
MEMORANDUM

To: AAHKS
From: Epstein Becker & Green, P.C.
Date: August 10, 2022
Re: Summary of the FY 2023 Hospital Inpatient Prospective Payment Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the fiscal year 2023 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Long-Term Prospective Payment System Final Rule on August 1, 2022.

In June, AAHKS submitted comments in response to the 2023 IPPS proposed rule. The following is a summary of CMS actions in the final rule related to the comments submitted by AAHKS. The final rule becomes effective October 1, 2022.

I. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights – IPPS Arthroplasty Rate Increases Highlight Disparity in Medicare Physician Reimbursement

CMS Proposal: CMS proposed increases in the relative weights of the four primary MS-DRGs associated with lower joint arthroplasty.¹ Combined with proposed increases in the national standardized amount, on which DRGs are calculated to derive payment amount, this leads to significant increases in Medicare payment rates for these arthroplasty codes.

AAHKS Comment: In response, AAHKS commented that it generally supports increased payment rates to facilities for arthroplasty due to the extreme complexity of the procedure, innovations in the standard of care and outcomes, and to recognize increased costs through the COVID-19 public health emergency. Nevertheless, the ongoing annual increases in Medicare facility payments for arthroplasty present a stark contrast with severely decreasing Medicare physician payments for arthroplasty.

AAHKS stated that it was unfair that Medicare payment formulas make physicians carry the burden of cost reductions while hospital payments continue to increase. Medicare payments for the professional component of arthroplasty have been cut by 9% since 2017.

¹ Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC (469); Major joint replacement or reattachment of the lower extremity (470); Hip replacement with Principal Diagnosis of Hip Fracture with MCC (521); Hip replacement with Principal Diagnosis of Hip Fracture.

CMS Action: Increases in cost data collected since the publication of the proposed rule led CMS to increase the national standardized amount leading to slight increases in rates from the proposed rule. CMS finalized the following rates:²

MS-DRG	2022		2023 Proposed		2023 Final		% Change from 2022
	Weight	Rate	Weight	Rate	Weight	Rate	
469	3.0859	\$18,890.79	3.2463	\$20,502.88	3.2314	\$20,602.56	+9.1%
470	1.9003	\$11,632.97	1.9249	\$12,157.22	1.9119	\$12,189.77	+4.6%
521	3.0662	\$18,770.20	3.0245	\$19,102.04	3.0192	\$19,249.63	+2.5%
522	2.1894	\$13,402.74	2.1812	\$13,775.95	2.1729	\$13,853.84	+3.3%

II. New Measures Being Proposed for the Hospital Inpatient Quality Reporting (IQR) Program - Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF#3559)

CMS Proposal: CMS proposed to formally add THA/TKA PRO-PM to the IQR Program on a mandatory basis for procedures occurring July 1, 2025, through June 30, 2026. CMS proposed to first allow two years of voluntary submission of data for this measure, beginning January 1, 2023, for which hospitals would receive confidential feedback reports that detail submission results from the reporting period. CMS proposed to calculate and provide each participating hospital with their risk-standardized improvement rate as part of the confidential feedback reports.

AAHKS Comment: Because CMS had previously incorporated AAHKS' suggestions on voluntary reporting and submission methods, AAHKS commented that it supports the proposal to add the measure to the IQR program. AAHKS also offered comments and questions on the THA/TKA PRO-PM, requesting that CMS address them before mandatory reporting commences in 2025. CMS will add THA/TKA PRO-PM to the IQR on its proposed timeframe, but CMS also responded to the following AAHKS concerns:

- **AAHKS Comment #1:** The THA/TKA PRO-PM cohort appears to include some procedures that are so complex as to no longer be relatable to other arthroplasties, such as reimplants for patients with a history of a prosthetic knee joint infections, and procedures with a diagnosis on nonunion.
 - **CMS Response:** CMS acknowledged this comment and stated that it will consider any adjustments to the measure as appropriate as part of normal ongoing measure reevaluation.

