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CY 2023 Medicare OPPS/ASC Proposed Rule Brings Minimal Rate Increase and Other Changes

The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2023 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule. Industry groups are once again expressing concern that the minimal rate increase does not keep pace with rising costs in today's inflationary environment. In addition to the rate change, the proposed rule also includes proposals relating to the new Rural Emergency Hospital (REH) model, as well as the 340B Drug Pricing Program. This article recaps significant provisions of the proposed rule.

Payment Rate

The proposed rule includes an increase of just 2.7% for both the OPPS and ASC payment rates, based on a market basket increase of 4.1% reduced by 0.4 percentage point as a result of the productivity adjustment. The payment rate would be reduced by 2% for hospitals that fail to comply with applicable outpatient quality reporting (OQR) requirements. Accordingly, the conversion factor for 2023 would be $86.7855, or $85.093 for hospitals that fail to meet OQR requirements. CMS estimates that the rate increases will result in an aggregate payment increase of $6.2 billion from estimated 2022 OPPS payments, and an increase of $130 million for ASC payments.

Sequestration Impact

It should be noted that the payment rates reflected in the OPPS/ASC proposed rule are prior to any reduction for sequestration. A 2% Medicare sequestration cut stems from a 2011 law that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Under this law, Medicare cuts cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share. Subsequent legislation suspended the application of sequestration to Medicare from May 1, 2020 through December 31, 2021, to provide relief to providers during the COVID-19 pandemic. Later legislation further delayed sequestration and invoked a phased-in return during 2022. For 2023, the full 2% sequestration will be in force.

In addition to sequestration, the Statutory Pay-As-You-Go Act ("PAYGO") was enacted in 2010 and requires spending cuts across the federal government if legislation enacted in a year results in a deficit increase. Medicare cuts resulting from this law cannot exceed 4%. To date, PAYGO has been waived by Congress to avoid cuts going into effect, but it is currently set to resume effective January 1, 2023.

OPPS and ASC services provided to Medicare beneficiaries in 2023 will be subject to both the 2% sequestration and 4% PAYGO cuts. Therefore, even with a proposed 2.7% rate increase, the actual reimbursement will be a reduction from pay rates in effect for 2022 unless Congress intervenes.

Changes to IPO & ASC Covered Procedures Lists

CMS proposes to remove ten services form the inpatient only (IPO) list after determining that they meet the following criteria:

1. Most outpatient departments are equipped to provide the services to Medicare patients;
2. The simplest procedure described by the code may be furnished in most outpatient departments;
3. The procedure is related to codes that have

already been removed from the IPO list;

4. The procedure is being furnished in numerous hospitals on an outpatient basis; and
5. The procedure can be appropriately and safely furnished in an ASC and is either included or proposed to be added to the ASC list.

In addition, eight new services that were created by the American Medical Association (AMA) CPT Editorial Panel for CY 2023 were added to the IPO list.

CMS also proposes to designate six surgical procedures as permanently office-based, as they are commonly (more than 50% of the time) performed in physicians' offices and are a level of complexity that makes them appropriate for an office setting.

CMS only identified one procedure that it is proposing to add to the ASC Covered Procedures List (CPL) after determining it can be safely and appropriately performed in an ASC without significant risk to Medicare patients.

Rural Emergency Hospitals

In responses to the number of rural hospitals and critical access hospitals that have closed in recent years, Congress established a new Medicare provider type in the Consolidated Appropriations Act, 2021 (CAA), to be effective beginning January 1, 2023. Generally, a critical access hospital or rural hospital can enroll as an REH if it has fewer than 50 beds and does not provide acute care inpatient services, except for extended care services provided in a distinct part unit licensed as a skilled nursing facility (SNF), has a transfer agreement in place with a Level I or II trauma center, and meets certain other requirements. According to the legislation, REH facilities can provide emergency department services, observation care, and other outpatient medical and health services. To qualify as an REH, the facility must have a staffed emergency department 24/7.

REH Payment Rate

The CAA stipulated that payment for REH services will include a 5% increase over the payment amount that would have been in effect for similar services provided by a facility without the REH designation. Accordingly, the proposed rule calls for a 5% increase to the OPPS payment rate for covered outpatient services provided by an REH. However, the additional 5% would not be subject to a copayment. In other words, the beneficiary's copayment amount would be determined based on the normal OPPS payment rate rather than the REH rate. Other outpatient services provided by REHs that would not otherwise be paid under OPPS, such as services normally paid under the Clinical Lab Fee Schedule, would not be considered REH services and would therefore be paid under the applicable fee schedule and not subject to the 5% fee increase.

