Issue Brief

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CMS Issues Proposed Update to the CY 2022 Hospital Outpatient and ASC Prospective Payment Systems

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule that would update policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and in ambulatory surgical centers (ASCs) beginning January 1, 2022 (CY 2022).

This rule would also update Hospital Price Transparency requirements penalties; update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program; and update and refine the design of the Radiation Oncology Model. Finally, this rule includes a Request for Information (RFI) focusing on the health and safety standards, quality measures and reporting requirements, and payment policies for Rural Emergency Hospitals (REHs), a new Medicare provider type.

This document is scheduled to be published in the ***Federal Register*** on August 4. A copy of the 863-page proposal is currently available at: https://public-inspection.federalregister.gov/2021-15496.pdf. A 60-day comment period is provided.

The Addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

The Addenda relating to the ASC payment system are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.

COMMENTS

The proposed changes regarding failure to comply with the hospital price transparency requirements maybe the most controversial item in the proposal.

While a more detailed table of contents would be very helpful, this rulemaking has a reasonable table of contents identifying major headings whereas other recent rules do not. One would expect CMS to be more consistent in its approach of issuing rules. Of course, there are no page numbers.

Again, the rule has much unneeded history that is no longer relevant or helpful.

For example, on page 6 the material says "In the past, a majority of the Addenda referred to in our OPPS/ASC proposed and final rules were published in the ***Federal Register*** as part of the annual

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rulemakings. However, beginning with the CY 2012 OPPS/ASC proposed rule, all of the Addenda no longer appear in the ***Federal Register*** as part of the annual OPPS/ASC proposed and final rules to decrease administrative burden and reduce costs associated with publishing lengthy tables." We commented on the same item last year. Here it is again. In other words, CMS keeps building on previous rule's.

There appears errors in the rule, too. For example, on page 21 the following is stated "Table U1 in section XXIV.B of this proposed rule displays the distributional impact of all the OPPS changes on various groups of hospitals and CMHCs for CY 2021 compared to all estimated OPPS payments in CY 2020. We estimate that the policies in this proposed rule would result in a 1.8 percent overall increase in OPPS payments to providers." There is no table U1 nor a section XXIV.B in this rule.

Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges (Page 731)
CMS is proposing to: (1) increase the amount of the penalties for noncompliance through the use of a proposed scaling factor based on hospital bed count; (2) deem state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180, and (3) "prohibit certain conduct that we have concluded are barriers to accessing the standard charge information. We believe these proposed modifications are responsive to stakeholders and are necessary to ensure compliance with the hospital price transparency disclosure requirements."

Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

Provide a written warning notice to the hospital of the specific violation(s). Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements. Impose a civil monetary penalty (CMP) on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan.

CMS proposes increasing the CMP amount using the number of beds for the noncompliant hospital, as specified on the most recently available, finalized cost report data.

CMS proposes the following approach to scaling the CMP amount based on the hospital's number of beds, and as summarized in the rule's Table 63. (Page 740)

Proposed Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years

Number of beds	Penalty applied per day	Total penalty amount for full calendar year of noncompliance
30 or less beds	$300 per hospital	$109,500 per hospital
31 up to 550 beds	$310 to $5500 per hospital (Number of beds times $10.00)	$113,150-$2,007,500 per Hospital
>550	$5,500 per hospital	$2,007,500 per hospital

CMS is seeking comments on its proposals.

continued

COMMENT

It appears many hospitals are not posting the charge requirements and deferring to accept the penalty. CMS' penalty changes seeks to reverse hospital non-compliance.

I. SUMMARY OF THE MAJOR PROVISIONS (Page 11)

The following items are adapted from the regulation's preamble text. The order of the material is from the rule. Not all items are addressed. There are additional pages with detailed information that are not reflected in the page numbering provided.

Proposed OPPS Update: For CY 2022: (Page 12)
CMS proposes to increase the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.3 percent. This increase is based on the proposed hospital inpatient market basket percentage increase of 2.5 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.2 percentage point. Based on this update, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for calendar year (CY) 2022 would be approximately $82.704 billion, an increase of approximately $10.757 billion compared to estimated CY 2021 OPPS payments.

Further, CMS would continue to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPPS payments and copayments for all applicable services.

COMMENT

CMS' updates may be somewhat misleading because CMS always uses the latest hospital inpatient prospective payment system (IPPS) updates for the OPPS irrespective of what it proposes.

Changes to the Inpatient Only (IPO) List: (Page 13)

CMS is reversing its CY 2021 policy that eliminated the IPO list. CMS now proposes to add the 298 services removed from the IPO list in CY 2021 back to the IPO list beginning in CY 2022. In addition, CMS is soliciting comment on several policy modifications including whether CMS should maintain the longer-term objective of eliminating the IPO list or maintain the IPO list but continue to systematically scale the list back so that inpatient only designations are consistent with current standards of practice.

