AAOS
American Association of Orthopaedic Surgeons

AAOS Summary: Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1752-P)

On April 27, 2021 the Centers for Medicare and Medicaid Services (CMS) released the Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1752-P). AAOS will be submitting formal comments to CMS, due on June 28, 2021. Major provisions in the proposed rule include an increase of approximately 2.8 percent to hospitals paid under the IPPS, repealing a requirement for hospitals to report certain payment information on their Medicare cost report to reflect market-based pricing and updating quality reporting measures to track health disparities. Below is a detailed summary of key proposals:

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

Proposed FY 2022 MS–DRG Documentation and Coding Adjustment

- CMS is proposing a .5 percent increase to the standardized amount for FY 2022. This would be a permanent increase to the payment rates.

Proposed Changes to Specific MS–DRG Classifications (pg. 71)

- CMS "analyzed how applying the NonCC [Non Complication or Comorbidity] subgroup criteria to all MS-DRGs currently split into three severity levels would effect the MS-DRG structure beginning in FY 2022."
- The CMS findings "indicated that approximately 32 MS-DRGs would be subject to change based on the three-way severity level split criterion finalized in FY 2021." They found that "applying the NonCC subgroup criteria to all MS-DRGs currently split into three severity levels would result in the deletion of 96 MS-DRGs (32 MS-DRGs x 3 severity levels = 96) and the creation of 58 new MS-DRGs." (Table 6P.1c)
    - Given the public health emergency (PHE), CMS is delaying the implementation of this proposal until FY 2023
- CMS "received a request to examine the procedure code combinations for procedures describing knee joint removal and replacement in MS-DRGs 466, 467, and 468." They found that "the procedure codes for right knee joint removal and replacement procedures were inadvertently excluded from the logic for MS-DRGs 466, 467, and 468.
- CMS is proposing to add the three procedure code combinations describing removal and replacement of the right knee joint that were inadvertently omitted from the logic to MS-DRGs 461, 462, 466, 467, and 468 in MDC 08 and MS-DRGs 628, 629, and 630 in MDC 10.
- CMS received a request "to reassign cases reporting a diagnostic code describing a pelvic fracture in combination with a procedure code describing a repair of a pelvic fracture with internal fixation, from the lower (NonCC) severity level MS-DRG of its current base MS-DRG assignment to the higher (MCC) severity level MS-DRG of its current base MS-DRG assignment."
- CMS analyzed the data and proposes to maintain the current structure of MS-DRGs 515, 516, and 517; MS-DRGs 907, 908, and 909; and MS-DRGs 957, 958, and 959 for FY 2022. However, they

agree that further analysis should be performed to determine the causes of the fractures and other contributing factors impacting cost and length of stay.

- CMS is announcing a multi-year project to review the process for determining when a procedure is considered an operating room procedure. This will be updated through a systematic review of ICD-10 codes.
- CMS is reviewing specific requests for ICD-10 codes from non-O.R. to O.R. and vice versa, which were received for FY 2022 consideration (pg. 189):
    - Removal of 22 codes (drainage of subcutaneous tissue and fascia) from the O.R. procedures list —these procedures would no longer impact MS-DRG assignment
- CMS rejected the addition of six ICD-10 codes for drainage of knee, hip, and shoulder joints (percutaneous endoscopic approach) to the O.R. designation (pg. 201) as well as the addition of ICD-10 codes 3E1U48X and 3E1U48Z (Irrigation of joints using irrigating substance, percutaneous endoscopic approach) to the O.R. designation
- CMS is proposing to add the two procedure codes for percutaneous reposition of the sacroiliac joint with internal fixation procedures (0SS734Z, 0SS834Z) to the O.R. procedures list for the FY 2022 ICD-10 MS-DRGs Version 39 Definitions Manual, assigned to MS-DRGs 515, 516, and 517 in MDC 08 and MS-DRGs 987, 988, and 989
- CMS is proposing to add the two procedure codes for percutaneous reposition of the hip joint with internal fixation procedures (0SS934Z, 0SSB34Z) to the O.R. procedure code list, assigned to MS-DRGs 480, 481, and 482 in MDC 08, as well as MS-DRGs 987, 988, and 989
- CMS is proposing to add the procedure codes for the insertion and removal of spacer from shoulder joint with an open or percutaneous endoscopic approach to the O.R. procedure list, assigned to MS-DRGs 510, 511, and 512 in MDC 08, and MS-DRGs 987, 988, and 989 (pg. 205)
- CMS is soliciting feedback on changing the severity level designation for unspecified ICD-10-CM diagnosis codes for FY 2022 (Table 6P.2a)
- Could result in a potential 29.2% decrease in the number of musculoskeletal system and connective tissue ICD codes (pg. 233), the largest reduction in any category

Recalibration of the FY 2022 MS–DRG Relative Weights

- For the purposes of establishing the FY 2022 MS-DRG relative weights, CMS is proposing to use the 2019 MedPAR claims data, based on claims received by CMS through March 31, 2020, as well as the March 2020 update of the FY 2018 HCRIS file where they typically would have used the FY 2020 MedPAR claims data, based on claims received by CMS through December 31, 2020 and the December 2020 updated of the FY 2019 HCRIS file.

