UnityPoint Health

CMS Releases FY 2022 IPPS Proposed Update

Summary

On April 27, 2021, the Centers for Medicare and Medicaid Services (CMS) posted the FY 2022 Inpatient Prospective Payment System (IPPS) proposed update, along with proposed policy and regulation changes. The proposed rule would update Medicare payment policies and quality reporting programs relevant for inpatient hospitals as well as address challenges related to the COVID-19 pandemic.

A CMS factsheet on the proposed rule is available here. The proposed rule is scheduled to be published in the Federal Register on May 10, 2021 and comments are due on June 28, 2021.

Key Takeaways

1. CMS estimates the proposed update would increase IPPS payments to hospitals in FY 2022 by approximately $2.5 billion.
2. The proposed FY 2022 standardized amount for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and that are meaningful electronic health record (EHR) users would be $6,140.29 - an increase of 3.0% compared to the final FY 2021 standardized amount.
3. CMS proposes to use FY 2019 MedPAR data as the best available data for the FY 2022 rate-setting process given the impact of the COVID-19 public health emergency (PHE) on inpatient utilization and case mix in FY 2020.
4. CMS proposes to repeal the requirement that hospitals report on the Medicare cost report, ending on or after January 1, 2021, the median payer-specific negotiated charge by MS-DRG that the hospital has negotiated with all of its Medicare Advantage payers.
5. As a one-time exception, also because of pandemic impacts, CMS proposes to extend the New Technology Add-on Payment (NTAP) period for one year for fourteen technologies with expiring NTAP periods.
6. Due to the COVID-19 pandemic, CMS proposes to suppress (i.e., not use) most value-based purchasing program (VBP) measures so that hospitals would receive neutral payment adjustments under the VBP for FY 2022.
7. CMS proposes to implement several provisions of the Consolidated Appropriations Act (CAA), including distributing 1,000 new Medicare-funded medical residency positions.
8. CMS solicits feedback on two Request for Information (RFIs), one focused on moving to digital quality measures and another on promoting health equity.

Standardized Amount

Key Takeaway	CMS proposes an increase of 3.0% for hospitals that successfully participate in CMS reporting programs

The Standardized Amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital Market Basket Index, and then applies a variety of other statutorily mandated or inspired adjustments.

The standardized amount varies based on an individual hospital's participation in the Hospital IQR Program and meaningful use of EHR. The proposed FY 2022 standardized amount for hospitals that successfully participate in both programs would be $6,140.29. This would result in an increase of 3.0% over the final FY 2021 standardized amount ($5,961.19). In comparison, CMS finalized a 2.76% update for FY 2021.

The update reflects a 2.5% market basket increase, less a 0.2% productivity adjustment, plus a 0.5% positive adjustment for documentation and coding mandated by Section 414 of MACRA for fiscal years 2018 through 2023. In addition to these enumerated updates, the standardized amount is also subject to budget neutrality adjustments discussed in the proposed rule. These updates in total result in a proposed 3.0% update from the FY 2021 final standardized amount. Hospitals that fail to submit quality data are subject to a –0.625% adjustment and hospitals that fail to be a meaningful EHR user are subject to a –1.875% adjustment.

Proposed FY 2022 standardized amounts are shown below in Table 1. Amounts shown are the sum of the labor-related and non-labor related shares without adjustment for geographic factors.

Table 1.

	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
FY 2022 Proposed Standardized Amount	$6,140.29	$6,027.75	$6,102.78	$5,990.23
FY 2021 Final Standardized Amount	$5,961.19	$5,856.40	$5,926.26	$5,821.47
Percent Change	3.0%	2.9%	3.0%	2.9%

Market-Based MS-DRG Relative Weight Methodology and Data Collection

Change in Methodology for Calculating MS-DRG Relative Weights

Key Takeaway	CMS proposes to repeal its policy to use market-based data for calculating MS-DRG relative weights.

