Outpatient Prospective Payment System
and
Physician Fee Schedule
CY 2022 Proposed Rules

August 20, 2021

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Welcome to AHPA's webinar on the CY 2022 OPPS and PFS proposed rules.

Thank you for joining us! We ask that you please:

Keep your microphone muted until the end.

Share questions in the chat box at any time.

Reach out to our team to get involved in comment submission.

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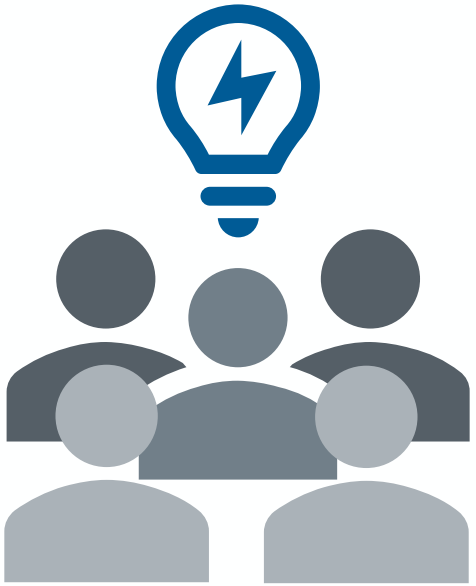
Adventist Health Policy Association (AHPA)



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What are OPPS and PFS?

Comments due September 17th.

- The OPPS rule sets the reimbursement rate for Medicare **Outpatient** payments, including Ambulatory Surgical Center (ASC) procedures.
- The PFS rule sets the reimbursement rate for Medicare **Physician** payments.
- Final rules are expected later this fall.

Overview of Policies: What Changed?

Previously Adopted Policies
OPPS and PFS

• Removal of the Inpatient Only List	**Reverse**
• Add additional 267 procedures to the list of procedures covered in Ambulatory Surgical Centers	**Reverse**
• Require the publication of hospitals' payer-specific negotiated rates	**Strengthen**
• Reduce payments for 340B drugs by 28.5%	**Continue**
• New temporary coverage of telehealth services	**Continue**
• Adopt MIPS Value Pathways (MVPs) to reimburse physicians in the future	**Continue**
• Radiation Oncology Model	**Continue, with changes**

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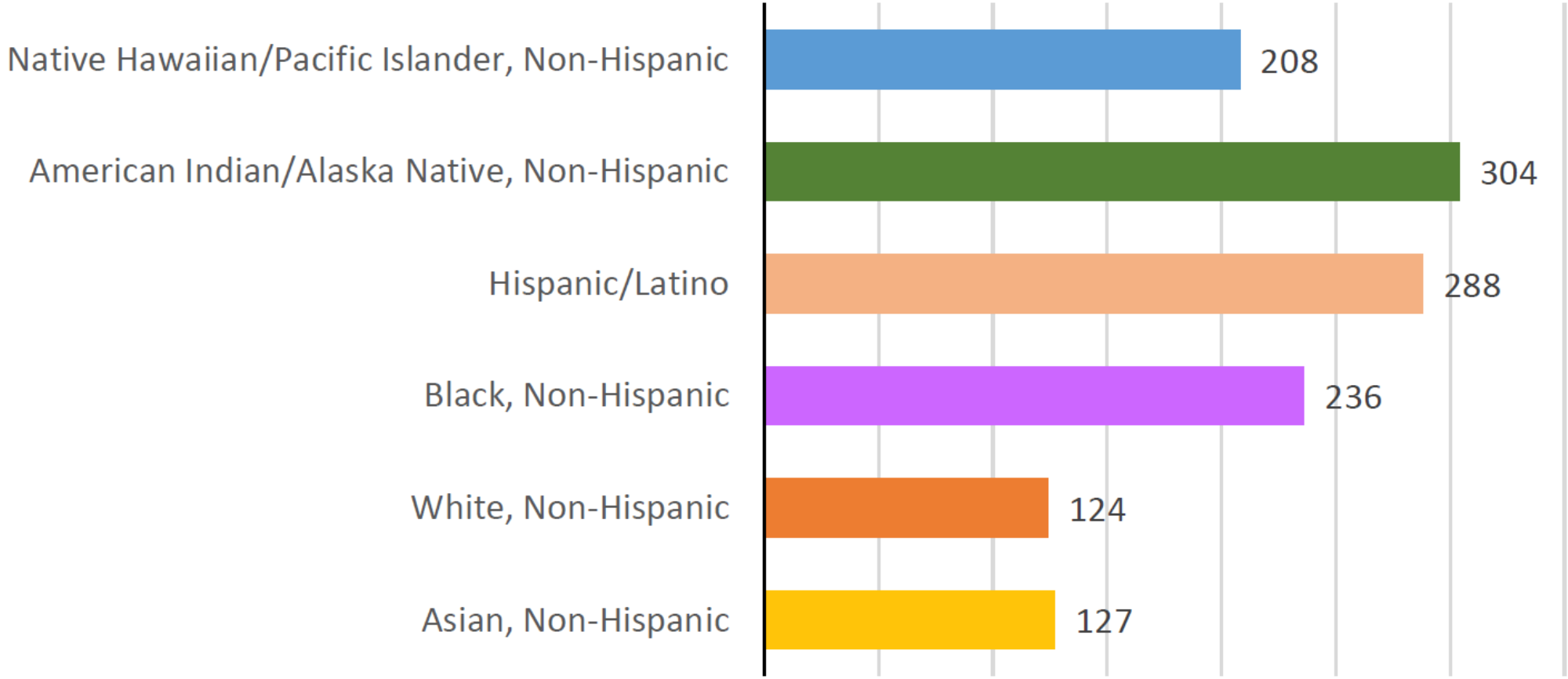
What's The Focus Now?

