CMS Releases Fiscal Year 2023 Hospital Inpatient Prospective Payment System Proposed Rule

Dagny Grillis, FSA, MAAA, PhD
727.259.6784 • dagny.grillis@wakely.com

Emily Janke, FSA, MAAA
470.777.3536 • emily.janke@wakely.com

Julie Steiner
720.221.9609 • julie.steiner@wakely.com

Executive Summary

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2023 Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule,[1] which contains potential modifications to Medicare inpatient hospital guidelines and fee-for-service (FFS) rates for the upcoming fiscal year. This white paper summarizes important CMS proposed changes to the IPPS methodology for FY 2023, along with Wakely's analysis of potential rate changes using national Medicare FFS data and the Wakely Medicare Repricing Analysis Tool (WMRAT).

Some observations from the proposed rule and our analysis include:

- Wakely analyzed the proposed changes in the 2023 Proposed Rule and found that relative to the 2022 Final IPPS Rule[2] the overall increase in Medicare IPPS FFS rates will be approximately 2.5% to 2.7%.[3]
- CMS proposes a 3.2% increase in operating payment rates for hospitals paid under IPPS that have meaningful electronic health records (EHR) and that participate in the Hospital Inpatient Quality Reporting (IQR) Program. CMS also proposes implementing a 1.6% increase to the standard federal capital rate in FY 2023.
- CMS proposes increasing the fixed-loss outlier threshold from $30,988 to $43,214.

Wakely analyzed these changes and others from the 2022 Final Rule to the 2023 Proposed Rule and found the overall increase in Medicare IPPS FFS rates to be approximately 2.5% to 2.7%.

[1] The FY 2023 IPPS Proposed Rule is located here: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page.

[2] The FY 2022 IPPS Final Rule is located here: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page.

[3] For more details on Wakely's analysis, see the *Analysis of IPPS Rates for 2023 Changes* section, which includes breakdowns by year, major diagnostic category, state, and more.

Wakely will be closely monitoring to see which of the proposed changes are finalized by CMS in the final rule, which is expected in August 2022.

Highlights from the FY 2023 IPPS Proposed Rule

Some of the key anticipated changes that are proposed in the FY 2023 IPPS Proposed Rule are summarized below. Note that these proposed numbers and policies could change, potentially materially, in the final rule.

- An increase to the operating rates of 3.2% for hospitals that have meaningful EHR and that participate in the Hospital IQR Program. This increase is a combination of a 3.1% increase to the projected hospital market basket, a 0.4% productivity adjustment decrease, and a 0.5% required statute increase. The 3.2% increase is expected to be partially offset by planned cuts and anticipated decreases to certain payments such as those related to disproportionate share hospitals (DSH) and uncompensated care (UCC).
- An increase to the standard federal capital rate of 1.6%.
- An increased fixed-loss outlier threshold of $43,214 (up 39% from the previous year), which is expected to result in fewer admits qualifying for an outlier payment.
- Expiration in FY 2023 of additional payments to Medicare Dependent Hospitals as well as the temporary change[4] in reimbursement for low-volume hospitals.
- Modification of methodology to calculate certain FY 2023 IPPS adjustments, factors, and thresholds due to the impact of the COVID-19 pandemic on recent data sources. For example, CMS proposes use of a weighted average methodology to calculate FY 2023 Medicare Severity-Diagnosis Related Group (MS-DRG)[5] relative weights that incorporates data with and without COVID-19 claims. Another example is consideration for a payment adjustment for increased costs caused by supply-chain issues and hospitals having to purchase domestically made surgical N95 respirators during the COVID-19 pandemic.
- Discontinuation of the use of low-income insured days to estimate UCC payments for Indian Health Services (IHS) and Tribal hospitals as well as hospitals in Puerto Rico starting in FY 2023.

[4] A temporary modification to the low-volume hospital definition is set to expire at the end of FY 2022. Without congressional action, beginning in FY 2023, hospitals will be considered low-volume provided they have fewer than 200 total discharges during the fiscal year and are located more than 25 road miles from the nearest hospital. This stricter definition of the low-volume criteria is expected to significantly decrease low-volume payments.