Medical Review of Certain Inpatient Hospital Admissions under Medicare Part A for CY 2021 and Subsequent Years (2-Midnight Rule): (Page 13)
CMS would exempt procedures that are removed from the inpatient only (IPO) list under the OPPS beginning on or January 1, 2021, from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and RAC reviews for "patient status" (that is, site-of-service) for a time period of 2 years.

340B-Acquired Drugs: (Page 14)
CMS would continue its current policy of paying an adjusted amount of ASP minus 22.5 percent for drugs and biologicals acquired under the 340B program. CMS would continue to exempt Rural SCHs, PPS-exempt cancer hospitals and children's hospitals from its 340B payment policy.

continued

Device Pass-Through Payment Applications: (Page 14)
CMS notes it received eight applications for device pass-through payments. One of these applications (the Shockwave C^2 Coronary Intravascular Lithotripsy (IVL) catheter) received preliminary approval for passthrough payment status through CMS' quarterly review process. CMS is soliciting public comment on all eight of these applications and final determinations on these applications will be made in the CY 2022 OPPS/ASC final rule.

Equitable Adjustment for Device Category, Drugs, and Biologicals with Expiring Pass-through Status: (Page 14)
CMS is proposing to use CY 2019 claims data, rather than CY 2020 claims data, to calculate CY 2022 rate-setting. CMS is proposing to use its "equitable adjustment authority" under 1833(t)(2)(E) to provide up to four quarters of separate payment for 27 drugs and biologicals and one device category whose pass-through payment status will expire between December 31, 2021 and September 30, 2022.

Cancer Hospital Payment Adjustment: (Page 14)
For 2022, 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 the other OPPS hospitals using the most recently submitted or settled cost report data. However, section 16002(b) of the ***21st Century Cures Act*** requires that this weighted average PCR be reduced by 1.0 percentage point. Based on the data and the required 1.0 percentage point reduction, CMS proposes that a target PCR of 0.89 would be used to determine the CY 2022 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.89 for each cancer hospital.

ASC Payment Update: (Page 15)
CMS proposes increasing payment rates under the ASC payment system by 2.3 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on a hospital market basket percentage increase of 2.5 percent minus a multifactor productivity adjustment of 0.2 percentage point. Based on this proposed update, CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2022 would be approximately $5.16 billion, a decrease of approximately $20 million compared to estimated CY 2021 Medicare payments.

ASC Payment Policy for Non-Opioid Pain Management Drugs and Biologicals under Section 6082 of the SUPPORT Act (Section 1833(t)(22) of the Social Security Act): (Page 15)
CMS would continue to pay separately for two drugs currently receiving separate payment in the ASC setting as non-opioid pain management drugs that function as surgical supplies. CMS proposes to modify its current non-opioid pain management payment policy and regulatory text to require that evidence-based non-opioid alternatives for pain management must have Food and Drug Administration (FDA) approval, an FDA-approved indication for pain management or analgesia, and for the drugs and biologicals to have a per-day cost in excess of the OPPS drug packaging threshold, which is proposed at $130 for CY 2022.

Changes to the List of ASC Covered Surgical Procedures: (Page 16)
CMS is proposing to re-adopt the ASC Covered Procedures List (CPL) criteria

continued

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.

Hospital Outpatient Quality Reporting (OQR) Program: (Page 16)
CMS is proposing changes for the CY 2023, CY 2024, CY 2025, and CY 2026 payment determinations and subsequent years. For the Hospital OQR Program measure set, CMS is proposing to: (1) Remove the OP-02: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival measure beginning with the CY 2025 payment determination; (2) remove the OP-03: Median Time to Transfer to Another Facility for Acute Coronary Intervention measure beginning with the CY 2025 payment determination; (3) adopt the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with the CY 2024 payment determination; (4) adopt the Breast Screening Recall Rates measure beginning with the CY 2023 payment determination; (5) adopt the ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination; (6) make voluntary the reporting of the OP-37a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based measures beginning with the CY 2023 reporting period and mandatory beginning with the CY 2024 reporting period/CY 2026 payment determination; and (7) make mandatory the reporting of the OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure beginning with the CY 2025 payment determination.

In addition, CMS is proposing data submission requirements for the OAS CAHPS Survey-based measures and the COVID-19 Vaccination Coverage Among HCP measure. Similarly, CMS is proposing data submission and certification requirements for eCQMs and expanding the Extraordinary Circumstances Exemption (ECE) policy to these measures.

Beginning with the CY 2024 payment determination, CMS is proposing three updates to the validation requirements by proposing to: (1) Use electronic file submissions for chart abstracted measure medical record requests; (2) change the chart validation requirements and methods; and (3) update the targeting criteria.

CMS is also requesting comment from stakeholders on: (1) The potential future development and inclusion of a patient-reported outcomes measure following elective total hip and/or total knee arthroplasty (THA/TKA); (2) the possibility of expanding current disparities methods to include reporting by race and ethnicity; and (3) the possibility of hospital collection of standardized demographic information for quality reporting and measure stratification.