- More gradual shift to the outpatient setting.
- Continued expansion of telehealth coverage.
- Strengthen price transparency.
- Measures specific to COVID-19 PHE.
- Health equity.

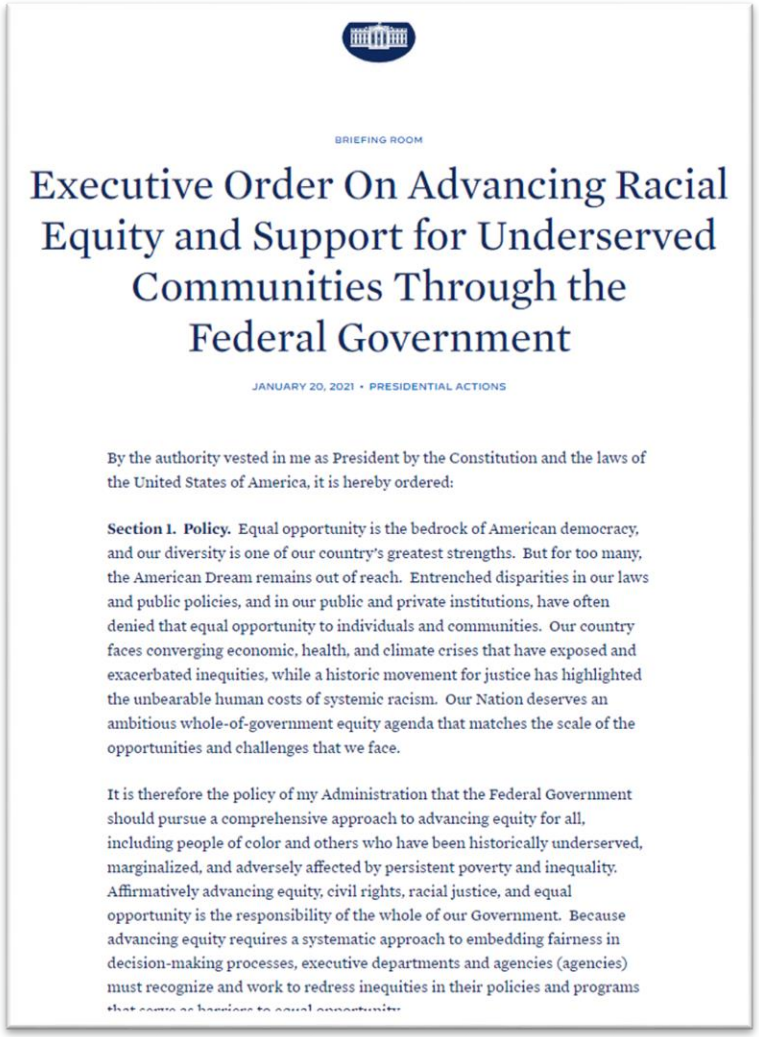
COVID-19 Brings Racial Disparities to the Forefront

