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MEMORANDUM

To: Health Care Clients and Friends

From: Powers Law Firm

Date: May 27, 2021

Subject: **Proposed Changes to Medicare Hospital Inpatient Prospective Payment System (IPPS) for Federal Fiscal Year (FFY) 2022**

This memorandum summarizes key changes to the acute-care hospital IPPS proposed by the Centers for Medicare and Medicaid Services (CMS) for FFY 2022. The proposed rule was published in the Federal Register on May 10. Comments are due by 5:00 pm Eastern on June 28, 2021. The tables and data files for the proposed FFY 2022 IPPS rule are available on the FFY 2022 Proposed Rule Home Page.

Among the proposed IPPS changes are the following:

- **IPPS Updates**

The proposed IPPS increase in operating payment and capital rates for acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 2.8%. **Table I** in the proposed rule (starting on page 25,746) shows the estimated impact of all the proposed changes on various categories of Medicare hospitals.

The tables below show the proposed updates to the standardized amounts for FFY 2022.

Table 1A. – Proposed Rule National Adjusted Operating Standardized Amounts; Labor/Nonlabor (67.6% Labor Share/32.4% Nonlabor Share If Wage Index Is Greater Than 1)

Hospital Submitted Quality Data and Is a Meaningful EHR User (Update = 2.6%)		Hospital Submitted Quality Data and Is NOT a Meaningful EHR User (Update = 0.35%)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 1.85%)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -0.4%)	
Labor-Related	**Nonlabor-Related**	**Labor-Related**	**Nonlabor-Related**	**Labor-Related**	**Nonlabor-Related**	**Labor-Related**	**Nonlabor-Related**
$4,084.16	$1,895.58	$3,994.60	$1,854.01	$4,054.31	$1,881.72	$3,964.74	$1,840.15

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Table 1B. – Proposed Rule National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62% Labor Share/38% Nonlabor Share If Wage Index Is Less Than or Equal to 1)

Hospital Submitted Quality Data and Is a Meaningful EHR User (Update = 2.6%)		Hospital Submitted Quality Data and Is NOT a Meaningful EHR User (Update = 0.35%)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 1.85%)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -0.4%)	
Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
$3,707.44	$2,272.30	$3,626.14	$2,222.47	$3,680.34	$2,255.69	$3,599.03	$2,205.86

Table 1D. – Proposed **Capital** Standard Federal Payment Rate: $471.89.

- **Outlier**

The outlier threshold for FFY 2021 was $29,064. CMS is proposing an increase to $30,967. CMS is basing the threshold on cost report data from dates before the COVID-19 public health emergency (PHE). If CMS used more current data, the outlier threshold would be higher.

- **Wage Index and Reclassification**

The proposed rule wage index tables 2, 3 and 4 are on the FFY 2022 Proposed Rule Home Page. CMS is continuing its "low wage index hospital policy," under which it increases the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals. See discussion on pages 25,407-08. CMS is proposing to continue its imputed rural floor policy, under which it imputes a rural floor for states that only consist of urban areas. CMS is proposing to include Washington, DC as a "state" for purposes of the imputed rural floor. See discussion at 25,405-07. For hospitals with a wage index greater than 1, CMS is proposing to decrease the labor-related share of the standardized amount from 68.3 to 67.6. See discussion at 25,427-29.

- **Charge Data for Medicare-Severity Diagnosis Related Groups (MS-DRG) (p. 25,527)**

Historically, MS-DRG weights have been calculated based on hospital cost to charge ratios (CCR) reported on the Medicare cost report and the gross charge data for the CCR is obtained from a hospital's chargemaster. CMS had finalized a rule to transition to calculating MS-DRG weights based on the negotiated charges from Medicare Advantage Organizations (MAOs) and to collect the data based on Medicare cost reports for cost-reporting periods ending

on or after January 1, 2021. CMS is proposed to repeal this change and is requesting comments on alternatives.

- **Disproportionate Share Hospital (DSH) and Uncompensated Care Pool Payments (p. 25,441-57)**

Since FFY 2014, eligible hospitals have received DSH payments equal to 25% of traditional DSH payments as calculated at 42 U.S.C. § 1395ww(d)(5)(F). CMS refers to this 25% payment as the "empirically justified DSH payment." In addition, eligible hospitals receive a payment that is based on an "uncompensated care pool." Specifically, the additional DSH payment is calculated using three factors: 1) 75% of the payments that would have been made to all hospitals under 42 U.S.C. § 1395ww(d)(5)(F); 2) the percentage change in the uninsured population since 2013; and 3) the ratio of each hospital's uncompensated care to uncompensated care for all DSH hospitals. A hospital's payment from the uncompensated care pool is the product of these three factors.

CMS proposes to continue its prior policy for Factor 1 in FFY 2022. CMS, thus, proposes that the Factor 1 amount will be $10,573,368,841.28, which is equal to 75% of the total amount of Medicare DSH payments for FY 2022 ($14,097,825,121.71 minus $3,524,456,280.43).

Factor 2 is an adjustment equal to 1 minus the percentage change in the national rate of uninsurance for the current year, as compared to a base of 2013. For FFY 2018 through FFY 2021, CMS used uninsured estimates produced by the Office of the Actuary as part of the development of the National Health Expenditure Accounts (NHEA), which reflect the rate of uninsurance in the U.S. across all age groups. In addition, CMS calculates the current-year rate of uninsurance based on a weighted average of the uninsurance estimate for the current and prior calendar years (CY).

CMS proposes to continue this methodology in FFY 2022. CMS estimates that the uninsurance rate for CYs 2021 and 2022 will be 10.2% and 10.1%, respectively, compared to the 2013 base rate of 14%. CMS estimates the percent of individuals without insurance for FY 2022 will be 10.1% ((0.25 times 0.0102) + (0.75 times 0.0101)). Therefore, CMS is proposing that Factor 2 for FY 2022 will be 72.14% (1- [((0.101-0.14)/0.14)] = 1-0.2786 = 0.7214 (72.14%)). This results in a proposed total uncompensated care pool of $7,627,628,282.10 (i.e., $10,573,368,841.28 times 0.7214).

