

Summary of the Fiscal Year (FY) 2023 Medicare Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule

On April 18th, the Centers for Medicare & Medicaid Services (CMS) issued the FY 2023 Inpatient Prospective Payment System (IPPS) proposed rule. CMS estimates that the overall proposed update and other rule changes would decrease IPPS payments to hospitals in FY 2023 by approximately \$300 million. CMS has also proposed to increase operating payment rates by 3.2% for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. AAOS will submit comments on this rule by June 17, 2022.

Major provisions in the rule include proposed changes to MS-DRG Classifications of Relative Weights including a proposed 10% cap on decreases for FY 2023, proposed refinements to Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for THA/TKA (NQF #3474), and updates and proposals to continue to address health disparities. Below is a high-level description of key proposals:

Proposed Changes to Medicare Severity-Diagnosis Related Group (MS-DRG) Classifications and Relative Weights

- CMS is changing the deadline to request updates to the MS-DRGs to November 1 of each year, which provides an additional five weeks for the data analysis and review process. This is based off the need for more time to evaluate requests and propose updates, as discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38010)
- CMS is proposing “to change the process for submitting requested updates to the MS-DRG classifications, beginning with the FY 2024 MS-DRG classification change requests. CMS is in the process of implementing a new electronic application intake system, Medicare Electronic Application Request Information System™ (MEARISTM), that will be available for users to begin gaining familiarity with a new approach and process to submit new technology add-on payment applications, requests for ICD-10-PCS procedure codes, and other requests. To simplify and streamline the process for submission of standardized applications and requests that inform payment policy under the IPPS, CMS will also be using this new system for submission of MS-DRG classification change requests. CMS believes that submission of MS-DRG reclassification requests through MEARISTM will not only help CMS to track such requests, but it will also create efficiencies for requestors when compared to the previous submission process.” (pg. 59)
- CMS is proposing to “remove codes OKBN3ZX, OKBN3ZZ, OKBP3ZX, and OKBP3ZZ from the FY 2023 ICD-10 MS-DRGs Version 40 Definitions Manual in Appendix E - Operating Room Procedures and Procedure Code/MS-DRG Index as O.R. procedures. Under this proposal, these procedures would no longer impact MS-DRG assignment.”

ICD-10-PCS Code	Description	MDC
OKBN3ZX	Excision of right hip muscle. percutaneous approach, diagnostic	08
OKBN3ZZ	Excision of right hip muscle, percutaneous approach	01; 08; 09; 21; 24
OKBP3ZX	Excision of left hip muscle. Percutaneous approach, diagnostic	08
OKBP3ZZ	Excision of left hip muscle, percutaneous approach	01; 08; 09; 21; 24

- CMS mentions that “clinical advisors state although a correlation cannot usually be made between procedures performed in general anatomic regions, such as the retroperitoneum, and procedures performed in specific body parts, such as muscle, because procedures coded with general anatomic region body parts represent a broader range of procedures that cannot be coded to a body part, they agree that in this instance procedures that describe the percutaneous excision of hip muscle should have the same designation as the ICD-10-PCS procedure codes that describe the percutaneous excision of the retroperitoneum that are currently designated as non-O.R. procedures.” (pg. 163)

Recalibration of the FY 2023 MS–DRG Relative Weights

- CMS would like to protect the integrity of the budget neutrality process by ensuring that no increase to the standardized amount occurs as a result of lower overall payments in a previous year that stems from using, “weights and case-mix that are based on lower severity MS-DRG assignments. If this would occur, the anticipated cost savings from the Hospital Acquired Condition (HAC) policy would be lost.” (pg. 229)
- With the uncertainty in the number of COVID-19 hospitalizations in FY 2023, CMS is proposing to use 50 percent of the relative weights calculated using all applicable cases in the FY 2021 claims data and 50 percent of the relative weights calculated without the COVID-19 cases in the FY 2021 claims data. (pg. 236)
 - This is consistent with the belief that Medicare inpatient hospitalizations will decrease in FY 2023
 - CMS believes that averaging the relative weight in this manner would reflect a reasonable estimation of the case mix for FY 2023 (based on the information available at this time)

