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CMS Publishes 2024 Hospital Payment Proposed Rule Addressing New Rates, "Health Equity" Including RFI on Safety-Net Hospitals, Wage Index and Other Rural Hospital Changes, DSH, Non-SNF Provider Ownership and Other "Quality" Related Reporting, and Interoperability

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On April 10, 2023, the Centers for Medicare & Medicaid Services ("CMS") published its federal fiscal year ("FFY") 2024 proposed rule for the inpatient prospective payment system ("IPPS") and long-term care hospital ("LTCH") payment system. Overall, CMS proposes an increase of 2.8 percent to the IPPS payment rates for FFY 2024. CMS proposes other policy changes and requests information on the following topics: A. market basket and other base rate updates; B. proposals related to "health equity" including an invitation to furnish information on safety-net hospitals; C. wage index, geographic reclassification, and other changes impacting rural hospitals; D. medical education programs; E. disproportionate share hospital payments; F. "quality of care" – ownership disclosures for additional providers as well as hospital performance and data reporting; G. low-volume hospitals' payment adjustment; and H. the Medicare interoperability program. Despite making numerous changes to the hospital cost report (CMS Form 2552-10) and accompanying instructions effective for cost reporting periods beginning on or after October 1, 2022, through its recent issuance of CMS Transmittal 18, the agency does not make any proposals related to those changes in this proposed rule.

Comments on these proposals are due to CMS by June 9, 2023. We recommend that you consider submitting comments on any provision potentially affecting your organization. Please feel free to reach out to your Ropes & Gray advisor with any questions about these proposals.

A. BASE RATE UPDATES

1. **Market Basket Update**. As discussed above, CMS proposes a net increase of 2.8 percent to the IPPS payment rates for FFY 2024, as compared to the 3.8 percent increase that was enacted for FFY 2023. The FFY 2024 2.8 percent increase is the result of a 3.0 percent increase to the market basket percentage estimate, offset by a 0.2 percent decrease due to the productivity adjustment. Furthermore, CMS proposes rates for the LTCH payment system that would decrease by 2.5 percent as compared to FFY 2023. Hospital groups have decried these as inadequate to address the financial pressures hospitals have faced in recent years due to inflation and higher costs of labor and supplies.

2. **2022 Data Used to Calculate MS-DRGs Despite COVID-19**. CMS proposes to use FFY 2022 claims data for Medicare rate-setting. In recent rulemakings, CMS had made additional adjustments on top of its standard updates to the Medicare rates based on prior year claims data to reflect the impact of COVID-19 hospitalizations. However, in this FFY 2024 proposed rule, CMS does not propose any modifications to its usual rate-setting methodology because, in CMS's view, the FFY 2022 data adequately accounts for COVID-19 hospitalizations, and there is no "reasonable basis for [CMS] to assume that there will be a meaningful difference in the number of COVID-19 cases" in FFY 2024 relative to FFY 2022.

B. PROPOSALS RELATED TO "HEALTH EQUITY"

1. **Request for Information on Challenges Facing Safety-Net Hospitals**. Acknowledging that safety-net hospitals may experience greater financial hardships compared to other hospitals, and that these challenges were exacerbated by COVID-19, CMS seeks general feedback on "the challenges faced by safety-net hospitals, and potential approaches to help safety-net hospitals meet those challenges." Specific questions to facilitate feedback include but are not limited to:

    - How should safety-net hospitals be identified or defined?
    - What factors should not be considered when identifying or defining a safety-net hospital and why?
    - What are the different types of safety-net hospitals?

CMS also seeks comments on two proposed approaches to identifying safety-net hospitals. The first is the Safety-Net Index, developed by MedPAC, and is calculated as the sum of (1) the share of the hospital's Medicare volume associated with low-income beneficiaries (defined as Medicare patients dually eligible for Medicaid or who are not eligible for Medicaid but receive the Part D low-income subsidy because they are below 150 percent of the Federal Poverty Level); (2) the share of a hospital's revenue spent on uncompensated care (measured as total uncompensated care costs on Worksheet S-10 over net patient revenues from Worksheet G-3); and (3) an indicator of how dependent the hospital is on Medicare (measured as 50 percent of the Medicare share of total inpatient hospital days on Worksheet S-3). CMS also seeks comment on the use of the "area deprivation index," developed by the National Institutes of Health, which uses census data to "capture local socioeconomic factors correlated with medical disparities and underservice." As it does with the Shared Savings Program for affordable care organizations, CMS would assign a risk factor score to each patient seen by a hospital, with patients enrolled in the Part D low-income subsidy or dually enrolled in Medicare and Medicaid receiving a risk score of 100 and the remaining patients' risk scores determined based on their mailing address's area deprivation index score. If this information is not available, the patient would be assigned a risk score of 50. CMS does not discuss the purpose or potential use of these potential additional measures.