[5] CMS is not proposing to add or remove any MS-DRGs for FY 2023, so the current list of 767 MS-DRGs would be maintained.

Due to the potential financial volatility this change may cause, CMS is proposing to add a new supplemental payment for these hospitals.

- Implementation of a 5% cap on the overall decrease to a hospital's wage index from its prior FY wage index in order to prevent large swings in wage index values from year-to-year.
- Suppression and/or refinement to several measures that are part of the Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, and Hospital Value-Based (VBP) Program. The intent is to not reward or penalize any hospitals for circumstantial outcomes caused by the COVID-19 pandemic and public health emergency (PHE) policies.
- Continuation of fifteen technologies that currently receive add-on payments as part of the New Technology Add-on Payment (NTAP) policy. CMS is still considering NTAP applications for a long list of new drug and device technologies for FY 2023.
- Modification to the identification of NTAP-eligible drugs by switching from using ICD-10-PCS codes to NDCs. This would be phased in over two years with both NDCs and ICD-10-PCS codes being utilized for FY 2023.
- Extension of the New COVID-19 Treatment Add-on Payment (NCTAP) policy due to ongoing financial impacts on providers from the pandemic. Similar to the 20 percent add-on payment for COVID-19 admits, NCTAP is expected to remain in effect until the close of the fiscal year following the end of the PHE (i.e., if for example the PHE ends in December 2022, NCTAP would remain in effect until September 2023).

CMS is also seeking public comments on several high priority issues including:

- How to better document diagnosis codes that reflect a patient's social and economic characteristics[6] and how improved reporting would advance understanding of recognizing illness severity and utilizing resources under the MS-DRG based payment system,
- How providers can prepare for climate change impacts and how CMS can support that initiative, and
- How to lessen the United States maternal health crisis and disparities that currently exist, including adding a hospital designation that indicates quality and safety of maternity care.

[6] Also known as social determinants of health (SDOH).

Analysis of IPPS Rates for FY 2023

Wakely used the 2019 and 2020[7] Medicare 5% Sample Limited Data Sets (LDS) to analyze the change in IPPS Medicare FFS rates from the 2022 Final Rule to the 2023 Proposed Rule. We filtered LDS to remove all beneficiaries except those who have only FFS Part A and B coverages. We excluded ESRD and Hospice members. We also removed data from the state of Maryland, since it is exempt from IPPS.

We used the 2022 IPPS Final Rule and 2023 IPPS Proposed Rule from CMS along with WMRAT to reprice LDS inpatient admits to Medicare FFS rates to compare the year-over-year change. We only repriced inpatient claims from LDS that occurred at hospitals that are paid under IPPS.[8] After repricing all applicable admits, we removed the impact of the low-volume hospital adjustment and NTAP from the final repriced amount from both years due to not having full information in the 2023 proposed rule to model these two payments.[9]

As shown in Table 1, the IPPS Medicare FFS average admit cost increased 2.7% and 2.5% from the 2022 Final Rule to the 2023 Proposed Rule for 2019 and 2020 LDS, respectively. These changes encompass both the increases to the operating and capital costs that CMS proposed for 2023 as well as the cuts to certain payment components such as the outlier payments (caused by increasing the fixed-loss outlier threshold).

Table 1: Change in Medicare IPPS FFS Rates from 2022 Final Rule to 2023 Proposed Rule

LDS Data Year	LDS Total Admit Count	LDS Total Allowed Amount	2022 Final Rule Average Admit Cost	2023 Proposed Rule Average Admit Cost	2023 Proposed to 2022 Final Change
2019	363,190	$5,174,891,484	$14,890	$15,299	2.7%
2020	301,568	$4,724,727,054	$16,047	$16,452	2.5%

[7] We used both 2019 and 2020 LDS due to the impact of COVID-19 that is in the 2020 data.

[8] Admits that occurred at providers such as long term care facilities, skilled nursing facilities, rehabilitation facilities, psychiatric facilities, children's hospitals, and cancer hospitals were excluded from repricing.

[9] More guidance related to these two payments is expected later this year in the final rule.