Additionally, CMS is requesting feedback across programs on potential actions and priority areas that would enable the continued transformation of quality measurement toward greater digital capture of data and use of the Fast Healthcare Interoperability Resources (FHIR) standard.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program: (Page 17)
For the ASCQR Program measure set, CMS is proposing to: (1) Adopt the COVID-19 Vaccination Coverage Among HCP measure beginning with the CY 2024 payment determination;

continued

(2) resume data collection for four measures beginning with the CY 2025 payment determination: (a) ASC-1: Patient Burn; (b) ASC-2: Patient Fall; (c) ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant; and (d) ASC-4: All-Cause Hospital Transfer/Admission; (3) require the ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure beginning with the CY 2025 payment determination; and (4) require the ASC-15a-e: OAS CAHPS Survey-based measures with voluntary reporting beginning with the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination.

In addition, CMS is proposing data submission requirements for the OAS CAHPS Survey-based measures and the COVID-19 Vaccination Coverage Among HCP measure.

Radiation Oncology Model (RO Model): (Page 19)
Section 133 of the ***Consolidated Appropriations Act*** (CAA), included a provision that prohibits the RO Model from beginning before January 1, 2022. This law supersedes the RO Model delayed start date established in the CY 2021 OPPS/ASC final rule. In this proposed rule, CMS is proposing provisions related to the additional delayed implementation due to the CAA as well as modifications to certain RO Model policies not related to the delay. These proposals if finalized would necessitate modifying 42 CFR 512.205, 512.210, 512.217, 512.220, 512.230, 512.240, 512.245, 512.250, 512.255, 512.275, 512.280, and 512.285 and add 42 CFR 512.292 and 512.294.

Request for Information on Rural Emergency Hospitals (REHs): (Page 19)
Congress enacted section 125 of the ***Consolidated Appropriations Act*** (CAA), which establishes REHs as a new provider type. In accordance with the statutory requirements in the CAA, REHs will provide emergency department services, observation care, and, at the election of the REH, other medical and health services on an outpatient basis, as specified by the Secretary through rulemaking.

REHs must **not** provide acute care inpatient services, with the exception of skilled nursing facility services furnished in a distinct part unit. The REH must have a staffed emergency department 24 hours a day, 7 days a week, with staffing requirements similar to those for Critical Access Hospitals (CAHs). The CAA provides that the statutory provisions governing Medicare payment to REHs shall apply to items and services furnished on or after January 1, 2023.

II. PROPOSED UPDATES AFFECTING OPPS PAYMENTS (Page 30)

A. Proposed Recalibration of APC Relative Payment Weights (Page 30)

Proposed Calculation of Single Procedure APC Criteria-Based Costs (Page 35)

- Blood and Blood Products

CMS proposes to continue to establish payment rates for blood and blood products using its blood-specific CCR methodology.

- *Brachytherapy Sources* (Page 37)

For CY 2022, except where otherwise indicated, CMS proposes to use the costs derived from CY 2019 claims data to set the proposed CY 2022 payment rates for brachytherapy sources.

continued

CMS would maintain the CY 2019 payment rate of $4.69 per mm^2 for HCPCS code C2645 for CY 2022.

Comprehensive APCs (C-APCs) for CY 2021 (Page 41)

CMS is not proposing to convert any standard APCs to C-APCs in CY 2022. The number of C-APCs for CY 2022 would be the same as the number for CY 2021, which is 69 C-APCs.

The rule's Table 1 (Page 52) lists the final 69 C-APCs for CY 2021. All C-APCs are displayed in Addendum J.

Mental Health Services Composite APC (Page 54)

CMS is setting its payment rate for composite APC 8010 for CY 2022 at the same payment rate that is set for APC 5863, which is the maximum partial hospitalization per diem payment rate for a hospital.

Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008) (Page 56)

For CY 2022, CMS proposes to continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology.

Table 2 (Page 58) lists the HCPCS codes that will be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC final geometric mean costs for CY 2022.

Proposed Changes to Packaged Items and Services (Page 62)

CMS proposes no changes to the overall packaging policy.

Proposed Payment Policy for Non-Opioid Pain Management Drugs and Biologicals that Function as Surgical Supplies under the ASC Payment System (Page 64)

CMS is proposing to continue to package payment for non-opioid pain management drugs that function as surgical supplies in the performance of surgical procedures in the hospital outpatient department setting.

Proposed Criteria for Eligibility for Separate Payment under the ASC Payment System for Non-Opioid Pain Management Drugs and Biologicals that Function as Surgical Supplies (Page 71)

For CY 2022, CMS is proposing the following criteria that non-opioid pain management drugs and biologicals would be required to meet to be eligible for separate payment under the ASC payment system in accordance with section 1833(t)(22)(C).

- Criterion 1: FDA Approval and Indication for Pain Management or Analgesia
- Criterion 2: Cost of the Product

Eligibility for Separate Payment in CY 2022 for Exparel, Omidria, and Other Non-Opioid Products for Pain Management (Page 76)

There are two products receiving separate payment in the ASC setting to pay separately for non-opioid pain management treatments that function as surgical supplies when furnished in the ASC setting. These two products are Exparel (HCPCS Code C9290, Injection, bupivacaine liposome, 1 mg) and Omidria (HCPCS Code J1097, phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml).