CMS calculates payment for a specific case under the IPPS by multiplying an individual hospital's geographically adjusted standardized amount per case by the relative weight for the MS-DRG to which the case is assigned. Each MS-DRG relative weight represents the average resources required to care for cases in that particular MS-DRG,

relative to the average resources required to care for cases across all MS-DRGs. MS-DRG classifications and relative weights are required to be adjusted at least annually to account for changes in resource consumption.

In the FY 2021 IPPS rulemaking cycle, CMS finalized a new market-based methodology for estimating MD-DRG relative weights that would be based on median payer-specific negotiated charge information collected on Medicare cost reports. This new methodology was scheduled to begin in FY 2024 without any phase-in period.

CMS now is proposing to reverse course and not pursue this policy. The Agency also proposes to repeal the corresponding requirement that hospitals must report on the Medicare cost report, ending on or after January 1, 2021, the median payer-specific negotiated charge by MS-DRG that the hospital has negotiated with all of its Medicare Advantage payers. This last requirement was largely contested by hospital advocates who argued that such disclosure would publish private negotiations that reflect the unique circumstances between payers and hospitals and not further the goal of patient access to their specific financial information.

CMS proposes to maintain its existing methodology for determining MS-DRG weights for FY 2024 and beyond, though it seeks input from stakeholders on alternative data sources or alternative methodologies that it could use in rate-setting.

MS-DRG Changes

Key Takeaway	CMS proposes to use FY 2019 MedPAR data and FY 2018 HCRIS file for analyzing MS-DRG changes and determining MS-DRG relative weights respectively.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS has relied on claims data captured in the MedPAR file and cost report data captured in the HCRIS file. In a traditional year, for rate-setting purposes, CMS would use data that captures claims from discharges that occurred for the fiscal year that is two years prior to the fiscal year addressed in the rulemaking. For FY 2022, the data that CMS would, in normal circumstances, analyze would be from FY 2020.

In light of the public health emergency, CMS evaluated whether it was appropriate to use the FY 2020, and is now proposing to continue to use FY 2019 MedPAR claims data rather than FY 2020 MedPAR data.

New Technology Add-on Payments (NTAP)

Cost Criterion for NTAP

Key Takeaway	CMS proposes to use FY 2019 MedPAR data for establishing proposed FY 2023 threshold values.

In assessing whether a new technology qualifies for add-on payment, one criterion is whether the charges for the new technology meet or exceed certain threshold amounts. Historically, CMS has evaluated this cost criterion using threshold amounts established in the prior year's final rule. In this rule, as finalized in the FY 2021 IPPS Final Rule, CMS proposes to use the proposed threshold amounts for the upcoming fiscal year for any proposed new MS-DRGs to evaluate whether the technology meets the cost criterion. Here too, because of the pandemic, CMS is proposing to use FY 2019 MedPAR data as opposed to FY 2020 MedPAR data.

CMS has proposed no other changes to the criteria (newness and substantial clinical improvement) considered when evaluating a new technology's eligibility for add-on payments.

Proposed One-Year Extension for Technologies with Expiring NTAP Period

Key Takeaway	CMS is proposing a one-year extension of new technology add-on payments for technologies whose NTAP period was scheduled to expire.

Under the NTAP program, CMS provides additional payment for new medical services or technologies ("new technologies") where the costs of the technology are not yet reflected in the MS-DRG weights. This period is to last for the first two to three years that the product is on the market, after which time, the costs are then captured in the DRG weights. CMS evaluates the eligibility of new technologies for this additional payment, based on their newness date, each year. Under current policy, the Agency only extends add-on payments for an additional year if the three-year anniversary for the newness date (typically defined as the date of market entry) occurs in the latter half of the upcoming fiscal year.

In light of the public health emergency, CMS has proposed to use FY 2019 MedPAR data for the FY 2022 rate-setting process for IPPS, rather than the FY 2020 MedPAR data. Given that the costs of the new technologies with expiring NTAP periods may not be fully reflected in the FY 2019 MedPAR data, CMS has proposed a one-time extension of NTAP for new technologies with expiring periods. If finalized as proposed, this policy would apply to fourteen technologies. This proposal for a one-time extension of the NTAP period is consistent with a policy discussion on the extension of the transitional pass-through period for devices in the hospital outpatient setting.