Tables 2 and 3 display a further breakdown of the change in IPPS rates from 2022 final to 2023 proposed at the major diagnostic category (MDC) level. While most of the MDC rate changes hover around 3%, they vary from -2.0% for “Myeloproliferative Diseases & Disorders, Poorly Differentiated Neoplasms” up to 7.1% for “Human Immunodeficiency Virus Infections”.

As expected due to the impact of COVID-19, we see an uptick in the percentage of admits and total allowed dollars for the “Diseases & Disorders of the Respiratory System” in the 2020 LDS. The percentage of admits identified as this MDC increases from 12% to 14% whereas the corresponding allowed dollars increase from 9% to 13% of total allowed. On the other hand, we see “Diseases & Disorders of the Circulatory System” and “Diseases & Disorders of the Musculoskeletal System & Connective Tissue” decrease as percentage of the total admits and allowed dollars. This change in the mix of services between the 2019 and 2020 LDS contributes to the difference we see in the rate changes from the 2022 final rule to the 2023 proposed rule.

Table 2: 2019 LDS: Changes by MDC in Medicare FFS Rates from 2022 Final Rule to 2023 Proposed Rule

Major Diagnosis Category Description	LDS Total Admit Count	LDS Total Allowed Amount	2022 Final Rule Average Admit Cost	2023 Proposed Rule Average Admit Cost	2023 Proposed/ 2022 Final Change
Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders	2,442	$21,551,813	$9,430	$9,732	3.2%
Burns	156	$6,758,061	$46,235	$45,848	-0.8%
Diseases & Disorders of Blood, Blood Forming Organs, Immunologic Disorders	5,205	$54,629,524	$10,904	$11,288	3.5%
Diseases & Disorders of the Circulatory System	74,054	$1,190,861,281	$16,619	$16,818	1.2%
Diseases & Disorders of the Digestive System	35,975	$420,635,965	$12,286	$12,473	1.5%
Diseases & Disorders of the Ear, Nose, Mouth & Throat	1,923	$14,465,066	$8,025	$8,415	4.9%
Diseases & Disorders of the Eye	438	$4,046,605	$9,906	$10,458	5.6%
Diseases & Disorders of the Female Reproductive System	1,392	$18,292,659	$13,970	$14,477	3.6%
Diseases & Disorders of the Hepatobiliary System & Pancreas	9,837	$122,273,184	$13,106	$13,491	2.9%
Diseases & Disorders of the Kidney & Urinary Tract	26,775	$259,272,163	$10,067	$10,411	3.4%
Diseases & Disorders of the Male Reproductive System	1,228	$13,323,491	$11,556	$12,101	4.7%
Diseases & Disorders of the Musculoskeletal System & Connective Tissue	54,056	$909,017,572	$17,464	$18,129	3.8%
Diseases & Disorders of the Nervous System	29,402	$385,767,301	$13,929	$14,384	3.3%
Diseases & Disorders of the Respiratory System	44,334	$484,948,579	$11,443	$11,629	1.6%
Diseases & Disorders of the Skin, Subcutaneous Tissue & Breast	8,230	$78,655,189	$10,158	$10,683	5.2%
Endocrine, Nutritional & Metabolic Diseases & Disorders	12,463	$120,052,753	$10,097	$10,362	2.6%
Factors Influencing Health Status & Other Contacts with Health Services	1,808	$14,879,545	$8,630	$8,842	2.5%
Human Immunodeficiency Virus Infections	265	$5,554,902	$21,688	$23,233	7.1%
Infectious & Parasitic Diseases, Systemic or Unspecified Sites	36,935	$619,577,744	$17,550	$18,357	4.6%
Injuries, Poisonings & Toxic Effects of Drugs	4,486	$59,293,697	$13,781	$14,122	2.5%
Mental Diseases & Disorders	4,215	$42,763,164	$11,040	$11,722	6.2%
Multiple Significant Trauma	745	$22,293,854	$30,965	$31,402	1.4%
Myeloproliferative Diseases & Disorders, Poorly Differentiated Neoplasms	2,349	$55,869,385	$24,826	$24,448	-1.5%
No MDC	3,888	$245,096,286	$67,267	$69,683	3.6%
Pregnancy, Childbirth & the Puerperium	589	$5,011,703	$8,913	$8,975	0.7%