Proposed Add-On Payments for New Services and Technologies for FY 2022

Alternative Pathway for Breakthrough Devices Applications:

- Aprevo Intervertebral Body Fusion Device: Formerly known as “Corra” it is an “interbody fusion implant that stabilizes the lumbar spinal column and facilitates fusion during lumbar fusion procedures indicated for the treatment of spinal deformities.” (pg. 705)

- CMS is proposing to approve the device subject to FDA approval by July 1, 2021 and that the maximum add-on payment for it would be $20,475 for FY 2022
- Cerament G "is an injectable bone-void filler made of calcium sulfate, hydroxyapatite, and gentamicin sulfate indicated for the surgical treatment of osteomyelitis." The "bone graft substitute fills gaps resulting from debridement of infected bone and prevents colonization of sensitive bacteria, promoting bone healing in two ways." (pg. 720)
- CMS is proposing to approve the device subject to FDA approval by July 1, 2021 and that the maximum add-on payment for it would be $3,913 for FY 2022

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

- "In connection with the adoption in FY 2021 of the updates in OMB Bulletin 18-04, CMS adopted a policy to place a 5 percent cap, for FY 2021, on any decrease in a hospital's wage index from the hospital's final wage index in FY 2020 so that a hospital's final wage index for FY 2021 would not be less than 95 percent of its final wage index for FY 2020."
- "As finalized in the FY 2021 IPPS/LTCH PPS final rule, this transition is set to expire at the end of FY 2021. However, given the unprecedented nature of the ongoing COVID-19 PHE, CMS also seeks comment on whether it would be appropriate to continue to apply a transition to the FY 2022 wage index for hospitals negatively impacted by adoption of the updates in OMB Bulletin 18-04."
- "For example, such an extended transition could potentially take the form of holding the FY 2022 wage index for those hospitals harmless from any reduction relative to their FY 2021 wage index. If CMS were to apply a transition to the FY 2022 wage index for hospitals negatively impacted by adoption of the updates in OMB Bulletin 18-04, CMS also seeks comment on making this transition budget neutral, as is CMS' usual practice, in the same manner that the FY 2021 transition was made budget neutral as discussed in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58755)."

Proposed Rebasing and Revising of the Hospital Market Baskets for Acute Care Hospitals

Background

- CMS is rebasing and revising the IPPS market basket, as they do every four years, with the last occurrence in FY 2018

Rebasing and Revising the IPPS Market Basket

- "There is no difference between the average percent change in the 2014-based and the proposed 2018-based IPPS market basket over the FY 2017 through FY 2020 time period. For FY 2022, the increase is projected to be 2.5 percent for both the 2014-based and proposed 2018- based IPPS market baskets."

Other Decisions and Changes to the IPPS for Operating System

Hospital Readmissions Reduction Program: Proposed Updates and Changes

- CMS is requesting comments on the "possible future stratification of results by race and ethnicity for condition/procedure-specific readmission measures and by expansion of

standardized data collection to additional social factors, such as language preference and disability status."

- CMS is also seeking feedback "on mechanisms of incorporating other demographic characteristics into analysis that address and advance health equity, such as the potential to include administrative and self-reported data to measure co-occurring disability status."
- CMS is "updating the measure specifications to exclude Medicare beneficiaries with a secondary diagnosis of COVID-19." This applies to five measures in the Hospital Readmissions Reduction Program, including Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551) (pg. 968)
- CMS is "seeking comment on expanding efforts to provide hospital-level results of both the Within- and Across-Hospital Disparity Methods...using indirectly estimated race and ethnicity, as well as additional social factors, such as language preference and disability status."
- These expanded methods would be "reported at the hospital-level, and provided to hospitals in confidential HSRs for six condition/procedure-specific readmission measures, stratified by both dual eligibility and race/ethnicity."
- This includes Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551) (pg. 989)

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

- CMS is updating the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550) to "exclude patients with either principal or secondary diagnoses of COVID-19 from the measure denominator beginning with the FY 2023 program year" (pg. 1020)