Factor 3 is each eligible DSH hospital's estimated uncompensated care amount relative to the estimated uncompensated care amount for all eligible DSH hospitals. CMS proposes to calculate Factor 3 for each hospital for FY 2022 using the following steps:

- Step 1: Select the hospitals longest cost report from its FFY 2018 cost reports. (If the hospital does not have a FFY 2018 cost report because the cost report for the previous FFY spanned the FFY 2018 time period, the previous FFY cost report would be used in this step.)

- Step 2: If the cost report is more than or less than 12 months, annualize the uncompensated care costs from Worksheet S-10 Line 30. (If applicable, use the statewide average cost to charge ratio (urban or rural) to calculate uncompensated care costs.)

- Step 3: Combine the adjusted and/or annualized uncompensated care costs for hospitals that merged using the merger policy.

- Step 4: Calculate Factor 3 for Indian Health Service and Tribal hospitals based on Medicaid days for FY 2013 and the most recent available year of data on Supplemental Security Income (SSI) days. Calculate Factor 3 for Puerto Rico hospitals that have a FY 2013 cost report based on Medicaid days for FY 2013 and 14% of the hospital's FY 2013 Medicaid days. Calculate the denominator using the low-income insured days proxy data from all DSH eligible hospitals.

- Step 5: Calculate Factor 3 for the remaining DSH eligible hospitals using annualized uncompensated care costs (Worksheet S-10 Line 30) based on FY 2018 cost report data from Step 1, 2, or 3. This calculation excludes new hospitals and the hospitals for which Factor 3 was calculated in Step 4.

Similar to previous years, in general, CMS performed the proposed Factor 3 calculation using HCRIS data updated through February 19, 2021. CMS intends to use the March 2021 update to HCRIS to calculate Factor 3 in the final rule, and CMS intends to use the March updates to calculate Factor 3 in all future final rules. For new hospitals that do not have an FY 2018 cost report to use in the Factor 3 calculation, CMS proposes to continue to apply the new hospital policy that it initially adopted in the FY 2020 IPPS/LTCH PPS final rule. The proposed rule also sets forth proposals regarding newly merged hospitals, the cost to charge ratio trim methodology, and the uncompensated care data trim methodology.

Since FY 2014, CMS has made interim uncompensated care payments during the fiscal year on a per discharge basis, using a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the hospital's uncompensated care payment per discharge. For FY 2022, CMS proposes to modify this calculation to be based on the average of FY 2018 and FY 2019 historical discharge data, as opposed to a 3-year average.

CMS published on its website a table listing Factor 3 for certain hospitals for FY 2022 and a supplemental data file with a list of the hospital mergers that CMS is aware of and the uncompensated care payments for each merged hospital. Hospitals should notify CMS within 60 days from the date of public display of the proposed rule of any inaccuracies. The proposed rule also notes that after publication of the FY 2022 final IPPS rule, hospitals will have fifteen business days to again review and submit comments on the accuracy of the table and supplemental data file. Changes to Factor 3 would be posted on the CMS website and would be effective beginning October 1, 2021.

- **Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) (p. 25,502-24)**

CMS proposes to implement three changes to DGME and IME mandated by the Consolidated Appropriations Act, 2021 (CAA). 86 Fed. Reg. at 25,503. Section 126 of the CAA makes available 1,000 additional full-time equivalent (FTE) resident slots for DGME and IME. Section 127 of the CAA changes the rural track FTE caps. Section 131 of the CAA changes how CMS will determine the DGME per-resident amount (PRA) and FTE caps for hospitals that host very small numbers of FTEs.

  - **Additional FTE Cap Slots**

The CAA creates 1,000 new FTE cap slots and limits CMS to distributing no more than 200 per year, starting in FY 2023 until all 1,000 are distributed. *Id.* at 25,503. CMS proposed to distribute 200 slots in FY 2023 and each subsequent year. *Id.* at 25,508. CMS also proposes to distribute at least 10% of the slots four categories of hospital: 1) hospitals in rural areas or urban hospitals treated as rural; 2) hospitals that have exceeded the FTE cap; 3) hospitals in states with new medical schools or additional locations/branches of existing schools; and 4) hospitals serving Health Professional Shortage Areas (HPSAs). However, CMS defines a "qualifying hospital" for any of the slots as one of these four categories, so all slots will go to these hospitals. *Id.* at 25,508.

CMS also proposes to prioritize applications from hospitals with main campuses or provider-based facilities that serve underserved populations within the Health Resources and Services Administration's (HRSA's) population-based HPSAs in order to address health inequities for underserved populations. *Id.* 25,508. This prioritization applies to all four categories. *Id.* at 25,509. CMS proposes that at least 50% of the resident time in the program for which the hospital is applying must occur at those locations in the HPSA over the course of the program. *Id.* at 25,508. CMS will use HRSA's HPSA scores to allocate slots. Hospitals in HPSAs with the highest scores would get priority over other hospitals. *Id.* at 25,509. CMS also proposes that applying hospitals attest that they meet the National Standards for Culturally and Linguistically Appropriate Services in Health Care. *Id.* at 25,510.

CMS considered an alternative approach for FY 2023, which would provide additional time for it to consider a more refined approach. Under the alternative, CMS "would distribute 200 additional residency positions for FY 2023 among hospitals that qualify in Category One, Category Two, Category Three, and/or Category Four, with higher priority given to applications from hospitals that qualify in more categories." *Id.* at 25,510. CMS seeks comments on this alternative.

The CAA establishes a maximum of 25 new FTE cap slots per hospital. *Id.* at 25,503. However, CMS proposes a limit of only 1.0 FTE per hospital (not per program) per year. *Id.* at 25,508. Therefore, a hospital could only obtain a maximum of five FTE slots over the five years

that CMS distributes these slots. Hospitals may only submit one application per year. *Id.* at 25,509. CMS also proposes that hospitals must agree to increase the FTE count by the number of cap slots given. *Id.* at 25,503-54

CMS describes the application process in detail at pages 25,510-11. Hospitals will have to demonstrate that they will likely fill the slots within five years. *Id.* at 25,504. CMS proposes that an applying hospital must show a likelihood that it does not have cap slots "to accommodate a planned new program or expansion of an existing program." A new program would have to be planned to be established on or within five years after the effective date of the cap increase. *Id.* at 25,504. For expansions of existing programs, as of the application date, the hospital would have to show that it is already training residents in a program or that residents will have begun rotating to the hospital on or after the effective date of the increase.