Proposed NTAP Applications for FY 2022

Key Takeaway	CMS continues to see a growth in the number of NTAP applications.

In the FY 2022 IPPS Proposed Rule, CMS discussed 37 NTAP applications. Twenty-one devices and drugs applied through the traditional pathway and 16 went through established alternative pathways (13 devices with breakthrough status and three products designated as QIDP). The number of applications for NTAP represents a 54% increase in the number of applications reviewed for FY 2021 with substantial increases in applications through the traditional and alternative pathways.

Taking into consideration the 14 new technologies who may receive a one-time extension of their NTAP period, CMS proposes to continue add-on payments for all 24 technologies currently eligible.

In response to the COVID-19 PHE and in light of the development of new drugs and biologics for the treatment, CMS established new COVID-19 treatment add-on payments (NCTAP), starting with discharges on or after November 2, 2020 that met certain criteria. Acknowledging the continued financial impact of COVID-19 on hospitals, CMS is proposing to continue NCTAP for qualified technologies that do not qualify for NTAP. If finalized, the NCTAP would remain in effect until the end of the fiscal year following the end of the public health emergency.

Hospital Inpatient Quality Programs and Initiatives

CMS monitors, rewards and penalizes quality improvements in the inpatient setting through a number of quality incentive programs, including the Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing Program, Hospital Acquired Condition Reduction Program (HAC), Hospital Inpatient Quality Reporting Program, Medicare and Medicaid Promoting Interoperability Programs and the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR). These programs feature a mix of financial rewards and penalties as well as the public release of quality data.

The proposed rule includes several proposals impacting these programs. These proposals are consistent with a longstanding agency priority of reducing the number of quality measures (*e.g.* Meaningful Measures Initiative). In general, CMS seeks to lessen the burden of quality reporting during the pandemic and proposes policies that are consistent with the Administration's COVID-19 national strategy and commitment to advancing health equity

Quality Measure Suppression

Key Takeaway	CMS proposes to suppress select quality measures to mitigate the impact of the pandemic on quality scores.

Throughout the pandemic, CMS has implemented policies to reduce the burden of quality reporting and to insulate providers from quality scores being negatively impacted by pandemic-related circumstances that were beyond the provider's control. In that spirit, CMS is proposing a policy to suppress data from select quality measures that they find may have been impacted by the pandemic. CMS discusses how these measures were not designed to accommodate changes to clinical practice that hospitals may have implemented because of COVID-19 and therefore should not impact quality scores. Suppressed measures would not have any impact on a quality score. The impacted measures are listed in the below table.

Program	Measure	Year
HRRP	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506)	FY 2023
HAC	CDC National Healthcare Safety Network Healthcare-Associated Infection (HAI)	3-4Q of CY 2020
	CMS PSI 90	FY 2022-2023
HVBP Program	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare Spending Per Beneficiary (MSPB), and five HAI measures	FY 2022
	Pneumonia (PN) 30-Day Mortality Rate (MORT-30-PN)	FY 2023

As a result of the data suppression, CMS does not believe there will be adequate data available to calculate a Total Performance Score (TPS) for the HVBP Program, and so will not be calculating them for FY 2022. Hospitals will not be rewarded or penalized under the HVBP Program in FY 2022. Instead, CMS will ensure that value-based payments will equal the amount of the reduction made to hospital's base-operating DRG payment amounts.

While hospitals may appreciate the reduced burden of reporting and reduced risk of penalties, certain hospitals that do well under the HVBP Program may be disappointed that there is not an opportunity to earn a value-based payment in FY 2022.

Inpatient Hospital Quality Programs and Initiatives

Key Takeaway	CMS proposes modest changes, some of which may increase participation burden, and solicits comments on advancing equity in the hospital readmissions program.

