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2022 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule

OVERVIEW

On July 19th, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule regarding the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2022, including proposals regarding:

- Hospital OPPS payment, including maintaining current 340B drug payment levels and reverting the Inpatient Only (IOP) list;
- ASC payment, including reverting the ASC Covered Procedures List (CPL);
- Hospital price transparency requirements;
- Minor changes to the Quality Reporting Program;
- A request for information on the definition of Rural Emergency Hospitals;
- A request for comment on the continuation of COVID-19 policies; and
- Changes to the Radiation Oncology model.

This document summarizes several major provisions of the proposed rule, which is available here. CMS will accept comments on the proposed rule until September 17th. The final rule with comment period will be released in early November.

OPPS PAYMENT UPDATE

CMS proposes an overall OPPS rate increase of 2.3 percent. This increase is based on the proposed 2.5 percent hospital inpatient market basket increase for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by the proposed multifactor productivity (MFP) adjustment of 0.2 percentage point. Based on these proposed changes, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) in CY 2022 would be approximately $82.704 billion, which is an increase of approximately $10.757 billion compared to estimated CY 2021 OPPS payments.

CMS proposes to use CY 2019 data to set CY 2022 OPPS and ASC payment rates. CMS notes it would normally use the most updated claims and cost report data available to set payment rates, which would be from CY 2020. However, because the COVID-19 Public Health Emergency (PHE) significantly affected outpatient service utilization, CMS has determined that CY 2019 data would better approximate expected CY 2022 outpatient service utilization.

Other proposed payment policy changes include, but are not limited to:

- *Cancer Hospital Payment Adjustment* – CMS proposes to continue to provide additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for other OPPS hospitals using the most recently submitted or settled cost report data. However, as required by the 21st Century Cures Act, the weighted average PCR will be reduced by 1.0 percentage point. A proposed

PCR target of 0.89 will be used to determine the CY 2022 cancer hospital payment adjustment to be paid at cost report settlement.

- *Rural Adjustment* – CMS proposes to continue the 7.1 percent adjustment to OPPS payments for certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs).
- *Partial Hospitalization Program (PHP) Per Diem Rates* – CMS proposes to continue to use the current Community Mental Health Center (CMHC) and hospital-based PHP geometric mean per diem costs, using updated data for each provider type and a cost floor that would maintain the per diem costs finalized in CY 2021. CMS proposes to use CY 2019 claims and cost report data for each provider type.
- *Inpatient-only (IPO) List* – In CY 2021, CMS finalized a policy to eliminate the IPO list over the course of three calendar years, starting with the removal of approximately 300 musculoskeletal-related services in 2021. In response to stakeholder comments regarding patient safety concerns, CMS is now proposing to halt the elimination of the IPO list and, after clinical review of each removed service, add the services removed from the IPO list in CY 2021 back to the IPO list beginning in CY 2022. CMS further proposes to codify the existing criteria for removal of procedures.
- *2-Midnight Rule* – In CY 2021, CMS finalized a policy under which procedures removed from the IPO list beginning January 1, 2021 would be indefinitely exempted from certain medical review activities related to the 2-midnight policy. CMS now proposes to return to the exemption period that was previously in effect (e.g., two years) so that all services paid under the OPPS are eventually subject to medical review.

Payment for 340B Drugs

CMS proposes to maintain the payment rate of average sales price (ASP) minus 22.5 percent, enacted under the Trump Administration, for drugs and biologicals acquired through the 340B Drug Pricing Program. CMS proposes that rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals be exempted from this policy and continue to be paid ASP with a 6 percent add-on.

ASC PAYMENT UPDATE

CMS is proposing to increase payment rates under the ASC payment system by 2.3 percent for ASCs that meet the Ambulatory Surgical Center Quality Reporting (ASCQR) requirements. This proposed increase is based on a proposed hospital market basket of 2.5 percent, reduced by a proposed 0.2 percentage point adjustment for MFP. CMS estimates that these changes would lead to approximately $5.16 billion in total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) in CY 2022, a decrease of approximately $20 million compared to estimated CY 2021 payments.

As described above, CMS proposes to use CY 2019 data to set CY 2022 ASC payment rates due to the effect of the COVID-19 PHE on outpatient utilization in 2020.

CMS also proposes to re-adopt the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020 and to remove 258 of the 267 procedures that were added to the ASC CPL in CY 2021 (See Table 45 of the proposed rule for a list of procedures proposed for removal). CMS requests comments on whether any of the 258 procedures meet the CY 2020 criteria. CMS also proposes to change the

notification process adopted in CY 2021 to a nomination process, by which stakeholders could nominate procedures they believe meet ASC CPL requirements.

