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Special Bulletin

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CMS Issues Hospital Outpatient, Ambulatory Surgical Center Final Rule for CY 2023

The Centers for Medicare & Medicaid Services (CMS) Nov. 1 posted its calendar year (CY) 2023 outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) final rule. The rule increases OPPS rates by a net 3.8% in CY 2023 compared to 2022. It also includes final policies related to the 340B Drug Pricing Program, Rural Emergency Hospital (REH) model, site-neutral clinic visit payment policy, payment for remote behavioral health services, prior authorization, the inpatient only (IPO) list and the ASC Covered Procedures List (CPL).

Most provisions will take effect on Jan. 1, 2023.

KEY HIGHLIGHTS

CMS' policies will:

- Increase Medicare hospital OPPS rates by a net 3.8% in CY 2023 compared to 2022.
- Finalize payment for 340B hospitals at average sales price (ASP) plus 6% for CY 2023 given the unanimous favorable Supreme Court decision.
- Defer the proposal for a remedy for the unlawful 340B policy for CYs 2018-2022 until sometime before next year's CY 2024 OPPS payment rule.
- Establish, beginning on Jan. 1, 2023, the Rural Emergency Hospital (REH) model, a new provider type for eligible critical access hospitals and small rural hospitals. The rule finalized proposals related to model payment, covered services, conditions of participation and quality measurement.
- Exempt rural sole community hospitals (SCHs) from the site-neutral clinic visit cuts, and instead pay for clinic visits furnished in grandfathered (excepted) off-campus provider-based departments (PBDs) of these hospitals at the full OPPS rate.
- Continue payment for remote behavioral health services beyond the end of the public health emergency (PHE) permanently.
- Require prior authorization for an additional service category — facet joint injections and nerve destruction.
- Revise the IPO list to remove 11 services and add eight services.
- Add four procedures to the ASC CPL.

AHA TAKE

While the AHA is pleased that CMS will provide hospitals and health systems with an improved update to outpatient payments next year compared to the agency's proposal in July, the increase is still insufficient given the extraordinary cost pressures hospitals face from labor, supplies, equipment, drugs and other expenses. As we urged, CMS will use more recent data in its calculations on the payment update, resulting in more accurate data that better reflects the historic inflation and tremendous financial pressures hospitals and health systems have confronted recently. However, hospitals are still dealing with a wide range of challenges in providing care, which is why the AHA is urging Congress for additional support by the end of the year.

We appreciate that CMS has finalized the payment policy for CY 2023 of ASP plus 6% for drugs and biologicals acquired through the 340B Program as a result of the unanimous Supreme Court's decision in *American Hospital Association v. Becerra*. This will help 340B hospitals provide important comprehensive health services to their patients and communities. In addition, AHA appreciates the agency's revision of its proposed reduction to the OPPS conversion factor that would have otherwise resulted in millions in underpayments to hospitals. However, we urge the Administration to promptly reimburse those hospitals that were harmed by their unlawful cuts in previous years. In addition, we continue to call on the agency to ensure the remainder of the hospital field is not penalized for the prior unlawful policy, especially as hospitals and health systems continue to face immense financial pressures and workforce shortages.

The AHA is glad that CMS has finalized several proposals related to the REH model. The REH model will help rural hospitals continue to serve as an access point to care in their communities, which is especially critical given the continued challenges they face in the current financial environment. We look forward to further engaging with the agency and Congress to refine the new provider type. See the AHA statement on the OPPS final rule.

Highlights of the OPPS/ASC final rule follow.

CY 2023 OPPS FINAL RULE CHANGES

Payment Update

CMS finalizes an update to OPPS rates of 3.8% for CY 2023 — higher than the 2.7% it had proposed. This update is based on a market basket percentage increase of 4.1%, reduced by 0.3 percentage points for productivity. These payment adjustments, in addition to other changes in the rule, are estimated to result in an overall increase in OPPS payments of 4.5% compared to CY 2022 payments. For hospitals that do not publicly report quality measure data, CMS will continue to impose the statutory 2.0 percentage point additional reduction in payment, resulting in a 1.8% OPPS update. CMS estimates that total payments to hospitals (including beneficiary cost-sharing) will increase by approximately $3.0 billion in CY 2023 compared to CY 2022.