Program	Brief Description	Proposal(s)
Hospital Readmissions Reduction Program	HRRP reduces payments to hospitals with excess readmissions. A hospital's performance is based on six unplanned readmission measures. The annual payment reduction is capped at 3% (i.e., payment adjustment factor of 0.97).	Measure modification: CMS proposes to exclude COVID-19 diagnosed patients from the denominator of five condition specific measures in FY 2023. Health equity: CMS solicits comments on methodologies to stratify results by: race and ethnicity, other demographic data, or the expansion of standardized data collection to additional social factors (e.g., language preference).
Hospital Value-Based Purchasing Program	The VBP Program withholds participating hospitals' Medicare payments by two percent and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.	Measure removal: CMS proposes to remove the *Patient Safety and Adverse Events Composite (CMS PSI 90)* measure beginning with the FY 2023 program year; this measure is also used in the HAC reduction program and CMS believes this policy will reduce provider burden. The agency is also proposing several technical changes.
Hospital Acquired Condition Reduction Program	Under the HAC Reduction Program, hospital report on a set of measures on hospital-acquired conditions. Hospitals with scores in the worst performing quartile will be subject to a 1% payment reduction.	Extraordinary Circumstances Exceptions (ECE): CMS proposes technical changes to the policy and clarifies that if a facility is approved for an ECE it would not be "except" from the entire program but from reporting data for approved data reporting periods.
Hospital Inpatient Quality Reporting Program	Under the Hospital IQR Program, hospitals are required to report data on measures in order to receive the full annual percentage increase for IPPS services that would otherwise apply.	Measure adoption: CMS is proposing to adopt the *Maternal Morbidity Structural measure*, the *Hybrid Hospital Wide Mortality measure*, the *COVID-19 Vaccination Coverage Among Healthcare Professionals measure* and two medication-related adverse event eCQMs for a variety of reporting periods. Measure removal: CMS is proposing to remove five measures from the program, two which are eCQMs. CMS is also proposing to make several other technical changes.

Medicare and Medicaid Promoting Interoperability Programs	The Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs) were established in 2011.	**Reporting period minimums**: For the Medicare Program in CY 2023, CMS is proposing to continue the EHR reporting period of a minimum of any continuous 90-day period for new and returning participants; CMS is proposing to increase the minimum to 180-days. **Payment deadline**: As required by statute, CMS noted in the proposed rule that December 31, 2021 is the last date that States could make Medicaid Promoting Interoperability Program payments to Medicaid eligible hospitals (other than pursuant to a successful appeal related to CY 2021 or a prior year). CMS is also proposing modifications to measures and other technical changes.
PPS-Exempt Cancer Hospital Quality Reporting Program	PCHQR is a quality reporting program for PPS-exempt cancer hospitals that was established by the Affordable Care Act.	**Measure removal**: CMS proposes to remove the *Oncology: Plan of Care for Pain – (NQF #0383)* measure beginning with the FY 2024 program year. CMS has concluded it is no longer feasible to implement the measure due to recent changes by the measure steward. **Measure adoption**: CMS proposes to adopt the *COVID-19 Vaccination Coverage Among HCPs*, measure beginning with the FY 2023 program year. CMS believes that adoption of this measure is consistent with the Biden Administration's national COVID-19 strategy. The agency is also making certain technical updates to the program.

Wage Index

Low Wage Index Hospital Policy

Key Takeaway	CMS will maintain a policy that supports hospitals in low wage index areas.

Medicare payments to hospitals (and a variety of other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (e.g., the perceived cost of labor is higher in New York City than it is in rural Oklahoma). CMS updates the wage index each year based on hospital cost report data and other inputs and policies.

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile. Impacted hospitals had their wage index value increased by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals. CMS

achieved budget neutrality for this change by adjusting the standardized amount that is applied across all IPPS hospitals. CMS maintained this policy in FY 2021, and now is proposing to continue this policy in FY 2022 as well.

Restoring the Imputed Wage Index "Rural Floor" for All Urban States

Key Takeaway	Hospitals in four states, Puerto Rico and the District of Columbia may see a boost in their wage index resulting from legislation enacted in March 2021.