Proposed Payments for Indirect and Direct Graduate Medical Education Costs

- The Consolidated Appropriations Act "makes available 1,000 new Medicare-funded GME positions (but not more than 200 new positions for a fiscal year), to be distributed beginning in fiscal year 2023, with priority given to hospitals in 4 statutorily-specified categories." (pg. 1070)
- "For FY 2023, and for each succeeding fiscal year until the aggregate number of full-time equivalent (FTE) residency positions distributed is equal to 1,000, the Secretary shall initiate separate rounds of applications from hospitals for these additional residency positions."
- "Specifically, the Secretary is required to distribute at least 10 percent of the aggregate number of total residency positions available to each of four categories of hospitals."
    (1) "hospitals located in rural areas or that are treated as being located in a rural area"
    (2) "hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit"
    (3) "hospitals in states with new medical schools or additional locations and branches of existing medical schools"
    (4) "hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)"

- "Hospitals applying for residency positions for programs that do not serve HPSAs are not categorically excluded, but those applications would have the lowest priority." (pg. 1091)
- CMS is "proposing that each time an urban hospital and rural hospital establish a Rural Training Track (RTT) program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes, both the urban and rural hospitals may receive a rural track FTE limitation. For example, Urban Hospital A has an existing internal medicine program. In July 2023, it partners with Rural Hospital 1 to create a RTT from the existing internal medicine program. CMS is proposing that both Urban Hospital A and Rural Hospital 1 may receive adjustments to their resident caps (rural track FTE limitations) to reflect their portions of FTE residents training in the RTT." (pg. 1102)
- "For all accredited specialties, we are proposing to require that an urban hospital may include in its FTE count, not to exceed its rural track FTE limitation, residents training in the urban hospital that are designated to rotate to a rural area for greater than 50 percent of the duration of the particular program. In addition, CMS is proposing that a rural hospital that is partnered with the urban hospital in the RTT would similarly include in its FTE count, not to exceed its rural track FTE limitation, the time residents train in the rural hospital only if the residents rotate to a rural area for greater than 50 percent of the duration of the particular program." (pg. 1109)

Market-Based MS-DRG Relative Weight--Proposed Policy Changes

- In the FY 2021 IPPS/LTCH PPS final rule CMS "finalized a requirement for a hospital to report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its MA organization payers, by MS-DRG, for cost reporting periods ending on or after January 1, 2021."
- CMS also finalized "the use of this data in a new market-based methodology for calculating the IPPS MS-DRG relative weights to reflect relative market-based pricing, beginning in FY 2024."
- CMS stated that they "will begin using the reported median payer-specific negotiated charge by MS-DRG for MA organizations in the market-based MS-DRG relative weight methodology beginning with the relative weights calculated for FY 2024."
- However, "After further consideration of the many contract arrangements hospitals use to negotiate rates with MA organization payers, and the usefulness, for rate setting purposes, of the market based data as reported in accordance with the FY 2021 IPPS/LTCH PPS final rule…CMS proposes to "repeal the requirement that a hospital report on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its MA organization payers, by MS-DRG, for cost reporting periods ending on or after January 1, 2021."
- CMS is also "proposing to repeal the market-based MS-DRG relative weight methodology that was adopted effective for FY 2024, and to continue using the existing cost-based methodology for calculating the MS-DRG relative weights for FY 2024 and subsequent fiscal years." (pg. 1147)

<u>Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers</u>

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

- In alignment with CMS's goal to fully transition to digital quality measurement in its quality reporting and value-based purchasing programs by 2025, they are requesting public input on expanding the definition of digital quality measures, respecification of current electronic clinical quality measures to use Fast Healthcare Interoperability Resources (FHIR) standards, and potential steps to advance the transition to digital quality measures (dQMs) by 2025.
- Of note, CMS is considering expanding and establishing policies for data aggregation, measure calculation, measure reporting process integrity, and market innovation to third-party aggregators, including, but not limited to, Health Information Exchanges, Qualified Registries, and Qualified Clinical Data Registries (QCDRs). The AAOS Registries are QCDRs.
- Additionally, the Agency is considering the future potential development of a common portfolio of dQMs across its regulated programs, agencies, and private payers.
- CMS will not be responding to specific comments submitted in response to this Request for Information in the FY 2022 IPPS/LTCH PPS final rule, though it will use the feedback in future rulemaking.

Closing the Health Equity Gap in CMS Hospital Quality Programs – Request For Information

- Improving health equity is a major long-term goal of the Biden Administration. In response to the Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS has issued an RFI on how the Agency can close the health disparity gap in the Medicare program.
- The Agency is interested in how it can improve reporting and application of health disparity data related to social risk factors and race and ethnicity and asks for stakeholder feedback on the following ideas:
    - Stratification of quality measure results by race and ethnicity as well as other factors in the future,
    - Improvements to demographic data collection; and
    - Creation of a Hospital Equity Score, which would synthesize results across multiple social risk factors.
- CMS will not be responding to specific comments submitted in response to this Request for Information in the FY 2022 IPPS/LTCH PPS final rule, though it will use the feedback in future rulemaking.

