



Fact sheet

CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC)

Nov 02, 2021 Ambulatory surgical centers, Billing & payments, Hospitals

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services. In addition to updating the payment rates, the Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Final 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 will also further 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 to close the health equity gap.

As with these 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- 1753-FC), which can be downloaded at: <https://www.federalregister.gov/public-inspection/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

Price Transparency of Hospital Standard Charges

CMS is committed to ensuring consumers have the information they need to make fully informed decisions regarding their health care. Hospital price transparency helps people know what a hospital charges for the items and services it provides. CMS expects hospitals to comply with these requirements, and is enforcing these rules to ensure people know what a hospital charges for items and services.

In this final rule, CMS is making modifications to the hospital price transparency regulation designed to increase compliance, after CMS's initial analysis strongly suggests there is sub-optimal compliance beginning January 1, 2022, including the following:

Increase in Civil Monetary Penalties (CMP): CMS is setting a minimum CMP of \$300/day that will apply to smaller hospitals with a bed count of 30 or fewer, and a penalty of \$10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of \$5,500. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be \$109,500 per hospital, and the maximum total penalty amount would be \$2,007,500 per hospital. This approach to scaling the CMP amount retains the current penalty amount for small hospitals, increases the penalty amount for larger hospitals, and affirms the Administration's commitment to enforcement and public access to pricing information.

Deeming State Forensic Hospitals as Having Met Requirements: CMS is modifying the hospital price transparency regulation's deeming policy to include state forensic hospitals as having met the requirements, so long as such facilities provide treatment exclusively to individuals who are in the custody of penal authorities and do not offer services to the general public.

Prohibiting Additional Specific Barriers to Access to the Machine-Readable File: CMS is updating the regulation's prohibition of certain activities that present barriers to access to the machine-readable file, specifically requiring that the machine-readable file be accessible to automated searches and direct downloads.

Updates to OPPS and ASC payment rates

In accordance with the Medicare statute, CMS is updating the CY 2022 OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.0 percent. This update is based on the projected hospital market basket increase of 2.7 percent reduced by 0.7 percentage point for the productivity adjustment.

In the CY 2019 OPPS/ASC final rule with comment period, CMS finalized a proposal to apply the hospital market basket update to ASC payment system rates for an interim period of five years (CY 2019 through CY 2023). Using the final productivity-adjusted hospital market basket update, CMS is updating the ASC payment rates for CY 2022 by 2.0 percent for ASCs that meet applicable quality reporting requirements.

Use of CY 2019 Claims Data for CY 2022 OPPS and ASC Payment System Ratesetting Due to the PHE

For the OPPS and ASC rate setting process, the best available data is used so that the payment rates can accurately reflect estimates of the costs associated with furnishing outpatient services. Ordinarily, the best available claims data is the most recent set of data, which would be from two years prior to the calendar year that is the subject of rulemaking. However, due to a number of COVID-19 PHE-related factors, CMS believes that the CY 2020 data are not the best overall approximation of expected outpatient hospital services in CY 2022. Instead, CMS believes the CY 2019 data, as the most recent complete calendar year of data prior to the COVID-19 PHE, are generally a better approximation of expected costs for CY 2022 hospital outpatient services for rate setting purposes. As a result, CMS is generally using CY 2019 claims data to set the CY 2022 OPPS and ASC payment system rates.

Changes to the Inpatient Only List

Since the beginning of the OPPS, CMS has maintained the Inpatient Only (IPO) list, which is a list of services that, due to their medical complexity, Medicare will only pay for when performed in the inpatient setting. In the CY 2021 OPPS/ASC final rule, CMS finalized a policy to eliminate the IPO list over a three-year period, removing 298 services from the IPO list in the first phase of the elimination. CMS received a large number of stakeholder comments throughout the CY 2021 rulemaking cycle and following issuance of the final rule with comment period that opposed the elimination of the IPO list primarily due to patient safety concerns, stating that the IPO list serves as an important programmatic safeguard.

CMS is finalizing its proposal to halt the elimination of the IPO list and add back to the IPO list the services removed in 2021, except for CPT codes 22630 (Lumbar spine fusion), 23472 (Reconstruct shoulder joint), 27702 (Reconstruct ankle joint) and their corresponding anesthesia codes. This change in policy promotes transparency and ensures that any service removed from the IPO list has been reviewed against Medicare's longstanding IPO list criteria to determine if it is appropriate for Medicare to pay for the provision of the service in the outpatient setting.

Two-Midnight Rule Medical Review Activities Exemptions

In the CY 2021 OPPS/ASC final rule, CMS established a policy in which procedures removed from the IPO list beginning January 1, 2021 would be indefinitely exempted from certain medical review activities related to the two-midnight policy. This policy change was made to accommodate the unprecedented number of procedures being removed from the IPO list beginning in CY 2021 due to the elimination of the IPO list. For CY 2022, because CMS is finalizing the proposal to halt the elimination of the IPO list and to return the majority of services removed in CY 2021 back to the list, CMS is also finalizing the proposal to revise the exemption for procedures removed on or after January 1, 2021 from the IPO list to the

exemption period that was previously in effect, that is, a two year period).