CMS will increase the conversion factor to $85.585 in CY 2023, as compared to $84.177 in CY 2022. This update reflects: the 3.8% OPPS payment update, the required wage index budget neutrality adjustment of 0.9998, the adjustment of 0.9691 to account for the change in policy for drugs purchased under the 340B Program, and the adjustment of 0.16 percentage point of projected OPPS spending for the difference in pass-through spending. CMS will use a reduced conversion factor of $83.934 in the calculation of payments for hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program.

Data Used in CY 2023 OPPS/ASC Ratesetting

CMS will use CY 2021 claims data, as well as cost data from before the COVID-19 public health emergency (PHE) to set CY 2023 OPPS and ASC rates. While it would typically use the CY 2020 cost report data, the agency believes that this year is not the best overall approximation of expected outpatient hospital services due to the COVID-19 PHE. Therefore, in order to mitigate the impact of some of the temporary changes in hospital cost report data from CY 2020, CMS uses cost report data from the June 2020 extract from the Healthcare Cost Report Information System, which includes cost report data from prior to the COVID-19 PHE. This is the same cost report extract CMS used to set OPPS rates for CY 2022.

340B Drug Payment Policy, Including in Off-Campus PBDs

For CY 2023, CMS finalized a payment of ASP plus 6% for drugs and biologicals acquired through the 340B Program as a result of the unanimous Supreme Court's decision in *American Hospital Association v. Becerra*. The payment rate of ASP plus 6% will also apply to such drugs and biologicals when furnished in non-excepted off-campus PBDs paid under the Medicare physician fee schedule (PFS). In addition, at the urging of the AHA, the agency revised its reduction to the OPPS conversion factor from -4.04% to –3.09% to ensure that the policy remains budget neutral for CY 2023 without resulting in millions in underpayments to all hospitals.

While the agency called for public comment on remedies for CYs 2018-2022 given the Supreme Court decision, CMS stated it would defer any proposal of a remedy, in separate rulemaking, in advance of the CY 2024 OPPS/ASC proposed rule. The AHA will continue to urge the United States District Court for the District of Columbia to order CMS to promptly reimburse those hospitals that were harmed by their unlawful cuts in previous years, while ensuring that the remainder of the hospital field is not penalized for the prior unlawful policy. Lastly, the agency will continue its requirement that 340B hospitals report drugs purchased under the 340B Program using either the "JG" or "TB" modifier for informational purposes depending on the type of 340B hospital.

PFS Policy to Require HOPDs and ASCs to Report Discarded Amounts of Certain Single-dose or Single-use Package Drugs

The Infrastructure Investment and Jobs Act requires drug manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The CY 2023 PFS final rule includes policies to implement these provisions, including a policy that hospital outpatient departments (HOPDs) and ASCs be required to report the JW modifier, or any successor modifier, to identify discarded amounts of refundable single-dose container or single-use package drugs that are separately payable under the OPPS (described by HCPCS codes assigned status indicator "K" or "G") or ASC payment system (described by HCPCS codes assigned payment indicator "K2").

Specifically, in the PFS final rule, CMS establishes a policy that, starting Jan. 1, 2023, for the purpose of calculating the refund amount during a relevant quarter, the JW modifier must be used to determine the total number of billing units of the Health Care Common Procedure Coding System (HCPCS) code of a refundable single-dose container or single-use package drug that were discarded. Further, beginning no later than July 1, 2023, CMS also will require HOPDs and ASCs to use a separate modifier, JZ, in cases where no billing units of such drugs were discarded and for which the JW modifier would be required if there were discarded amounts. The agency will begin claims edits for both the JW and JZ modifier beginning Oct. 1, 2023.

