

CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

Nov 01, 2022

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and ambulatory surgical center (ASC) services. The Calendar Year (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Final Rule is published annually.

In addition to payment rates, this year's rule includes policies that align with several key goals of the Administration, including addressing the health equity gap, fighting the COVID-19 Public Health Emergency (PHE), encouraging transparency in the health system, and promoting safe, effective, and patient-centered care.

The final rule advances the Agency's commitment to strengthening Medicare and uses the lessons learned from the COVID-19 PHE to inform the approach to quality measurement, focusing on changes that will help close the health equity gap.

These policies will affect approximately 3,500 hospitals and approximately 6,000 ASCs. As with other rules, CMS is publishing this final rule to meet the legal requirements to update Medicare payment policies for OPPS hospitals and ASCs on an annual basis. This fact sheet discusses the major provisions of the final rule (CMS- 1772-FC), which can be downloaded at: <https://www.cms.gov/files/document/cy2023-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-final-rule.pdf>

Updates to OPPS and ASC payment rates

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 3.8%. This update is based on the projected hospital market basket percentage increase of 4.1%, reduced by 0.3 percentage point for the productivity adjustment.

In the CY 2019 OPPS/ASC final rule with comment period, CMS finalized a proposal to apply the productivity-adjusted hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). Using the hospital market basket update, CMS is finalizing a productivity-adjusted hospital market basket update factor to the ASC rates for CY 2023 of 3.8%. The update applies to ASCs meeting relevant quality reporting requirements. This update is based on the hospital market basket percentage increase of 4.1%, reduced by 0.3 percentage point for the productivity adjustment.

Rural Emergency Hospitals: New Medicare Provider Type

There has been a growing concern that closures of rural hospitals and critical access hospitals (CAHs) are leading to a lack of services for people living in rural areas. Section 125 of the Consolidated Appropriations Act, 2021 (CAA) established a new Medicare provider type called Rural Emergency Hospitals (REHs), effective January 1, 2023. For information on the establishment of this new Medicare provider type, view the Rural Emergency Hospital fact sheet <https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-1>

OPPS Payment for Drugs Acquired Through the 340B Program

Section 340B of the Public Health Service Act (340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices. In the CY 2018 OPPS/ASC final rule with comment period, CMS reexamined the appropriateness of paying the average sales price (ASP) plus 6% for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, CMS adopted a policy to pay an adjusted amount — generally ASP minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B Program. CMS continued this policy in CYs 2019 through 2022.

For CY 2023, in light of the Supreme Court’s decision in *American Hospital Association v. Becerra* (No. 20-1114, 2022 WL 2135490), CMS is finalizing a general payment rate of ASP plus 6% for drugs and biologicals acquired through the 340B Program, consistent with our policy for drugs not acquired through the 340B program. As required by statute, CMS is implementing a –3.09% reduction to the payment rates for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023. CMS will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 OPPS/ASC proposed rule. We note that claims for 340B-acquired drugs paid after the district court’s September 28, 2022 ruling are paid at the default rate (generally ASP plus 6%).

Payment for Non-Opioid Products Under Section 6082 of the SUPPORT Act

Section 1833(t)(22)(A) and section 1833(i)(8) of the Social Security Act, as added by section 6082(a) and (b), respectively, of the SUPPORT Act, require that the Secretary must review payments under the OPPS and ASC for opioids and evidence-based non-opioid alternatives for pain management with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives. For CY 2023, CMS is maintaining its current policy to provide for separate payment for those non-opioid pain management drugs and biologicals that function as supplies in the ASC setting that CMS determines are FDA approved, have an FDA-approved indication for pain management or as an analgesic, and have a per-day cost above the OPPS drug packaging threshold. CMS is finalizing two technical clarifications to the criteria in the regulation text to reflect our current policy.

Under this policy, for CY 2023, CMS is finalizing separate payment in the ASC setting for five non-opioid pain management drugs that function as surgical supplies, including certain local anesthetics and ocular drugs, that meet the criteria in 42 CFR 416.174.

