Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

JULY 2022

CY 2023 MEDICARE OPPS PROPOSED RULE – CMS-1772-P

On July 15, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2023 outpatient prospective payment system (OPPS) proposed rule.

Comments are due Sept. 13.

340B: In response to the U.S. Supreme Court decision in *American Hospital Association v. Becerra*, CMS anticipates finalizing a CY 2023 reimbursement rate for 340B-acquired drugs and biologicals of Average Sales Price (ASP) plus 6%. CMS states it will make a corresponding decrease to the CY 2023 conversion factor to ensure this payment policy is budget neutral (more information below).

CMS stated it is still evaluating how to apply the Supreme Court's decision to prior calendar years, and it solicits comments on the best way to craft any potential remedies affecting cost years 2018 through 2022.

OPPS Market Basket Update: CMS proposed a 3.1% market basket update and a 0.4 percentage point productivity reduction for OPPS payments, resulting in a 2.7% update to OPPS rates for hospitals that meet quality data submission requirements. These proposed adjustments result in a CY 2023 conversion factor of $86.785. Hospitals that fail to submit quality data will be subject to a 2-percentage point reduction to payments, resulting in a conversion factor of $85.093. CMS proposed using CY 2021 claims data and cost report data from the June 2020 Healthcare Cost Report Information System (HCRIS) extract for CY 2023 rate-setting purposes.

In light of the U.S. Supreme Court's decision in *American Hospital Association v. Becerra* discussed above, CMS stated it anticipates reimbursing providers for 340B acquired drugs at ASP plus 6%. However, the OPPS is a budget neutral payment system, meaning CMS believes it needs to offset total OPPS payments to account for increased 340B reimbursement. CMS stated that increasing 340B reimbursement will result in an increase of approximately $1.96 billion in OPPS drug payments. This will necessitate a budget neutrality adjustment of 0.9596, resulting in an estimated revised conversion factor of $83.279. CMS seeks comments on this budget neutrality adjustment, and provides information in the Addenda on its website regarding the effects of removing the 340B program payment policy for CY 2023.

Rural Emergency Hospital (REH): By statute, REH services include emergency department services and observation care, as well as other outpatient medical and health services as specified by the U.S. Secretary of Health and Human Services. These services will be paid at applicable OPPS rates plus 5%. Medicare beneficiaries will not be charged a copayment on the additional 5% payment.

In addition to statutorily required services, CMS proposed considering all covered outpatient department services that would otherwise be paid under the OPPS as REH services. If finalized, REHs will be paid the OPPS payment rate plus 5% for such items and services.

Regardless of Medicare utilization, REHs will also receive a monthly facility payment estimated at $268,294 per month for CY 2023. The facility payment amount will increase in subsequent years by the hospital market basket percentage increase.

CMS also proposed allowing REHs to provide outpatient services that are not otherwise paid under the OPPS (e.g. Clinical Lab Fee Schedule services), as well as post-hospitalization extended care services furnished in a distinct part of the facility licensed as a skilled nursing facility. Such services will not be considered REH services, and will be paid under the applicable fee schedule without the additional 5% payment increase.

CMS also proposed changes to the Physician Self-Referral law (Stark Law) to account for REHs. Proposed changes include a new exception for ownership or investment interests in an REH; and revisions to certain existing exceptions to make them applicable to compensation arrangements to which an REH is a party.

Finally, CMS outlined proposals for a Rural Emergency Hospital Quality Reporting (REHQR) Program, including requiring a QualityNet account and a Security Official for data submission and facility-level report access. CMS requests information on:

- Measures recommended by the National Advisory Committee on Rural Health and Human Services;
- Additional suggested measures for the REHQR program; and
- Comments on measures specific to telehealth, behavioral and mental health, and maternal health services.

Remote Mental Health Services: For CY 2023, CMS proposed considering mental health services furnished via telehealth by hospital staff to beneficiaries in their homes as covered outpatient department services payable under the OPPS. If finalized, CMS will create OPPS-specific coding for these services. CMS proposed reimbursement rates for such services that align with the Medicare Physician Fee Schedule (PFS), stating that the time and intensity required for remote services better resemble PFS payment amounts that do not account for certain practice expense costs such as clinical labor, equipment or supplies. If finalized, this will be a decline in payments for remote mental health services compared to current reimbursement.

