

CMS Released FY 2023 IPPS Proposed Rule

On Monday, April 18th, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) [2023 Hospital Inpatient Prospective Payment Systems \(IPPS\) for Acute Care Hospitals and the Long Term Care Hospital \(LTCH\) Prospective Payment System](#) Proposed Rule. The proposed rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2023. CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs). Comments are due to CMS by 5pm EDT on June 17, 2022.

Proposed Payment for FY 2023

CMS proposes a base FY 2023 IPPS payment update of +3.2%. This is based on a market basket update of 3.1 percent and the multifactor productivity (MFP) adjustment, which CMS estimates a 0.4 percent reduction. This also includes a 0.5 percent increase to the standardized amount per section 414 of the MACRA. CMS will also reduce the market basket increase portion of the formula by one-quarter for hospitals that fail to submit quality data; and a three-quarters reduction of the market basket increase portion of the formula for hospitals not considered "meaningful EHR users."

Data Used in Rate Setting

CMS proposes to use FY 2021 MedPAR claims and FY 2020 cost reports for purposes of FY 2023 rate setting, with certain proposed modifications to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries at IPPS hospitals and LTCHs as compared to FY 2021.

Proposed MS-DRG Documentation and Coding Adjustment

Determined by prior rulemakings, section 631 of the American Taxpayer Relief Act of 2012 (ATRA) amended section 7(b)(1)(B) of Pub. L. 110-90 requires the Secretary to make a recoupment adjustment to the standardized amount of Medicare payments to acute care hospitals to account for changes in MS-DRG documentation and coding that do not reflect real changes in case-mix, totaling \$11 billion by FY 2017. Section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) then replaced the single positive adjustment CMS intended to make in FY 2018 once the recoupment required by section 631 of the ATRA was complete with a 0.5 percentage point positive adjustment to the standardized amount of Medicare payments to acute care hospitals for FYs 2018 through 2023. (The FY 2018 adjustment was subsequently adjusted to 0.4588 percentage point by section 15005 of the 21st Century Cures Act.). For FY 2023, CMS proposes to make an adjustment of +0.5 percentage point to the standardized amount consistent with the MACRA; this is the final adjustment prescribed by section 414.

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

CMS proposes to modify the calculation of the FY 2023 MS-DRG relative weights by first calculating two sets of weights, one including, and one excluding COVID-19 claims in the FY 2021 data, and then averaging the two sets of relative weights to determine the proposed FY 2023 MS-DRG relative weight

values. The purpose of this is to account for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries at IPPS hospitals during FY 2023. Also, CMS proposes to modify their methodologies for determining the FY 2023 outlier fixed-loss amount for IPPS cases by using charge inflation factors and CCR adjustment factors based on the last 1-year period prior to the COVID-19 public health emergency. CMS is also considering an alternative to this proposal in which FY 2021 data would be used for FY 2023 rate setting without any of the previously mentioned modifications. CMS is seeking comments on the use of the FY 2021 data without these proposed modifications to their usual methodologies.

Proposed FY 2023 Applications for New Technology Add-On Payments

In general, CMS extends new technology add-on payments for an additional year only if the 3-year anniversary date of the product's entry onto the U.S. market occurs in the latter half of the upcoming fiscal year.

FY 2023 Applications for New Technology Add-On Payments (Traditional Pathway)

CMS received 18 applications for the new technology add-on payments (NTAP) under the traditional pathway for FY 2023. We have highlighted one of those applications below.

Xenoview

Polarean, Inc. and The Institute for Quality Resource Management applied for new technology add-on payments for XENOVIEW for FY 2023. XENOVIEW is a gas blend used in chest magnetic resonance imaging (MRI) that is processed to consist of 89% Helium, 10% Nitrogen, and 1% Xenon. The applicant stated that the 1% Xenon in the gas blend is hyperpolarized (HP) to create Xenon-129 (^{129}Xe) (that is, 80% purity of ^{129}Xe isotope), which allows for high resolution 3-dimensional (3-D) images of the lungs and assessment of the lungs' functional status when inhaled by a patient during a pulmonary MRI scan. The applicant stated that XENOVIEW rapidly and directly quantifies regional lung function without ionizing radiation or compromising patient comfort and aids clinical decision-making by directly quantifying gas exchange across three compartments (airspace and ventilation, interstitial barrier tissues, and transfer to red blood cells (RBCs)) to provide a complete picture of lung function. The applicant stated that this makes it well-suited for longitudinal therapeutic evaluation and assessment of disease progression.

