Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

DECEMBER 2021

CY 2022 MEDICARE OPPS FINAL RULE – CMS-1753-FC

On Nov. 16, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2022 outpatient prospective payment system (OPPS) final rule. CMS estimates an overall increase in OPPS and Ambulatory Surgical Center (ASC) payments of 2% in calendar year (CY) 2022 compared with CY 2021.

CMS used CY 2019 claims data to set CY 2022 rates. Normally, CMS uses the most recent complete year of claims data available for rate setting. However, CY 2020 is the most recent complete year of claims data, and CMS believes the COVID-19 public health emergency (PHE) significantly affected item and service access and utilization. Thus, CMS finalized forgoing its usual process and will use CY 2019 claims data instead.

Price Transparency: CMS finalized several amendments and clarifications to the Hospital Price Transparency final rule, including:

1. Increasing civil monetary penalties (CMPs) for noncompliant hospitals;
2. Deeming state forensic hospitals meeting certain requirements as compliant;
3. Prohibiting the use of specific barriers to accessing the required machine-readable file; and
4. Clarifying output expectations for hospital online price estimator tools.

See IHA's summary of these changes here.

340B: CMS will continuing paying for non-pass-through, separately payable drugs and biologicals acquired under the 340B program at average sales price (ASP) minus 22.5%, including when furnished at non-excepted off-campus provider based departments (PBDs).

Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals are exempt from this payment policy. Such providers must still append modifier "TB" on claims for drugs purchased through the 340B program, but CMS will pay the claim at ASP plus 6%. All non-exempt 340B hospitals must append the "JG" modifier to claims for drugs purchased through the 340B program.

The U.S. Supreme Court heard oral arguments on Tuesday, Nov. 30 in *American Hospital Association v. Becerra*, which challenges the authority of the U.S. Department of Health and Human Services to make these payment cuts to 340B hospitals. Thirty-seven state and regional hospital associations, including IHA, filed an amicus brief supporting AHA's arguments in the case. You can find the briefs in the case here.

Inpatient Only List (IPO): Prior to CY 2021, CMS used five criteria decide whether to remove a procedure from the IPO list. These criteria were:

1. Most outpatient departments are equipped to provide the service to the Medicare population.

2. The simplest procedure described by the code may be furnished in most outpatient departments.
3. The procedure is related to codes that were already removed from the IPO list.
4. CMS determines the procedure is being furnished in numerous hospitals on an outpatient basis.
5. CMS determines the procedure can be appropriately and safely furnished in an ASC and is on the ASC covered procedures list (CPL) or has been proposed by CMS for addition to the ASC CPL.

In CY 2021, CMS finalized the elimination of the IPO list over a three-year phase out period. Additionally, CMS moved away from using the above criteria, removing 298 codes from the IPO list beginning in CY 2021 without assessing them against these criteria.

In the CY 2022 OPPS final rule, CMS reversed this 2021 decision, halting the elimination of the IPO list and returning most of the removed codes to the IPO list beginning CY 2022. CMS also codified the five criteria listed above for assessing the removal of codes from the IPO.

Based on studies and submitted comments, CMS kept the following procedures and their associated anesthesia codes off the IPO list for CY 2022:

- CPT code 22630 (Lumbar spine fusion);
- CPT code 23472 (Reconstruct shoulder joint);
- CPT code 27702 (Reconstruct ankle joint)
- CPT code 00630 (Anesthesia for procedures in lumbar region; not otherwise specified);
- CPT code 00670 (Anesthesia for extensive spine and spinal cord procedures [e.g., spinal instrumentation or vascular procedures]);
- CPT code 01638 (Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement); and
- CPT 01486 (Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement).

The complete CY 2022 IPO list is included in Addendum E of the final rule, available here. Table 48 in the final rule lists the changes to the IPO list for CY 2022.