Based on the current information available CMS is proposing that both products would be eligible for separate payment in CY 2022.

B. Proposed Conversion Factor (CF) (Page 87)

To set the OPPS conversion factor for 2022, CMS proposes to increase the CY 2021 conversion factor of $82.797 by 2.3 percent. Further, CMS proposes to adjust the conversion factor for CY 2022 to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis.

CMS proposes to calculate an overall budget neutrality factor of 1.0012 for wage index changes.

CMS estimated that proposed pass-through spending for drugs, biologicals, and devices for CY 2022 would equal approximately $1.03 billion, which represented 1.24 percent of total projected CY 2022 OPPS spending. Therefore, the proposed conversion factor would be adjusted by the difference between the 0.92 percent estimate of pass-through spending for CY 2021 and the 1.24 percent estimate of proposed pass-through spending for CY 2022, resulting in a proposed decrease to the conversion factor for CY 2022 of 0.32 percent.

CMS estimates for the proposed rule that outlier payments would be 1.06 percent of total OPPS payments in CY 2021; the 1.00 percent for proposed outlier payments in CY 2022 would constitute a 0.06 percent decrease in payment in CY 2022 relative to CY 2021.

Therefore, CMS proposes to use a conversion factor of **$84.457.** The current CF is $82.797.

CMS has not provided a complete formula showing its calculations of the proposed CY 2022 conversion factor. However, in a separate article, CMS provides the following:

Steps	2021 OPPS CF	Return PT and outliers (/)	Wage Index (x)	Cancer Hospital (x)	Rural Hospital (x)	Hospital Outpatient Update (x)	Remove PT, Adjustment for Drugs and Devices PT expiring between Dec 31, 2021 and Sep 30, 2022, and outliers (x)	2022 OPPS CF
Value applied		(1-.01-.0092)	1.0012	1.0000	1.0000	1.023	(1-.01-.0132)	
CF	82.797	84.418	84.519	84.519	84.519	86.463	84.457	$84.457

C. Proposed Wage Index Changes (Page 91)

The OPPS labor-related share remains at 60 percent of the national OPPS payment.

The wage index that applies to a particular acute care, short-stay hospital under the IPPS also applies to that hospital under the OPPS.

The ***American Rescue Plan Act***, provides that for discharges occurring on or after October 1, 2021, the area wage index applicable under the IPPS to any hospital in an all-urban State may not be less than the minimum area wage index for the fiscal year for hospitals in that State established using the methodology described in § 412.64(h)(4)(vi) as in effect for FY 2018. States that would be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2022: New Jersey, Rhode Island, Delaware, Connecticut, and Washington, D.C.

Any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the imputed floor adjustment and any transition that may be applied would be reflected in the final

CY 2022 OPPS wage index beginning on January 1, 2022.

D. Proposed Statewide Average Default CCRs (Page 101)

CMS would calculate the default ratios for CY 2022 using cost report data from the same set of cost reports originally used in the CY 2021 OPPS rate-setting,

E. Proposed Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) under Section 1833(t)(13)(B) of the Act for CY 2021 (Page 102)

For CY 2022, CMS proposes to continue the current policy of a 7.1 percent payment adjustment that is done in a budget neutral manner for rural SCHs, including EACHs,

continued

for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy.

F. Proposed Payment Adjustment for Certain Cancer Hospitals for CY 2021 (Page 103)

The rule's Table 4 (Page 107) identifies the add-on amounts to the 11 eligible cancer hospitals.

G. Proposed Hospital Outpatient Outlier Payments (Page 108)

For CY 2022, CMS proposes to continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. CMS proposes that a portion of the 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPPS payments), would be allocated to Community Mental Health Centers (CMHCs) for Partial Hospital Program (PHP) outlier payments.

CMS is setting the outlier threshold that exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus **$6,100.** The current threshold is $5,300

For CMHCs, the threshold would be 3.40 times the payment rate, and the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times APC 5853.

H. Proposed Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment (Page 112)

The national unadjusted payment rates for most APCs are contained in Addendum A and for most HCPCS codes to which separate payment has been assigned in Addendum B .

III. PROPOSED OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES

(Page 122)

A. Proposed OPPS Treatment of New CPT and Level II HCPCS Codes

CMS recognizes the following codes on OPPS claims:

- Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures; and
- Level II HCPCS codes (also known as alphanumeric codes), which are used primarily to identify drugs, devices, ambulance services, durable medical equipment, orthotics, prosthetics, supplies, temporary surgical procedures, and medical services not described by CPT codes.

The following reflects CMS' treatment of new codes added during the year.