For Category 1 hospitals (in rural areas or treated as rural), CMS proposes that a hospital with a *main campus* located outside an urban core-based statistical area (CBSA) would be treated as rural. *Id.* at 25,504. "Treated as rural" means treatment as rural in the table accompanying most recent IPPS final rule. If a hospital is treated as rural after this, it must submit its approval letter with the application for cap slots. *Id.* at 25,505.

For Category 2 hospitals (over the cap), CMS would define the reference resident level (i.e., the FTE count) as the most recent cost reporting period ending on or before December 27, 2020 (date of enactment of the CAA). This would be the unweighted allopathic and osteopathic FTE count. *Id.* at 25,505. The "otherwise applicable resident limit" (i.e., the FTE cap) would be the FY 1996 FTE cap adjusted for new medical residency training programs; GME affiliation agreements; emergency GME affiliation agreements; hospital mergers; urban hospitals with a rural track program(s); and increases or decreases under § 422 of the Medicare Modernization Act and/or §§ 5503 or 5506 of the Affordable Care Act. *Id.* at 25,505.

For Category 3 hospitals (in states with new medical schools or additional locations/branch campuses), CMS consulted with the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) and determined that hospitals in 35 states are eligible under Category 3. *Id.* at 25,505-06. These states are listed on page 25,506. All hospitals in these states are eligible. Hospitals in other states with new schools/locations can submit a comment to the proposed rule or provide documentation with its application of a new school/branch/location.

For Category 4 hospitals (in HPSAs), CMS proposes that a hospital must show that its main campus or provider-based location is physically located in a primary care or mental health HPSA. Providers that qualify based on location in a mental health HPSAs could only receive cap slots for psychiatric training programs.

CMS proposes an application deadline of January 31 of the year prior to the year the slots would be awarded. For example, the deadline for FY 2023 would be January 31, 2022.

- **Rural Track Training Program FTE Caps**

Currently, if an urban hospital with an existing family medicine program establishes a rural track training (RTT) program, only the urban hospital can receive an RTT program FTE cap increase. A rural hospital's cap is only increased if the program is a new medical residency training program. *Id.* at 25,513. CAA § 127 now permits the rural hospital to receive a cap increase for RTT programs even if the program is not new. *Id.* at 25,513. CMS proposes that "each time an urban hospital and a rural hospital establish a RTT program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes, both the urban and rural hospitals may receive a rural track FTE limitation." *Id.* at 25,513.

Currently, if an urban hospital has a RTT it cannot receive a cap adjustment for *additional* RTT training slots unless those RTTs qualify as "new" program(s). *Id.* at 25,513. Section 127 permits cap adjustments for additional RTTs for cost reporting periods beginning on or after October 1, 2022. *Id.* at 25,513. CMS will permit cap adjustments for RTTs expanded in a cost reporting period beginning on or after October 1, 2022. *Id.* at 25,513. CMS proposes "that if, in a cost reporting period beginning on or after October 1, 2022, an urban hospital with an existing RTT ("hub") adds an addition RTT ("spoke") to the existing urban core program of the same specialty, the urban and rural hospitals may receive adjustments to their rural track FTE limitation." *Id.* at 25,513. CMS also proposes "to limit the provision of an increase to the urban and rural hospitals' RTT FTE limitations only to the instance where additional residents are recruited to add a new rural RTT "spoke" to the existing urban "hub," and *not* to allow increases under this section to the RTT FTE limitations in the instance where the urban and rural hospital add additional FTE residents to an existing rural RTT "spoke." *Id.* at 25,514. CMS also proposes to permit cap increases if a hospital adds a new RTT with a rural hospital with which it already had an RTT (i.e., the second RTT is a different training program). *Id.* at 25,514.

Currently, the Medicare statute requires that an RTT be "separately accredited." The Accreditation Council for Graduate Medical Education (ACGME) only separately accredits family medicine RTTs, so hospitals can only receive an RTT cap increase for family medicine programs. *Id.* at 25,514. Section 127 removes the "separately accredited" requirement. *Id.* at 25,514. CMS proposes "that effective for cost reporting periods beginning on or after October 1, 2022, so long as the program in its entirety is accredited by the ACGME, regardless of the specialty, it may qualify as a RTT and urban and/or rural hospitals receive rural track limitations, assuming all other requirements are met." *Id.* at 25,514.

Currently, CMS regulations require that at least 50% of the training occur in the rural site. Section 127 adds the requirement of 50% of the time in a rural area for cost reporting periods beginning on or after October 1, 2022. *Id.* at 25,515. Therefore, any RTT, including those other than family medicine, are subject to this requirement. *Id.* at 25,515.

Currently, CMS regulations do not permit exclusion of RTT FTEs from the 3-year rolling FTE averages or the IME resident-to-bed ratio (RBR) during the five-year cap building period.

Id. at 25,515. Section 127 amends the statute to pattern it after new programs, which exempts RTTs from the 3-year rolling FTE average and the RBR. *Id.* at 25,515.

- **Resetting Low PRAs and FTE caps**

CAA § 131(a) resets low PRAs and FTE caps based on resident training on or after December 27, 2020 and before December 26, 2025. *Id.* at 25,520. The PRA provision of the statute applies to two classifications of hospitals, which CMS refers to as "Category A" and "Category B." A Category A hospital is one that, as of December 27, 2020, has a PRA that was established based on less than 1.0 FTE in the most recent cost reporting period ending on or before December 31, 1996 and received a very low or zero PRA. *Id.* at 25,520. A Category B hospital is one that, as of December 27, 2020, has a PRA based on more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997 and before December 27, 2020. *Id.* at 25,520.