2. **Proposed Changes to the Severity Level Designation for Codes Describing Homelessness**. CMS proposes to change the severity level designation for social determinants of health ("SDOH") diagnosis codes describing homelessness from non-complication or comorbidity ("NonCC") to complication or comorbidity ("CC") for FFY 2024. SDOH are defined by CMS as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH Z codes describe a range of issues, including education and literacy, employment, and housing. In the FFY 2023 IPPS/LTCH PPS proposed rule, CMS requested public comment on which specific SDOH Z codes were most likely to increase hospital resource utilization related to inpatient care, stated SDOH Z diagnosis codes describing homelessness can be reasonably expected to have such an impact, and reviewed the data on the impact on resource use for these codes. For the FFY 2024 IPPS/LTCH PPS proposed rule, CMS again reviewed the data on the impact of resource use for the codes that describe homelessness and found that the resources involved in caring for a patient experiencing homelessness support increasing the severity level from a NonCC to a CC. CMS continues to accept feedback on how to foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to reflect more accurately each health care encounter and improve the reliability and validity of the coded data, including in support of efforts to advance health equity.

3. **Hospital Value-Based Purchasing Program: Policy Changes**. In this proposed rule, CMS estimates that the total amount available for value-based incentive payments for FFY 2024 is approximately $1.7 billion. Notably, the agency proposes to revise the Hospital Value-Based Purchasing ("VBP") program scoring methodology to

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award Health Equity Adjustment bonus points for dual eligible status patients that would be calculated as the product of a proposed measure performance scaler and underserved multiplier. CMS also proposes updates to its tool that measures hospitals' efficiency by comparing how much Medicare pays at a given hospital for an inpatient stay to hospitals nationally, the so-called Medicare Spending per Beneficiary Hospital measure, beginning with the FFY 2028 program year and changes to the Hospital-Level Risk-Standardized Complication Rate beginning with the FFY 2030 program year. CMS further proposes to adopt a standard operating procedure for sepsis care, the so-called Severe Sepsis and Septic Shock: Management Bundle measure, for the Hospital VBP program. Finally, the agency proposes two changes to the survey process for the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") system effective for discharges in January 2025 – (1) that the survey be offered via "web-mail" permanently after an initial experimental period, and (2) requiring that the official CMS Spanish translation of the survey be administered to any patient who expresses a desire for a Spanish version.

C. WAGE INDEX, GEOGRAPHIC RECLASSIFICATION, AND CHANGES IMPACTING RURAL HOSPITALS

1. **Calculation of the Rural Wage Index**. In response to prior litigation and public comments on earlier proposals, CMS proposes to revise how it treats for wage index purposes hospitals that are reclassified as rural under 42 C.F.R. § 412.103. CMS catalogues a series of cases in which a variety of its wage index policies for hospitals reclassified under section 412.103 have been overturned and highlights numerous prior rules that the agency issued over the last decade in response to those decisions. CMS indicates that these prior changes were made "piecemeal in reaction to litigation," and that CMS has now taken "the opportunity to systematically revisit" the caselaw, prior comments, and the statutory framework under 42 U.S.C. 1395ww(d)(8)(E). Following its review, CMS proposes that hospitals reclassified from urban to rural under section 412.103 would be treated "the same as geographically rural hospitals for the wage index calculation." Specifically, CMS proposes to include hospitals reclassified as rural under section 412.103 in the rural wage index calculations for FFY 2024 (the agency made a change last year to include those hospitals in the calculation of rural floor). CMS also addresses so-called "dual reclass" hospitals, *i.e.*, hospitals with simultaneous section 412.103 urban-to-rural and Medicare Geographic Classification Review Board ("MGCRB") reclassifications. CMS states that these hospitals would be excluded from the rural wage index calculation, in accordance with a statutory hold harmless provision intended to limit the effect of reclassifications on the underlying wage indexes. *See* 42 U.S.C. §1395ww(d)(8)(C)(ii). CMS also requests comments on whether any other wage index policies should be changed based on its "reinterpretation" of the statute and accompanying proposal to treat hospitals that reclassify under section 412.103 the same as geographically rural hospitals for purposes of the wage index calculation.

