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CY 2023 Hospital OPPS & ASC Payment System Final Rule: Key Provisions

The Centers for Medicare and Medicaid Services (CMS) issued the Calendar Year (CY) 2023 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule on November 1. Though industry groups were pleased that the payment rates will be higher than what was reflected in the proposed rule, they remain concerned that the increase does not keep pace with rising costs in today's inflationary environment. In addition to the rate change, the final rule also implements provisions relating to the new Rural Emergency Hospital (REH) model, as well as updates to the 340B Drug Pricing Program. This article recaps significant provisions of the final rule.

Payment Rate

The final rule includes an increase of 3.8% for both the OPPS and ASC payment rates, which is an improvement over the 2.7% increase reflected in the proposed rule. This rate is based on a market basket increase of 4.1% reduced by 0.3 percentage point as a result of the productivity adjustment. The payment rate will be reduced by 2% for hospitals that fail to comply with applicable outpatient quality reporting (OQR) requirements. Accordingly, the OPPS conversion factor for 2023 is $85.585 (or $83.934 for hospitals that fail to meet OQR requirements), and the ASC conversion factor is $50.855. CMS estimates that the rate increases and other budget neutrality adjustments will result in an aggregate payment increase of $6.5 billion from 2022 OPPS payments, and an increase of $230 million from 2022 ASC payments.

As a result of the OPPS rate increase and other budget neutrality adjustments, CMS estimates that urban hospitals will see an increase in payments of around 5.3% while rural hospitals will experience a 2.7% increase. Nonteaching hospitals are expected to yield a 3.4% increase, while minor teaching hospitals and major teaching hospitals are anticipated to experience 4.6% and 7.2% increases, respectively.

Surgical specialties will experience different levels of payment increases as a result of the ASC provisions in the final rule. CMS estimates 2023 payments to increase from 2022 levels as noted below:

Surgical Specialty	Estimated Payment Increase
Musculoskeletal	7%
Gastrointestinal	5%
Nervous System	4%
Genitourinary	4%
Eye	3%
Cardiovascular	2%

Derived from Table 111 in the CY 2023 Medicare Hospital OPPS and ASC Payment System Final Rule.

Sequestration Impact

It should be noted that the payment rates reflected in the OPPS/ASC final 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 the 3.8% rate increase reflected in the final rule, 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 removed eleven services from 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.

This included nine services that were included in the proposed rule, as well as two additional services that were addressed in the final rule (CPT codes 47550 and 21255). CMS reversed its decision on one of the services that it had proposed to remove from the IPO list (CPT code 16036), after determining that it would typically be performed in the inpatient setting.

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, consistent with the proposed rule.

CMS also finalized its proposal 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.

In addition to the one procedure (CPT code 38531) CMS had originally proposed to add to the ASC Covered Procedures List (CPL), the final rule adds three more procedures (CPT codes 19307, 37193, and 43774) to the CPL after determining they can be safely and appropriately performed in an ASC without significant risk to Medicare patients. The rule states that these four codes correspond to procedures that have few to no inpatient admissions and are largely performed in outpatient settings. An additional sixty codes were recommended by commenters, but CMS declined to add them to the CPL due to patient safety concerns.[i]

Rural Emergency Hospitals

In response 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 must provide emergency department services and observation care, and may also elect to provide other outpatient medical and health services. To qualify as an REH, the facility must have a staffed emergency department 24/7 and meet applicable staffing requirements similar to critical access hospitals.

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 final rule calls for a 5% increase to the OPPS payment rate for covered outpatient

services provided by an REH. However, the additional 5% is not subject to a copayment. In other words, the beneficiary's copayment amount will 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 final rule includes a monthly facility payment in the amount of $272,866, which will increase in subsequent years by the hospital market basket percentage increase. This equates to an annual facility payment of $3,274,392. This amount is slightly higher than the payment amount reflected in the proposed rule due to a correction in one of the underlying assumptions.

REH Enrollment

The final 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. This is consistent with the provisions outlined in the proposed rule.