1. *April 2021 HCPCS Codes for which CMS is Soliciting Public Comments*

   For the April 2021 update, 26 new HCPCS codes were established and made effective on April 1, 2021. These codes and their long descriptors are listed in the rules' Table 5. (Page 125)

2. *July 2021 HCPCS Codes for which CMS is Soliciting Public Comments*

   For the July 2021 update, 55 new codes were established and made effective July 1, 2021. The codes and long descriptors are listed in the rule's Table 6. (Page 127)

continued

3. *October 2021 HCPCS Codes for which CMS Will Be Soliciting Public Comments in the CY 2022 OPPS/ASC Final Rule*

   For CY 2022, CMS is proposing to continue its established policy of assigning comment indicator "NI" in Addendum B to the OPPS/ASC final rule with comment period to those new HCPCS codes that are effective October 1, 2021 to indicate that CMS is assigning them an interim status indicator, which is subject to public comment.

4. *January 2022 HCPCS Codes* (Page 132)

   CMS will solicit comments on the new Level II HCPCS codes that will be effective January 1, 2022 in the CY 2022 OPPS/ASC final rule, thereby allowing CMS to finalize the status indicators and APC assignments for the codes in the CY 2023 OPPS/ASC final rule with comment period.

B. Proposed OPPS Changes – Variations within APCs (Page 135)

The Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group (referred to as the "2 times rule"). The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low volume items and services.

Table 8 (Page 140) lists the 23 APCs that CMS will exempt from the 2 times rule for CY 2022.

C. Proposed New Technology APCs (Page 140)

Procedures Assigned to New Technology APC Groups for CY 2022 (Page 146)

a. Retinal Prosthesis Implant Procedure (Page 147)

CMS proposes to continue to assign the Argus® II procedure to New Technology APC 1908 for CY 2022 with a payment rate of $152,500.50.

b. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1561) (Page 149)

CMS is proposing to continue its policy from CY 2021 to assign the services described by HCPCS code C9770 to a New Technology APC with a cost band that contains the geometric mean cost for HCPCS code 67036. Based on this data, the geometric mean cost of HCPCS code 67036 is $3,434.91.

c. Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy (Page 151)

CMS proposes to continue to assign HCPCS code C9751 to APC 1562 (New Technology—Level 25 ($3501–$4000)), with a proposed payment rate of $3,750.50 for CY 2022.

d. Fractional Flow Reserve Derived from Computed Tomography (FFRCT) (Page 153)

CMS proposes to continue to use its equitable adjustment authority under section 1833(t)(2)(E) of the Act to assign CPT code 0503T to the same New Technology APC in CY 2022 as in CY 2020 and CY 2021: New Technology APC 1511 (New Technology—Level 11 ($901–$1000)), with a payment rate of $950.50 for CY 2022.

e. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (Page 157)

CMS proposes to continue to assign CPT code 78431 to APC 1522 (New Technology—Level 22 ($2001–$2500)) with a payment rate of $2,250.50. Further, CMS proposes that CPT codes 78432 and 78433 would continue to be assigned to APC 1523 (New Technology—Level 23 ($2501–$3000)) with a payment rate of

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$2,750.50. The proposed CY 2022 payment rates for CPT codes 78431, 78432, and 78433 can be found in Addendum B to the CY 2022 OPPS/ASC proposed rule.

f. V-Wave Medical Interatrial Shunt Procedure (Page 158)

CMS is proposing to continue to assign HCPCS code C9758 to New Technology APC 1590 with a payment rate of $17,500.50 for CY 2022.

g. Corvia Medical Interatrial Shunt Procedure (Page 160)

CMS proposes to continue to assign HCPCS code C9760 to New Technology APC 1592.

h. Supervised Visits for Esketamine Self-Administration (HCPCS codes G2082 and G2083 APCs 1508 and 1511) (Page 161)

CMS is proposing to continue to assign HCPCS code G2082 to New Technology APC 1508 (New Technology - Level 8 ($601 - $700)) and to assign HCPCS code G2083 to New Technology APC 1511 (New Technology - Level 11 ($901 - $1000)).

D. Proposed OPPS APC-Specific Policy: Stromal Vascular Fraction (SVF) Therapy (Page 164)

SVF therapy is intended to treat knee osteoarthritis. SVF therapy is currently described by CPT codes 0565T and 0566T, which were effective January 1, 2020.

For CY 2022, CMS is proposing not to pay under the OPPS for either code. Specifically, CMS is revising the status indicator for CPT code 0565T from "Q1" (conditionally packaged; separately payable) to "E1" to indicate that the code is not payable by Medicare.

Similarly, CMS is revising the status indicator for CPT code 0566T from "T" (separately payable) to "E1" to indicate that the code is not payable by Medicare and deleting the APC assignment for this code.

IV. Proposed OPPS Payment for Devices (Page 165)

A. Expiration of Transitional Pass-Through Payments for Certain Devices (Page 166)

There currently are 11 device categories eligible for pass-through payment. The table below identifies the status of each.