CMS is proposing a limited policy change to implement a provision included in the American Rescue Plan (ARP), COVID relief legislation enacted in March 2021, but CMS is proposing an unexpected interpretation of the statutory change that could broaden its application to more areas and hospitals than originally anticipated.

CMS calculates one wage index for each urban area and one for each rural area within each state. The Medicare statute provides that the wage index used to adjust hospital inpatient and outpatient payments for hospitals in an urban area cannot be less than the wage index applicable to hospitals in rural areas within that same state. Historically, this rule left a gap for three states that have no rural areas: New Jersey, Delaware and Rhode Island. Congress has periodically provided a patch for these three states, and CMS on its own volition perpetuated this patch through FY 2018.

Effective October 1, 2021, the ARP restores the wage index "rural floor" protection for the all-urban states of New Jersey, Delaware, Rhode Island, but CMS is interpreting the change in a way that would make it applicable to and also beneficial for hospitals in Connecticut, Puerto Rico and the District of Columbia.

Wage index changes are often controversial because historically they have been implemented in a budget-neutral fashion, which means the benefit given to some hospitals comes at the expense of others. The ARP spent new money to implement this change, so the benefit to hospitals in all-urban areas does not come at the expense of others.

Urban-to-Rural Reclassification

Key Takeaway	CMS proposes steps that make it harder for hospitals to withdraw from urban-to-rural reclassification.

Medicare regulations allow hospitals geographically located in urban areas to seek to be redesignated to rural areas of their state for Medicare payment purposes. In recent years, because of some litigation that has broadened availability and appeal of this opportunity, CMS has seen an increase in the number of hospitals seeking urban-to-rural reclassification. CMS also has seen hospitals attempting to time these reclassifications to favorably impact the wage index in their state. CMS has in recent years taken steps to try to minimize these maneuvers and their impact, and the agency is now once again proposing two technical but notable rule changes.

First, CMS is proposing that requests to cancel rural reclassifications cannot be made earlier than one year after the reclassification effective date. For example, a hospital that was approved to receive a rural reclassification effective October 1, 2021, could not request to cancel that reclassification until October 1, 2022. If finalized, this change will require hospitals to maintain rural designation for at least one-year before asking to cancel that designation.

Relatedly, CMS is proposing to eliminate the current rule that a request to cancel must be requested 120 days prior to the end of the hospital's fiscal year, and that such cancelation will be effective beginning with the hospital's next fiscal year. Instead, CMS is now proposing to require that a hospital approved for rural reclassification (and that does not receive an additional reclassification) would have its data included in the calculation of the rural wage index for at least one Federal fiscal year before the rural reclassification status could be canceled. Specifically, CMS is

proposing to make cancellation requests effective for the Federal fiscal year that begins in the calendar year after the calendar year in which the cancelation request is submitted. For example, a cancelation request submitted on December 31, 2021 would be effective October 1, 2022; a cancellation request submitted one day later on January 1, 2022 would not become effective until October 1, 2023.

Graduate Medical Education (GME)

Key Takeaway	CMS is proposing to implement legislative provisions, making available new Medicare funding for graduate medical education.

Section 126 of the Consolidated Appropriations Act, 2021 (CAA) enacted by Congress at the end of 2020, provided for the distribution of 1,000 additional Medicare-funded full-time equivalent (FTE) resident cap slots to qualifying hospitals subject to certain requirements. Consistent with the statutory language, CMS is proposing the distribution would involve 200 FTE cap slots for each of the next five years, beginning with 2023. The proposed deadline for applications for the first round of distribution would be January 31, 2022.