REH Facility Payment

In addition to the increased payment rate, the CAA also established that REH facilities would receive a monthly facility payment. Accordingly, the proposed rule includes a monthly facility payment in the amount of $268,294. This would equate to an annual facility payment of $3,219,528.

REH Enrollment

The proposed rule details the process providers and suppliers must follow to enroll as an REH. Importantly, critical access hospitals may submit a change of information application (Form CMS-855A) rather than an initial application to convert to an REH, which should expedite the process.

REH Stark Law Provisions

In the proposed rule, CMS expresses concern that "the physician self-referral law could inhibit access to medically necessary designated health services furnished by REHs that are owned or invested in by physicians … and thwart the underlying goal … to safeguard or expand such access." Accordingly, the proposed rule establishes an REH exception to the physician self-referral law, commonly known as the "Stark Law." The proposal includes a new exception for ownership or investment interests in an REH as well as changes to existing exceptions within the Stark Law that would make them applicable to compensation arrangements involving an REH.

340B Drug Program

In 2018, CMS changed its methodology for determining payments for outpatient drugs acquired through the 340B program, which allows participating hospitals to acquire drugs at discounted prices. The change in methodology resulted in a significant decrease in payments to hospitals. As a result, the program has been the subject of litigation the last few years. On June 15, 2022, the Supreme Court ruled that the payment rates paid by CMS in 2018 and 2019 were inappropriate, as the Department of Health and Human Services (HHS) did not have the authority to vary payment rates among groups of hospitals without a survey of the hospitals' acquisition costs. A survey was not conducted until 2020. Accordingly, CMS must determine how to make hospitals whole for the pay cuts they experienced in 2018 and 2019, which were

around $1.6 billion annually in aggregate.

The CY 2023 OPPS/ASC proposed rule notes that "while the Supreme Court's decision concerned payment rates for CYs 2018 and 2019, it obviously has implications for CY 2023 payment rates. However, given the timing of the Supreme Court's decision, we lacked the necessary time to incorporate the adjustments to the proposed payment rates and budget neutrality calculations to account for that decision before issuing this proposed rule…" Instead, the proposed rule continues the current payment rate of average sales price (ASP) minus 22.5% for drugs acquired through the 340B program. However, it further states that "we fully anticipate applying a rate of ASP+6 percent to such drugs and biologicals in the final rule for CY 2023, in light of the Supreme Court's recent decision." Further, "we are still evaluating how to apply the Supreme Court's decision to prior cost years."

Other Provisions

Remote Behavioral Health Services

CMS proposes to allow remote behavioral health services provided by clinical staff of hospital outpatient departments to Medicare patients in their homes to be considered as covered services payable under the OPPS. This extends a policy that has been in place in connection with the COVID-19 public health emergency (PHE), but would otherwise expire when the PHE ends. However, the proposed rule requires that the patient received an in-person service within six months of the first remote behavioral health service, and within 12 months of each remote behavioral health service provided. This requirement may be waived in certain circumstances. The proposed rule also allows audio-only communication when patients are unable or unwilling to use audio/visual technology.

N95 Respirators

The proposed rule includes a provision that would incentivize facilities to acquire surgical N95 respirator masks from domestic manufacturers. CMS is proposing to apply payment adjustments that would offset the marginal cost of procuring the masks domestically, to reduce reliance on foreign sources. Payments would be made on a bi-weekly basis and reconciled in the cost report.

What's Next?

CMS will be receiving comments on the proposed rule through September 13, and a final rule is expected to be released in early November. Clearly, the final rule will include some changes from the proposal, most notably in connection with the 340B program. Meanwhile, industry groups are expected to continue applying pressure to both CMS and Congress, maintaining that the proposed payment rates and mandated sequestration and PAYGO cuts will result in insufficient funding to support operations and will inhibit Medicare beneficiaries' access to care. However, Congress already has issues it must address prior to the August recess, including a continuing resolution to keep the government running after September 30, and relatively few legislative days to accomplish those tasks. Accordingly, even if they decide to take up this issue it likely won't happen until after the mid-term elections in November. This leaves healthcare facilities in the unfortunate position of planning for 2023 without knowing what, if any, relief may be provided.

JTaylor's healthcare consulting team includes experienced professionals who focus on strategy and operations for all types of providers. If you are interested in finding out how the CY 2023 OPPS/ASC Proposed Rule would impact reimbursement for your facility, we can help. Our team can also support you from a strategic perspective as you determine how to respond to the upcoming changes in Medicare reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Fact Sheet: CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule
- CY 2023 OPPS/ASC Payment System proposed rule