HCPCS Codes	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	1/1/2019	12/31/2021
C1824	Generator, cardiac contractility modulation (implantable	1/1/2020	12/31/2022
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2022
C1839	Iris prosthesis	1/1/2020	12/31/2022
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2022
C2596	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2022
C1748	Endoscope, single-use (that is, disposable), Upper GI, imaging/ illumination device (insertable)	7/1/2020	6/30/2023
C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
C1825	Generator, neurostimulator (implantable), nonrechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024

continued

B. New Device Pass-Through Applications (Page 169)

CMS notes that it received eight complete applications by the March 1, 2021 quarterly deadline, which

was the last quarterly deadline for applications to be received in time to be included in the CY 2022 OPPS/ASC proposed rule.

They are: (1) RECELL System; (2) Shockwave C2 Coronary Intravascular Lithotripsy (IVL) catheter; (3) AngelMed Guardian® System; (4) BONEBRIDGE Bone Conduction Implant System; (5) EluviaTM Drug-Eluting Vascular Stent System; (6) Cochlear™ Osia® 2 System; (7) Pure-Vu® System; and (8) Xenocor Xenoscope™.

COMMENT

Once again, CMS is spending an inordinate amount of effort describing the new device pass-through applications it has received. Some 83 pages which is 10 percent of the entire rule.

c. Proposed Device-Intensive Procedures (Page 248)

CMS' proposal would assign device offset percentages using CY 2020 claims data to the following 11 procedures:

- 0266T (Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed));
- 0414T (Removal and replacement of permanent cardiac contractility modulation system pulse generator only);
- 0511T (Removal and reinsertion of sinus tarsi implant);
- 0587T (Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve);
- 0600T (Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous);
- 0614T (Removal and replacement of substernal implantable defibrillator pulse generator);
- 66987 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (for example, iris ansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation);
- 66988 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation);
- C9757 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar);

continued

- C9765 (Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed); and
- C9767 (Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed).

V. PROPOSED OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS (Page 263)

A. Proposed OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2020 (Page 265)

There are 25 drugs and biologicals whose pass-through payment status will expire during CY 2021 as listed in the rule's Table 27. (Page 266)

2. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in CY 2022. (Page 268)

There are 26 drugs and biologicals for which pass-through payment status will expire in CY 2022. They are shown in the rule's Table 28. (Page 270)

3. *Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Continuing in CY 2022* (Page 272)

CMS proposes to continue pass-through payment status in CY 2022 for 46 drugs and biologicals. These drugs and biologicals, which were approved for pass-through payment status with effective dates beginning between April 1, 2020, and April 1, 2021, and are listed in Table 29.

B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status (Page 279)

The packaging threshold for CY 2022 is proposed at **$130**, which is also the current threshold.

C. Proposed CY 2022 OPPS Payment Methodology for 340B Purchased Drugs (Page 289)

For CY 2022, CMS is proposing to continue its payment policy to pay for separately payable drugs and biologicals, with the exception of 340B acquired drugs, at **ASP+6 percent.**

CMS is proposing to pay for drugs acquired under the 340B program at **ASP minus 22.5 percent.**

VI. ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES (Page 316)

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage," currently not to exceed 2.0 percent of total program payments estimated to be made for all covered services under the OPPS furnished for that year.

CMS estimates that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2022 and those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2022 would be approximately $1,024.7 million (approximately $552.3 million for device categories and approx-

continued

imately $472.4 million for drugs and biologicals) which represents 1.24 percent of total projected OPPS payments for CY 2022 (approximately $83 billion). Therefore, CMS estimates that pass-through spending in CY 2022 will not amount to 2.0 percent of total projected OPPS CY 2022 program spending.

VII. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES (Page 325)

CMS proposes to continue with its current clinic and emergency department (ED) hospital outpatient visits payment policies.

CMS will continue to utilize a PFS-equivalent payment rate for the hospital outpatient clinic visit service described by HCPCS code G0463 when it is furnished by excepted off-campus provider-based departments. The PFS-equivalent rate for CY 2022 is 40 percent of the proposed OPPS payment (that is, 60 percent less than the proposed OPPS rate). Under this policy, these departments will be paid approximately 40 percent of the OPPS rate (100 percent of the OPPS rate minus the 60-percent payment reduction that is applied in CY 2022) for the clinic visit service in CY 2022.

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES (Page 326)

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

The following table provides the proposed CY 2022 values.

CY 2022 PHP APC Geometric Mean Per Diem Costs

CY 2022 APC	Group Title	Proposed PHP APC Geometric Mean Per Diem Costs
5853	Partial Hospitalization (3 or more services per day) for CMHCs	$136.14
5863	Partial Hospitalization (3 or more services per day) for hospital-based PHPs	$253.08

COMMENT

This section is another example of how much history and non-germane information is presented. CMS spends 15 pages explaining the development of the partial hospitalization payment amounts. What is important is the CY 2022 values and not what happened in CY 2008.

IX. PROCEDURES THAT WILL BE PAID ONLY AS INPATIENT PROCEDURES (IPO) (Page 347)

In the CY 2021 OPPS/ASC final rule, CMS finalized, with modification, its proposal to eliminate the IPO list over the course of three years. As part of the first phase of this elimination of the IPO list, CMS removed 298 codes from the list beginning in CY 2021.