Add-On Payments for New Services and Technologies for FY 2023

- CMS is proposing to use the FY 2021 claims data to set the proposed thresholds for applications for new technology add-on payments for FY 2024.
- CMS is proposing to average the relative weights as calculated with and without COVID-19 cases in the FY 2021 data to determine the MS-DRG relative weights for FY 2023. (pg. 247)

Other Decisions and Changes to the IPPS for Operating Costs (pg. 777)

- CMS is “proposing to base the FY 2023 market basket update used to determine the applicable percentage increase for the IPPS on IHS Global Inc.’s (IGI’s) fourth quarter 2021 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through third quarter 2021, which is estimated to be 3.1 percent.”

Hospital Readmissions Reduction Program: Proposed Updates and Changes

- The Hospital Readmissions Reduction Program (HRRP) currently includes six conditions, one of which is elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA) (pg. 829)
- Beginning with the FY 2023 program year, CMS is modifying the technical measure specifications for each of the six procedures included in the HRRP to include a covariate adjustment for patient history of COVID-19 in the 12 months prior to admission.
- CMS is considering the use of a beneficiary’s dual Medicaid-Medicare eligibility status as a measure of the beneficiaries’ social risk that could be used to incorporate hospitals’ performance for socially at-risk populations into the HRRP (pg. 852)
- CMS is seeking comments on approaches to update the HRRP in ways through which this incorporation can be achieved, including through the consideration of non-clinical factors (pg. 854)

- Specifically, the RFI is requesting public comment on: “the benefit and potential risks, unintended consequences, and costs of incorporating hospital performance for beneficiaries with social risk factors in the HRRP; the approach of linking performance in caring for socially at-risk populations and payment reductions by calculating the reductions based on readmission outcomes for socially at-risk beneficiaries compared to other hospitals or compared to performance for other beneficiaries within the hospital; measures of social risk that should be used to achieve equity in the HRRP. (pg. 855)

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes

- CMS is proposing to suppress several measures for FY 2023 (pg. 859)
- One of these is the “*American College of Surgeons-Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753)*”
- CMS is proposing to use a special rule for FY 2023 scoring by calculating measure rates for all measures in FY 2023
- For the measures proposed to be suppressed, CMS would not use the measure rates to generate achievement and improvement points within the Hospital VBP current scoring methodology. Instead, CMS would only calculate the achievement and improvement points, along with the domain score, for the remaining measures in the Clinical Outcomes and Efficiency and Cost Reduction domains. (pg. 873)
- As a result of this proposed plan, no hospitals would receive a Total Performance Score (TPS) for FY 2023
- Since no TPS would be awarded, CMS is proposing to reduce each hospital’s base-operating DRG payment amount by two percent and then assign to each hospital a value-based incentive payment that matches the two percent reduction to the base operating DRG payment amount to result in a neutral payment adjustment for hospitals (pg. 873)
- *Implications for Merit-based Incentive Payment System (MIPS):* “Under the facility-based measurement option within MIPS, clinicians eligible for facility-based measurement may have their MIPS quality and cost performance category scores based on the total performance score (TPS) of the applicable hospital.”
- For the CY 2022 MIPS performance year/CY 2024 MIPS payment year, the TPS under the Hospital VBP for FY 2023 would be applied. If the hospital does not have a TPS for FY 2023, facility-based measurement would not be available for the MIPS eligible clinicians to whom that hospital’s TPS are applicable. (pg. 875)
- *If the proposed scoring policy is finalized, hospitals would not have the TPS for FY 2023 and clinicians would need to identify another method of participating in MIPS for the CY 2022 performance period/CY 2024 payment period or apply for reweighting a performance category (pg. 875)*
- In the FY 2022 final rule, CMS announced an update to the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure to exclude admissions with a principal or secondary COVID-19 diagnosis present on admission from the measure denominators beginning in FY 2023 (pg. 881)
 - CMS is also modifying the technical measure specifications to include a covariate adjustment for patient history of COVID-19 in the 12 months prior to admission effective for the FY 2023 program year (pg. 882)
- For the FY 2025 program year, CMS is proposing that the performance period for the clinical outcome’s domain COMP-HIP-KNEE measure be April 1, 2020-March 31, 2023 (pg. 890)
- For the FY 2028 program year, the newly established performance standards for the Clinical Outcomes domain and Efficiency and Cost Reduction domain are .029758 and .022002 respectively for COMP-HIP-KNEE (pg. 898)