CMS would require an in-person service within six months prior to the initiation of the remote service, and then every 12 months thereafter with exceptions to the in-person visit requirement made based on beneficiary circumstances. More frequent in-person visits would be allowed if clinically necessary. In-person visit requirements would not apply until the 152 day after the COVID-19 public health emergency (PHE) ends.

CMS also proposed allowing audio-only telehealth in instances where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology.

CMS clarified that it will not recognize applicable behavioral health therapy services furnished remotely by hospital staff via telehealth as partial hospitalization (PHP) services, but will make such services available to the PHP program. Hospitals would be permitted to bill for these remote non-PHP behavioral health services but would need to continue to comply with documentation requirements that apply to PHP patients.

CMS seeks comments on whether there are gaps in OPPS current procedural terminology (CPT) coding that may limit access to needed levels of care for treatment of mental health or substance use disorders for Medicare beneficiaries.

Direct Supervision of Certain Cardiac and Pulmonary Rehabilitation Services: CMS seeks comment on whether it should continue to allow direct physician supervision for pulmonary, cardiac and intensive cardiac rehabilitation services to include presence of the supervising practitioner physician via two-way, audio/video communication technology through the end of CY 2023. CMS also seeks comment on whether there are safety and/or quality of care concerns regarding adopting this policy beyond the PHE, and what policies CMS could adopt to address those concerns if the policy were extended post-PHE.

Supervision by Non-Physician Practitioners of Outpatient Diagnostic Services: CMS proposed clarifying in statute that nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists and certified nurse midwives may provide general, direct, and personal supervision of outpatient diagnostic services to the extent that they are authorized to do so under their scope of practice and applicable State law. This change applies to hospitals and critical access hospitals (CAHs), and aligns with non-physician supervision allowances under the Medicare PFS.

Hospital Outpatient Department Prior Authorization Process: CMS proposed adding facet joint intervention services to the prior authorization process for hospital outpatient departments beginning with dates of service on or after March 1, 2023. See Table 79 for the list of affected codes.

Software as a Service (SaaS) Add-On Codes: There are currently two ways to bill for SaaS procedures: either as a standalone service, or an add-on code billed concurrent with a diagnostic imaging service. In 2021 and 2022, CMS approved New Technology applications for a variety of SaaS procedures, and applicants indicated that these services should not be paid as add-on codes. Rather, they should always be paid separately because the technologies are new and associated with significant costs. Specifically, CMS proposed not to recognize CPT codes 0649T, 0722T, and 0724T as add-on codes under the OPPS and instead establish HCPCS C-codes to describe them as standalone services that would be billed with the associated imaging service. Proposed C-codes include:

- C97X1: Quantitative magnetic resonance analysis of tissue composition (e.g., fat, iron, water content), includes multiparametric data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure).
- C97X2: Quantitative computed tomography (CT) tissue characterization, includes data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with concurrent CT examination of any structure contained in the acquired diagnostic imaging dataset.
- C97X3: Quantitative magnetic resonance cholangiopancreatography (QMRCP) includes data acquisition, preparation, transmission, interpretation and report, performed in the

same session and/or same date with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure).

Proposed payment rates for C97X1, C97X2, and C97X3, as well as the standalone CPT codes that describe the same SaaS procedures, are in Addendum B on CMS' website.

Payment for Domestic National Institute for Occupational Safety & Health (NIOSH)-Approved Surgical N95 Respirators: CMS proposed providing payment adjustments to hospitals under the inpatient prospective payment system (IPPS) and OPPS for additional resource costs incurred to acquire domestically-made, NIOSH-approved surgical N95 respirators. Initial payment adjustments will be based on the IPPS and OPPS shares of the estimated difference in the reasonable costs to purchase such respirators compared to purchasing non-domestic respirators.

Payments would be provided biweekly as interim lump-sum payments and would be reconciled at cost report settlement. Any provider could request these biweekly interim lump sum payments for an applicable cost reporting period. If finalized as proposed, IPPS payment adjustments would not be budget neutral but OPPS payment adjustments would be budget neutral. This is because, by statute, OPPS payments must be budget neutral.

CMS stated it might use future rulemaking to consider expanding this policy to include other forms of personal protective equipment (PPE) that are critical for responding to a public health emergency, including but not limited to elastomeric respirators, surgical/procedures masks, gloves, and medical gowns.

COVID-19 Vaccine and Monoclonal Antibody Administration Services: For CY 2023, CMS proposed maintaining a payment rate of $40 for each of the COVID-19 vaccine administration Ambulatory Payment Classifications (APCs) 9397 and 9398. CMS will provide an additional $35.50 for the administration of COVID-19 vaccines when provided under certain circumstances in a patient's home.