² These calculations assume national standardized amount for a hospital with a 67.3% labor share, participating as an EHR Meaningful User and a wage index greater than 1.0.

- AAHKS Comment #2: It is not clear whether measure adjustments for non-response bias account for patients with limited English proficiency, as the measure already adjusts for other patient demographic factors associated with lower completion rates: age, sex, race, low SES, and postoperative complication.
 - CMS Response: CMS stated that although preferred language spoken is not a variable currently included in the non-response bias approach, the measure as proposed includes health literacy in the risk model. CMS stated that it will consider this and other adjustments to the measure as appropriate as part of normal ongoing measure reevaluation.

- AAHKS Comment #3: It is not clear if analysis has been conducted on whether the additional patient questions in THA/TKA PRO-PM along with those in HOOS Jr/KOOS Jr. and PROMIS-Global, and VR-12, begin to impact patient responsiveness and question completion.
 - CMS Response: “This measure was developed with extensive input from patients, who indicated strong support for a PRO-PM following elective primary THA and TKA . . . Regarding survey fatigue, we designed the measure to illuminate a patient’s pain and functional status before and after a THA or TKA, which is different than other surveys such as HCAHPS that capture patient experience. Regarding the comment that the THA/TKA PRO-PM may have a reporting impact on other measures, such as HCAHPS, we anticipate a minimal impact to other measures as the THA/TKA PRO-PM’s eligible population is procedure-specific which reduces the likelihood of the same patient receiving the HCAHPS and a PRO survey.”

- AAHKS Comment #4: The addition of new patient-reported questions to this measure (total painful joint count, quantified spine pain) increases the administrative burden of the measure and likely have some impact on completion rates. AAHKS asked if the impact on completion rate has been measured and suggested CMS use the two years of voluntary reporting to assess if completion rates are different with these new questions from completion rates of similar PROMs under the CJR.
 - CMS Action: “We have collected feedback from CJR participating hospitals and applied lessons learned to the THA/TKA PRO-PM proposal for adoption into the Hospital IQR Program. These lessons learned include requiring hospitals to collect and submit fewer variables, allowing hospitals flexibility in data collection options to better integrate into their workflows, and influenced the decision to set the reporting threshold to a moderate rate of 50 percent. We highlight that our proposal includes two voluntary reporting periods in which we will gather feedback from participating hospitals on their experience collecting and submitting data and apply any lessons learned prior to mandatory reporting.”

III. New Measure Being Proposed for the Hospital Inpatient Quality Reporting (IQR) Program - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF #1550)

CMS Proposal: CMS proposed to adopt a newly refined version of THA/TKA Complication measure into the Hospital IQR Program that would expand the measure outcome to include 26 additional mechanical complication ICD–10 codes. CMS believes that the 26 additional complication codes that would be added would make the THA/TKA Complication measure more accurate in accurately capturing complications following arthroplasty. Presumably, more accurate to a degree to make it worth the cost to CMS of administering the measure.

AAHKS Comment: AAHKS endorsed the inclusion of the 26 additional mechanical complication ICD–10 codes THA/TKA Complication measure. These complications codes are clinically appropriate to be paired with arthroplasty and will improve the measure’s accuracy. Also, AAHKS did not object to the addition of this measure to the IQR program as the data for the measure is derived by CMS from Medicare claims and therefore creates no additional reporting burden for patients or surgeons.

CMS Action: After consideration of the public comments received, CMS finalized the adoption as proposed.

IV. Proposed Refinement of the Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure (NQF #3474)

CMS Proposal: CMS proposed a refinement to the current IQR Program THA/TKA Payment measure, to expand the measure outcome to include 26 clinically vetted mechanism complication ICD–10 codes, for the FY 2024 payment determination and subsequent years. These are the same 26 complications codes that CMS added to the THA/TKA Complication measure.

AAHKS Comment: As AAHKS believes that these 26 complication codes are appropriate to include in arthroplasty measures, AAHKS supported this refinement to the THA/TKA Payment measure.

CMS Action: After consideration of the public comments received, CMS finalized the adoption as proposed.