Behavioral Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes

For CY 2023, CMS is finalizing its proposal to consider behavioral health services furnished remotely by clinical staff of hospital outpatient departments, including staff of critical access hospitals (CAHs), through the use of telecommunications technology to beneficiaries in their homes, covered outpatient services for which payment is made under the OPPS. Currently, this flexibility is available through the PHE-specific policy referred to as Hospitals Without Walls (HWW), but the emergency waivers that enable this flexibility will expire when the PHE for COVID-19 ends. If beneficiaries cannot continue to receive these services in their homes from hospital clinical staff, they may not be able to continue receiving behavioral health services, which may lead to loss of access to care, particularly in rural or other underserved areas.

CMS is finalizing its proposal to require that payment for behavioral health services furnished remotely to beneficiaries in their homes may only be made if the beneficiary receives an in-person service within 6 months prior to the first time hospital clinical staff provides the behavioral health services remotely, and that there must be an in-person service without the use of communications technology within 12 months of each behavioral health service furnished remotely by hospital clinical staff. CMS is finalizing our proposal to permit exceptions to the in-person visit requirement when the hospital clinical staff member and beneficiary agree that the risks and burdens of an in-person service outweigh the benefits of it, among other requirements.

CMS is also clarifying that, in instances where there is an ongoing clinical relationship between practitioner and beneficiary at the time the PHE ends, the in-person requirement for ongoing, not newly initiated, treatment will apply. CMS is also finalizing its proposal that audio-only interactive telecommunications systems may be used to furnish these services in instances where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology. Audio-only communications can help advance equity, since many rural and underserved communities lack stable access to broadband services, making two-way, audio/visual communication difficult.

IPPS and OPPS Payment Adjustments for Additional Costs of Domestic NIOSH- Approved Surgical N95 Respirators

The COVID-19 pandemic has illustrated how overseas production shutdowns, foreign export restrictions, and shipping delays can jeopardize the availability of raw materials and components needed to make critical public health supplies. The supply of surgical N95 respirators — a specific type of filtering facepiece respirator used in clinical settings — was one type of personal protective equipment that was strained in hospitals in the early stages of the pandemic. In a future pandemic or increase in transmission of COVID-19, hospitals need to be able to count on domestic manufacturers of surgical N95 respirators. Sustaining a level of domestic production of

National Institute for Occupational Safety and Health (NIOSH)-approved surgical N95 respirators would help to maintain that assurance.

CMS recognizes that hospitals may incur additional costs when purchasing domestic NIOSH-approved surgical N95 respirators. Therefore, CMS is finalizing our proposal to provide payment adjustments under the IPPS and OPPTS that would reflect, and offset, the additional marginal resource costs that hospitals face in procuring domestically made NIOSH-approved surgical N95 respirators. Under this policy, these payments would be provided biweekly as interim lump-sum payments to the hospital and would be reconciled at cost report settlement. The rule also outlines the information that would be collected on the cost report to determine payments under this policy, which would apply to cost reporting periods beginning on or after January 1, 2023.

Rural Sole Community Hospital Exemption from the Clinic Visit Payment Policy

CMS currently pays the Physician Fee Schedule (PFS)-equivalent payment rate for the clinic visit service when provided at an excepted off-campus provider-based department (PBD) paid under the OPPTS, as a method to control the unnecessary increases in volume CMS had observed for that covered outpatient department service. The PFS-equivalent payment rate is approximately 40% of the OPPTS payment rate, and the clinic visit is the most frequently billed service under the OPPTS. In order to maintain access to care in rural areas, CMS is finalizing its proposal to exempt Rural Sole Community Hospitals (SCHs) from this policy and pay for clinic visits furnished in excepted off-campus PBDs of these hospitals at the full OPPTS rate. CMS believes that implementing this exemption will help to maintain access to care in rural areas by ensuring rural providers are paid for clinic visit services provided at off-campus PBDs at rates comparable to those paid by on-campus departments. This exemption for rural SCHs is in keeping with prior CMS policies to provide rural SCHs a 7.1% add-on payment for OPPTS services, to account for their higher costs compared to other hospitals.