CMS proposes "that to redetermine the PRA, the training occurring at a Category A Hospital or a Category B Hospital need *not necessarily* be training residents in a *new* program; the residents may be in either an approved program that is 'new' for Medicare IME and direct GME purposes, or may be in an existing approved program." *Id.* at 25,520. CMS states, "However, for a Category A Hospital, we propose not to reset its PRA until we determine that the Category A Hospital trains at least 1.0 FTE, and that training must occur in a cost reporting period beginning on or after December 27, 2020 … and before December 26, 2025…. Similarly, for a Category B Hospital, we propose not to reset its PRA until we determine that the Category B Hospital trains more than 3.0 FTEs, and that training must occur in a cost reporting period beginning on or after December 27, 2020 … and before December 26, 2025…." *Id.* at 25,521.

Previous training of more than 1.0 or 3.0 FTEs does not preclude resetting the PRA. *Id.* at 25,521. CMS proposes "that the relevant factor in determining when to reset their PRAs is if and when the hospital trains the requisite amount of FTE residents in a cost reporting period beginning on or after December 27, 2020 … and 5 years after…" *Id.* at 25,521. CMS proposes to recalculate the PRA using the existing regulation at 42 C.F.R. § 413.77(e). The PRA base period will be "the first cost reporting period in which either the Category A Hospital or Category B Hospital trains their requisite threshold FTEs; that is, the cost report beginning on or after December 27, 2020 in which at least 1.0 FTE is trained at a Category A Hospital, and the cost reporting period beginning on or after December 27, 2020 in which more than 3.0 FTEs are trained at a Category B Hospital." *Id.* at 25,521.

CMS explains that "even if a hospital trains less than 1.0 FTE … but has entered into a Medicare GME affiliation agreement for that training, we believe the law is directing the Secretary to establish a PRA for that hospital. Thus, effective for a cost reporting period beginning on or after enactment (December 27, 2020), we are proposing to establish a PRA in the instance where a hospital trains less than 1.0 FTE and that hospital has entered into a Medicare GME affiliation agreement for that training." *Id.* at 25,521. If the hospital has not

entered into an affiliation agreement, then the PRA is only established when at least 1.0 FTE is trained. *Id.* at 25,521.

CMS states that hospitals must accurately report FTEs on Worksheet E, part A and Worksheet E-4 when either category of hospital trains at least 1.0 FTE on or after December 27, 2020. *Id.* at 25,521. Therefore, for cost reporting periods beginning on or after December 27, 2020, a hospital must report FTEs if it trained at least 1.0 and was not part of an affiliation agreements or it trained less than 1.0 FTE and was part of an affiliation agreement. *Id.* at 25,522.

For purposes of revising low FTE caps, the CAA also applies to two types of hospitals, which CMS again refers to as Category A and Category B. A Category A hospital "has an IME and/or direct GME FTE resident cap that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997." *Id.* at 25,522. A Category B hospital "has an IME and/or direct GME FTE resident cap that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment (December 27, 2020)." *Id.* at 25,522. CMS proposes "that the FTE resident caps would only be reset when a Category A Hospital or Category B Hospital 'begins training' FTE residents in a new residency program(s)…." *Id.* at 25,522.

CMS proposes "that 'begins training' means *future* training in a new program *for the first time on or after enactment*. We propose that for both Category A and B Hospitals, it is not relevant whether they may have trained at least 1.0 FTE or more than 3.0 FTEs in a new program in a cost reporting period or periods prior to December 27, 2020; rather, we propose that the relevant factor in determining the timing of resetting their FTE resident cap is if the hospital *first begins training* the requisite amount of FTE residents at some point in a cost reporting period beginning on or after December 27, 2020 (date of enactment) and 5 years after (December 26, 2025)." *Id.* at 25,522 (emphasis in original).

CMS proposes to use the existing regulation at 42 C.F.R. § 413.79(e)(1) to recalculate the caps. *Id.* at 25,523. The first program year would be the year after December 27, 2020 that the hospital trains at least 1.0 or more than 3.0 FTEs. *Id.* at 25,523.

Prospectively, CMS will "not establish permanent FTE resident caps for hospitals training resident in new programs begun on or after December 27, 2020, until we determine that in a cost reporting period beginning on or after December 27, 2020, the hospital trains at least 1.0 FTE." *Id.* at 25,523. CMS proposes "to continue to be consistent with our existing predicate fact regulations at 42 CFR 405.1885 such that we would not reopen cost reports beyond their 3-year reopening period, but would refer to and use whatever contemporaneous documentation we would need to establish the FTE resident caps." *Id.* at 25,523.

Finally, CMS proposes changes to the Interns and Residents Information System (IRIS): CMS is "in the process of issuing new Extensible Markup Language (XML)-based IRIS file format that captures FTE resident count data consistent with the manner in which FTEs are reported on the cost report." *Id.* at 25,523. CMS proposes "to remove the reference in the current

regulations to a diskette and instead reference "Intern and Resident Information System data." *Id.* at 25,523-24. CMS will require that the IRIS data match the FTE counts on Worksheets E-4 and E, Part A. *Id.* at 25,524.

- **Medicare Bad Debts (p. 25,654-56)**

Medicaid programs often have policies that limit their responsibility to pay cost-sharing amounts for Medicare/Medicaid dual eligible individuals if the Medicaid payment for the service is less than the Medicare payment. In these situations, a hospital may claim any cost-sharing amount as a Medicare bad debt if the hospital bills the Medicaid program and receives a remittance advice stating that the Medicaid program will not pay (or will pay a lesser amount than the hospital plans to claim as bad debt). This policy is referred to as the bad debt "must bill" policy.

CMS states that certain types of providers and suppliers have been unable to submit claims to Medicaid programs in accordance with the "must bill" policy because the Medicaid program does not recognize that category of provider or supplier under its Medicaid State Plan and therefore refuses enrollment. CMS is proposing that, for purposes of determining Medicare cost sharing obligations only, State Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements and even if a provider or supplier is of a type not recognized as eligible to enroll in the State Medicaid program.

CMS is also considering a rule that would require Medicaid agencies to process claims for services when the claim complies with Medicaid payment and certification standards but does not comply with Medicaid payment and certification standards. As an example, CMS describes a situation in which a Medicaid agency refuses to process a claim by an oxygen therapy provider because the provider did not complete various Medicaid payment requirements, such as a State's Medicaid certificate of medical necessity. CMS is requesting comments on this issue.