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 established an REH exception to the physician self-referral law, commonly known as the "Stark Law," for ownership or investment interests in an REH. However, CMS did not finalize this proposal out of concern that it may present a risk of patient or program abuse, potentially leading to "cherry-picking and lemon-dropping" and other harms.

The proposal also included changes to existing exceptions within the Stark Law that would make them applicable to compensation arrangements involving an REH. In the final rule, CMS did implement these changes, noting that a properly structured compensation arrangement between an REH and a physician (or immediate family member) would not post a risk of program or patient abuse.

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 for 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.[ii]

In light of the Supreme Court ruling, the CY 2023 OPPS/ASC final rule applied the default rate of average sales price (ASP) plus 6% to drugs and biologicals for participants of the 340B program. However, the final rule did not address how CMS will remedy the underpayment from prior years.

Other Provisions

Remote Behavioral Health Services

CMS finalized its proposal 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 rule requires that the patient receive an in-person service within six months prior to the initiation of the remote service and every 12 months thereafter. This requirement may be waived in certain circumstances, and the 6-month requirement does not apply to beneficiaries who began receiving mental health telehealth services during the PHE or during the 151-day period following expiration of the PHE. The final rule also allows audio-only communication when patients are unable or unwilling to use audio/visual technology.

N95 Respirators

The final rule includes a provision that would

incentivize facilities to acquire surgical N95 respirator masks from domestic manufacturers. CMS will apply payment adjustments that would offset the marginal cost of procuring the masks domestically, to reduce reliance on foreign sources. Payments will be made on a bi-weekly basis and reconciled in the cost report. Payment adjustments will be applied for cost reporting periods beginning on or after January 1, 2023.

What's Next?

Industry groups are continuing to apply pressure to both CMS and Congress, maintaining that the payment rates combined with mandated sequestration and PAYGO cuts will result in insufficient funding to support operations and will inhibit Medicare beneficiaries' access to care.

In addition, the American Hospital Association (AHA) and other hospital advocacy organizations are pushing for CMS to rectify the underpayments hospitals received from 2018 to 2022 as a result of the 340B payment methodology that the Supreme Court ruled was inappropriate. On September 28, a federal judge vacated the 340B drug reimbursement rate in the 2022 OPPS Final Rule with respect to proactive application. In response, CMS announced on October 13 that it would revert to paying the statutory rate of ASP plus 6% for the remainder of 2022, and reprocess claims on or after September 28, 2022, that were paid at the lower rate.[iii] However, to date there has been no action pertaining to claims processed in prior years. The final rule notes that "in the CY 2023 OPPS/ASC proposed rule, we solicited public comments on the best way to craft any potential remedies affecting cost years 2018-2022, and we will take these comments into consideration for separate rulemaking that will be published in advance of the CY 2024 OPPS/ASC proposed rule." AHA contends that "no further public comments are needed for the agency to remediate years of illegal underpayments and … to promptly pay hospitals the difference between ASP plus 6% and what they were previously paid, without seeking retroactive claw backs in the name of budget neutrality."[iv]

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 Final Rule may 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 Final Rule with Comment Period
- Fact Sheet: CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule: Rural Emergency Hospitals – New Medicare Provider Type
- CY 2023 OPPS/ASC Payment System final rule

[i] The CPT/HCPCS Codes recommended by commenters to be added to the CPL are listed in Table 81 of the *CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule.*
[ii] *American Hospital Assn.* v. *Becerra,* 596 U. S. ___ (2022)
[iii] King & Spalding. (2022, November 1). *CMS Begins Reprocessing Payment to 340B Hospitals Following Federal Court Ruling.* https://www.jdsupra.com/legalnews/cms-begins-reprocessing-payment-to-340b-2639817/
[iv] American Hospital Association. (2022, November 2). *AHA asks court to order HHS to promptly repay 340B hospitals for past unlawful cuts.* https://www.aha.org/news/headline/2022-11-04-aha-asks-court-order-hhs-promptly-repay-340b-hospitals-past-unlawful-cuts