Supporting Organ Procurement and Research

CMS is supporting organ procurement and research in this final rule. CMS is finalizing its proposal for a method of accounting for research organs that will improve payment accuracy and maintain organ availability for the research community. CMS is also finalizing its proposal to address potential financial barriers to organ donation after cardiac death, which may increase organ procurement and promote equity within the transplant ecosystem.

In the proposed rule, CMS requested information to promote transparency and inform potential future organ acquisition payment policy. Specifically, CMS requested information on possible alternative methodologies for counting organs to calculate Medicare's share of organ acquisition costs for transplant hospitals and organ procurement organizations. While CMS is not responding to comments in the final rule, CMS will continue to take all comments into consideration for potential future policy development.

OPPS Transitional Pass-through Payment for Drugs, Biologicals, and Devices

For CY 2023, CMS received eight applications for device pass-through payments. One of these applications (aprevo™ Intervertebral Fusion Device) received preliminary approval for pass-through payment status through our quarterly review process. Based on the information provided in the applications and the comments received during the notice and comment period of the CY 2023 OPPS/ASC proposed rule, CMS determined that four of the eight devices qualified (or continued to qualify) for transitional device pass-through status effective beginning January 1, 2023. The remaining four devices did not meet one or more of the eligibility criteria and do not qualify for device pass-through payments.

In addition, for CY 2023, CMS is finalizing its proposal to resume our usual process of using claims data from two years prior to the year to set rates for the calendar year; specifically, CY 2021 claims data for CY 2023 OPPS rate setting, consistent with the overall OPPS rate setting methodology for CY 2023. Therefore, CMS is finalizing its proposal to not provide any additional quarters of separate payment for any device category whose pass-through payment status will expire between December 31, 2022, and September 30, 2023.

Further, CMS is finalizing its proposal to publicly post the completed OPPS device pass-through application forms and related materials that we receive from applicants online, excluding certain copyright or other materials that cannot otherwise be released to the public. CMS is finalizing the alternative implementation date of March 1, 2023 and therefore will publicly post all OPPS device pass-through applications for the CY 2025 OPPS proposed rule beginning with applications received on or after March 1, 2023.

OPPS Payment for Software as a Service

Algorithm-driven services that assist practitioners in making clinical assessments can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). These technologies are referred to as software as a service (SaaS). In the CY 2023 OPPS/ASC proposed rule, CMS sought comments on the specific payment approach we might use for these services under the OPPS as SaaS-type technology becomes more widespread. For CY 2023, CMS is finalizing an exception to our general packaging policy for SaaS add-on codes. The SaaS add-on codes will be assigned to identical APCs and have the same status indicator assignments as their standalone codes, thereby allowing for separate payment for these services. We will also continue to consider for future rulemaking how payment policies should adapt to better recognize these evolving services.

OPPS Payment for Dental Services

CMS is finalizing coding changes for billing of covered dental services in the CY 2023 OPPS/ASC final rule with comment period. First, CMS is creating a new G-code to describe dental rehabilitation services that require monitored anesthesia and the use of an operating room (OR). CMS is assigning this new G-code to APC 5871 (Dental Procedures), effectively increasing the payment for these dental rehabilitation services from about \$200 to about \$2000. This code can be used to bill for covered services furnished to patients with special health needs

that require general anesthesia in an OR to receive dental care. Second, CMS is clarifying that existing unlisted CPT code 41899 should be used to bill for covered, non-surgical dental services, or surgical dental services not performed under monitored anesthesia in an OR, not otherwise described by existing dental codes already assigned to an APC. We are further clarifying that for Medicare payment to be made for dental services, including services that may be described by G0330, Medicare coverage requirements for dental services as finalized in the CY 2023 PFS final rule, must be met.