Hospital-Acquired Conditions (HAC) Reduction Program: Proposed Updates and Changes

- CMS is proposing two updates to the HAC Reduction Program’s measure suppression policy for FY 2023:
 - (1) Suppress the CMS Patient Safety Indicator (PSI) 90 measure and the five CDC National Healthcare Safety Network Healthcare-associated Infections (NHSN HAI) measures (*CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI*) from the calculation of the measure scores as well as the Total HAC Score, thus eliminating any penalty to hospitals under the program for the FY 2023 year.
 - National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
 - National Healthcare Safety Network (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)
 - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcomes Measure (NQF #1716)
 - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
 - (2) Not calculate or report measure results for the CMS PSI 90 measure for the FY 2023 year for the HAC reduction program (pg. 906)
- CMS is proposing to suppress all HAC Reduction Program measures (CMS PSI 90, CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI) from the calculation of the Total HAC Score for FY 2023 (pg. 907)
- Should CMS finalize these proposals, all hospitals would receive a Total HAC score of zero and no hospital would receive a penalty for FY 2023 (pg. 914)
- CMS is also proposing to suppress CY 2021 CDC NHSN HAI data from the FY 2024 HAC Reduction Program (pg. 918)

Applicable Periods for FY 2023, FY 2024, and FY 2025 for the HAC Reduction Program		
Fiscal Year	Measure Set	Current Applicable Periods that Resulted from ECE and Measure Suppression Policies
FY 2023	CDC NHSN HAI	January 1, 2021, through December 31, 2021
	CMS PSI 90	July 1, 2019, through December 31, 2019; and January 1, 2021, through June 30, 2021
FY 2024	CDC NHSN HAI	January 1, 2022, through December 31, 2022
	CMS PSI 90	January 1, 2021, through June 30, 2022
FY 2025	CDC NHSN HAI	January 1, 2022, through December 31, 2023
	CMS PSI 90	July 1, 2021, through June 30, 2023

- CMS is announcing an increased minimum volume for the CMS PSI 90 measure which would result in hospitals being required to meet the below criteria to receive a CMS PSI 90 composite score:
 - 1) one or more component PSI measure with at least 25 eligible discharges; and
 - 2) seven or more component PSI measures with at least three eligible discharges.
- CMS has put out an RFI on the potential future adoption of two digital NHSN measures, Healthcare-associated CDiff Infection Outcome Measure and the NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure in the Hospital IQR Program, PCHQR Program, and the LTCH QRP (pg. 924)

- CMS is also requesting information on the potential inclusion of these digital CDC NHSN measures in the HAC Reduction Program (pg. 924)

Quality Data Reporting Requirements for Specific Providers and Suppliers: Assessment of the Impact of Climate Change and Health Equity

- CMS is seeking input on what HHS and CMS can do to “support hospitals, nursing homes, hospices, home health agencies, and other providers in more effectively assessing and addressing the impact that climate change will have on access to health care” (pgs. 1020-1021)

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs—Request for Information

- CMS is “seeking input on five specific areas that could inform their approach to address healthcare disparities (pg. 1027):
 - “Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Programs”
 - “Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting Across CMS Quality Reporting Programs”
 - “Principles for Social Risk Factor and Demographic Data Selection and Use”
 - “Identification of Meaningful Performance Differences”
 - “Guiding Principles for Reporting Disparity Results”
- CMS is soliciting feedback on how to identify and prioritize measures for possible stratification at the program level. This includes “prioritize existing clinical quality measures”, “prioritize measures with identified disparity in treatment or outcomes for the selected social or demographic factor”, “prioritize measures with sufficient sample size to allow for reliable and representative comparisons”, “prioritize outcome measures and measures of access and appropriateness of care” (pg. 1033)
- In addition to using patient-reported sources for social risk and demographic information, CMS is considering three other sources of social risk and demographic data that would provide stratified measure results: (pg. 1039)
 - 1) billing and administrative data
 - 2) area-based indicators of social risk information and patient demographics
 - 3) imputed sources of social risk information and patient demographics