Provisional COVID-19 Age-Adjusted Death Rates Per 100,000 Persons by Race & Ethnicity



ASPE, March 16, 2021, (Issue Brief)

Health Equity



BRIEFING ROOM

Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

JANUARY 20, 2021 • PRESIDENTIAL ACTIONS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Policy. Equal opportunity is the bedrock of American democracy, and our diversity is one of our country's greatest strengths. But for too many, the American Dream remains out of reach. Entrenched disparities in our laws and public policies, and in our public and private institutions, have often denied that equal opportunity to individuals and communities. Our country faces converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism. Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face.

It is therefore the policy of my Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Affirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our Government. Because advancing equity requires a systematic approach to embedding fairness in decision-making processes, executive departments and agencies (agencies) must recognize and work to redress inequities in their policies and programs

The federal government has been ordered to pursue "a comprehensive approach to advancing equity for all people, including **people of color** and others who have been historically **underserved**, **marginalized**, and adversely affected by persistent **poverty** and inequality."

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Health Equity a Priority Across Regulations

CMS has prioritized closing the health equity gap, seeking comments across IPPS, OPPS and PFS on:

- Ways to enhance quality programs to monitor and decrease health disparities
- Opportunities to improve demographic data, including data around race, ethnicity, gender identity and primary language

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Outpatient Prospective Payment System (OPPS) Proposed Rule

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OPPS Overview

- Payment Update
- Price Transparency
- The Inpatient Only List
- The Ambulatory Surgical Center Covered Procedures List
- Quality Reporting
- The Radiation Oncology Model
- RFI: Rural Emergency Hospitals

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Outpatient and ASC Payments

Contributing Factor	Outpatient	ASC
Net Update	+ 2.3% ($10.76 billion compared to CY 2021)	+2.3% (-$20 million compared to CY 2021)

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Price Transparency

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Price Transparency

Price Transparency Rule of 2019

- Provide a list of *all* standard charges in machine-readable format.
- Provide, in a consumer-friendly manner, standard charges for 300 shoppable services.
- Provide the payer-specific negotiated rates for 300 shoppable services.

Penalty: $300 a day

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Media and Political Pressure

"I have fought anti-competitive practices before and strongly believe health care must be in reach for everyone. With today's proposed rule, we are simply showing hospitals through stiffer penalties: **concealing the costs of services and procedures will not be tolerated by this Administration**."

- HHS Secretary Xavier Becerra

JUL 19 | MORE ON QUALITY AND SAFETY

Just 5.6% of hospitals are compliant with price transparency rule

Failing to follow through on price transparency requirements could alienate a large swath of a given health system's customer base.

Jeff Lagasse, *Associate Editor*

Newly Proposed Policy

- **Increase Civil Monetary Penalties on a sliding scale for noncompliance with the new price transparency requirements**. The scale to be based on each hospital's bed count.

Hospital Bed Count	Proposed CMP
30 Beds or Fewer	$300 per hospital, per day
More than 30 Beds	$10, per bed, per day

Penalties are not to exceed a maximum daily amount of $5,500.

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Inpatient Only (IPO)
and
Ambulatory Surgical Center (ASC) Lists

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Overview

CMS uses these lists to regulate the site of service for various health care procedures. Inclusion or omission is determined by many factors, including patient safety, quality of care and cost.

Inpatient Only (IPO) List

These procedures are only reimbursable if performed in an inpatient setting.

Ambulatory Surgical Center (ASC) List

These procedures may be performed at an ASC, to reduce cost.