Skin Substitutes

CMS is not finalizing our proposal to change the terminology of skin substitutes. After considering public comments, we believe that additional dialogue will be beneficial before finalizing new terminology. We intend to host a Townhall in early 2023 to further understand the concerns interested parties have regarding changes in terminology and payment policies for these products and would address additional changes in future rulemaking. CMS is finalizing its policy to eliminate HCPCS code C1849, which is the code that providers have been using in the OPPS to report the usage of synthetic skin substitute products. We finalized that providers should use product-specific HCPCS codes for synthetic skin substitute products that are currently described by HCPCS code C1849. Furthermore, we finalized a policy to assign any synthetic skin substitute product that is currently described by HCPCS code C1849, would have been described by HCPCS code C1849, or is assigned a code in the HCPCS A2XXX series, to the high-cost skin substitute group. These products will be assigned to the high-cost skin substitute group even if cost and pricing data are not available for any individual product.

Partial Hospitalization Program

Partial Hospitalization Program (PHP) Rate Setting

The CY 2023 OPPS/ASC final rule updates Medicare payment rates for partial hospitalization program (PHP) services furnished in hospital outpatient departments and community mental health centers (CMHCs). The PHP is an intensive, structured outpatient program provided as an alternative to psychiatric hospitalization, consisting of a group of mental health services paid on a per diem basis under the OPPS based on PHP per diem costs.

Update to PHP Per Diem Rates

CMS is finalizing its proposal to maintain the existing rate structure, with a single PHP Ambulatory Payment Classification (APC) for each provider type, for days with three or more services per day.

Consistent with the OPPS for this CY 2023 rate setting, based on public comments and in order to protect access to PHP services in CMHCs, CMS is finalizing for only CY 2023, and not for subsequent years, to utilize the authority set forth in section 1833(t)(2)(E) of the Act to make an equitable adjustment to the CY 2023 CMHC APC payment rate. That is, for only CY 2023, we will maintain the CY 2022 CMHC APC payment rate of \$142.70 for the CY 2023 CMHC APC final payment rate.

Non-PHP Outpatient Behavioral Health Services Furnished Remotely to Partial Hospitalization Patients

CMS is clarifying that the new HCPCS codes being adopted under the OPSS describing certain behavioral health therapy services furnished remotely, by hospital staff using communications technology to beneficiaries in their homes, will not be recognized as partial hospitalization services, but will be available to those in a partial hospitalization program. Specifically, CMS is clarifying that a hospital could bill for non-PHP outpatient services furnished to a PHP patient, including remote therapy services furnished by a hospital outpatient department. Hospitals will be permitted to bill for these remote non-PHP behavioral health services, but will need to continue to comply with documentation requirements that apply to PHP patients.

Hospital Outpatient/ASC/REH Quality Reporting Programs

CMS is finalizing changes and responding to requests for comment for the Hospital Outpatient Quality Reporting (OQR), Ambulatory Surgical Center Quality Reporting (ASCQR), and Rural Emergency Hospital Quality Reporting (REHQR) Programs to further meaningful measurement and reporting for quality of care in the outpatient setting.

Hospital Outpatient Quality Reporting (OQR) Program

The Hospital OQR Program is a pay-for-reporting quality program for the hospital outpatient department setting. The Hospital OQR Program requires hospitals to meet program requirements or receive a reduction of 2.0 percentage points in their annual payment update.

In the CY 2023 OPSS/ASC final rule, CMS is finalizing a policy of maintaining voluntary reporting of the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31) measure due to the ongoing COVID-19 public health emergency (PHE). Interested parties have indicated that they are still recovering from the COVID-19 PHE, and that the requirement to report OP-31 would be burdensome due to national staffing and medical supply shortages, coupled with unprecedented changes in patient case volumes. CMS is also finalizing the alignment of Hospital OQR Program patient encounter quarters for chart-abstracted measures to the calendar year, for annual payment update (APU) determinations, and the addition of adding a targeting criterion, in the selection of hospitals for data validation, for hospitals with fewer than four quarters of data subject to validation due to receiving an extraordinary circumstance exception (ECE) for one or more quarters.

CMS also sought comment on the future reimplementation of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26) measure or the future adoption of another volume indicator as a quality measure.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

The ASCQR Program is a pay-for-reporting quality program for the ASC setting. The ASCQR Program requires ASCs to meet program requirements or receive a reduction of 2.0 percentage points in their annual fee schedule update.