Hospital Inpatient Quality Reporting (IQR) Program

- CMS is considering future inclusion of Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (NQF# 3559) to the Hospital IQR Program. The Agency would like to hear feedback from the public on the following:
    - Implementation approach, including whether reporting should be voluntary, mandatory, or a hybrid phased approach. CMS would also like feedback on timing/duration of reporting periods.
    - Data collection and submission, including anticipated barriers and solutions to data collection and submission.

    - Threshold requirements for the quantity of data.
    - Expansion of the measure to non-inpatient settings, which is an important consideration given the recent removal of TKA and THA procedures from the Inpatient Only List in the CY 2021 OPPS/ASC final rule.
- CMS proposes the addition of the COVID-19 Vaccination Coverage Among Health Care Personnel Measure to the Hospital ICR Program. This measure would assess the proportion of a hospital's health care workforce that has been vaccinated against COVID-19. Due to ongoing pandemic, CMS is proposing a shorted initial reporting period from October 1, 2021 through December 31, 2021 for the FY 2023 payment determination.
- Beginning with the CY 2023 reporting period/FY 2025 payment determination and subsequent years, CMS is proposing to require hospitals to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for the Hospital IQR Program data. This change is meant to align the Hospital IQR Program with the ONC's 21st Century Cures Act final rule, which updated the 2015 Edition of health IT certification criteria.

Proposed Changes to the Medicare Promoting Interoperability Program

- For CY 2023, the minimum reporting period for the Medicare Promoting Interoperability Program will remain at 90 continuous days. However, for CY 2024, is CMS proposing increasing the reporting period to a minimum of any continuous 180-day period.
- CMS is also proposing changes to several measures, most notably increasing the bonus points awarded for reporting the optional Query of Prescription Drug Monitoring Program Measure to ten and making the following measures required beginning with the CY 2022 reporting period:
    - Syndromic Surveillance Reporting,
    - Immunization Registry Reporting,
    - Electronic Case Reporting, and
    - Electronic Reportable Laboratory Result Reporting
- To address overlap and prevent confusion with the information blocking provisions of section 3022 of the Public Health Service Act and the Office of the National Coordinator for Health Information Technology (ONC) 21st Century Cures Act final rule, CMS is proposing to no longer require attestation for statements 2 and 3 beginning with the CY 2022 EHR reporting period.
- Statement 2 requires attestation to a series of statements related to the use of certified technology and the way in which it is implemented. Statement 3 addresses how requests to retrieve or exchange electronic health information are handled.
- Like the Hospital IQR Program, CMS is proposing to require hospitals to use only certified technology updated consistent with the 2015 Edition Cures Update to submit data for the Medicare Promoting Interoperability Program beginning with the CY 2023 reporting period/FY 2025 payment determination.

<u>Proposed Changes for Hospitals and Other Providers and Suppliers</u>

Medicaid Enrollment of Medicare Providers and Suppliers for Purposes of Processing Claims for Cost-Sharing for Services Furnished to Dually Eligible Beneficiaries—Proposed Policy Changes

- To clarify the determination of Medicare cost-sharing obligations for dually eligible beneficiaries (I.e. beneficiaries receiving both Medicare and Medicaid benefits), CMS is proposing that "State Medicaid programs must accept enrollment of all Medicare-enrolled providers and suppliers (even if a provider or supplier is of a type not recognized as eligible to enroll in the State Medicaid program) if the provider or supplier otherwise meets all Federal Medicaid enrollment requirements."

Medicare Shared Savings Program—Proposed Policy Changes

- In the May 2020 COVID-19 Interim Final Rule with Comment (IFC), CMS provided flexibility for Accountable Care Organizations (ACOs) participating in the BASIC track's glide path to maintain their level of participation for Performance Year (PY) 2021 and not automatically progress to a higher level, which requires greater risk. In light of the continued challenges and uncertainty of the COVID-19 pandemic, CMS is proposing to expand this flexibility into PY 2022.
- Specifically, CMS proposes "that before the automatic advancement for PY 2022, an applicable ACO may elect to remain in the same level of the BASIC track's glide path in which it participated during PY 2021. For PY 2023, an ACO that elects this advancement deferral option would be automatically advanced to the level of the BASIC track's glide path in which it would have participated during PY 2023 if it had advanced automatically to the required level for PY 2022."
- ACOs retain the ability to advance more quickly if they choose.

Read the complete rule.