For CY 2022, CMS proposes to halt the elimination of the IPO list and, proposes to add the 298 services removed from the IPO list in CY 2021 back to the IPO list beginning in CY 2022.

The rule's table 35 (Page 363) contains the proposed additions to the IPO list for CY 2022.

continued

COMMENT

CMS spends some 32 pages explaining why it eliminated the IPO list and is now reversing itself in reinstating the list. This is a good example of CMS "believing" what it is doing is the best outcome. Perhaps CMS did not listen to the comments on this item. If they did, maybe they wouldn't have proceeded.

X. PROPOSED NONRECURRING POLICY CHANGES (Page 379)

For CY 2021 and subsequent years, CMS proposes to return to the 2-year exemption from site-of-service claim denials, BFCC-QIO referrals to RACs, and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the IPO list under the OPPS on January 1, 2021 or later. Under this proposal, services removed beginning on January 1, 2021 would receive the same 2-year exemption from 2-Midnight medical review activities as currently applies to services removed between January 1 and December 30, 2020, and not the indefinite exemption finalized in the CY 2021 OPPS/ASC final rule with comment period.

XI. PROPOSED CY 2022 OPPS PAYMENT STATUS AND COMMENT INDICATORS (Page 426)

For CY 2022, CMS is not proposing to make any changes to the existing definitions of status indicators that were listed in Addendum D1 to the CY 2021 OPPS/ASC final rule.

The complete list of the proposed payment status indicators and their definitions that would apply for CY 2022 is displayed in Addendum D1 to this proposed rule, which is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

The proposed CY 2022 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule, which are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

XII. UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM (Page 430)

Calculation of the ASC Payment Rates and the ASC Conversion Factor (Page 501)

For 2022, CMS proposes to adjust the CY 2021 ASC conversion factor ($48.952) by the proposed wage index budget neutrality factor of 0.9993 in addition to the productivity-adjusted hospital market basket update of 2.3 percent, which results in a proposed CY 2022 ASC conversion factor of **$50.043** for ASCs meeting the quality reporting requirements.

For ASCs not meeting the quality reporting requirements, CMS proposes to adjust the CY 2021 ASC conversion factor ($48.952) by the proposed wage index budget neutrality factor of 0.9993 in addition to the quality reporting/productivity-adjusted hospital market basket update of 0.3, which results in a proposed CY 2022 ASC conversion factor of $49.064.

Addenda AA and BB to this proposed rule (which are available on the CMS website) display the proposed ASC payment rates for CY 2022 for covered surgical procedures and covered ancillary services, respectively.

Treatment of New and Revised Codes (Page 434)

1. *April 2021 HCPCS Codes for which CMS is Soliciting Public Comments* (Page 436)

For the April 2021 update, there was one new CPT code and there were 11 new Level II HCPCS codes.

The rule's Table 39 lists the new Level II HCPCS codes that were implemented April 1, 2021, along with their proposed payment indicators for CY 2022.

continued

2. *July 2021 HCPCS Codes for Which CMS is Soliciting Comments* (Page 437)

The rule's table 40 lists the new HCPCS codes that are effective July 1, 2021.

3. *October 2021 HCPCS Codes for Which CMS will be Soliciting Public* (Page 440)

For CY 2022, CMS proposes that the Level II HCPCS codes that will be effective October 1, 2021, will be flagged with comment indicator "NI" in Addendum BB to indicate that CMS has assigned the codes on an interim OPPS payment status for CY 2022.

4. *January 2022 HCPCS Codes* (Page 440)

These codes are listed in Addendum AA and Addendum BB with short descriptors only, CMS is listing them again in Addendum O with the long descriptors.

XIII. PROPOSED REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM (Page 521)

Proposed Removals Beginning with the CY 2023 Reporting Period/CY 2025 Payment Determination:

CMS is proposing to remove two chart-abstracted measures:

- Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department (ED) Arrival (OP-2); and
- Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3).

CMS is proposing to adopt the ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) into the Hospital OQR Program measure set, which would serve as a replacement for these two measures.

CMS is also proposing to adopt three new measures: (1) COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure, beginning with the CY 2022 reporting period; (2) Breast Screening Recall Rates measure, beginning with the CY 2022 reporting period; and (3) STEMI eCQM, beginning as a voluntary measure with the CY 2023 reporting period, and then as a mandatory measure beginning with the CY 2024 reporting period.

The table below, summarizes the previously finalized Hospital OQR Program measure set for the CY 2023 payment determination and subsequent years. (Page 558)

NQF #	Measure Name
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0514	OP-8: MRI Lumbar Spine for Low Back Pain†
None	OP-10: Abdomen CT – Use of Contrast Material
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

continued

NQF #	Measure Name
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	Breast Screening Recall Rate

The following table summarizes the previously finalized and newly proposed Hospital OQR Program measure set for the CY 2024 payment determination, which includes the proposed COVID-19 Vaccination Coverage Among HCP measure:

Hospital OQR Program Measure Set for the CY 2024 Payment Determination

NQF #	Measure Name
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-10: Abdomen CT – Use of Contrast Material
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
None	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	Breast Screening Recall Rate
None	Covid-19 Vaccination Coverage Among Health Care Personnel

COMMENT

Over the years, Quality reporting requirements have been complex and extensive. This rule is no different. This section is nearly 100 pages. There is much more information and requirements than reported above.