- **Organ Acquisition Costs (p. 25,656-76)**

CMS proposes to add regulations to address various policies related to organ acquisition costs that are currently stated in manuals and to change some of its current policies and regulations. CMS is proposing to move existing regulations addressing organ acquisition to new proposed Part 413, subpart L, so that all organ acquisition payment policies are under this subpart.

  - **Medicare Share of Organ Acquisition Costs**

The most significant change addresses the categories of organs that are included in the formula to determine Medicare's share of organ acquisition costs. Medicare determines its share of organ acquisition costs for transplant hospitals (THs) and organ procurement organizations

(OPOs) by multiplying total organ acquisition costs by the ratio of Medicare usable organs (numerator) to total usable organs (denominator). Medicare's policy has been to assume that any organ that was harvested and shipped to another facility for transplant was transplanted into a Medicare patient and, therefore, included in the numerator of the ratio. CMS states that tracking capabilities of THs and OPOs have improved since the time that this policy was adopted and THs and OPOs now have the ability to track whether an organ is transplanted into a Medicare beneficiary. Therefore, effective for cost reporting periods beginning on or after October 1, 2021, CMS is proposing that, if an organ is shipped to another facility for transplant into an individual who is not a Medicare beneficiary, that organ is not included as a Medicare usable organ in the numerator of the ratio described above. See discussion at pages 25,664-67 and proposed 42 C.F.R. § 413.408 (hospitals), § 413.410 (OPOs).

CMS is proposing that organs that are intended to be used for research, or that are determined, after harvesting, not to be medically suitable for transplant, are not counted as usable organs. CMS is proposing rules related to counting of organs that are transplanted en bloc. See discussion at page 25,668 and proposed 42 C.F.R. § 413.412(b)(2), (c)(1)(i).

Other changes that CMS is proposing are described below.

- **Definitions –** CMS proposes several definitions related to organ acquisition costs, including a proposal to change references to freestanding OPOs to independent OPOs, or IOPOs. See discussion at pages 25,657-58 and proposed 42 C.F.R. § 413.400.

- **List of Allowable Organ Acquisition Costs –** The proposed rule lists the costs that may be included as organ acquisition costs, which appears to comport with current policy. See discussion at pages 25,659-60 and proposed 42 C.F.R. § 413.402(a), (b). The preamble to the rule discusses in greater detail the allowable organ acquisition costs related to a living kidney donor. See discussion at pages 25,662-63. CMS is proposing a regulation that states that complications related to a live kidney donation that arise after discharge are not covered as an organ acquisition cost. Those costs are covered by Medicare Part A or Part B, as applicable, with no liability for co-payments for the donor. See discussion at pages 25,662-63 and proposed 42 C.F.R. § 413.402(c). CMS proposes that all costs incurred in the procuring organs that are intended for transplant may be included in organ acquisition costs. See discussion at page 25,668 and proposed 42 C.F.R. § 413.412(a)(2).

  In the preamble, CMS clarifies that certain costs related to organ transplant recipients are not organ acquisition costs and must be paid under Part B to the transplant recipient's Medicare number. These costs include standard backbench preparation services; physician services for the surgeon who performs the transplant; routine post-operative surgical care and/or immunosuppressant therapy management; and recipient laboratory services after discharge from the hospital. See discussion at page 25,663.

- **Standard Acquisition Charges –** CMS is adding to the regulations its long-standing policies requiring THs and OPOs to develop Standard Acquisition Charges (SACs) for each type of organ. The TH or OPO charges its SAC when it receives an organ from another facility for transplant. See discussion at pages 25,661-62 and proposed 42 C.F.R. § 413.404.

- **Donor Community Hospitals** – In response to reports that some community hospitals are overcharging OPOs for procuring cadaveric organs, CMS is proposing that, for cost reporting periods beginning on or after October 1, 2021, a donor community hospital that excises a cadaveric organ must bill the OPO its customary charges that are reduced to cost by applying its most recently available hospital specific CCR for the period in which the service was rendered. See discussion at pages 25,673-74 and proposed 42 C.F.R. § 413.418.

- **Cap on Surgeon Fees for Cadaveric Kidney Retrievals –** CMS is requesting comments on whether it should change the current $1,250 per donor surgeon fee limit for cadaveric kidney retrievals. See discussion at pages 25,675-76.

- **Other Proposals** – CMS is also proposing regulations related to organ acquisition charges for kidney paired exchanges (see discussion at pages 25,669-73 and proposed 42 C.F.R. § 413.413.416) and acquisition and delivery of pancreatic islet cells for transplantation into Medicare beneficiaries (see discussion at page 25,663 and proposed 42 C.F.R. § 413.406).

- **<u>Hospital Inpatient Quality Reporting (IQR) Program (p. 25,561-25,601)</u>**

As further detailed below, CMS proposes the following changes to the Hospital IQR program: adopting five new measures, removing five existing measures, and making changes to the existing EHR certification requirements along with other administrative updates. CMS is also requesting comment on the potential future adoption of a COVID-19 mortality measure and patient reported outcome measure following elective primary total hip and/or knee arthroplasty.

- CMS proposes to adopt the Maternal Morbidity Structural Measure beginning with shortened reporting period from October 1, 2021 through December 31, 2021, affecting the FY 2023 Payment Determination followed by annual reporting periods for subsequent years. For more information, please refer to pages 25,562-65.

- CMS proposes to adopt a Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (Hybrid HWM) measure beginning with a voluntary submission period which would run from July 1, 2022 through June 30, 2023, and followed by mandatory reporting beginning with the reporting period which runs July 1, 2023 through June 30, 2024, affecting the FY 2026 payment determination. This measure is designed to measure hospital level, risk-standardized mortality within 30 days of

hospital admission for most conditions or procedures. For more information, please refer to pages 25,565-71.

- CMS proposes to add the COVID–19 Vaccination Coverage Among HCP Measure beginning with shortened reporting period from October 1, 2021 through December 31, 2021, affecting the CY 2021 Reporting Period/FY 2023 Payment Determination and for subsequent years. This measure would track the percentage of healthcare personnel with a complete COVID-19 vaccination course. For more information, please refer to pages 25,571-75.