Table 3: 2020 LDS: Changes by MDC in Medicare FFS Rates from 2022 Final Rule to 2023 Proposed Rule

Major Diagnosis Category Description	LDS Total Admit Count	LDS Total Allowed Amount	2022 Final Rule Average Admit Cost	2023 Proposed Rule Average Admit Cost	2023 Proposed/ 2022 Final Change
Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders	2,014	$19,487,737	$9,889	$10,121	2.3%
Burns	135	$5,642,699	$43,900	$43,380	-1.2%
Diseases & Disorders of Blood, Blood Forming Organs, Immunologic Disorders	4,558	$52,316,137	$11,807	$12,172	3.1%
Diseases & Disorders of the Circulatory System	57,999	$1,001,724,789	$17,533	$17,699	0.9%
Diseases & Disorders of the Digestive System	29,318	$368,434,367	$12,927	$13,069	1.1%
Diseases & Disorders of the Ear, Nose, Mouth & Throat	1,432	$11,580,478	$8,375	$8,777	4.8%
Diseases & Disorders of the Eye	337	$3,201,993	$9,740	$10,300	5.8%
Diseases & Disorders of the Female Reproductive System	1,114	$15,142,969	$14,121	$14,525	2.9%
Diseases & Disorders of the Hepatobiliary System & Pancreas	8,387	$112,976,122	$13,923	$14,295	2.7%
Diseases & Disorders of the Kidney & Urinary Tract	21,313	$214,746,063	$10,308	$10,628	3.1%
Diseases & Disorders of the Male Reproductive System	1,003	$11,249,447	$11,547	$11,969	3.7%
Diseases & Disorders of the Musculoskeletal System & Connective Tissue	38,426	$686,607,891	$18,197	$18,821	3.4%
Diseases & Disorders of the Nervous System	24,741	$351,090,205	$14,640	$15,066	2.9%
Diseases & Disorders of the Respiratory System	43,515	$615,165,458	$14,451	$14,666	1.5%
Diseases & Disorders of the Skin, Subcutaneous Tissue & Breast	5,938	$60,567,551	$10,552	$11,083	5.0%
Endocrine, Nutritional & Metabolic Diseases & Disorders	10,579	$106,276,979	$10,247	$10,516	2.6%
Factors Influencing Health Status & Other Contacts with Health Services	1,354	$11,372,296	$8,520	$8,737	2.5%
Human Immunodeficiency Virus Infections	244	$6,328,504	$26,286	$27,908	6.2%
Infectious & Parasitic Diseases, Systemic or Unspecified Sites	34,359	$643,612,150	$19,225	$20,086	4.5%
Injuries, Poisonings & Toxic Effects of Drugs	3,580	$48,799,276	$14,027	$14,449	3.0%
Mental Diseases & Disorders	3,751	$40,433,843	$11,246	$11,906	5.9%
Multiple Significant Trauma	633	$19,591,615	$31,563	$31,604	0.1%
Myeloproliferative Diseases & Disorders, Poorly Differentiated Neoplasms	1,992	$50,438,878	$26,147	$25,626	-2.0%
No MDC	4,252	$263,060,688	$64,775	$67,456	4.1%
Pregnancy, Childbirth & the Puerperium	594	$4,878,921	$8,372	$8,473	1.2%

From our investigation, the outlier payments were one of the IPPS components with significant changes from 2022 to 2023. This was mainly driven by the 39% increase in the fixed-loss outlier payment threshold from $30,988 in the 2022 Final Rule to $43,214 in the 2023 Proposed Rule. Table 4 shows the annual change in the average outlier payment per admit based off repricing 2019 and 2020 LDS. The decrease was approximately 30% for both years of data. While in our analysis the average outlier per admit payment decreased due the significant increase in the outlier threshold, it is worth noting that CMS updates the outlier threshold each year based on their modeling, which targets outlier payments comprising 5.1% of total IPPS payments.