CMS believe that based on its proposed FDA indication, cases involving the use of XENOVIEW would be assigned to the same MS-DRGs as cases involving the use of other MRIs and imaging modalities for pulmonary function and imaging of the lungs. Additionally, CMS believes that may use the same or similar mechanism of action as other inhaled gases (^{133}Xe) and oxygen-enhanced pulmonary imaging. CMS is inviting public comments on the application.

FY 2023 Applications for New Technology Add-On Payments (Alternative Pathways)

Beginning with applications for FY 2021, a medical device that is part of FDA's Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation may qualify for the new technology add-on payment under an alternative pathway. Under the alternative pathway, a technology will be considered new and not substantially similar to an existing technology for purposes of the new technology add-on payment under the IPPS and will not need to meet the requirement that it represents an advance that substantially improves the diagnosis or treatment of Medicare beneficiaries. These technologies must still meet the cost criterion.

Nelli® Seizure Monitoring System

The Nelli® Seizure Monitoring System is software designed to automate the analysis of audio and video data to identify seizure events with a positive motor component as an adjunct to seizure monitoring in a hospital inpatient or home setting for adults and children 6 years of age and older. Per the applicant, the software provides objective summaries of semiological components of identified events (including velocity and acceleration of movements, seizure frequency, seizure duration, heart rate, and respiratory rate) to enable the detection and classification of epileptic events using pretrained artificial intelligence (AI).

Nelli® Seizure Monitoring System received Breakthrough Device designation from FDA on October 9, 2020 for the automated analysis of audio and video data to identify seizure events with a positive motor component in children and adults as well as to characterize seizures and peri-ictal events. The applicant stated that the Nelli® Seizure Monitoring System is not yet commercially available as it is awaiting 510(k) clearance of the device from the FDA for the same indication, which the applicant submitted on August 17, 2021.

CMS agrees that the Nelli® Seizure Monitoring System meets the cost criterion and therefore are proposing to approve the Nelli® Seizure Monitoring System for new technology add on payments for FY 2023, subject to the technology receiving FDA marketing authorization for the automated analysis of audio and video data to identify seizure events with a positive motor component in children and adults by July 1, 2022. CMS proposes that the maximum new technology add-on payment for a case involving the use of the Nelli® Seizure Monitoring System would be \$650 for FY 2023 (that is 65% of the average cost of the technology). CMS is inviting public comments on whether the Nelli® Seizure Monitoring System meets the cost criterion and CMS's proposal to approve new technology add-on payments for the Nelli® Seizure Monitoring System for FY 2023

Precision TAVI™ Coronary Obstruction Module

The Precision TAVI Coronary Obstruction Module, which would be an added feature of the Precision TAVI Software System, is intended to provide intelligent decision support powered by artificial intelligence (AI) and machine learning to help physicians accurately predict potential coronary artery obstructions in transcatheter aortic valve replacement (TAVR) procedures.

Based on information from the applicant at the time of the proposed rule, the cost of Precision TAVI™ Coronary Obstruction Module is \$1,995 per patient. CMS proposes that the maximum new technology add-on payment for a case involving the use of Precision TAVI™ Coronary Obstruction Module would be \$1,296.75 for FY 2023. CMS is inviting public comments on whether the Precision TAVI Coronary Obstruction Module meets the cost criterion and CMS's proposal to approve new technology add-on payments for the Precision TAVITM Coronary Obstruction Module.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

To prevent large year-to-year variations in wage index values, CMS is proposing to apply a 5 percent cap on any decrease to a hospital's wage index from their prior FY's wage index, regardless of the circumstances causing the decline. A hospital's wage index would not be less than 95% of its final wage index for the prior FY. CMS is proposing to apply this wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount. CMS proposes that that the maximum new technology add-on payment for a case involving the use of Precision TAVI™ Coronary Obstruction Module would be \$1,296.75 for FY 2023. CMS is inviting public comments on whether the Precision

TAVI Coronary Obstruction Module meets the cost criterion and their proposal to approve new technology add-on payments for the Precision TAVITM Coronary Obstruction Module

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2022

CMS proposed to distribute roughly \$6.5 billion in uncompensated care payments for FY 2023, a decrease of approximately \$654 million from FY 2022. For FY 2023, CMS proposes using the two most recent years of audited data on uncompensated care costs from Worksheet S-10 of the FY 2018 cost reports and the FY 2019 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals.

For FY 2024 and subsequent years, CMS proposes to use a three-year average of the data on uncompensated care costs from Worksheet S-10 for the three most recent fiscal years for which audited data are available. Beginning in FY 2023, CMS proposes to discontinue the use of low-income insured days as a proxy for uncompensated care to determine Factor 3 for Indian Health Service (IHS) and tribal hospitals, and hospitals located in Puerto Rico.