Exemption of Rural SCHs from Site-Neutral Clinic Visit Cuts

In CY 2019, CMS finalized a policy to pay for hospital outpatient clinic visit services furnished in grandfathered (excepted) off-campus PBDs at the "PFS-equivalent" rate of 40% of the OPPS payment amount. For CY 2023, CMS finalizes its proposal to exempt rural SCHs from this policy. As such, CMS will pay the full OPPS payment rate, rather than 40% of the OPPS rate, when a clinic visit (described by HCPCS code G0463) is furnished in a grandfathered (excepted) off-campus PBD of a rural SCH. The agency adopts this change because it believes the volume of clinic visit services in off-campus PBDs of these hospitals is driven by factors other than the payment differential for this service and restoring full OPPS payment will help to maintain access to care in rural areas. CMS estimates that this exemption will increase payments to rural SCHs by 1.1%.

Addition to the Prior Authorization Program

CMS finalizes its proposal to require prior authorization for a new service category, facet joint interventions. This policy will be effective for dates of services on or after July 1, 2023.

Changes to the IPO List

CMS finalizes its proposal to remove 11 services from the IPO list. In addition, CMS will add eight services that were newly created by the AMA CPT Editorial Panel to the IPO list for CY 2023.

Partial Hospitalization Program (PHP) Update

Update to PHP Per Diem Rates. CMS will maintain the existing rate structure, with a single PHP ambulatory payment classification (APC) for each provider type (i.e. hospital and community mental health center (CMHC)), for days with three or more services per day. For CY 2023 rate setting, CMS uses CY 2021 claims data and cost information from prior to the COVID-19 PHE; that is, the cost information that was available for the CY 2021 OPPS/ASC rulemaking.

CMS follows its existing methodology to calculate the hospital-based geometric mean per diem costs for CY 2023. This results in a CY 2023 PHP payment rate for hospital-based PHPs of $268.22 for APC 5863. This is an increase for hospital-based PHPs compared to CY 2022. However, in response to public comments and to protect access to PHP services in CMHCs, for CY 2023 only, CMS is using its equitable adjustment authority to maintain the CY 2022 CMHC APC 5853 payment rate of $142.70 as the CY 2023 CMHC final payment rate.

Non-PHP Outpatient Behavioral Health Services Furnished Remotely to PHP Patients. CMS clarifies that PHP patients can continue to receive the full range of hospital outpatient services, including the new HCPCS codes that describe mental health services, furnished to beneficiaries in their homes by clinical staff of the hospital (as described below). The agency also clarifies that for PHP patients, the plan of care should be updated to reflect that remote services are being provided.

Outpatient Quality Reporting Program (OQR)

CMS did not propose to adopt or remove any measures from the OQR. However, the agency finalized its proposal to change the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31) measure from mandatory to voluntary beginning with the CY 2027 payment determination (CY 2025 reporting period).

CMS also finalized a few programmatic updates, including alignment of patient encounter quarters for chart-abstracted measures to the calendar year (as opposed to the current timeframe of Quarter 2 of two years prior to payment determination through Quarter 1 of one year prior to the payment determination) and an additional targeting criterion for measure data validation.

CY 2023 ASC FINAL RULE CHANGES

ASC Payment Update

For CYs 2019 through 2023, CMS adopted a policy to update the ASC payment system using the hospital market basket update. As such, for CY 2023, the agency increases payment rates under the ASC payment system by 3.8% for ASCs that meet the quality reporting requirements under the ASC quality reporting (ASCQR) program.

Changes to the List of ASC-covered Surgical Procedures

CMS evaluates the ASC covered procedures list each year to determine whether procedures should be added to or removed from the list. For CY 2023, the agency adds four procedures to the ASC CPL based upon its existing regulatory criteria.

ASCQR Policies

CMS did not adopt or remove any measures from the ASCQR program. However, as in it did for the OQR, the agency finalized its proposal to change 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 (CY 2025 reporting period).