Medical Review of Services Removed from IPO List: In CY 2021, CMS altered its medical review policy, indefinitely exempting procedures removed from the IPO list after Jan. 1, 2021 from site-of-service claim denials under Medicare Part A, eligibility for Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractors (RACs) for noncompliance with the 2-Midnight rule, and RAC reviews for "patient status." The exemption would remain in place until there were enough Medicare claims data indicating that the outpatient setting was a more common site-of-service than the inpatient setting.

In this final rule, and consistent with the decision to halt the elimination of the IPO list, CMS reinstated the 2-year exemption from 2-Midnight medical review activities for services removed from the IPO list on or after Jan. 1, 2021. Reverting to past policy, procedures removed from the IPO List will be exempt from site-of-service claim denials under Medicare Part A, BFCC-QIO referrals to RACs for persistent noncompliance with the 2-Midnight rule, and RAC reviews for

"patient status." CMS stressed it expects providers to continue using their complex medical judgment when deciding on the most appropriate site of service for an individual beneficiary, and to comply with the 2-Midnight rule.

Coinsurance for Certain Colorectal Cancer Screenings: CMS finalized changes made to coinsurance requirements specific to colorectal cancer screenings established in the Consolidated Appropriations Act (CAA) for hospital outpatient departments. Starting Jan. 1, 2022, CMS will waive coinsurance for screening flexible sigmoidoscopies and screening colonoscopies. This policy applies to colorectal screenings regardless of eventual diagnosis, removal of tissue, or other matters or procedures furnished in connection with or resulting from the same clinical encounter as the screening test. CMS reminds providers that claims for colorectal screenings provided in the OPPS setting must include the modifier "PT."

OPPS Market Basket Update: CMS finalized a 2.7% market basket update and a 0.7 percentage point productivity reduction for OPPS payments, resulting in a 2.0% update to OPPS rates for hospitals that meet quality data submission requirements. These adjustments result in a CY 2022 conversion factor of $84.177 (proposed at $84.457). Hospitals that fail to submit quality data will be subject to a 2-percentage point reduction to payments, resulting in a conversion factor of $82.526.

Wage Index: CMS will continue using an OPPS labor-related share of 60%, and adopt the federal fiscal year (FFY) 2022 inpatient prospective payment system (IPPS) post reclassified wage index.

Outlier Payments: CMS finalized a CY 2022 outlier fixed-dollar threshold of $6,175 (proposed at $6,100).

Sole Community Hospital (SCH) and Essential Access Community Hospital (EACH) Update: CMS will continue with its current policy of a 7.1% budget neutral payment adjustment for rural SCHs and EACHs for all OPPS services and procedures. This payment add-on 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: CMS finalized a CY 2022 packaging threshold of $130 (as proposed).

Payment for Hospital Outpatient Visits and Critical Care Services: CMS will continue utilizing the Medicare physician fee schedule-equivalent payment rate for hospital outpatient clinic visits (HCPCS code G0463) when furnished by excepted off-campus provider-based departments (PBDs). This results in a payment rate that is 60% less than the OPPS rate.

Hospital Outpatient Quality Reporting Program (OQR): CMS finalized several changes to the OQR program, including the removal of two measures beginning with the CY 2023 reporting period/CY 2025 payment determination include:

1. Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department (ED) Arrival (OP-2); and
2. Median Time to Transfer to Another Facility for Acute Coronary Intervention.

CMS adopted two measures for the CY 2023 reporting period/CY 2025 payment determination:

1. ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) (OP-40); and
2. Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS HCAHPS) Survey (OP-37a-e).

Both measures are voluntary for the CY 2023 reporting period, with mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination.

Also for the CY 2023 reporting period, CMS added Breast Screening Recall Rates measure (OP-39). For the CY 2024 reporting period, which begins Jan. 1, 2022, CMS adopted the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure (OP-38). For the CY 2025 reporting period, CMS made mandatory the reporting of the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31) measure.