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IPO List: A Reversal from Last Year

In the CY 2021 rule, CMS finalized the elimination of the IPO list over the course of three years.

This year, CMS proposes to halt the three-year phased elimination of the IPO list.

- Re-add the 298 services removed from the IPO list this year back onto the list, beginning in CY 2022.
- Revise the "two-midnight" exemption for procedures removed from the list on or after January 1, 2021.

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IPO List Comment Opportunity

“We no longer believe there is a need for the IPO list in order to identify services that require inpatient care.”

- Administrator Verma
OPPS CY 2021 Final Rule

“Should we maintain the longer-term objective of eliminating the IPO list?”

- Administrator Brooks-LaSure
OPPS CY 2022 Proposed Rule

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Proposed Changes to the ASC Covered Procedures List

In the CY 2021 OPPS final rule, CMS eliminated a subset of the ASC CPL addition criteria and added 267 surgical and "surgery-like" procedures to the CPL.

This year, the new Administration proposes to:

- Reinstate the eliminated ASC CPL addition criteria.
- Remove 258 of the 267 procedures added in CY 2021.
- Adopt a new stakeholder nomination process for adding surgical procedures to the ASC CPL.

"We believe that our current policy needs to be modified to better ensure that surgical procedures added [...] can be performed in the outpatient setting."

- CMS

The Outpatient Quality Reporting System

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Outpatient Quality Reporting (OQR) System

CMS proposes to adopt:

- COVID-19 Vaccination Among Health Care Personnel (HCP) measure for CY 2024
- If finalized hospitals and ASCs will be required to submit data by Jan. 1, 2022.
  - Not endorsed by the NQF.
- Breast Screening Recall Rates measure for CY 2023
  - Not endorsed by the NQF.

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Outpatient Quality Reporting (OQR) System

CMS proposes to adopt:

- ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM) for CY 2023
  - Takes the place of Fibrinolytic Therapy Received within 30 Minutes of ED Arrival (OP-2) and Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3) measures
  - Voluntary reporting for CY 2023 and mandatory reporting for CY 2024
  - Under review for NQF endorsement

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Outpatient Quality Reporting (OQR) System

CMS proposes to require reporting for:

- Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
  - Restart voluntary reporting beginning CY 2023
- Outpatient and ASC Consumer Assessment of Healthcare Providers and Systems (OA-CAHPS) survey-based measures
  - Voluntary reporting beginning CY 2023 and mandatory reporting by CY 2024

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Outpatient Quality Reporting (OQR) System

Regarding eCQM reporting requirements, CMS proposes:

- Requiring hospitals to use CEHRT with the 2015 Edition Cures Update by CY 2023.
- Requiring hospitals to submit eCQM data in the QRDA Category I file format.
- Providing exceptions for hospitals with few or no patients relevant to individual measures.
- Providing exceptions for hospitals with five or fewer applicable discharges per quarter for any quality measure.
- Requiring eCQM data submission by the end of two months following the close of the calendar year beginning in CY 2023.
    - Same as Promoting Interoperability and IQR programs

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Outpatient Quality Reporting (OQR) System

Regarding validation processes, CMS proposes:

- Updating validation requirements to better align with IQR
  - File submission of Medical Records Requests
  - Additional Target Criteria
  - Requests for Information
  - Expanding Extraordinary Circumstances Exemption (ECE) to eCQMs

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Outpatient Quality Reporting (OQR) System

CMS is requesting feedback on the following topics:

- Patient Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) Measure
- Health Equity
- Digital Quality Measurement and the Use of Fast Health care Interoperability Resources
- Future Development of a Pain Management Measure for the ASCQR
- Safe Use of Opioids – Concurrent Prescribing eCQM in the IQR and Promoting Interoperability Programs

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The Radiation Oncology Model

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Radiation Oncology (RO) Model

CMS developed a mandatory Radiation Oncology (RO) Model to test whether site-neutral, modality-agnostic bundled payments for radiotherapy (RT) could reduce Medicare costs.

CMS proposes to:

- Keep the official start of the model as January 1, 2022, instead of delaying it further.
- Update the baseline period for the model to from January 1, 2017, to December 31, 2019.