2. **Continuation of Low Wage Index Policy**. CMS again proposes to continue its low wage index policy that increases the Medicare wage index calculation for hospitals in the lowest quartile and offsets that adjustment by reducing the wage index for all other hospitals. Under that policy, CMS increases the wage index for hospitals below the 25th percentile wage index by half the difference between the otherwise applicable final wage index for that hospital and the 25th percentile wage index for the year across all hospitals. CMS recognizes that its low wage index policy is "the subject of pending litigation," and that the U.S. District Court for the District of Columbia in *Bridgeport Hospital v. Becerra* "found that the Secretary did not have the authority" under the Medicare statute "to adopt the low wage index hospital policy for [F]FY 2020." Nevertheless, the agency notes that it has "appealed the court's decision" and plans to continue the policy for FFY 2024, given the agency's current "lack of sufficient data" needed to evaluate the policy.

3. **Effective Date of Rural Reclassification for Hospitals Qualifying for Sole Community Hospital Status Based on Merger**. CMS proposes to change the effective date of rural reclassification for certain hospitals that qualify for rural reclassification under 42 C.F.R. § 412.103(a)(3) by meeting the criteria for sole community

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hospital status (other than location in a rural area). For such hospitals whose eligibility for sole community hospital status depends on a hospital merger, the effective date of a rural reclassification under section 412.103(a)(3) would be the effective date of the approved merger, provided that the Medicare contractor received a completed application within 90 days of CMS's written notification to the hospital of the merger. Under existing rules, reclassification would be effective as of the date CMS receives a complete application, and the proposed rule is designed to provide sufficient time for a hospital to submit a complete application while addressing the concerns that a merger approval may be delayed for reasons beyond a hospital's control.

4. **Requirements for Enrollment as Rural Emergency Hospital**. CMS proposes to codify requirements for eligible facilities to submit certain information when applying for enrollment as a Rural Emergency Hospital ("REH"). Congress established this new type of provider in the Consolidated Appropriations Act of 2021, and in the calendar year ("CY") 2023 Outpatient Prospective Payment System final rule (published November 23, 2022), the agency adopted the enrollment methods for a provider to become an REH. On January 26, 2023, the agency also released further instructions for enrollment as an REH, and the agency proposes to codify those instructions. CMS also proposes to add a requirement for a facility applying for enrollment as an REH to submit an action plan containing (1) a plan for initiating REH services; (2) a detailed transition plan listing the specific services that the provider will retain, modify, add, and discontinue as an REH; (3) a detailed description of other outpatient medical and health services that it intends to furnish on an outpatient basis as an REH; and (4) information regarding how the provider intends to use the additional facility payment it will receive as an REH, including a description of the services that the additional facility payment would be supporting, such as the operation and maintenance of the facility and the furnishing of covered services.

D. OTHER MEDICAL EDUCATION PROGRAMS

1. **Graduate Medical Education Payments**. In addition to the changes specific to rural hospitals discussed above, CMS also proposes a new paragraph (d) at 42 C.F.R. § 419.92 addressing payments for REHs. This paragraph would state that, effective for portions of cost reporting periods beginning on or after October 1, 2023, an REH may decide to be a non-provider site and can either include the full-time equivalent ("FTE") residents training at the hospital in its GME and indirect graduate medical education ("IME") FTE counts for Medicare payment purposes or incur GME costs and be paid based on reasonable costs for those training costs. CMS also proposes to clarify the instructions on Form CMS-2552-10 Worksheet E, Part A for hospitals participating in regular or rural track Medicare GME affiliation agreements under 42 C.F.R. § 413.79(f). CMS specifically explains which lines on that Form hospitals are supposed to use to calculate their current year's FTE caps, allowable FTE counts, and numerators of the resident-to-bed ratios. CMS also announces the closure of St. Vincent Charity Medical Center Located in Cleveland, Ohio, and initiates another round of the section 5506 application and selection process to redistribute that provider's residency slots.