Changes to the ASC Covered Procedures List

In the CY 2021 OPPTS/ASC final rule, CMS revised the long-standing safety criteria that were historically used to add covered surgical procedures to the ASC Covered Procedures List (ASC CPL) and adopted a notification process for surgical procedures the public believes can be added to the ASC CPL under the criteria we retained. Using these revised criteria, CMS added 267 surgical procedures to the ASC CPL beginning in CY 2021.

For CY 2022, CMS is reinstating the criteria for adding procedures to the ASC CPL that were in place in CY 2020. In the CY 2022 OPPTS/ASC proposed rule, CMS requested comment on whether any of the 258 procedures proposed for removal from the ASC CPL met the proposed reinstated criteria. CMS received 140 procedure recommendations, including new procedures and procedures that were already on the CPL and not proposed for removal. Based upon review of these procedure recommendations, CMS is keeping six procedures, three that were already on the ASC CPL and three that were proposed for removal, and removing of 255 of the 258 procedures proposed for removal. The three codes that were proposed for removal and are being retained are CPT codes 0499T, 54650, and 60512.

CMS is also finalizing the adoption of a nomination process, which will begin in March 2022, to allow an external party to nominate a surgical procedure to be added to the ASC CPL. If CMS determines that a surgical procedure meets the requirements to be added to the ASC CPL, including a surgical procedure nominated by an external party, it would propose to add the surgical procedure to the ASC CPL for January 1, 2023.

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 OPPTS/ASC final rule, CMS reexamined the appropriateness of paying the Average Sale Price (ASP) plus 6 percent for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, Medicare adopted a policy to pay an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals acquired through the 340B Program.

In this rule, for CY 2022, we are finalizing our proposal to continue the payment rate of ASP minus 22.5 percent for certain separately payable drugs or biologicals acquired through the 340B Program. Under the final rule, rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals would continue to be excepted from this policy.

Payment for Non-Opioid Pain Management Drugs and Biologicals 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 of the SUPPORT Act, requires that the Secretary review payments under the OPPS and ASC for opioids and evidence-based non-opioid alternatives for pain management to ensure there are not financial incentives to use opioids instead of non-opioid alternatives. For CY 2022, CMS is modifying its current policy to provide for separate payment for non-opioid pain management drugs and biologicals that function as surgical supplies in the ASC setting when those products meet certain criteria finalized in this rule.

CMS is finalizing its proposal that beginning January 1, 2022, a non-opioid pain management drug or biological that functions as a surgical supply in the ASC setting would be eligible for separate payment when such product is FDA approved, FDA indicated for pain management or as an analgesic, and has a per-day cost above the OPPS drug packaging threshold.

OPPS Transitional Payment for Drug and Biological Pass-Through and Transitional Payment for Device Pass-Through

For CY 2022, CMS received eight applications for device pass-through payments. One of these applications received preliminary approval for pass-through payment status through the quarterly review process. CMS solicited public comment on all eight of these applications in the CY 2022 OPPS/ASC proposed rule and is approving three devices for pass-through status in this final rule:

In addition, CMS will continue pass-through payment status in CY 2022 for 46 drugs and biologicals. This includes 27 drugs and biologicals that CMS is using the equitable adjustment authority under section 1833(t)(2)(E), since CY 2019 rather than CY 2020 claims data is used to inform CY 2022 ratesetting, to provide up to four quarters of separate payment whose pass-through payment status will expire between December 31, 2021 and September 30, 2022.

Partial Hospitalization Program

Partial Hospitalization Program (PHP) Rate Setting

The CY 2022 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 a structured intensive outpatient program 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 unified rate structure, with a single PHP Ambulatory Payment Classification (APC) for each provider type for days with three or more services per day. In order to maintain consistency with OPPS, for this CY 2022 ratesetting, CMS is finalizing its proposal to use CY 2019 claims and the cost information from prior to the COVID-19 PHE, that is, the cost information that was available for the CY 2021 OPPS/ASC rulemaking. CMS believes this is appropriate and necessary for PHP services because of the substantial decrease in the number of PHP days in the CY 2020 claims dataset, which we would normally use for ratesetting.

Radiation Oncology Model

The Radiation Oncology (RO) Model is designed to test whether making payments to hospital outpatient departments and physician group practices (including freestanding radiation therapy centers) for radiotherapy (RT) services that do not vary based on care setting or how much or what type of care is delivered over time, preserves or enhances the quality of care furnished to Medicare beneficiaries while reducing Medicare spending. The RO Model seeks to align incentives to give radiation oncologists the flexibility to provide high-quality, patient-centered care aligned with the latest evidence-based guidelines, without worrying that providing less care, if applicable, will reduce their payments.