Finally, CMS finalized its proposal to require hospitals to utilize CEHRT updated consistent with the 2015 Edition Cures Update beginning CY 2023 (this was also finalized in the FFY 2022 IPPS final rule). CMS will require hospitals to report data elements formatted according to the Quality Reporting Document Architecture (QRDA) standard using the QRDA Category I file format. Hospitals will be allowed to use third parties to submit these files on their behalf, and may either ruse abstraction or pull the date from non-certified sources and then input the data into CEHRT to report via QRDA I. CMS did not finalize its proposal to require eCQM data submission by the end of the two months following the close of the calendar year beginning CY 2023, which would have aligned with the Medicare Promoting Interoperability Program and the inpatient quality reporting program. Instead, CMS established May 15 as the data submission deadline for eCQMs beginning in CY 2023.

CMS also made several updates to previously finalized validation requirements to better align the outpatient quality reporting program with the inpatient quality reporting program. This includes allowing hospitals to request an exception from eCQMs reporting requirements based on hardships preventing them from electronic reporting, including infrastructure challenges or unforeseen circumstances. Hospitals must submit requests for an exception to CMS by April 1 following the end of the calendar year in which the extraordinary circumstances occurred.

Partial Hospitalization Program (PHP) and Community Mental Health Center (CMHC) Updates: CMS finalized CY 2022 PHP geometric mean per diem costs and payments as follows:

- APC 5853 Partial Hospitalization (three or more services per day) for CMHCs
  - Final PHP APC Geometric Mean per Diem Cost: $136.14
  - Final Payment Rate: $142.70
- APC 5863 Partial Hospitalization (three or more services per day) for hospital-based PHPs
  - Final PHP APC Geometric Mean per Diem Cost: $253.76
  - Final Payment Rate: $265.97

ASC Market Basket Update: CMS finalized a 2.7% market basket update and a 0.7 percentage point productivity reduction for ASC payments, resulting in a 2.0% update to ASC payments. These adjustments result in a CY 2022 conversion factor of $49.916. ASCs that fail to submit quality data will be subject to a 2-percentage point reduction to payments, resulting in a conversion factor of $48.937.

ASC Covered Procedure List (CPL): Aligning with the halt in eliminating the IPO list, CMS reinstated specifications for adding surgical procedures to the ASC covered procedures list that were in place prior to CY 2021. These specifications state that ASC CPL services furnished on or after Jan. 1, 2022 are those specified by the Secretary of Health and Human Services (HHS) and published in the *Federal Register* and/or via CMS' website. These procedures should not pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and standard medical practice should dictate that the beneficiary would not typically require active medical monitoring and care at midnight following the procedure. The ASC CPL would not include procedures that:

- Generally result in extensive blood loss;
- Require major or prolonged invasion of body cavities;
- Directly involve major blood vessels;
- Are generally emergent or life threatening in nature;
- Commonly require systemic thrombolytic therapy;
- Are designated as requiring inpatient care under § 419.22(n);
- Can only be reported using a CPT unlisted surgical procedure code; or
- Are otherwise excluded under § 411.15.

ASC Quality Reporting Program (ASCQR): CMS adopted the COVID-19 Vaccination Coverage among HCP measure beginning with the CY 2022 reporting period/CY 2024 payment determination. CMS will also require reporting of Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (ASC-11), mandatory with the CY 2025 reporting period, and Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures (ASC-15-a-e), voluntary reporting CY 2023, mandatory reporting beginning with CY 2024 reporting period/CY 2026 payment determination.

CMS will also require reporting on previously suspended measures including:

- Patient Burn beginning with the CY 2023 reporting period/CY 2025 payment determination (ASC-1);
- Patient Fall (NQF #0266) beginning with the CY 2023 reporting period/CY 2025 payment determination (ASC-2);
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267) beginning with the CY 2023 reporting period/CY 2025 payment determination (ASC-3);
- All-Cause Hospital Transfer/Admission (NQF #0265) beginning with the CY 2023 reporting period/CY 2025 payment determination (ASC-4);

Sources:

Centers for Medicare & Medicaid Services. Hospital Outpatient Prospective Payment – Notice of Final Rulemaking with Comment Period. CMS-1753-FC. Available from: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc. Accessed December 9, 2021.