Consistent with the proposal in the Hospital OQR Program, CMS is finalizing a policy of maintaining voluntary reporting of the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (ASC-11) measure due to the ongoing COVID-19 public health emergency (PHE). Interested parties have indicated that they are still recovering from the COVID-19 PHE, and that the requirement to report ASC-11 would be burdensome due to national staffing and medical supply shortages, coupled with unprecedented changes in patient case volumes. CMS also sought comment on measures and topics for future considerations, including reimplementing of the ASC Volume on Selected ASC Surgical Procedures (ASC-7) measure or adoption of another volume indicator as a quality measure, a specialty center approach for ASC quality measures, and interoperability and EHR use in the ASCQR Program.

Rural Emergency Hospital Quality Reporting (REHQR) Program

Section 1861(kkk)(7) of the Social Security Act, as added by section 125(a)(1)(B) of Division CC of the Consolidated Appropriations Act, 2021, requires the Secretary to establish quality measurement reporting requirements for Rural Emergency Hospitals (REHs).

CMS is finalizing that, in order for REHs to participate in the REHQR Program, they must have an account with the Hospital Quality Reporting (HQR) System secure portal and a designated Security Official (SO). CMS also sought information on several potential measures for the new Rural Emergency Hospital Quality Reporting Program, as well as on topics of interest for the REHQR Program for future rulemaking, including rural emergency department services, rural behavioral and mental health, rural maternal health, rural telehealth services, and health equity.

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs

Significant and persistent inequities in healthcare outcomes exist in the United States. Belonging to a racial or ethnic minority group; being a member of a religious minority; living with a disability; being a member of lesbian, gay, bisexual, transgender, and queer (LGBTQIA+) community; living in a rural or other underserved area; or being near or below the poverty level is often associated with worse health outcomes.

One approach under consideration for reducing inequity across our programs is the expansion of efforts to report quality measure results stratified by patient social risk factors and demographic variables. The Request for Information (RFI) included in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28479), titled “Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs,” described key considerations that we might take into account across all CMS quality programs, including the Hospital OQR, ASCQR, and REHQR Programs, when advancing the use of measure stratification to address healthcare disparities and advance health equity across our programs.

In the CY 2023 OPPI/ASC proposed rule, we asked that readers review the full RFI in the FY 2023 IPPS/LTCH PPS proposed rule for full details on these considerations. CY 2023 OPPI/ASC

Overall Hospital Quality Star Ratings

CMS and the nation's hospitals work collaboratively to publicly report hospital quality performance information on the Care Compare website located at www.medicare.gov/care-compare/ and the Provider Data Catalog on data.cms.gov.

Care Compare displays hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. The Overall Hospital Quality Star Rating was first introduced and reported on our Hospital Compare website in July 2016 (now reported on its successor website at <https://www.medicare.gov/care-compare> and has been refreshed multiple times, with the most recent refresh occurring in July 2022. The overarching goal of the Overall Hospital Quality Star Rating (Overall Star Rating) is to improve the usability and interpretability of information posted on Care Compare, a website designed for consumers to use along with their healthcare provider to make decisions on where to receive care. CMS developed this methodology with the input of a broad array of stakeholders to summarize the results of many measures currently publicly reported. The Overall Star Rating provides consumers with a simple overall rating generated by combining multiple dimensions of quality into a single summary score.

CMS is finalizing a change to § 412.190(c) to use publicly available measure results on Hospital Compare or its successor websites from a quarter from within the previous twelve months (instead of the "previous year").

Protecting Taxpayer Dollars

CMS continues to focus on reducing unnecessary increases in the volume of covered outpatient department (OPD) services by requiring prior authorization for certain hospital outpatient department services. In the CY 2023 OPPS/ASC final rule with comment period, CMS is adding Facet Joint Interventions to the list of services that require prior authorization. CMS believes prior authorization can be an effective mechanism to ensure Medicare beneficiaries receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in volume, by virtue of improper payments, without adding new documentation requirements for providers. In response to the comments received, we are changing the implementation date for prior authorization for the Facet Joint Interventions service category from March 1, 2023 to July 1, 2023.

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