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Radiation Oncology Model

CMS proposes to:

- Exclude HOPDs participating in a Pennsylvania Rural Health and in the Community Health Access and Rural Transformation (CHART) models.
- Modify its low volume opt-out policy.
- Modify included cancer types and RT modalities:
  - Removal of liver cancer from included cancer types
  - Remove brachytherapy from included RT services
  - Modify criteria for determining included cancer types

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Radiation Oncology Model

CMS proposes to:

- Modify the RO Model Pricing Methodology.
- Amend when CAHPS can be administered to patients to account for the model delays.
- Create two tracks for Professional and Dual participants who meet all the model requirements and do not meet certain RO model monitoring requirements.
- Reconcile incomplete episodes
- Define an “Extreme and Uncontrolled Circumstance”

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RFI: Rural Emergency Hospitals

CMS requests information on Rural Emergency Hospitals (REHs).

Specifically, CMS is soliciting comments on:

- Type and scope of services offered
- Health and safety standards
- Health equity issues
- Quality measures
- Payment provisions
- Enrollment processes

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Physician Fee Schedule (PFS) Proposed Rule

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PFS Overview

- General Payment Updates
- Appropriate Use Criteria
- Telehealth
- Quality Payment Programs
- Merit-based Incentive Payment System (MIPS) Value Pathways
- Medicare Shared Savings Program
- Opioid Use Disorder Treatment Services
- Electronic Prescribing of Controlled Substances
- Evaluation and Management (E/M) Office/Outpatient Visits
- Indirect Compensation Arrangements/Stark Law
- RFI: Vaccine Administration Services

Conversion Factor Update

- CMS finalized a 10.2% decrease to the PFS conversion factor for CY 2021 to offset increases in physician payments under E/M codes.
- Anticipated CY 2022 Specialty Clinical Labor Pricing Effect:

Specialty	Allowed Charges (Mill)	New CL Pricing Change
Portable X-Ray Supplier	$95	10%
Family Practice	$6,020	2%
Endocrinology	$508	2%
Radiation Oncology	$1,809	-4%
Interventional Radiology	$499	-5%
Diagnostic Testing Facilities	$748	-6%

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Conversion Factor Update

- The Consolidated Appropriations Act provided a 3.75% increase to offset this deduction in light of the COVID-19 pandemic for *only* CY 2021.
- **For CY 2022, CMS proposes to reduce the conversion factor to $33.58.**
  - This is a 3.89% decrease from what was finalized in CY 2021.

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Appropriate Use Criteria (AUC)

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AUC Program: Overview

- The Protecting Access to Medicare Act (PAMA) directed the Secretary to establish a program to promote the use of Appropriate Use Criteria for diagnostic imaging services.