- CMS proposes to add two Medication-Related Adverse Event Electronic Clinical Quality Measures beginning with the CY 2023 Reporting Period/FY 2025 Payment Determination. The first measure would measure the rate at which severe hypoglycemia events (blood glucose level of less than or equal to 70 mg/dl) occur in the setting of hospital administration of antihyperglycemic medications during hospitalization. The second measure would measure the number of inpatient hospital days with a severe hyperglycemic event (extremely elevated blood glucose level) among hospitalized patients diagnosed with diabetes. For more information, please refer to pages 25,575-79.

- CMS also proposes to remove:

    - The Death Among Surgical Inpatients with Serious Treatable Complications measure (NQF #0351) beginning with the FY 2023 payment determination. CMS is proposing to remove this measure because it is also proposing a more broadly applicable measure, Hospital HWM, for adoption in this proposed rule. The Hybrid HWM measure captures more conditions or procedures than CMS PSI-04. The Hybrid HWM measure also captures mortality within 30 days of hospital admission for most conditions or procedures, compared to deaths for surgical discharges (or pregnancy, childbirth, and puerperium) as measured by CMS PSI-04;

    - The Exclusive Breast Milk Feeding (NQF #0480) measure beginning with the FY 2026 payment determination. CMS is proposing to remove this measure because of the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic. Specifically, in keeping with the agency's focus on maternal health, we are proposing to adopt the Maternal Morbidity Structural Measure for inclusion in the Hospital IQR Program beginning with a shortened CY 2021 reporting period/FY 2023 payment determination;

    - The Admit Decision Time to Emergency Department (ED) Departure Time for Admitted Patients (NQF #0497) measure beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS is proposing to remove this

measure because the costs associated with the measure outweigh the benefit of its continued use in the program;

- The two stroke-related electronic clinical quality measures (eCQMs) (Anticoagulation Therapy for Atrial Fibrillation/Flutter eCQM (STK-03) (NQF #0436) and Discharged on Statin Medication eCQM (STK-06) (NQF #0439) beginning with the CY 2024 reporting period/FY 2026 payment determination. While CMS continues to believe that ensuring appropriate pharmacotherapy for stroke patients is an important topic, within the eCQM portfolio of stroke measures, CMS identified STK 03 and STK-06 as candidates for removal. For STK-03 specifically, the patient population (patients prescribed anticoagulation therapy, which is a type of antithrombotic therapy), can be considered a subpopulation of the global population of ischemic stroke patients captured under the STK-02 eCQM, which measures the number of patients prescribed antithrombotic therapy at hospital discharge. For STK-06, CMS believes other measures like STK-02, Discharged on Antithrombotic Therapy, and STK-05, Antithrombotic Therapy by The End of Hospital Day 2, already support the agency's efforts to improve care and patient outcomes in the acute period.

For more information, please refer to pages 25,579-82.

- CMS is considering the potential inclusion of a new hospital-level measure of all-cause mortality for Medicare beneficiaries admitted with COVID–19 infection (COVID–19 mortality measure). CMS notes that such a measure would likely be similar to other hospital-level mortality measures currently in use in CMS programs. For more information, please refer to page 25,588.

- CMS is also considering the potential inclusion of a hospital-level, risk standardized patient reported outcomes measure following elective primary total hip and/or total knee arthroplasty. For more information, please refer to pages 25,588-92.

- Beginning with CY 2023 reporting/FY 2025 payment determination, CMS is proposing to require hospitals to use certified technology that has been updated consistent with the 2015 Edition Cures Update and is clarifying that certified technology must support the reporting requirements for all available eCQMs. For more information, please refer to pages 25,595-98.

- **Hospital Acquired Condition Reduction Program (p. 25,496-25,502)**[1]

CMS proposes to suppress the third and fourth quarters of CY 2020 for both the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) and the CDC National Healthcare Safety Network (NHSN) healthcare-associated infections (HAI) measures. This would impact performance calculations for 2022 and 2023 performance years, meaning that CMS proposes calculating measure rates for those program years but then "suppressing" the use of those rates to generate Total HAC Scores for determining reductions in hospital reimbursement. CMS proposes this measure suppression policy to reduce the impact of the HAC measures in light of the COVID-19 PHE. CMS also proposes to update regulation to reflect that the public reporting site, Hospital Compare, has been renamed Care Compare. Please refer to pages 25,496-25,502 for more information.

- **Hospital Readmissions Reduction Program (HRRP) (p. 25,459-69)**

CMS proposes the following with respect to the HRRP:

  - CMS proposes to adopt a cross-program measure suppression policy due to the impact of the COVID-19 public health emergency on quality measurement and pay-for-performance programs, including the HRRP. Refer to pages 25,460-62 for more information.

  - CMS proposes to suppress the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506) and to provide information on technical specification updates for the remaining five condition/procedure-specific readmission measures to exclude COVID-19 diagnosed patients from the measure denominators beginning in FY 2023. Refer to pages 25,462-64 for more information.

  - CMS proposes to use the MedPAR data to determine aggregate payments that aligns with the applicable period for FY 2022. Refer to pages 25,464-65 for more information.

  - CMS proposes automatic adoption of the use of MedPAR data corresponding to the applicable period beginning with the FY 2023 program year and all subsequent program years, unless otherwise specified by the Secretary. Refer to page 25,465 for more information.

[1] The Hospital-Acquired Condition (HAC) Reduction Program incentivizes "subsection (d)" hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary of Health and Human Services (HHS) to reduce the hospital's payment by one percent if the hospital ranks in the worst performing quartile, those with the highest Total HAC Scores, on select measures of hospital-acquired conditions. "Subsection (d) hospitals" are eligible acute care inpatient hospitals paid under the hospital IPPS and are located in one of the 50 states or the District of Columbia. They do not include Critical Access Hospitals (CAHs). 42 U.S.C. § 1395ww(d)(1).

CMS also provides clarification on its Extraordinary Circumstances Exception (ECE) policy under the HRRP. Refer to pages 25,466-69 for more information on the ECE policy. CMS did not propose any changes to the calculation of payment adjustment factors or calculation of payment methodology for FY 2022.