In September 2020, the Center for Medicare and Medicaid Innovation (the Innovation Center) published a final rule that established the Radiation Oncology (RO) Model with a start date of January 1, 2021. As a result of the ongoing COVID-19 PHE, CMS published an interim final rule with comment period (IFC) in the CY 2021 OPPS/ASC Final Rule to delay the start of the RO Model's model performance period until July 1, 2021. Subsequently, the Consolidated Appropriations Act, 2021 included a provision that prohibits implementation of the RO Model prior to January 1, 2022. CMS is finalizing the proposals, as proposed and some with modification, put forth in the CY 2022 OPPS/ASC Payment System proposed rule to address necessary changes as a result of the legislatively mandated delay and additional proposed modifications to the model design.

The CY 2022 OPPS and ASC Payment System final rule includes the following modifications to the RO Model's timing and design:

- The RO Model will begin on January 1, 2022, with a five-year model performance period (ending December 31, 2026);
- The baseline period is 2017-2019 rather than 2016-2018;

- The discounts are 3.5 percent (Professional Component) and 4.5 percent (Technical Component);
- Brachytherapy is not included on the list of included modalities under the RO Model; it will still be paid fee-for-service;
- In cases where a beneficiary switches from traditional Medicare to Medicare Advantage during an episode before treatment is complete, CMS will consider this an incomplete episode and RT services will be paid the traditional Medicare rate instead of being paid under the RO Model;
- The RO Model will include an extreme and uncontrollable circumstances policy. This policy will provide CMS with flexibility to delay the model performance period, reduce the administrative burden of Model participation, including reporting requirements, and adjust the pricing methodology. If and when CMS invokes any of the EUC provisions, we will communicate this decision via the RO Model website and written correspondence to RO participants;
- The RO Model excludes hospital outpatient departments that are participating in the Community Transformation track of the Community Health Access and Rural Transformation (CHART) Model. For the CHART ACO Transformation track, we follow the same policy for overlap between the RO Model and the Medicare Shared Savings Program ACOs;
- Only the hospital outpatient departments that are participating in the Pennsylvania Rural Health Model (PARHM) will be excluded from the RO Model rather than all HOPDs eligible to participate in PARHM;
- Liver cancer will no longer be included in the RO Model as it does not satisfy the model's cancer inclusion criteria;
- There are three tracks related to status under the Quality Payment Program, based on RO participant type and compliance with RO Model requirements. We are finalizing with modification to define a Track Three for the RO Model, where Track One would be the same: it would include those Professional participants and Dual participants who follow all RO requirements, including CEHRT, and that we expect will qualify as an Advanced Alternative Payment Model (APM) and a Merit-Based Incentive Program (MIPS) APM. Track Two would be for those Professional participants and Dual participants who follow all RO requirements except for CEHRT, and that we expect would qualify as a MIPS APM only. Track Three would be for all other RO participants and would not be a MIPS APM or Advanced APM.

For more information on the RO Model, visit: <https://innovation.cms.gov/initiatives/radiation-oncology-model/>

Hospital Outpatient/ASC Quality Reporting Programs

CMS is finalizing proposals to the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) 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. Hospitals that do not meet the program's quality reporting requirements receive a reduction of 2.0 percentage points in their annual payment update. In the CY 2022 OPPTS/ASC final rule, CMS is finalizing proposals to (1) adopt three new measures, including the COVID-19 Vaccination of Health Care Personnel (NQF #0431); (2) make the reporting of two voluntary or suspended measures mandatory; (3) remove two measures; and (4) update the validation policies of the Hospital OQR Program to reduce provider burden and improve processes.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

The ASCQR Program is a pay-for-reporting quality program for the ASC setting. ASCs that do not meet the program's reporting requirements receive a reduction of 2.0 percentage points in their annual fee schedule update. CMS is finalizing proposals to (1) adopt one new measure, the COVID-19 Vaccination of Health Care Personnel (NQF #0431) and (2) to make the reporting of six voluntary or suspended measures mandatory.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare Promoting Interoperability Program

The Hospital IQR Program is a pay-for-reporting quality program. Hospitals that fail to meet all Hospital IQR Program requirements are subject to a one-fourth reduction in their Annual Payment Update under the Inpatient Prospective Payment System (IPPS). The Medicare Promoting Interoperability Program is intended to incentivize the meaningful use of certified electronic health record technology (CEHRT) by eligible hospitals and critical access hospitals (CAHs). By law, eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT and satisfy all Medicare Promoting Interoperability Program requirements are subject to a Medicare payment reduction.

Currently hospitals are required to report (1) three self-selected electronic clinical quality measures (eCQMs), and (2) the Safe Use of Opioids eCQM for the CY 2022 reporting period and subsequent years for the Hospital IQR Program and the Medicare Promoting Interoperability Program.

As CMS considers future reporting on the Safe Use of Opioids eCQM, CMS sought

comments in the CY 2022 OPPS/ASC proposed rule on the appropriateness of maintaining this previously finalized policy or instead proposing in future rulemaking to allow hospitals to self-select the Safe Use of Opioids eCQM from the finalized set of eQMs.

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