AAOS
American Association of Orthopaedic Surgeons

**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. 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 "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)

**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."

**Proposed Payment for Indirect and Direct Graduate Medical Education (GME) Costs (pg. 802)**

- CMS is "proposing to make changes to the calculation of GME full time equivalent (FTE) caps for certain hospitals and to allow certain urban and rural hospitals participating in Rural Training Tracks to enter into Medicare GME affiliation agreements in order to share FTE caps."

**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.

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

- CMS is proposing to suppress several measures for FY 2023 (pg. 859)
- 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."
- 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)

**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:
    - Suppress the CMS PSI (Patient Safety Indicator) 90 measure and the five CDC National Healthcare Safety Network Healthcare-associated Infections (NHSN HAI) measures 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.
    - Not calculate or report measure results for the CMS PSI 90 measure for the FY 2023 year for the HAC reduction program (pg. 906)

**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"

**Hospital Inpatient Quality Reporting (IQR) Program**

- CMS is proposing to adopt 10 new measures, four of which are electronic clinical quality measures (eCQMs). These include:
  - Hospital-Harm—Opioid-Related Adverse Events eCQM, beginning with the CY 2024 reporting period/FY 2026 payment determination (pg. 1133)
  - **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)
  - **Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA beginning with the FY 2024 payment determination** (pg. 1183)

**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) (hereinafter referred to as the THA/TKA Payment measure), which expands the measure outcome to include 26 clinically vetted mechanism complication ICD-10 codes, for the FY 2024 payment determination and subsequent years."
- 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)

*Read the complete rule*