XIV. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM (Page 610)

CMS is proposing to adopt one new measure: COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with the CY 2022 reporting period/2024 payment determination.

CMS is proposing to again require and resume data collection for ASC-1, ASC-2, ASC-3, and ASC-4 beginning with the CY 2023 reporting period/CY 2025 payment determination and subsequent years. Under CMS' proposal, providers would submit data via the HQR System (formerly referred to as the QualityNet Secure Portal).

continued

CMS also is proposing to Require ASC–11: Cataracts—Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536) Beginning with the CY 2023 Reporting Period/CY 2025 Payment Determination.

CMS proposes to Require ASC–15a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures Beginning with Voluntary Reporting in CY 2023 Reporting Period and Mandatory Reporting Beginning with the CY 2024 Reporting Period/CY 2026 Payment Determination and for Subsequent Years.

The table below summarizes the previously finalized and Proposed ASCQR Program measure set for the CY 2024 payment determination and subsequent years.

Previously Finalized and Proposed ASCQR Program Measure Set for the CY 2024 Reporting Period/CY 2026 Payment Determination and Subsequent Years		
ASC #	NQF #	Measure Name
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265	All-Cause Hospital Transfer/Admission
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	OAS CAHPS – About Facilities and Staff
ASC-15b	None	OAS CAHPS – Communication About Procedure
ASC-15c	None	OAS CAHPS – Preparation for Discharge and Recovery
ASC-15d	None	OAS CAHPS – Overall Rating of Facility
ASC-15e	None	OAS CAHPS – Recommendation of Facility
ASC-17	3470	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
ASC-18	3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures
ASC-19	3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
	None	COVID-19 Vaccination Coverage Among Health Care Personnel*

Radiation Oncology Model (Page 677)

On September 29, 2020, CMS published the final rule entitled "Specialty Care Models to Improve Quality of Care and Reduce Expenditures," hereafter referred to as the Specialty Care Models Rule and codified policies at 42 CFR part 512. The Radiation Oncology (RO) Model is designed to test whether prospective episode-based payments for radiotherapy (RT) services (also referred to as radiation therapy services) will reduce Medicare program expenditures and preserve or enhance quality of care for beneficiaries.

The ***Consolidated Appropriations*** Act, 2021, included a provision that prohibits implementation of the RO Model prior to January 1, 2022.

The RO Model will test whether making site-neutral, modality agnostic, prospective episode-based payments to Hospital

continued

Outpatient Departments (HOPDs) and physician group practices (including freestanding radiation therapy (RT) centers) for RT episodes of care preserves or enhances the quality of care furnished to Medicare beneficiaries while reducing or maintaining Medicare spending.

Proposals to Address the RO Model Timing and Design

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

- To begin the RO Model on January 1, 2022, with a 5-year Model performance period (ending December 31, 2026).
- To change the baseline period from 2016-2018 to 2017-2019.
- To lower the discounts to 3.5 percent (Professional Component) and 4.5 percent (Technical Component).
- To remove brachytherapy from the list of included modalities under the RO Model so that it would still be paid FFS.
- To revise the cancer inclusion criteria under the RO Model.
- In cases where a beneficiary switches from traditional Medicare to Medicare Advantage during an episode before treatment is complete, CMS would consider this an incomplete episode and RT services would be paid the traditional Medicare rate instead of being paid under the RO Model.
- To adopt an extreme and uncontrollable circumstances policy. This policy would provide flexibility to reduce administrative burden of Model participation, including reporting requirements, and/or adjust the payment methodology as necessary when extreme and uncontrollable circumstances exist.
- To exclude hospital outpatient departments participating in the Community Transformation track of the CHART Model from participation in the RO Model. For the CHART ACO Transformation track, we would follow the same policy for overlap between the RO Model and the Medicare Shared Savings Program ACOs.
- That only hospital outpatient departments that are participating in the Pennsylvania Rural Health Model (PARHM) would be excluded from the RO Model, rather than those that are eligible to participate in PARHM.
- To remove liver cancer from the RO Model as it does not satisfy the model's cancer inclusion criteria.

FINAL THOUGHTS

While this rule is logically well constructed, it nonetheless, is full of repetitive history that simply adds to the length to the document. To some, CMS' continued historical time frames maybe helpful. To most, it is "overkill." It adds significant unneeded verbiage. We believe most would like to see updates that simply focus on what is the current policy and to what is changing for the following year(s).

The OPPS and ASC payment systems rely on extensive coding. While certain payment issues are simple to understand, the amount of coding changes are both extensive and impact final payments.