2. **Revising Medicare Part C Nursing and Allied Health Payments**. Congress recently passed a statutory provision that retroactively removed the $60 million annual cap on additional nursing and allied health ("NAHE") payments for CYs 2010 through 2019 ("Part C NAHE payments"). *See* Consolidated Appropriations Act of 2023, Pub. L. No. 117-328, § 4143. In response, CMS proposes a data table for calculation of those Part C NAHE payments for CYs 2010 through 2019 that eliminates the cap and uses the most recent CY 2022 available data. CMS's proposal recalculates the pool amounts pursuant to 42 U.S.C. § 1395ww(l)(2) for CYs between 2010 and 2019, ranging from a low of nearly $63 million for CY 2010 and a high of approximately $140 million for CY 2019. This proposal is the same as the methodology in the agency's March 16, 2023, Transmittal 11904. In this proposed rule, CMS also calculates the CY 2022 payment rates based on 2020 cost reporting data located in HCRIS. The agency says it maintains the statutory $60 million for CY 2022 because the recent legislation only removed the cap for 2010 through 2019. The agency also proposes to reduce Part C GME payments by

3.27 percent for 2022, as the statute directs CMS to reduce these GME payments to fund the NAHE Part C payment pool. CMS highlights that the recent legislation did not call for CMS to revise the Part C GME reduction percentage for 2010 through 2019.

E. DISPROPORTIONATE SHARE HOSPITAL PAYMENT

Consistent with prior proposed rules, CMS proposes to reduce DSH uncompensated care payments. The proposed rule is again silent on the ongoing ramifications of the *Allina* litigation and does not address the treatment of Medicare Part C days in the DSH payment calculation, but the final Part C rule—which has been pending at OMB since April 7, 2023—should address those topics following the proposed rule in August 2020. CMS has been required by statute, 42 U.S.C. § 1395ww(r), since FFY 2014 to use three factors to determine the amount of those payments to hospitals. These factors represent CMS's estimate of 75 percent of the amount of Medicare DSH payments that would have been paid under the pre-2014 system, an adjustment to that amount to account for changes in the national uninsured rate, and each eligible hospital's estimated uncompensated care amounts relative to total uncompensated care for all eligible hospitals. CMS proposes to pay a total of $6.712 billion in DSH uncompensated care payments to hospitals, marking a decrease of 2.4 percent from the $6.874 billion in payments for FFY 2023 and far less than the $7.192 billion in payments for FFY 2022 and the $8.290 billion in payments for FFY 2021 due mainly to a decline in the estimated uninsured rate for FFYs 2023 and 2024. The agency started with a baseline of DSH payments made in 2020, and then used fundamentally the same assumptions and estimates as prior years, to arrive at an estimated figure of DSH amounts that would be paid in 2024 (the so-called Factor 1). As for prior years, CMS assumes that new Medicaid enrollees under expansions are healthier than traditional Medicaid recipients and, in turn, estimates that per capita spending for Medicaid beneficiaries who enrolled due to Medicaid expansion is 80 percent of the per capita spending for Medicaid beneficiaries who enrolled before the Medicaid expansion. Similar to the last few years, Factor 2 uses the same data from the CMS actuary to estimate that the ratio of the nationwide uninsured fell from 14 percent in FFY 2013 to an average of 9.2 percent in CY 2024 (down from 9.3 percent in CY 2023), which by statute further reduced the pool of available funds to the proposed amount of $6.712 billion. To calculate Factor 3 (distribution of the pool), CMS proposes to use an average of the uncompensated care figures from hospitals' audited FFYs 2018, 2019, and 2020 cost report Worksheet S-10s, instead of just the FFYs 2018 and 2019 cost report Worksheet S-10s used in FFY 2023. CMS proposes to use FFYs 2018-2020 because it says, "computing a 3-year average using the most recent 3 years of discharge data would potentially underestimate the number of discharges for FFY 2024, due to the effects of the COVID-19 pandemic during FFY 2020, which was the first year of the COVID-19 pandemic." CMS requests comments on this proposal. CMS uses a December 2022 HCRIS extract for the Worksheet S-10 data for this proposed rule and proposes to use a March 2023 extract in the final rule calculations. Hospitals identifying any errors with their Factor 3 data have a deadline of June 9, 2023, to notify CMS by emailing the following account: Section3133DSH@cms.hhs.gov.