Currently, payment rates for COVID-19 vaccine administration services are site-neutral across most outpatient and ambulatory settings. CMS requests comment on whether it should continue a site-neutral payment policy for COVID-19 vaccine administration for CY 2023, or whether alternative approaches should be developed. Further, CMS requests comments on the appropriate payment methodology for the administration of Part B preventive vaccines, including the COVID-19 vaccine, post PHE.

Regarding monoclonal antibody products, CMS proposed using the equitable adjustment authority to maintain the CY 2022 New Technology APC assignments (1503, 1504, 1505, 1506, 1507, or 1509) and corresponding payment rates for each of the COVID-19 monoclonal antibody product administration Healthcare Common Procedure Coding System (HCPCS) codes for as long as these products are considered covered and paid under the Medicare B vaccine benefit. Under this policy, if the PHE ends, the benefit category and corresponding payment methodology under the OPPS will remain site neutral. Once these products are no longer considered to be covered and paid under the Medicare Part B vaccine benefit, CMS notes it expects COVID-19 monoclonal antibody product administration services to be paid similar to monoclonal antibody products used in the treatment of other health conditions (i.e., biologicals).

Wage Index: CMS proposed continuing an OPPS labor-related share of 60%, and adopting the CY 2023 IPPS post reclassified wage index for outpatient payments. The final CY 2023 OPPS wage index will reflect any adjustments made to the IPPS wage index in the fiscal year (FY) 2023 IPPS final rule. We refer readers to IHA's FY 2023 IPPS proposed rule summary for an overview of additional wage index policies proposed by CMS this year.

Outlier Payments: CMS proposed outlier payments trigger when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds a proposed fixed-dollar loss amount of $8,350.

Sole Community Hospitals (SCHs): CMS proposed continuing its current policy of a 7.1% budget neutral payment adjustment for rural SCHs for all OPPS services and procedures. This proposal excludes separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to cost, and devices paid under the pass-through payment policy.

Payment for Drugs, Biologicals and Radiopharmaceuticals without Pass-Through Status: The proposed CY 2023 packaging threshold is $135.

CMS reviewed the four drugs finalized to receive separate payment in the Ambulatory Surgical Setting (ASC) for CY 2022 under the policy for non-opioid pain management drugs and biologicals that function as surgical supplies. CMS stated it believes the following drugs should continue to receive separate payment under this policy in the ASC setting:

- C9290 (Injection, bupivacaine liposome, 1 mg);
- J1097 (Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml);
- C9088 (Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg); and
- C9089 (Bupivacaine, collagen-matrix implant, 1 mg).

CMS also reviewed and proposed separate payment for Dextenza (J1096 (Dexamethasone, lacrimal ophthalmic insert, 0.1mg)). CMS seeks comment on its proposal to add Dextenza to the list of separately payable non-opioid pain management drugs that function as surgical supplies for CY 2023, as well as on additional non-opioid pain management drugs and biologicals that function as surgical supplies. CMS also seeks comment on potential policy modifications and additional criteria that may help further align the ASC payment system policy for non-opioid pain management drugs and biologicals that function as surgical supplies, as well as non-drug or on-biological products that should qualify for separate, or modified, payment under this authority and any data regarding any such products.

Clinic Visits at Excepted Off-Campus Provider-Based Departments (PBDs): CMS proposed continuing using a Medicare PFS-equivalent payment rate for hospital outpatient clinic visit services (HCPCS code G0463) when furnished by excepted off-campus PBDs. The PFS-equivalent rate for CY 2023 is 40% of the proposed OPPS payment.

CMS also proposed exempting rural SCHs from the site-specific Medicare PFS-equivalent payment for clinic visit services when provided at an off-campus PBD.

Organ Acquisition Payment Policy: CMS proposed several changes to its organ acquisition payment policy, including excluding research organs from the calculation of Medicare's share of

organ acquisition costs and requiring a cost offset; and covering as organ acquisition costs certain hospital costs typically incurred when donors die from cardiac death.

CMS also requests information on counting Medicare organs for use in calculating Medicare's share of organ acquisition costs. CMS will use this information in future rulemaking.

Inpatient Only List (IPO): CMS proposed removing ten services from the IPO list. These include CPT codes 16036; 22632; 21141; 21142; 21143; 21194; 21196; 21347; 21366; and 21422.