In anticipation of significant demand for limited FTE slots and a statutory per-hospital cap of 25 FTEs, CMS proposes to limit the distribution to 1.0 FTE per hospital per year, although hospitals could receive less subject to the award formula. In order to receive any FTE slots, hospitals would need to demonstrate likelihood to fill the slots by either establishing a new residency program or expanding an existing residency program. To comply with the statutory requirement that at least 10% of the FTE slots be awarded to identified categories of hospitals, CMS intends to prioritize awards to hospitals in those categories, specifically: (1) hospitals located in or being treated as being located in a rural area; (2) hospitals currently training residents above their FTE cap; (3) hospitals located in states with new medical schools or campuses; and (4) hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs). CMS will allocate the FTE cap slots among eligible applicants based on the HPSA score of the area in which the hospital is located, with hospitals outside of a HPSA receiving the lowest priority.

CMS is also proposing to implement Section 127 of the CAA, expanding GME and IME FTE resident cap slots for both urban and rural hospitals participating in Rural Training Track (RTT) programs, as well as providing additional flexibility to encourage new and expanded RTTs. Under the proposed rule, CMS would address several concerns that have long been expressed regarding RTTs. Specifically, CMS would: (1) allow for FTE slot increases for both urban and rural hospitals when participating in a new RTT, even if the RTT does not meet CMS criteria as a "new" residency program; (2) allow for FTE slot increases for both urban and rural hospitals when an urban hospital expands an existing RTT to new rural hospital training site; (3) remove the requirement that a RTT must be separately accredited, so long as the program in its entirety is accredited by ACGME and residents in the program as a whole spend more than 50% of their training in a rural area; and (4) exempt residents in RTTs from the 3-year rolling average during the 5-year "cap building" period for RTTs.

Lastly, CMS is proposing to implement Section 131 of the CAA, which addresses adjustments of "per resident amounts" (PRA) and GME/IME FTE resident caps for hospitals that had such metrics set based on training low numbers of residents. As to the PRA recalculations, hospitals that a PRA set based on training less than 1.0 FTE resident before October 1997 or no more than 3.0 FTE residents after October 1997 will be able to have a new PRA calculated under the standard PRA methodology once they train at least 1.0 FTE or more than 3.0 FTEs, respectively, during a cost report year beginning between December 27, 2020 and December 26, 2025. The residents do not have to be training in a "new" residency program for the PRA to be reset. As to the FTE cap, for hospitals with FTE caps set based on the same thresholds and dates referenced above for the PRA, new FTE caps could be set using the standard FTE cap setting methodology if the hospital begins training at least 1.0 FTE or more than 3.0 FTEs, respectively, in a new residency program during the dates set forth above for the PRA recalculation. In connection

with implementation of these provisions, CMS is also proposing new requirements for reporting resident FTE counts and other resident training information for all hospitals training more than 1.0 FTEs.

Rural Community Hospital Demonstration

Key Takeaway	CMS is implementing a program extension required by legislation enacted in late 2020.

Legislation enacted in 2003 required CMS to establish a "demonstration" program whereby certain eligible rural hospitals would be paid under a reasonable cost-based methodology for a defined period of time. Congress has several times extended and expanded this program. Nearly 30 hospitals participate in this program.

The Consolidated Appropriations Act, 2021 enacted late in 2020, requires a 15-year extension period (that is, an additional five years beyond the current extension period), to begin on the date immediately following the last day of the initial 5-year period. In addition, the statute provides for continued participation for all hospitals participating in the demonstration program as of December 30, 2019.

Long-Term Care Hospitals (LTCHs)

Key Takeaway	CMS proposed no major policy changes concerning Long-term Care Hospitals.

LTCHs are acute-care facilities providing care to patients with average stays of more than 25 days. LTCHs are excluded from payment under IPPS and are instead paid under the LTCH prospective payment system. CMS routinely updates the LTCH-PPS concurrent with the IPPS updates. For FY 2022, CMS is proposing routine payment adjustments and updates, but no major policy changes.

Changes to Medicare Shared Savings Program (MSSP)

Key Takeaway	CMS offers additional flexibility on the risk timeline for certain Accountable Care Organization (ACOs).

LTCHs are acute-care facilities providing care to patients with average stays of more than 25 days. LTCHs are excluded from payment under IPPS and are instead paid under the LTCH prospective payment system. CMS routinely updates the LTCH-PPS concurrent with the IPPS updates. For FY 2022, CMS is proposing routine payment adjustments and updates, but no major policy changes.

