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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: April 30, 2021

Re: **2022 Medicare Inpatient Prospective Payment System Proposed Rule**

On April 27, 2021, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule (Proposed Rule) that updates payment policies, payment rates, and quality provisions for service furnished under the Medicare Inpatient Prospective Payment System (IPPS) for acute and long-term care hospitals in fiscal year 2022. This summary covers proposals that may be relevant to AAHKS members' surgical practice, as well as other initiatives that are significant to hospitals and the health industry more broadly. CMS will accept comments on this proposed rule through June 28, 2021.

I. Changes to Payment Rates

CMS proposes to increase all operating payment rates by a net of approximately 2.8% 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. This reflects the projected hospital market basket update of 2.5% reduced by a 0.2% productivity adjustment and increased by a 0.5% adjustment required by law.

The proposed new rates for lower joint arthroplasty codes is as follows:

MS-DRG	2021		2022 (proposed)		% Change from 2021
	Weight	Rate	Weight	Rate	
469	3.0989	$18,530.61	3.0866	$18,952.62	**+2.3%**
470	1.9104	$11,423.69	1.9015	$11,675.76	**+2.2%**
521	3.0652	$18,329.99	3.0663	$18,827.97	**+2.7%**
522	2.1943	$13,121.34	2.1903	$13,449.08	**+2.5%**

II. Proposal to Add a Patient-Reported Outcomes Measure (PROM) Following Elective Total Hip and/or Total Knee Arthroplasty (THA/TKA) to the Hospital Inpatient Quality Reporting (IQR) Program

CMS requests comment from stakeholders regarding the potential future development and inclusion of a PROM following elective THA/TKA under the Hospital IQR Program, which is a

pay-for-reporting quality program that subjects hospitals that fail to meet program requirements to a ¼ reduction in their Annual Payment Update under the IPPS. CMS explained that that THA/TKA procedures are specifically intended to improve function and reduce pain, making patient-reported outcomes (PROs) a meaningful outcome metric to assess, and that studies indicate hospitals and providers can improve outcomes of their patients by addressing aspects of pre-, peri-, and postoperative care. CMS previously established the voluntary PRO data collection opportunity under the Comprehensive Care for Joint Replacement (CJR) model and developed the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary THA/TKA performance measure (THA/TKA PRO-PM)[1] to be submitted by participating hospitals. CMS subsequently updated the measure based on stakeholder feedback.

The THA/TKA PRO-PM would report the hospital-level risk-standardized improvement rate (RSIR) in PROs 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 from the preoperative assessment (collected 90 to 0 days before surgery) to the postoperative assessment (collected 300 to 425 days following surgery). The measure outcome would assess patient improvement in PROs using the HOOS, JR following elective primary THA and the KOOS, JR following elective primary TKA. The hospital-level THA/TKA PRO-PM measure results would be calculated by aggregating all patient-level results across the hospital and presented as a RSIR. Response rates for PRO data for this measure would be calculated as the percentage of elective primary THA or TKA procedures for which complete and matched preoperative and postoperative PRO data have been submitted divided by the total number of eligible THA or TKA procedures performed at each hospital and may be reported with measure results for transparency.

CMS is considering allowing hospitals to submit hospital-level THA/TKA PRO-PM data voluntarily before submission becomes mandatory as part of the Hospital IQR Program. CMS is considering three implementation approaches: (1) hospitals collecting their own data and sending it to CMS for measure calculation; (2) collection by an external entity, such as through a vendor or CMS; and (3) hospitals could collect their own data and send their data to a registry or other entity for storage, standardization, and submission to CMS for measure calculation. CMS acknowledges that providers have previously expressed concerns over survey fatigue, the resources needed to collect data, and issues with the integration with electronic health systems, but highlighted the importance of aligning data collection and data submission efforts for hospital reporting of PRO data.

CMS seeks public comment on:

- The possible future inclusion of the THA/TKA PRO-PM in the Hospital IQR Program
- A phased approach to implementation, including voluntary followed by mandatory reporting, and the timing/duration of such reporting period

[1] NQF ID # 3559; CMIT ID # 3198.

- The mechanism of data collection and submission, including anticipated barriers and solutions to data collection and submission
- The required thresholds for the quantity of data (that is, number of completed PRO instruments) hospitals should submit for voluntary and mandatory reporting
- The application of the THA/TKA PRO-PM measure to settings such as hospital outpatient departments, ambulatory surgical centers, or hospital inpatient procedures followed by observation stays, such as through aligned PRO-PMs across the relevant measurement programs

III. Proposal to Exclude COVID-19 Diagnosed Payments from Measure Denominators Starting in FY 2023 for the Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary THA/TKA (NQF #1551) Measure under the Hospital Readmissions Reduction Program

CMS proposes modifying the Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Primary THA/TKA (NQF #1551) condition-specific readmission measure—and four other measures[2]—to exclude COVID-19 diagnosed patients from the measure denominators beginning with the FY 2023 program year. Although COVID-19 impacted these condition/procedure-specific measures, CMS explained that the impacts were less severe overall compared to other measures and could be further mitigated by updating the measure specifications to exclude Medicare beneficiaries with a secondary diagnosis of COVID-19. CMS noted the measures would not need to be updated for the FY 2022 program year because the only data that would have been affected by the COVID-19 public health emergency was from the first and second quarters of CY 2020, which was excluded under the Extraordinary Circumstances Exceptions granted in response to the public health emergency.