RURAL EMERGENCY HOSPITALS

REH Model Policies

CMS finalized several proposals to establish the REH model, a new Medicare provider type established by the Consolidated Appropriations Act, 2021. Specifically, critical access hospitals and small rural hospitals will be able to convert to REHs and furnish REH services for Medicare payment beginning Jan. 1, 2023. In addition, CMS finalized its proposed method to determine the additional monthly facility payment for REHs. Specifically for CY 2023, the additional facility payment will be $272,866 monthly ($3,274,392 annually). This figure is slightly higher than the proposed amount of $268,294 monthly ($3,219,528 annually). In addition, among others, CMS also finalized policies related to covered outpatient department services, conditions of participation and quality measurement requirements.

Requirements for the Rural Emergency Hospital Quality Reporting Program (REHQR)

CMS finalizes the foundational administrative requirements for REHs participating in the REHQR, including registration on QualityNet and designation of a Security Official. The agency stated that it intends to propose additional administrative requirements for the REHQR Program in subsequent rulemaking.

OTHER ISSUES

Telehealth for Behavioral Health

During the COVID-19 PHE, CMS allowed hospitals to provide and bill for remote outpatient mental health services. In this rule, CMS finalizes its proposal to allow these remote services to be furnished to beneficiaries when in their homes beyond the end of

the COVID-19 PHE and the agency creates OPPS-specific coding to describe these services. In an amendment to its original proposal, however, CMS will allow these services to be furnished under a physician's overall direction and control without the physician's physical presence in the hospital during the performance of the service.

CMS also finalized its proposal to require that beneficiaries newly receiving telehealth mental health services beginning the 152nd day after the end of the COVID-19 PHE receive an in-person service within six months prior to the first remote mental health service. It also finalized its proposal that there must be an in-person service within 12 months after each remotely furnished mental health service. CMS will allow exceptions to these requirements if hospital clinical staff and the beneficiary agree, and provide documentation in the medical record, that the risks and burdens of an in-person service outweigh its benefits, and that the patient has a regular source of general medical care. CMS also will allow hospital staff to use audio-only communications if an individual patient is not capable of or does not wish to use two-way audio/video technology.

Supervision by Non-physician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients

CMS finalizes its proposal to extend the end date of the flexibility allowing for the virtual supervision of outpatient diagnostic services through audio/video real-time communications technology (excluding audio-only) from the end of the COVID-19 PHE to the end of the calendar year in which the PHE ends. In addition, the agency clarifies that certain non-physician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwifes) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable state law.

Organ Acquisition Payment Policy

CMS finalizes its proposal to exclude research organs from the ratio used to calculate Medicare's share of organ acquisition costs and modifies its requirement to offset costs by allowing providers to follow their accounting practices of adjusting costs, offsetting revenue or establishing a non-reimbursable cost center, which will maintain or lower the cost of procuring and providing research organs to the research community. Finally, as it proposed, CMS will cover as organ acquisition costs certain hospital services provided to donors whose death is imminent, to promote organ procurement and enhance equity.

IPPS and OPPS Payment Adjustments for Domestic NIOSH-approved Surgical N95 Respirators

CMS finalizes its proposal to provide payment adjustments to hospitals under the IPPS and OPPS for the additional resource costs incurred to acquire domestic NIOSH-approved surgical N95 respirators. These surgical respirators, which faced severe shortage at the onset of the COVID-19 pandemic, are essential for

the protection of beneficiaries and hospital personnel that interface with patients. The payment adjustments will commence for cost reporting periods beginning on or after Jan. 1, 2023.

FURTHER QUESTIONS

Most of the policies and payment rates will take effect Jan. 1, 2023. Watch in the coming weeks for a more detailed analysis of the final rule as well as an announcement of an AHA members-only webinar on the final rule changes.

If you have further questions, contact Roslyne Schulman, AHA's director of outpatient payment policy at rschulman@aha.org.