F. "QUALITY OF CARE" – OWNERSHIP DISCLOSURES FOR ADDITIONAL PROVIDERS AS WELL AS HOSPITAL PERFORMANCE AND DATA REPORTING

1. **Disclosures of Ownership on Medicare Enrollment Forms for Providers Other than SNFs**. Under the current Administration, CMS has increased its focus on gathering more information related to the ownership of providers and publicizing that information with the stated goals of ensuring competition in health care and allowing policy makers to track health care quality by ownership type. In that vein, CMS proposes that for purposes of disclosing provider ownership interests, the definitions of "private equity company" and "real estate investment trust" that it proposed in a recent skilled nursing facility ("SNF") rulemaking would also apply to all providers and suppliers completing the Form CMS-855A enrollment application. While published in the IPPS/LTCH proposed payment rule, CMS proposes to require this additional information from "all providers and suppliers that complete the Form CMS-855A." The SNF proposed rule defined "private equity company" as a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and

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purchases an ownership share of a provider, and defined a "real estate investment trust" as a publicly traded or non-publicly traded company that owns part or all of the buildings or real estate in or on which the provider operates. CMS has expressed concerns about the quality of care furnished by SNFs owned by such entities and states in this proposed rule that the agency's concern about the quality of care furnished by providers owned by these entities is not limited to SNFs, which is why CMS says it seeks this information for all provider types. In addition to its proposal, CMS seeks specific comments on whether the definition of "private equity company" should include publicly traded private equity companies and more generally whether CMS should consider other ownership types for disclosure.

2. **Hospital-Acquired Conditions Reduction Program: Suppression of Measures and Data Collection**. CMS proposes to adopt new electronic clinical quality measures ("eCQMs") for inclusion in the Hospital-Acquired Condition ("HAC") Reduction Program. Specifically, CMS proposes for the HAC Reduction Program to adopt three patient safety-related eCQMs, which are currently in use in the Hospital Inpatient Quality Reporting ("IQR") Program: (1) Hospital Harm—Opioid-Related Adverse Events, (2) Hospital Harm-Severe Hypoglycemia, and (3) Hospital Harm-Severe Hyperglycemia. Additionally, CMS seeks input on three additional new eCQMs: (1) Hospital Harm-Acute Kidney Injury, (2) Hospital Harm-Pressure Injury, and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults. In addition to these new quality measures, CMS proposes to add a validation reconsideration process to the HAC Reduction Program, giving hospitals the opportunity to request reconsideration of their final validation scores. Under this proposal, CMS would send a notification letter to hospitals that failed the HAC Reduction Program validation requirement instructing them on how to submit a request for reconsideration. To obtain reconsideration, a hospital would be required to submit a reconsideration request form, with the basis for reconsideration and all documentation and evidence that supports the hospital's request, within 30 days from the date stated on the notification letter. The reconsideration process would begin with the FFY 2025 program year.

3. **New and Modified Measures for Hospital Inpatient Quality Reporting Program**. CMS proposes the adoption of three new measures for the Hospital Inpatient Quality Reporting ("IQR") Program to "assess clinical processes, patient safety and adverse events, patient experiences with care, care coordination, and clinical outcomes, as well as cost of care." The measures include 1) Hospital Harm-Acute Kidney Injury, (2) Hospital Harm-Pressure Injury, and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computer Tomography in Adults. CMS proposes to modify three measures within the Hospital IQR Program measure set as well. Specifically, CMS proposes to expand the cohorts of the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality ("HWM") measure and Hybrid Hospital-Wide All-Cause Readmission ("HWR") measure, beginning with the FFY 2027 payment determination, from only Medicare fee-for-service ("FFS") patients to cohorts that include both FFS and Medicare Advantage patients 65 to 94 years old. CMS proposes to remove the following three measures from the Hospital IQR Program measure set: (1) the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty); (2) Medicare Spending Per Beneficiary; and (3) Elective Delivery Prior to 39 Completed Weeks Gestation. The agency also proposes to remove the THA/TKA Complication measure and MSPB Hospital measure, contingent upon finalizing CMS's proposal to add both measures to the Hospital VBP Program, to prevent duplicative reporting and to simplify administration. CMS further proposes to remove the Elective Delivery measure, as performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