The SUPPORT Act requires the Secretary to review payments for opioids and evidence-based non-opioid alternatives for pain management to ensure there are not financial incentives to use opioids rather than non-opioid alternatives. For CY 2022, CMS proposes to modify its current policy in order to provide for separate or modified payment for non-opioid pain management dugs and biologicals that function as supplies in the ASC setting when those products are FDA-approved and indicated for pain management or as an analgesic, and with a per-day cost above the OPPS/ASC drug packaging threshold

PRICE TRANSPARENCY OF HOSPITAL STANDARD CHARGES

CMS proposes several modifications to existing hospital price transparency regulations to increase compliance and reduce hospital burden. These include:

- *Increasing Civil Monetary Penalties (CMP):* CMS proposes to retain the current penalty for smaller hospitals with a bed count of 30 or fewer ($300/day or $109,500 per calendar year) but apply an additional penalty of $10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily penalty amount of $5,500. Under this proposal, the maximum annual penalty would be $2,007,500 per hospital. CMS seeks comment on additional or alternative criteria that could be used to scale a CMP.
- *Deeming State Forensic Hospitals as Having Met Requirements:* CMS proposes to deem state forensic hospitals as having met price transparency requirements so long as such facilities provide treatment exclusively to those in custody.
- *Prohibiting Barriers to Access to Machine-Readable File:* CMS proposes to update the list of activities that present barriers to access to a machine-readable file to require that such file is accessible to automated searches and direct downloads.
- *Clarifications and Comment Requests:* CMS clarifies that if a hospital chooses to use an online price estimator tool in lieu of posting its standard charges for 300 shoppable services, the output of such tool must provide a cost estimate to an individual that takes into account the individual's insurance information. CMS seeks public input on a variety of issues it may consider in future rulemaking.

QUALITY REPORTING PROGRAM CHANGES

Overall Hospital Quality Star Rating

In the CY 2021 final rule, CMS finalized a methodology for calculating the Overall Star Rating. CMS is not proposing any changes to this policy for CY 2022.

Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR)

CMS proposes to continue to implement the 2 percentage point reduction in payments for hospitals that fail to meet the Hospital OQR requirements. ASCs will also continue to receive a 2 percentage point reduction if they fail to meet quality reporting requirements.

In the Hospital OQR, CMS proposes to:

1. Adopt three new measures, including a measure on COVID-19 Vaccination of Health Care Personnel;
2. Make the reporting of two voluntary or suspended measures mandatory;
3. Remove two measures; and
4. Update the program's validation policies to reduce provider burden and improve processes.

Page 16 of the rule contains a more detailed overview of these changes.

In the ASC Quality Reporting (ASCQR) Program, CMS proposes to:

1. Adopt one new measure on COVID-19 Vaccination of Health Care Personnel; and
2. Make the reporting of six voluntary or suspended measures mandatory.

Page 17 of the proposed rule contains an overview of these measures.

CMS seeks comment on ideas to revise both programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. CMS also seeks comment on future plans to modernize its quality measurement enterprise.

RFI: RURAL EMERGENCY HOSPITAL (REH) DESIGNATION

The 2020 year-end omnibus bill, the Consolidated Appropriations Act of 2021 (CAA), established a new provider type, Rural Emergency Hospitals (REHs), effective January 1, 2023. The statute defines REHs as facilities that convert from either a critical access hospital or a rural hospital with less than 50 beds and that do not provide acute care inpatient services, with the exception of skilled nursing facility services furnished in a distinct unit.

In the proposed rule, CMS includes a Request for Information (RFI) on a range of issues that should be considered in establishing this new provider type, such as health and safety standards, payment policies, and quality measures.

REQUEST FOR COMMENTS: COVID-19 POLICIES

CMS requests comment on the extent to which stakeholders utilized flexibilities CMS provided via emergency rulemaking during the COVID-19 PHE and whether stakeholders believe certain policies should be made permanent. Specifically, CMS seeks comment on policies related to:

- Mental health services furnished to beneficiaries in their homes via telehealth;
- Shifting practice patterns that rely on technology to provide mental health services to beneficiaries in their homes;
- The use of audio/visual real-time communications technology to provide direct physician supervision for pulmonary, cardiac, and intensive cardiac rehabilitation services; and
- Whether CMS should keep the HCPCS code C9803 (Hospital outpatient clinic visit specimen collection for SARS-COV2) active beyond the PHE.

RADIATION ONCOLOGY MODEL

CMS proposes several changes to the Radiation Oncology model timing and design, partially in response to the Consolidation Appropriations Act which delayed the model until January 1, 2022, at the earliest. Proposed changes include:

- Changing the model's start date to January 1, 2022, with a 5-year performance period;

- Changing the baseline period to 2017 – 2019 (from 2016 – 2018);
- Lowering the discounts to 3.5% (professional component) and 4.5% (technical component). These amounts were previously lowered from the originally proposed 4% and 5%, respectively, to 3.75% and 4.75%, by the Trump Administration;
- Removing brachytherapy from the included modality list, so that it would still be paid under FFS, revising the cancer inclusion criteria, and removing liver cancer from the model;
- Changing the process for assignment of episodes when a beneficiary switches from traditional Medicare to Medicare Advantage;
- Adopting an extreme and uncontrollable circumstances policy; and,
- Excluding hospital outpatient departments from participating in the Community Transformation track of the CHART model from participating in the Radiation Oncology model.