Continuing to Advance Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs-Request for Information

- CMS is putting out an RFI on activities related to leveraging and advancing standards for digital data and approaches to transition to the FHIR eCQM reporting as first steps in the transition to digital quality measurement (pg. 1048)
- CMS is defining dQMs as “quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems” (pg. 1049)
- dQMs data sources include “administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, laboratory systems, prescription drug monitoring programs (PDMPs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection

of patient-generated data such as a home blood pressure monitor, or patient-reported health data), health information exchanges (HIEs) or registries, and other sources”

- CMS is also considering how eQMs which are based on EHR data can be updated or repackaged to “fit within the dQM umbrella”
- CMS is seeking comments on approaches to optimize data flows for quality measurement to retrieve data from EHRs via FHIR APIs as well as to combine data needed for measure score calculation for measures that require aggregating data across multiple providers (such as risk-adjusted outcome measures) plus multiple data sources (like hybrid claims-EHR measures) (pg. 1055)

Advancing the Trusted Exchange Framework and Common Agreement-Request for Information

- CMS is proposing to add a new measure in the Medicare Promoting Interoperability Program: Enabling Exchange Under TEFCA (pg. 1060)
- The proposed measure “would provide eligible hospitals and CAHs with the opportunity to earn credit for the Health Information Exchange objective if they: are a signatory to a “Framework Agreement” as that term is defined in the Common Agreement; enable secure, bi-directional exchange of information to occur for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and all unique patient records stored or maintained in the EHR for these departments; and use the functions of certified EHR technology (CEHRT) to support bi-directional exchange” (pg. 1060)
- *CMS is requesting input on the expansion of TEFCA, including by asking the following questions:*
 - “What are the most important use cases for different stakeholder groups that could be enabled through widespread information exchange under TEFCA? What key benefits would be associated with effectively implementing these use cases, such as improved care coordination, reduced burden, or greater efficiency in care delivery?”
 - What are the key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different stakeholders, including those in rural areas, under TEFCA? In addition to the ideas discussed previously, are there other programs CMS should consider in order to advance exchange under TEFCA?
 - How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs? Under what conditions would it be appropriate to require information exchange under TEFCA by stakeholders for specific use cases?
 - What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some stakeholders? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?”