4. **Proposed Modification of the COVID-19 Vaccination Coverage among Health Care Personnel Measure**. CMS proposes to modify the COVID-19 Vaccination Coverage among Health Care Personnel ("HCP") measure to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition. Whether an HCP is "up to date" would be determined by reference to the definition of "up to date" used by the Centers for Disease Control and Prevention as of the first day of the applicable reporting quarter. The measure

would be calculated as the cumulative number of HCPs eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination, who are considered up to date with recommended COVID-19 vaccines, divided by the total number of such eligible HCPs. This modification would take effect beginning with the Q4 CY 2023 reporting period/FFY 2025 payment determination for the Hospital IQR Program, and the FFY 2025 program year for the LTCH QRP and the PPS-Exempt Cancer Hospital Quality Reporting ("PCHQR") Program. Public reporting of the modified version of the COVID-19 Vaccination Coverage among HCP measure would begin with the October 2024 Care Compare refresh, or as soon as technically feasible after then.

G. LOW-VOLUME HOSPITALS' PAYMENT ADJUSTMENT

Consistent with last year, CMS proposes to extend the temporary changes to the low-volume hospital definition (15 road miles from another subsection (d) hospital and with less than 3,800 discharges during the fiscal year) and payment adjustment methodology (determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 500 or fewer discharges to 0 percent for low-volume hospitals with greater than 3,800 discharges) under section 4101 of the Consolidated Appropriations Act of 2023 for FFY 2024. The agency proposes to make conforming changes to the regulation text at 42 C.F.R. § 412.101. Also consistent with last year, CMS proposes that hospitals must submit written requests for low-volume hospital status to their Medicare contractor by September 1, 2023, and include sufficient documentation to establish that they meet the applicable mileage and discharge criteria.

H. MEDICARE INTEROPERABILITY

CMS proposes the following relatively minor changes to the Promoting Interoperability ("PI") Program in this proposed rule. First, CMS proposes a 180-day reporting period in CY 2025 (an increase from the 90-day period used in CY 2023 and consistent with the 180-day EHR reporting period in CY 2024), with a note that CMS may consider a longer reporting period for CY 2026 and future years but clarifying that the agency does not make a specific proposal at this time. CMS also proposes changing the payment adjustment year for new PI Program participating hospitals ("PI Participating Hospitals") beginning with the reporting period in CY 2025 to two years after the calendar year in which the reporting period occurs, aligning data reporting and attestation timelines for both new and prior PI Participating Hospitals. Beginning with the reporting period in CY 2024, CMS proposes requiring PI Participating Hospitals to attest "yes" to having conducted the annual Safety Assurance Factors for EHR Resilience ("SAFER") Guides self-assessments (https://www.healthit.gov/topic/safety/safer-guides). Finally, beginning with the reporting period in CY 2025, CMS proposes adopting three new electronic Clinical Quality Measures ("eCQMs") that PI Participating Hospitals can choose to report for their required self-selected eCQMs: the Hospital Harm – Pressure Injury eCQM; the Hospital Harm – Acute Kidney Injury eCQM; and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM. As discussed above, these are the same quality measures the agency is proposing to include in the Hospital Inpatient Quality Reporting Program, and CMS seeks feedback on the potential inclusion in the Hospital-Acquired Condition Reduction Program for future years.

This alert should not be construed as legal advice or a legal opinion on any specific facts or circumstances. This alert is not intended to create, and receipt of it does not constitute, a lawyer-client relationship. The contents are intended for general informational purposes only, and you are urged to consult your attorney concerning any particular situation and any specific legal question you may have. © 2023 Ropes & Gray LLP

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