Table 4: Changes in Average Outlier per Admit from 2022 Final Rule to 2023 Proposed Rule

LDS Data Year	2022 Final Rule Outlier Threshold	2023 Proposed Rule Outlier Threshold	2022 Final Rule Average Outlier per Admit Payment	2023 Proposed Rule Average Outlier per Admit Payment	2022 Final to 2023 Proposed Change
2019	$30,988	$43,214	$393	$281	-28.7%
2020	$30,988	$43,214	$555	$393	-29.1%

One of the components of IPPS methodology that can change significantly year-over-year is the UCC. UCC[10] is paid to hospitals that treat a higher than average amount of low-income patients to help offset the financial impacts. Tables 5 and 6 show the providers from our analysis with the top five increases and top five decreases in UCC from the 2022 Final Rule to the 2023 Proposed Rule.

Table 5: Top 5 UCC Increases by Provider

Provider Name	2022 Final Rule UCC Payment	2023 Proposed Rule UCC Payment	2023 Proposed to 2022 Final Change
Texas Center For Infectious Disease	$0	$92,456	$92,456
Uab Callahan Eye Hospital Authority	$0	$14,916	$14,916
Rancho Los Amigos National Rehabilitation Center	$27,353	$35,103	$7,750
New York Eye and Ear Infirmary	$29,693	$37,235	$7,542
Spectrum Health Lakeland Watervliet Hospital	$0	$6,302	$6,302

[10] Along with DSH operating and capital payments.

Table 6: Top 5 UCC Decreases by Provider

Provider Name	2022 Final Rule UCC Payment	2023 Proposed Rule UCC Payment	2023 Proposed-2022 Final Change
Laguna Honda Hospital & Rehabilitation Center	$33,028	$6,177	($26,851)
Provident Hospital Of Chicago	$110,916	$89,644	($21,272)
John H. Stroger, Jr. Hospital of Cook County	$63,636	$46,121	($17,515)
Ascension Seton Southwest Hospital	$12,619	$0	($12,619)
UCHealth Broomfield Hospital	$29,908	$17,325	($12,583)

As we see with the UCC, IPPS rates are provider specific. That means the change in overall IPPS Medicare FFS rates can vary for different parts of the country. We mapped each IPPS provider to the state where it is located and analyzed rate changes by geography. Figures 1 and 2 show the change in Medicare FFS rates from the 2022 IPPS Final Rule to the 2023 IPPS Proposed Rule by state.[11] As can be seen in these maps, the most frequent rate change was between 2% to 3%, although changes by state ranged from -0.7% to 5.6%.

[11] Maryland is excluded from Figures 1 and 2, since it is exempt from IPPS.

Figure 1: 2019 LDS: Changes by State in Medicare FFS Rates from 2022 Final Rule to 2023 Proposed Rule