Hospital Inpatient Quality Reporting (IQR) Program

- It should be noted that the Hospital IQR program “must first adopt measures and publicly report them on the Compare tool hosted by HHS...for at least one year before the Hospital Value-Based Purchasing (VBP) Program is able to adopt them.” (pg. 1065)
- CMS is proposing to adopt 10 new measures, four of which are electronic clinical quality measures (eCQMs). These 10 include:
- “Hospital Commitment to Health Equity measure, beginning with the CY 2023 reporting period/FY 2025 payment determination; Screening for Social Drivers of Health measure, beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;
- Screen Positive Rate for Social Drivers of Health measure, beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination;
- **Hospital-Harm—Opioid-Related Adverse Events eCQM, beginning with the CY 2024 reporting period/FY 2026 payment determination; (pg. 1133)**
 - This is an outcome measure for opioid-related adverse events during an admission to an acute care hospital by assessing the administration of naloxone within 12 hours of the administration of the opioid medication
 - CMS states that the goal of the measure “is to incentivize hospitals to closely monitor patients who receive opioids during their hospitalization to prevent serious adverse events”. The measure will require evidence of a hospital opioid administration prior to the naloxone administration during the first 24 hours after hospital arrival to ensure that the harm was hospital acquired and not due to an overdose that happened outside the hospital.
- **Hospital-Level, Risk Standardized Patient-Reported Outcomes Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA), beginning with two voluntary reporting periods followed by mandatory reporting for the reporting period which runs from July 1, 2025, through June 30, 2026, impacting the FY 2028 payment determination; (pg. 1155).**
 - This Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) performance measure (THA/TKA PRO-PM) was developed and tested using PRO instruments and risk variable data collected and submitted by CJR participant hospitals. PRO data from the first few performance years for the CJR model revealed hospital level variation in these outcomes across U.S. hospitals, although the full degree and extent of variation is unknown.” (pg. 1158)
- *In response to stakeholder feedback, CMS is proposing that hospitals “may determine a data collection mode that accommodates their clinical workflow.” (pg. 1161)*
- CMS is “proposing a phased implementation approach, with two voluntary reporting periods in CY 2025 and 2026 reporting periods prior to mandatory reporting beginning with the CY 2027 reporting period/FY 2028 payment determination” (pg. 1162)
- “The THA/TKA PRO-PM reports the hospital-level risk-standardized improvement rate (RSIR) in patient reported outcomes following elective primary THA/TKA for Medicare FFS beneficiaries aged 65 years and older. Substantial clinical improvement would be measured by achieving a pre-defined improvement in score on joint-specific PRO instruments measuring hip or knee pain and functioning, from the pre-operative assessment (data

collected 90 to 0 days before surgery) to the post-operative assessment (data collected 300 to 425 days following surgery).” (pg. 1163)

- “The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. The measure uses PRO data collected by hospitals pre-operatively and post-operatively and limited patient-level risk factor data collected with PRO data and identified in claims. The measure includes PRO data collected with several PRO instruments, among them are two joint-specific PRO instruments—the Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR) for completion by THA recipients and the Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR) for completion by TKA recipients—from which scores are used to assess substantial clinical improvement. For risk adjustment by pre-operative mental health score, hospitals would submit one of two additional PRO instruments, either all the items in the Patient-Reported Outcomes Measurement Information System (PROMIS)-Global Mental Health subscale or all the items in the Veterans RAND 12-Item Health Survey (VR–12) Mental Health subscale. The risk model also includes a one-question patient-reported assessment of health literacy—the Single Item Literacy Screener questionnaire.” (pg. 1164)
- “Claims data are used to identify eligible elective primary THA/TKA procedures for the measure cohort to which submitted PRO data can be matched, and to identify additional variables for risk adjustment and in the statistical approach to accounting for response bias, including patient demographics and clinical comorbidities up to 12 months prior to surgery. The Medicare Enrollment Database (EDB) identifies Medicare FFS enrollment and race, and the Master Beneficiary Summary File allows for determination of Medicare and Medicaid dual eligibility enrollment status. Demographic information from the U.S. Census Bureau’s American Community Survey allows for derivation of the AHRQ SES Index score. Race, dual eligibility, and AHRQ SES Index score are used in the statistical approach to accounting for non-response bias.” (pg. 1166)
- **In response to comments on the FY 2022 proposed rule and stakeholder feedback, CMS is proposing to adopt multiple submission approaches including the utilization of an external entity such as a registry to submit data on behalf of the hospital for CMS measure calculation (pg. 1168)**
- “CMS is proposing a phased implementation approach for adoption of this measure to the Hospital IQR Program, with two voluntary reporting periods prior to mandatory reporting in the Hospital IQR Program. Voluntary reporting prior to mandatory reporting would allow time for hospitals to incorporate the THA/TKA PRO-PM data collection into their clinical workflows and is responsive to stakeholder comments as summarized in the FY 2022 IPPS final rule” (pg. 1170)