IV. Proposal for Suppressing Certain Measures and Using a Special Rule Under the Hospital Value-Based Purchasing (VBP) Program for a Neutral Payment Adjustment for Hospitals

Due to the impacts of COVID-19, CMS proposes suppressing seven measures under the Hospital VBP Program and would use a special rule to not award a Total Performance Score to any hospital for FY 2022. CMS further proposes reducing each hospital's base-operating DRG payment amount by 2% and then assigning a value-based incentive payment amount to each hospital that matches the 2% reduction to the base operating DRG payment amount. The net result of these payment adjustments would be neutral for hospitals.

[2] Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0505); Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2515); Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891); Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure Hospitalization (NQF #0330).

V. Repeal of the Collection of Market-Based Rate Information

In 2020, CMS finalized a new policy to require hospitals to report median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage ("MA") payers, by MS-DRG; and median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG, on their Medicare cost reports. CMS intended at the time to use this collected data to change the methodology of calculating the IPPS DRG relative weights in 2024 to reflect relative market-based pricing.

At the time, AAHKS urged CMS to not to collect average MA and commercial rates through hospital cost reports and to not use such data as a factor in establishing DRG weights, emphasizing that any such efforts would require vastly more analysis of the secondary impacts of the proposal on MA contracting, providers, and access to care. AAHKS argued that making providers' historically proprietary and confidential negotiated rates public would limit providers' leverage in negotiating private reimbursement rates with payers, undermining principles of achieving efficient prices through confidential negotiations with competing players.

AAHKS further commented that CMS' proposal in pursuit of transparency would put the weight of system-wide cost reduction on providers through reimbursement cuts. AAHKS asserted that CMS's underlying assumption that prices paid by commercial plans reflect hospitals' true relative costs across DRGs fails to take into account unique circumstances impacting rates. AAHKS further emphasized that areas with dominant MA programs would have greater leverage compared to those with fewer hospital systems. Additionally, AAHKS stated that hinging reimbursement to MA rates—which can sometimes be lower than Medicare FFS rates—would create a further downward spiral of reimbursement. AAHKS suggested MA plans with higher rates than FFS might also attempt to renegotiate contracts.

In the 2022 Proposed Rule, CMS is now proposing to repeal the collection of market-based rate information on the Medicare cost report. CMS attributes this change of course to "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." CMS is also proposing to repeal the market-based MS-DRG relative weight methodology that it planned for 2024, and to continue using the existing cost-based methodology for calculating the MS-DRG relative weights for 2024 and beyond.

VI. Request For Information on Adjustments to the CMS Hospital Quality Programs to Better Address Health Equity ad Social Risk Factors

CMS is considering expanded efforts to provide stratified data for additional social risk factors and measures and is seeking public comment on several related initiatives, including future potential stratification of quality measure results by race and ethnicity. Specifically, CMS invites stakeholder comments on the following:

- Future potential stratification of quality measure results by race and ethnicity

- The potential future application of an algorithm to indirectly estimate race and ethnicity to permit stratification of measures (in addition to dual-eligibility) for hospital--level disparity reporting, until more accurate forms of self-identified demographic information are available
- Ways to address the challenges of defining and collecting, accurate and standardized, self-identified demographic information, including information on race and ethnicity, disability, and language preference for the purposes of reporting, measure stratification, and other data collection efforts relating to quality
- Recommendations for other types of feasibly collected data elements for measuring disadvantage and discrimination, for the purposes of quality reporting and measure stratification, in addition to, or in combination with, race and ethnicity
- Recommendations for other types of quality measures or measurement domains, in addition to readmission measures, to prioritize for stratified reporting by dual eligibility, race and ethnicity, and disability.
- Examples of approaches, methods, research, and/or considerations for use of data-driven technologies that do not facilitate exacerbation of health inequities, recognizing that biases may occur in algorithms or be encoded in datasets

- Improving Demographic Data Collection - The possible collection of a minimum set of demographic data elements (such as race, ethnicity, sex, sexual orientation and gender identity (SOGI), primary language, tribal membership, and disability status), by hospitals at the time of admission, using electronic data definitions which permit nationwide, interoperable health information exchange, for the purposes of incorporating into measure specifications and other data collection efforts relating to quality

- Potential Creation of a Hospital Equity Score to Synthesize Results Across Multiple Social Risk Factors - The possible creation and confidential reporting of a *Hospital Equity Score* to synthesize results across multiple social risk factors and disparity measures

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