CMS also proposed adding eight services that were newly created by the American Medical Association (AMA) CPT Editorial Panel for CY 2023 to the IPO list. Effective Jan. 1, 2023, these would include CPT codes 157X1; 228XX; 49X06; 49X10; 49X11; 49X12; 49X13; and 49X14.

Proposed PHP and Community Mental Health Center (CMHC) Updates: Using CY 2021 claims and cost data, CMS proposed a CY 2023 PHP per diem cost for hospital-based PHP of $264.06 for APC 5863 and a CY 2023 PHP per diem geometric mean cost for CMHCs of $131.71 for APC 5853.

Hospital Outpatient Quality Reporting Program (OQR): CMS proposed several changes to the OQR program, including:

- Making the reporting of OP-31 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery voluntary instead of mandatory beginning with the CY 2027 payment determination;
- Aligning patient encounter quarters with the calendar year, beginning with the CY 2024 reporting period/CY 2026 payment determination; and
- Adding a criterion for including hospitals in CMS' OQR data validation efforts beginning with the CY 2023 reporting period/CY 2025 payment determination. Specifically, CMS would include any hospital with a two-tailed confidence interval that is less than 75 percent, and that had less than four quarters of data due to receiving an Extraordinary Circumstances Exception (ECE) for one or more quarters.

CMS requests comment on the future adoption of a volume indicator in the Hospital OQR program, suggesting it might re-adopt measure OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures.

Tables 61 through 63 list the hospital OQR program measure sets finalized for payment determination during CYs 2024 through 2026.

Overall Hospital Star Ratings: CMS intends to publish Overall Hospital Quality Star Ratings in 2023. However, it may apply its suppression policy should data analysis demonstrate that the COVID-19 PHE substantially affected the underlying measure data.

ASC Market Basket Update: CMS proposed a 3.1% market basket update and a 0.4 percentage point productivity reduction for ASC payments, resulting in a 2.7% rate update.

ASC Procedures: CMS proposed adding 38531: Biopsy or excision of lymph node(s); open, inguinofemoral node(s) to the ASC Covered Procedures List (CPL) for CY 2023.

CMS proposed adding six CPT/HCPCS codes to the ASC permanently office-based covered surgical procedures list. These include CPT/HCPCS codes 0101T; 0446T; 15275; 21198; 31574; and 40830.

There are also eight surgical procedures currently designated as temporarily office-based. CMS proposed to continue designating these procedures as temporarily office-based for CY 2023. These include CPT/HCPCS codes 64454; 65785; 67229; 0402T; 0512T; 0588T; 93985; and 93986.

ASC Quality Reporting Program (ASCQR): CMS did not propose to adopt or remove any measures from the ASCQR. CMS did propose changing the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (ASC-11) measure from mandatory to voluntary beginning with the CY 2027 payment determination.

CMS also requests comment on:

- The potential future implementation of a measures value pathways approach in the ASCQR;
- The status and feasibility of interoperability initiatives in the ASCQR; and
- The potential re-adoption of the ASC Facility Volume Data on Selected ASC Surgical Procedures (ASC-7) measure or another volume indicator in the ASCQR.

Finalized ASCQR measures sets for the CY 2023 reporting period/CY 2025 payment determination and the CY 2024 reporting period/CY 2026 payment determination are in Table 70. Proposed ASCQR measures for the CY 2025 reporting period/CY 2027 payment determination are in Table 71.

Discarded Amounts of Certain Single-does or Single-use Package Drugs: In the CY 2023 Medicare PFS proposed rule, CMS seeks comment on proposals to implement section 90004 of the Infrastructure Investment and Jobs Act. This section includes requirements for manufacturers to refund CMS for discarded amounts from certain single-dose container or single-use package drugs. Implementing this policy requires hospital outpatient departments and ASCs to report the JW modifier or any successor modifier, identifying discarded amounts of applicable single-dose container or single-use package drugs that are separately payable under the OPPS or ASC payment systems.

RFI: Use of CMS Data to Drive Competition in Healthcare Marketplaces: CMS seeks information on how data that CMS collects could be used to promote competition across the healthcare system or protect the public from the harmful effects of consolidation. CMS cites the need to address excessive concentration, abuses of market power, unfair competition, and the effects of monopoly and monopsony.

Contact:

Cassie Yarbrough, Senior Director, Medicare Policy
630-276-5516 | cyarbrough@team-iha.org

Sources:
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