TABLE IX.E-07. PRE-OPERATIVE AND POST-OPERATIVE PERIODS FOR THA/TKA PRO-PM FOR VOLUNTARY REPORTING

<i>Reporting Period</i>	<i>Performance Period</i>	<i>Pre-operative Data Collection Window</i>	<i>Pre-operative Data Submission Deadline</i>	<i>Post-operative Data Collection Window</i>	<i>Post-operative Data Submission Deadline</i>
<i>Voluntary Reporting 1 (2025)</i>	January 1, 2023 through June 30, 2023	October 3, 2022 through June 30, 2023	October 2, 2023	October 28, 2023 to August 28, 2024	September 30, 2024
<i>Voluntary Reporting 2 (2026)</i>	July 1, 2023 through June 30, 2024	April 2, 2023 through June 30, 2024	September 30, 2024	April 26, 2024 to August 29, 2025	September 30, 2025

- Following the two voluntary reporting periods, CMS is proposing that “mandatory reporting of the THA/TKA PRO-PM would begin with eligible elective primary THA/TKA procedures from July 1, 2024 through June 30, 2025 with affecting the FY 2028 payment determination. (pg. 1172)
- During the voluntary reporting periods, CMS is proposing to publicly report which hospitals “choose to participate in voluntary reporting and/or the percent of pre-operative data submitted by participating hospitals for the first voluntary reporting period, and their percent of pre-operative and post-operative matched PRO data submitted for subsequent voluntary reporting periods.” (pg. 1172)

Proposed Data Submission and Reporting Requirements for Patient-Reported Outcome-Based Performance Measures (PRO-PMs)

- For the THA/TKA PRO-PM CMS is proposing the following methods for submission: (1) Send their data to CMS for measure calculation directly; or (2) utilize an external entity, such as through a vendor or registry, to submit their data on behalf of the hospital to CMS for measure calculation. (pg. 1247)
- CMS is proposing that “both hospitals and vendors use the HQR System for data submission for the THA/TKA PRO-PM. Use of the HQR System leverages existing CMS infrastructure already utilized for other quality measures (such as, HCAHPS or the Sepsis measure). The HQR System allows for data submission using the following file formats: CSV, XML, and a manual data entry option; allowing hospitals and vendors flexibility in data submission. We would provide hospitals with additional detailed information and instructions for submitting data using the HQR System through CMS’ existing websites, such as on QualityNet, and through listservs or both.”
- “For hospitals participating in voluntary reporting, CMS is proposing that hospitals submit pre-operative PRO data, as well as matching post-operative PRO data for at least 50 percent of their eligible elective primary THA/TKA procedures.” (pg. 1248)

TABLE IX.E-16. PROPOSED VOLUNTARY REPORTING OF PRE-OPERATIVE AND POST-OPERATIVE PERIODS FOR THA/TKA PRO-PM

<i>Reporting Period</i>	<i>Performance Period</i>	<i>Pre-Operative Data Collection</i>	<i>Pre-Operative Data Submission Deadline</i>	<i>Post-Operative Data Collection</i>	<i>Post-Operative Data Submission deadline</i>
Voluntary Reporting 1 (2025)	January 1, 2023 through June 30, 2023	October 3, 2022 through June 30, 2023	October 2, 2023	October 28, 2023 to August 28, 2024	September 30, 2024
Voluntary Reporting 2 (2026)	July 1, 2023 through June 30, 2024	April 2, 2023 through June 30, 2024	September 30, 2024	April 26, 2024 to August 29, 2025	September 30, 2025

- For mandatory reporting, CMS is proposing that it would begin with “reporting PRO data for eligible elective THA/TKA procedures for the FY 2028 payment determination. The initial mandatory reporting would include pre-operative PRO data collection from three months preceding the applicable performance period and from 10 to 14 months after the performance period.” (pg. 1250)
- CMS is “proposing that hospitals would be required to submit 50 percent of eligible, complete pre-operative data with matching eligible, complete post-operative data as a minimum amount of data for mandatory reporting in the Hospital IQR Program” (pg. 1250)

TABLE IX.E-17. PROPOSED MANDATORY REPORTING OF PRE-OPERATIVE AND POST-OPERATIVE PERIODS FOR THA/TKA PRO-PM

<i>Reporting Period</i>	<i>Performance Period</i>	<i>Pre-operative Data Collection</i>	<i>Pre-operative Data Submission Deadline</i>	<i>Post-Operative Data Collection</i>	<i>Post-Operative Data Submission Deadline</i>
Mandatory Reporting (2027)	July 1, 2024 through June 30, 2025	April 2, 2024 through June 30, 2025	September 30, 2025	April 27, 2025 to August 29, 2026	September 30, 2026