CMS requests public comment on the following: (1) possible future stratification of results by race and ethnicity for its condition/procedure-specific readmission measures and by expansion of standardized data collection to additional social factors, such as language preference and disability status; and (2) mechanisms of incorporating other demographic characteristics into analysis that address and advance health equity, such as the potential to include administrative and self-reported data to measure co-occurring disability status.

- **Hospital Value-Based Purchasing Program (p. 25,469-96)**

CMS begins this section of the preamble by noting that the agency has "identified the need for flexibility in our quality programs to account for the impact of changing conditions that are beyond participating hospitals' control." CMS noted that the COVID-19 PHE "has impeded effective quality measurements in many way" and proposes to establish new requirements and revise existing requirements for the Hospital Value-Based Purchasing (VBP) Program in response to the impact of the COVID-19 public health emergency.

In response to the COVID-19 PHE, CMS proposes to a policy that would allow CMS to suppress the use of measure data and the resulting quality scores significantly. CMS is proposing to suppress the following measures for the FY 2022 program year:

  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (NQF #0166)
  - Medicare Spending Per Beneficiary (MSPB) (NQF #2158)
  - National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
  - NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
  - American College of Surgeons—Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753)
  - NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcomes Measure (NQF #1716)
  - NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717).

CMS is also proposing to suppress the Hospital 30-Day, All Cause, Risk Standardized Mortality Rate Following Pneumonia (PN) 30-Day Mortality Rate (MORT-30-PN) measure (NQF #0468) for the FY 2023 program year. Refer to pages 25,472-77 for more information about the above factors.

CMS believes that, if the above suppressions are finalized, calculating a total performance score (TPS) for hospitals using only data from the remaining measures, all of which are in the Clinical Outcomes Domain, would not provide a fair national comparison. Thus, CMS proposes to not calculate a TPS for any hospital using one domain, rather CMS would provide a value-based payment amount for each discharge that is equal to the amount withheld. CMS also proposes to calculate the rates for all measures and publicly report those rates when feasible and with the appropriate caveats. CMS also proposes to update the baseline period for certain measures affected by the ECE that were granted in response to the COVID-19 PHE, along with making a few technical administrative updates.

CMS proposes to remove the Patient Safety and Adverse Events Composite (CMS PSI 90) measure beginning with the FY 2023 program year. Refer to pages 25,478-79 for more information about removal of this measure.

CMS proposes to update the following condition-specific mortality measures and one procedure-specific complication measure to exclude patients with either principal or secondary diagnoses of COVID–19 from the measure denominators beginning with the FY 2023 program year.

- 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)
- Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550).

Refer to pages 25,479-80 for more information about updates to the above-mentioned condition-specific mortality measures and procedure-specific complication measure.

In addition to the proposals discussed above, CMS also addresses the following topics with respect for the Hospital VBP Program:

- For details regarding previously adopted Hospital VBP Program measures and measure removal factors, refer to page 25,478. CMS is not proposing any changes to these policies at this time.

- For a summary of CMS's previously adopted measures for the FY 2022 through FY 2025 program years, refer to page 25,480.

- For details regarding previously adopted baseline and performance periods, refer to page 25,483. CMS is proposing to update the baseline periods for certain measures due to the ECE granted in response to the COVID-19 PHE. For additional information, refer to pages 25,483-84.

- For details regarding proposed and previously adopted performance standards for various program years, refer to pages 25,484-88.

- For details regarding previously adopted domain weighting policies, the minimum number of measures for Hospital VBP Program domains, and the minimum number of cases for Hospital VBP Program measures, refer to pages 25,493-94. CMS is not proposing any changes to these policies at this time.

- For details regarding previously adopted administrative policies for NHSN HAI measures, refer to page 25,495.

- **Quality Data Reporting Requests for Information (RFIs)**

As part of the proposed rule, CMS has issued two RFIs seeking public comment on new quality data reporting requirements being considered for development and implementation.

- *Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs (p. 25,549-54)*

CMS plans to transition to a fully digital quality monitoring system by 2025. To aid in this transition, CMS poses a number of questions on topics related to (1) the definition of digital quality measures (dQMs); (2) use of FHIR for current eCQMs; and (3) changes under consideration to support the development and adoption of digital quality measures. As a starting point for the RFI, CMS provides the following definition of dQMs: quality measures that use one or more source of health information that are captures and can be transmitted electronically via interoperable systems.

Despite requesting information as part of the FY 2022 IPPS proposed rule, CMS says that it will NOT be responding to comments received in response to the RFI through the FY 2022 IPPS final rule. Instead, the input will be considered as part of the drafting process for future regulations and policies.

- *Closing the Health Equity Gap in CMS Hospital Quality Programs (p. 25,554-61)*

CMS also seeks comments on its efforts to revise program to make reporting of health disparities based on social determinants (e.g., race, ethnicity) more comprehensive and of more utility to stakeholders. Specifically, CMS seeks comments regarding three major initiatives:

- The possibility of expanding CMS's current disparities methods to specifically include race and ethnicity by way of indirect estimation;
- The possibility of hospital collection of standardized demographic information for the purposes of incorporation into measure specifications to permit better equity measurement; and
- The design of a Hospital Equity Score (HES) for calculating results across multiple social risk factors and measures.

CMS goes on to explain that the HES could be developed based on prior work used to develop a Health Equity Summary Score (HESS) used in Medicare Advantage plans. CMS also notes that the HES, once developed would be provided confidentially to hospitals; any proposal to publicly report such scores would be subject to further rulemaking.