Advancing to Digital Quality Measurement RFI:

Key Takeaway	CMS aims to move fully to digital quality measurement in CMS quality reporting and value-based purchasing programs by 2025.

CMS has previously outlined, as part of its Meaningful Measures Framework, a path to update and align its quality measures across its different reporting programs. This RFI seeks comment on a four-stage plan to transition CMS' quality measurement enterprise to be fully digital by 2025.

As a starting point, CMS proposes a common definition for digital quality measures (dQMs) as follows: "a software that processes digital data to produce a measure score or measure scores." Based on this definition, data sources for dQMs may include: administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (e.g., medical devices and wearable devices), patient portals or applications (e.g., for

collection of patient generated health data), health information exchanges (HIEs) or registries, and other sources defined by the Secretary.

CMS is then considering whether to require a common standard—specifically, the Fast Healthcare Interoperable Resources (FHIR® (http://hl7.org/fhir)—to reduce reporting burden and facilitate the reporting and exchange of the dQMs. Federal regulations have increasingly referenced and required FHIR as a requirement for data exchange and as a part of EHR certification. Under its four-part plan, CMS would then:

(1) Leverage and advance standards for digital data and obtain all EHR data required for quality measures via provider FHIR-based application program interfaces (APIs)
(2) Redesign its quality measures to be self-contained tools (meaning it can retrieve data; calculate measure score(s), and produce reports)
(3) Better support data aggregation
(4) Work to align measure requirements across reporting programs and the private sector, where appropriate.

CMS notes that it will not be making updates to specific program requirements or responding to comments on this issue in the final rule but will address responses in future rulemaking.

Health Equity RFI

Key Takeaway	CMS solicits comments on how the agency can improve data collection and measurement to help advance health equity in the Medicare program.

As part of the Biden Administration's commitment to advancing health equity and the Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS issued a RFI on closing the health equity gap in CMS quality programs. In addition to the executive order, the Administration has also included other RFIs related to health equity in other recently proposed rules. We anticipate the Administration in general, and CMS in particular will continue its focus on health equity, and that there may be similar RFIs in other Medicare proposed payment rules expected later this year (e.g., Medicare Physician Fee Schedule).
CMS asks stakeholders to provide information about how the agency can improve reporting and application of health disparity data related to social risk factors and race and ethnicity. Specifically, the agency requests public feedback on:

- Potential future stratification of quality measure results by race and ethnicity as well as other factors;
- Improvements to demographic data collection including expansion of data elements and improving interoperability; and
- Creation of a Hospital Equity Score in order to synthesize results across multiple social risk factors.

While CMS is seeking comment about a potential Health Equity Score, the agency stated that any potential public reporting of health equity measures would be addressed in future rulemaking.

Conclusion

There are two over-arching takeaways from this proposed rule. First, the new Administration, like its predecessor, but perhaps more so in some key takeaways, continues to be sensitive to the burden imposed on healthcare providers, and particularly hospitals, and to seek ways to create flexibilities during this public health emergency. Second, perhaps because this rule was developed while a new Administration was transitioning in, and because many key political leadership positions, including the Administrator of CMS, have not yet been filled, this rule is light on major policy proposals relative to some years. In fact, most of the major changes contained herein were required by congressional legislative action in 2020 and the first quarter of 2021. Do not expect this to be the case in future rulemakings as this Administration gets its footing.

The policies in the proposed rule are subject to change as stakeholders provide comments and CMS drafts the final rule. There were also a number of major issues that were not included in the proposed rule, including enforcement of hospital price transparency requirements and provisions implementing surprise medical billing requirements enacted in the No Surprises Act. Stakeholders should watch for future agency action on these issues in separate rulemakings.

For more information contact:

Cathy Simmons
UnityPoint Health Government and External Affairs Executive Director
cathy.simmons@unitypoint.org

Stephanie Collingwood
UnityPoint Health Government and External Affairs Specialist
stephanie.collingwood2@unitypoint.org