- **Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA measure beginning with the FY 2024 payment determination” (pg. 1183)**
- This measure was removed from the Hospital IQR Program in the FY 2018 final rule to reduce provider burden since it was also being reported under the Hospital VBP Program
- CMS is now proposing to adopt the re-evaluated form of the measure with an expanded measure outcome, which includes 26 mechanical complication ICD-10 codes identified during measure maintenance (pg. 1184)
- CMS is proposing to adopt this measure in the Hospital IQR Program with the “intention to eventually propose the updated measure into the Hospital VBP Program after the required year of public reporting in the Hospital IQR Program.” (pg. 1184)
- “Based on projections of the annual demand for THA and TKA procedures, researchers estimate that Medicare expenditures on Total Joint Arthroplasty (TJA) could climb from \$3.95 billion and \$7.42 billion for both primary THA and TKA, respectively, in 2005, to \$50 billion by 2030.” (Pg. 1184)
- “The proposed updated THA/TKA Complication measure uses index admission diagnoses and in-hospital comorbidity data from Medicare Part A claims. Additional comorbidities prior to the index admission are assessed using Part A inpatient, outpatient, and Part B office visit Medicare claims in the 12 months prior to index (initial) admission. Enrollment status is obtained from the Medicare Enrollment Database which contains beneficiary demographic, benefit/coverage, and vital status information. We are proposing to use claims data with admission dates beginning from April 1, 2019 – March 31, 2022 (excluding data from the period covered by the ECE granted by CMS related to the COVID-19 Public Health Emergency (PHE)) that is associated with the FY 2024 payment determination. As a claims-based measure, hospitals would not be required to submit additional data for calculating the measure.” (pg. 1187)

Proposed Refinements to Current Measures in the Hospital IQR Program Measure Set

- CMS is “proposing a refinement to the Hospital-Level, Risk Standardized Payment Associated with an Episode of Care for Primary Elective THA and/or TKA Measure (NQF #3474)...which expands the measure outcome to include 26 clinically vetted mechanism complication ICD-10 codes, for the FY 2024 payment determination and subsequent years.”
- The proposed ICD-10 codes can be found beginning on pg. 1195
- For the purposes of describing the refinement of this measure, CMS notes that the “outcome” is defined as hospital level, risk-standardized payment associated with a 90-day episode-of-care for primary elective THA and/or TKA.” (pg. 1192)
- If finalized as proposed, CMS states that the measure would be effective for admissions from April 1, 2019- March 31, 2022, and impact the FY 2024 payment determination and subsequent years (pg. 1198)
- For CY 2024/FY 2026 CMS is proposing the below eCQM reporting requirements: (pg. 1236)

TABLE IX.E-15. CURRENT AND PROPOSED eCQM REPORTING AND SUBMISSION REQUIREMENTS FOR THE CY 2022 REPORTING PERIOD/FY 2024 PAYMENT DETERMINATION AND FOR SUBSEQUENT YEARS

Reporting Period / Payment Determination	eCQM Data Publicly Reported	Total Number of eCQMs Reported	eCQMs Required to be Reported
CY 2022 / FY 2024	Three Quarters of Data	Four	<ul style="list-style-type: none"> • Four self-selected eCQMs
CY 2023 / FY 2025	Four Quarters of Data	Four	<ul style="list-style-type: none"> • Three self-selected eCQMs; and • Safe Use of Opioids—Concurrent Prescribing eCQM
Proposed: CY 2024 / FY 2026 (and for subsequent years)	Four Quarters of Data	Six	<ul style="list-style-type: none"> • Three self-selected eCQMs; and • Safe Use of Opioids—Concurrent Prescribing eCQM; and • Proposed Cesarean Birth eCQM; and • Proposed Severe Obstetric Complications eCQM

[Read the complete rule...](#)

[Read the high-level summary...](#)