- *Medicare Promoting Interoperability Program (p. 25,628-54)*[2]

CMS's proposed changes to the Promoting Interoperability Program include:

- Continuing a 90-day EHR reporting period for CY 2023, with an increase to a 180-day period in CY 2024. CMS states that increasing the reporting period would provide eligible hospitals and CAHs (collectively, Hospitals) the opportunity to continuously monitor their performance and identify areas that may require investigation and corrective action. Please refer to pages 25,628-29 for more information.
- Increasing the minimum score for objectives and measures for determining whether a Hospital is a meaningful EHR user from 50 total points (out of 100 points) to 60 points in CY 2022. CMS intends to heighten the required standards for the Promoting Interoperability Program's performance levels and encourage higher performance through advanced use of CEHRT. Please refer to page 25,649 for more information.
- Adding a new Health Information Exchange (HIE) Bi-Directional Exchange measure, beginning in CY 2022, to the HIE objective as an optional alternative to the two existing measures.[3] The HIE Bi-Directional Exchange measure, which is entered as a "yes/no" attestation, is more expansive than existing measures because it requires the Hospital to establish technical capacity and workflows to query for or receive health information for ***all*** unique patients admitted to or discharged from the Hospital inpatient or emergency department and ***all*** unique patient records stored or maintained in the EHR, as well as enabling sending or sharing information for these patients regardless of known referral or transition status or timing. The

[2] In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) to encourage eligible professionals and Hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT).
[3] The two existing measures are Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information.

current HIE objective measures only apply to new patients and known transitions or referrals received that occur during the EHR reporting period. Please refer to pages 25,632-34 for more information.

- Continuing the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure as optional but increasing the total available bonus points from 5 to 10 points.[4] Please refer to pages 25,629-30 for more information.
- Adding a data availability requirement to the Provide Patients Electronic Access to Their Health Information measure requiring Hospitals to make health information available to patients indefinitely beginning with CY 2022 and applicable to encounters on or after January 1, 2016. Please refer to page 26,631 for more information.
- Requiring Hospitals to report "yes/no" for all four measures under the Public Health and Clinical Data Exchange objective, rather than the current option for Hospitals to select two measures of their choice.[5] Hospitals may claim an exclusion on three or fewer of the four measures. Hospitals that report "yes" for all four measures, or claim requisite exclusions, would receive all ten points for the Promoting Interoperability Program, while those reporting "no" for any measure will receive zero points. Also making Public Health Registry Reporting and Clinical Data Registry Reporting measures optional and available for a maximum of five bonus points for Hospitals reporting "yes" on either measure beginning in CY 2022. Please refer to pages 26,634-38 for more information.
- Adding a new Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) measure to the Protect Patient Health Information objective beginning with the CY 2022 EHR reporting period. A Hospital must attest "yes/no" to having conducted an annual self-assessment of all nine SAFER Guides[6] at any point during the calendar year in which the EHR reporting period occurs. Beginning in CY 2022, the SAFER Guides measure will be required but will not be scored nor affect total points for the Promoting Interoperability Program. Please refer to pages 26,638-39 for more information.
- Removing the second and third of three required attestations[7] (the Second and Third Attestations) relating to preventing blocking of information sharing by Hospitals. The Second Attestation relates to minimal standards for and the implementation of CEHRT. The Third Attestation relates to

[4] While recognizing challenges to implementing PDMP into EHR, CMS states that "maintaining it as an optional measure with bonus points . . . can help spur development and innovation in order to reduce barriers and challenges."
[5] The four measures are Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Laboratory Result Reporting.
[6] SAFER Guides are available at https:// www.healthit.gov/topic/safety/saferguides. Attesting Hospitals would be expected to complete the checklist at the beginning of each SAFER Guide.
[7] 42 C.F.R. § 495.40(b)(2)(I)(2) and (3).

good faith and timely responses to requests for electronic health information and provides flexibilities if information is not provided due to "technical, legal and other practical constraints." CMS proposes to remove the two attestations because they are similar to the practices described as "information blocking" in separate regulations issued by the Office of the National Coordinator (ONC) for Health Information Technology and may cause confusion.[8] Importantly, ONC's "information blocking" definition appears broader than the Second and Third Attestations.[9]

- Adopting two new eCQMs to the Promoting Interoperability Program's eCQM measure set beginning with the reporting period in CY 2023.[10] CMS also proposes removing four eCQMs from the measure set beginning with the reporting period in CY 2024 (in alignment with proposals for the Hospital Inpatient Quality Reporting Program).[11] CMS also proposes to require use of certified technology consistent with the 2015 Edition Cures Update for eCQM reporting beginning in reporting period in CY 2023.[12]

- *Medicare Shared Savings Program (MSSP) (p. 25,676-79)*

  - Due to the ongoing nature of the COVID-19 PHE, and in response to requests from MSSP Accountable Care Organizations (ACOs) for a second opportunity to defer advancement on the risk-allocation scale, CMS proposed to allow such a "freeze" to be sought by an ACO executive who has authority to legally bind the ACO. CMS also proposes to make changes that will allow suspension of automatic advancement on the risk-allocation scale for a second year.

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[8] 45 C.F.R. § 171.103.
[9] Regarding the Second Attestation, ONC's definition does not limit Hospitals' obligations to the use of CEHRT that is compliant with specific standards nor does it limit responsibilities to the use of certain functionality. Under ONC's definition, Hospitals may still be determined to have engaged in information blocking regardless of whether they are using certified technology. Regarding the Second Attestation, ONC's definition removes Hospitals' flexibilities by specifying activities that are not considered information blocking, rather than the broadly applicable exception for "technical, legal and other practical constraints." Please refer to pages 25,639-41 for more information.
[10] Hospital Harm—Severe Hypoglycemia (NQF #3503e), and Hospital Harm—Severe Hyperglycemia (NQF #3533e).
[11] STK–03 (Anticoagulation Therapy for Atrial Fibrillation/Flutter), STK–06 (Discharged on Statin Medication), PC–05 (Exclusive Breast Milk Feeding), and ED–2 (Admit Decision Time to ED Departure Time for Admitted Patients).
[12] This change is proposed to reduce burden on health IT developers by making eCQM reporting standards consistent with the ONC Health IT certification program by using CMS Quality Reporting Document Architecture (QRDA) Implementation Guides rather than the Health Level 7 QRDA standard. Please refer to pages 25,650-52 for more information.

If you have any questions, please call Barbara Straub Williams, Ron Connelly, Christina Hughes, or the attorney with whom you usually work at (202) 466-6550. Leela Baggett, Mark Ogunsusi, Megan La Suer, and Natalie Dobek contributed to this memorandum.