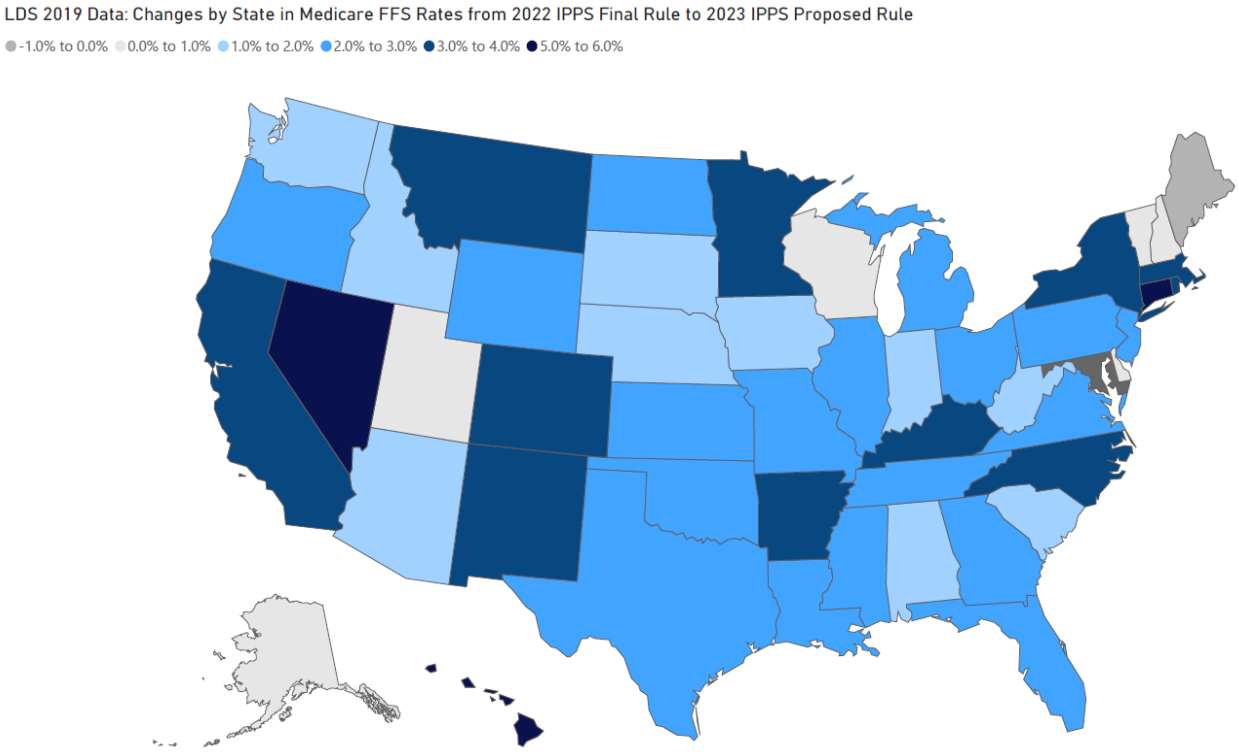
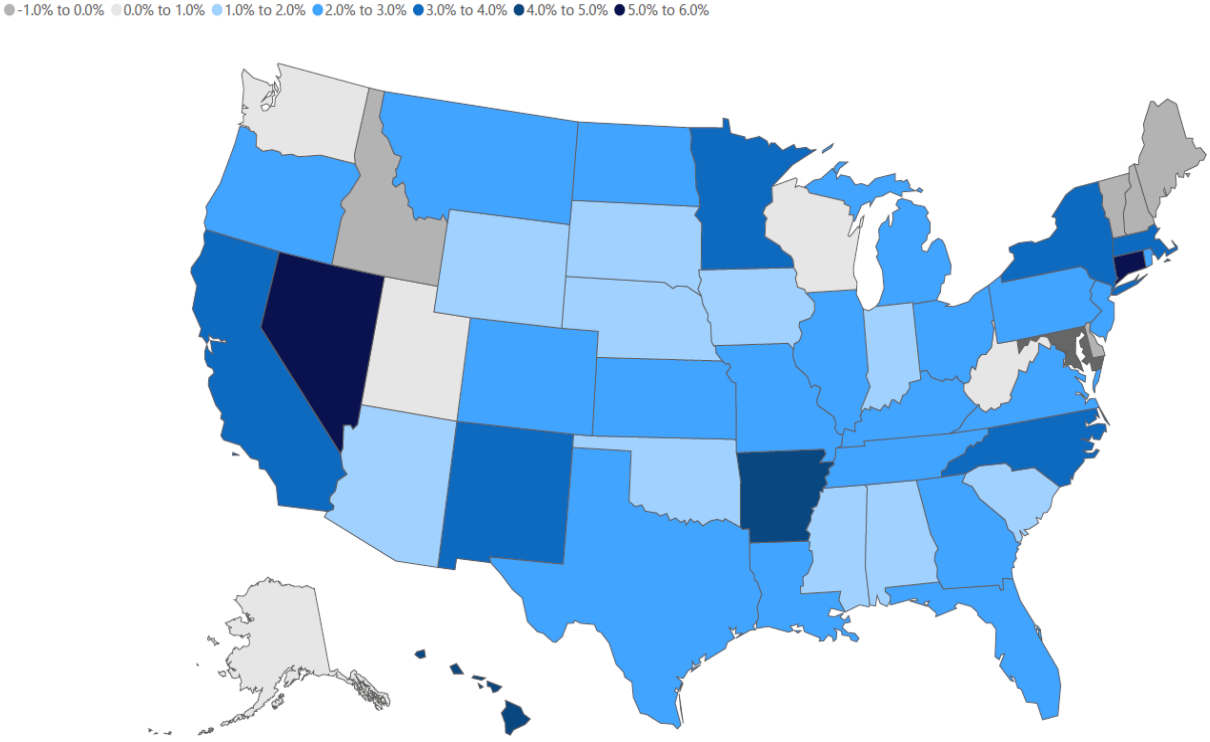


