implement several provisions of the Consolidated Appropriations Act, including its requirement for 1,000 new Medicare-funded medical residency positions. Specifically, CMS proposes to, beginning in FY 2023, phase in no more than 200 positions each year. Additionally, CMS proposes to prioritize applications for residency positions in programs serving underserved populations.

CMS also proposes to implement the Promoting Rural Hospital GME Funding Opportunity, which would allow certain rural training hospitals to receive a GME cap increase. Specifically, the agency would make changes related to the determination of both an urban and rural hospital's resident limit with regard to residents training in an accredited rural training track. In addition, the agency would implement changes to the determination of direct GME per-resident amounts and certain FTE resident limits for hospitals that host a small number of residents for a short duration.

Medicare Shared Savings Program (MSSP). Due to the uncertainty of the COVID-19 pandemic, CMS proposes to allow accountable care organizations (ACOs) participating in the "BASIC" track's glide path to forgo automatic advancement and once again "freeze" their participation for performance year (PY) 2022 at their PY 2021 level. CMS first finalized such a policy in last year's physician fee schedule final rule, allowing ACOs to freeze their PY 2020 participation level and avoid automatic advancement in PY 2021. ACOs that froze their participation for PY 2021 at their PY 2020 level would be permitted to freeze their participation a second time, thus remaining at their PY 2020 participation level for PY 2022. Any ACO that elects to remain at its current participation level for PY 2022 will be automatically advanced to the BASIC track level in which it would have participated during PY 2023 if it had advanced automatically in PY 2022 (unless the ACO chooses to advance more quickly).

For example, an ACO that participated in BASIC Level A for PY 2020 and did not freeze its participation level would have automatically advanced to BASIC Level B in PY 2021. If that ACO elects to remain at Level B for PY 2022, instead of advancing to Level C, it would automatically advance to Level D for PY 2023. Similarly, if an ACO participated in BASIC Level A for PY 2020 and did elect to freeze its participation level, it would have participated in BASIC Level A in PY 2021. If that ACO again elects to remain at Level A for PY 2022, it would automatically advance to Level D for PY 2023.

Promoting Interoperability Program. CMS proposes to continue the 90-day reporting period for CY 2023 but proposed to make a number of other changes to the program, including requiring a 180-day reporting period for CY 2024, expanding the number of required Public Health and Clinical Data Exchange Objective measures from two to four and 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.

Hospital Quality Reporting and Value Programs. CMS proposes a number of significant policy changes to account for the impact of the COVID-19 PHE on its hospital quality reporting and value programs. The agency also proposes to add five new measures for the inpatient quality reporting (IQR) program, while removing five current IQR measures. The proposed rule also includes several requests for information (RFI) related to health equity.

- Measure Suppression Policy. In light of the COVID-19 PHE, CMS proposes a measure suppression policy that it would use across all of its hospital quality measurement and value programs. Under the policy, CMS would "suppress" (i.e., not use) measure data it believes have been affected by COVID-19 in calculating hospital performance. The agency's goal is to ensure hospitals are not rewarded or penalized for their performance based on non-representative quality data affected by the pandemic. The suppression policy would be applies to several programs, as described below.

- Hospital Value-based Purchasing (HVBP). CMS proposes to suppress most of the HVBP program's measures for FY 2022, includes the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures, Medicare Spending per Beneficiary, and five health care associated infection measures**. As a result, CMS believes it cannot calculate fair scores for hospitals nationally, and proposes that all hospitals would receive neutral payment adjustments under the VBP for FY 2022.** However, CMS also proposes to calculate and report measure scores publicly where feasible and appropriate.

  For the FY 2023 HVBP program, CMS proposes to suppress the pneumonia mortality measure, and to remove the claims-based patient safety indicator (PSI 90) from the program permanently.

- Hospital Readmissions Reduction Program (HRRP). For the FY 2023 HRRP, CMS proposes to suppress the pneumonia readmissions measure, and to exclude COVID-19 diagnosed patients from the remaining five measures.

- Hospital Acquired-Condition (HAC) Reduction Program. CMS proposes to suppress performance data from the third and fourth quarters of 2020 in calculating HAC Reduction Program performance for FYs 2022 and 2023. When combined with the waiver of the first two quarters of 2020 data CMS adopted last year, hospital HAC scores for FYs 2022 and 2023 would be based on one year of performance data (rather than the customary two years).

- Inpatient Quality Reporting (IQR). CMS proposes to add five new measures to the IQR program, while removing five other measures. Most notably, CMS proposes a new measure reflecting COVID-19 vaccination coverage among health care personnel that hospitals would be required to report starting on Oct. 1, 2021. Furthermore, CMS is proposing that beginning in CY 2023, hospitals would be

required to report the IQR's electronic clinical quality measures using certified EHR technology consistent with 2015 Edition Cures Update.

- Health Equity. In the proposed rule, CMS includes several RFIs asking for feedback on ideas for advancing health equity using its quality measurement programs. Among other policy ideas, CMS asks for comment on:

    - The notion of a "hospital equity score" modeled off of the agency's equity scores in the Medicare Advantage program in which CMS would aggregate the scores of several hospital quality measures and then assess to what extent disparities exist along the lines of race and dual-eligible status. The score would initially be confidential for hospital internal use, but could be made public in the future.

    - Demographic and social risk data collection, including the collection of a "minimum set" of demographic elements (e.g., race, ethnicity, language, disability status) that could be used for a variety of tracking and quality measurement purposes. The agency is considering using EHRs as a data collection mechanism.

    - Additional reporting of "stratified" results for several measures, including readmissions. For example, CMS could report a hospital's readmission rates for its dual-eligible and non-dual eligible patients.

    - Potential attestation measure(s) to for the IQR program asking whether hospitals are implementing certain practices related to health equity. For example, CMS may ask whether hospitals have plans for language access, or for assessing treatment algorithms for sources of bias.

NEXT STEPS

CMS will accept comments on the proposed rule through June 28. The final rule will be published around Aug.1, and the policies and payment rates will take effect Oct.1. Watch for a more detailed analysis of the proposed rule in the coming weeks.

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