Payments for Indirect and Direct Graduate Medical Education Costs

Proposed Changes to Graduate Medical Education (GME) Payments Based on Litigation

The U.S. District Court for the District of Columbia struck down CMS' method of calculating direct GME payments to teaching hospitals when those hospitals' weighted full-time equivalent (FTE) resident counts exceed their direct GME FTE cap. In the case, the court ordered CMS to recalculate reimbursement owed, holding that CMS' regulation impermissibly modified the statutory weighting factors.

After reviewing the statutory language regarding the direct GME FTE cap and the court's opinion, CMS proposes a modified policy to be applied prospectively for all teaching hospitals and retroactively to the providers and cost years in the case. The proposed modified policy would address situations for applying the FTE cap when a hospital's weighted FTE count is greater than its FTE cap. Still, it would not reduce residents' weighting factor beyond their initial residency period to an amount less than 0.5.

Specifically, effective for cost reporting periods beginning on or after Oct. 1, 2022, CMS is proposing that if the hospital's unweighted number of FTE residents exceeds the FTE cap, and the number of weighted FTE residents also exceeds that FTE cap, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the FTE cap.

Additionally, CMS proposes to allow an urban and a rural hospital participating in the same rural track program (RTP) to enter into an "RTP Medicare GME affiliation agreement" effective for the academic year beginning July 1, 2023.

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes (p.865)

CMS proposes suppressing several VBP measures stemming from COVID-19 impacts. CMS would lack the data volume necessary for assigning hospitals their Total Performance Score (TPS) under the VBP for the 2023 fiscal year (FY). Hospitals would automatically earn a neutral adjustment under this program. However, they would continue to receive confidential feedback on nonsuppressed measures. The limited

data volume would prevent CMS from allowing MIPS facility-based scoring for MIPS 2022 since it immediately links to FY 2023 hospital VBP performance.

Hospital Inpatient Quality Reporting (IQR) Program (p. 1063)

The Hospital IQR Program is a pay-for-reporting quality program that reduces payment to hospitals that fail to meet program requirements. Hospitals that do not submit quality data or fail to meet all Hospital IQR Program requirements are subject to a one-fourth reduction in their Annual Payment Update under the IPPS. CMS proposes to adopt ten measures, refine two current measures, make changes to the existing eCQM reporting and submission requirements, remove the zero denominator declaration and case threshold exemptions for hybrid measures, propose updates to the eCQM validation requirements for medical record requests, and propose reporting and submission requirements for patient-reported outcome-based performance measures (PRO-PMs). CMS is requesting comments on the potential future adoption of two Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) measures

New Measures Being Proposed for the Hospital IQR Program Measure Set (p. 1065)

CMS proposes ten new measures. Of these new measures, three address health equity and social drivers of health. If finalized, the measures would be available during the CY 2023 IQR reporting period/FY 2025 payment determination and subsequent years.

1. Hospital Commitment to Health Equity Measure (p. 1067)
2. Screening for Social Drivers of Health (p. 1082)
3. Screen Positive Rate for Social Drivers of Health (p. 1096)

Proposed Updates to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

For FY 2023, CMS proposes adopting a patient safety exception into the measure removal policy. CMS also proposes to begin public display of the 30-Day Unplanned Readmissions for Cancer Patients measure (PCH-36), the Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life measure (PCH-32), the Proportion of Patients Who Died from Cancer Not Admitted to Hospice measure (PCH-34), the Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life measure (PCH-33), and the Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days measure (PCH-35).

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs—Request for Information (p. 1022)

CMS has highlighted the reduction in healthcare disparities as one of the aspects to improve health equity. Measuring healthcare disparities and reporting results to healthcare providers is a cornerstone of our approach to advancing healthcare equity. CMS seeks input on methods for advancing measurement and stratification as tools to address health care disparities and advance health care equity across hospital quality and value-based purchasing programs.

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs—Request for Information (p. 1046)

CMS continues its effort to modernize its digital quality measurement enterprise. As such, input is sought regarding advancements in digital quality measurement and approaches to optimize data flows to support Fast Healthcare Interoperability Resources (FHIR)-based eCQM data retrieval and reporting across quality reporting programs, specifically for the Hospital IQR Program. CMS recognizes that data sources for digital quality measures may include registries in this proposed rule.

Patient Access to Health Information Measure – Request for Information (RFI) (p. 1366)

CMS seeks feedback on further promoting equitable patient access and use of their health information without adding unnecessary burden on the hospital or health care provider.