Figure 2: 2020 LDS: Changes by State in Medicare FFS Rates from 2022 Final Rule to 2023 Proposed Rule



Disclosures and Limitations

We have relied on published data from CMS for the Medicare 5% Sample LDS and for the FY 2022 IPPS Final Rule and FY 2023 IPPS Proposed Rule.[12] We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. Wakely did not make any adjustments or changes to published data. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty.

Before repricing, we filtered the data to remove all beneficiaries except those who have only FFS Part A and B coverages. We excluded ESRD and Hospice members. We also removed data from the state of Maryland, since it is exempt from IPPS.

We used WMRAT to reprice 2019 and 2020 LDS inpatient medical claims to FY 2022 final and FY 2023 proposed standard (i.e., non-HMO) rates for comparison. We have relied upon the LDS inpatient designation as well as bill type codes and revenue codes on the claims to identify inpatient admits.

The IPPS Medicare Repriced amount is calculated based on the submitted DRG, and no additional pricing adjustment has been applied to account for Hospital Acquired Conditions (HACs). Similarly, the special add-on payment for costs of furnishing blood-clotting factor to those with hemophilia has not been calculated nor are charges removed for purposes of calculating cost outliers. We made no adjustment for limited instances where condition code or value code may impact inpatient reimbursement.

We have not performed any steps to exclude interim claims from the data set. We assume the data represents final adjudicated claims. No trends or completion factors have been applied to the allowed or repriced amounts, and we calculated repriced amounts gross sequestration (i.e. no adjustments to net it out).

After repricing all applicable admits, we removed the impact of the low-volume hospital adjustment and NTAP from the final repriced amount from both years due to not having full information in the 2023 proposed rule to model these two payments.

This paper and the analysis contained herein are based on our interpretation and understanding of CMS' published proposed guidance as of April 18, 2022. Results may vary significantly from the FY 2023 IPPS Final Rule, and CMS or OMB may make further changes.

[12] We used the cost-to-charge ratios and other factors from the 2022 Final Rule and 2023 Proposed Rule Impact Files rather than the provider specific files (PSFs).

Wakely Medicare Repricing Analysis Tool

At Wakely, we use our Wakely Medicare Repricing Analysis Tool (WMRAT) to assist clients in repricing medical claims to Medicare FFS rates. Comparing medical claim allowed amounts to Medicare FFS rates is a common practice across the industry, as this analysis provides a useful benchmark for payers to better understand their data and payment practices and for providers to more easily analyze how they are being reimbursed. WMRAT offers a common language for comparing payment rates across multiple lines of business, categories of service, geographic locations, and providers.

Medicare FFS payments are based on a complex set of rules that change frequently and the logic and results can be nuanced. Whether you are interested in creating pricing assumptions, negotiating more competitive contracts, validating internal payment procedures, or setting up new capitation arrangements, Wakely's Medicare Repricing team can work quickly to assist you with understanding how your medical claims payments compare to Medicare FFS rates and how Medicare fee schedules from different years impact your data. Wakely has Medicare Repricing capabilities for payment systems such as IPPS, Outpatient Prospective Payment System (OPPS), Physician and other Professional fee schedules, Federally Qualified Health Centers (FQHC), Ambulatory Surgical Centers (ASC), and more.

For more information about Wakely's capabilities in this area, please contact Dagny Grillis at dagny.grillis@wakely.com, Emily Janke at emily.janke@wakely.com, or Julie Steiner at julie.steiner@wakely.com with any questions or to follow up on any of the concepts presented here, or reach out to the WMRAT team for a demo at WMRATSupport@wakely.com.[13] Special thanks to Jacob Schiferl for his contribution to this paper.

[13] For more information, please visit our website at: https://www.wakely.com/services/product/wakely-medicare-repricing-analysis-tool-wmrat

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Going Beyond the Numbers

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