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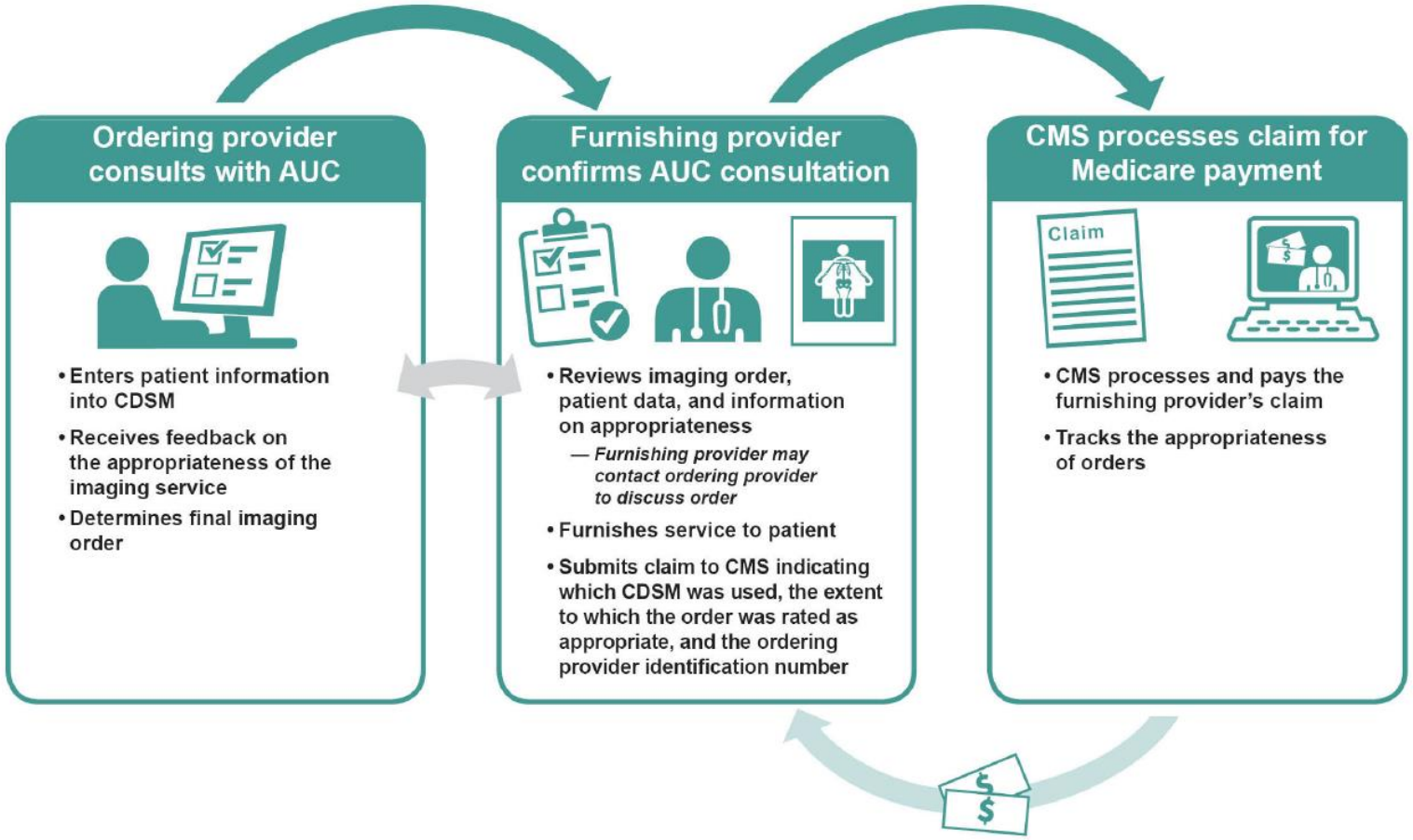
AUC Process



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AUC – Proposed Changes

- Delay the payment penalty phase of the AUC until January 1, 2023, or the January 1st that follows the declared end of the PHE.

Questions raised by CMS:

- Should claims that lack AUC information be returned to the provider for correction and resubmission?
- Are there any areas in the AUC program that are *not* clear, or areas where CMS should provide more education?

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Telehealth

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Telehealth: Summary of Proposals

Temporary Coverage

Retain all added Medicare telehealth services on the Category 3 list until the end of CY 2023.

Tele Mental Health Services

Implement Consolidated Appropriations Act (CAA):

- Remove Medicare originating site requirements.
- Allow for audio-only communications.
- Adopt guardrails.

Extended Virtual Check-in

Permanently adopt code G2252 for an extended virtual check-in (11-20 minutes).

Rural Emergency Hospitals

Implement CAA:

- Beginning CY 2023, establish Rural Emergency Hospitals as a telehealth originating site.

Note: No new telehealth services were proposed for permanent adoption.

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Temporary Covered Services

- CMS added 135 services to the Medicare telehealth list in CY 2020 on an interim basis due to COVID-19 PHE.
- Created a “Category 3” list for services to allow more time to review the telehealth services and assess permanent adoption.
- **New Proposal:** Retain all added Medicare telehealth services on the Category 3 list until the end of CY 2023.

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Additional Category 3 Services?

- Radiation Oncology
- Ophthalmological Services
- Speech, Language and Audiology services
- Cardiology Services
- Ventilation Assistance Management
- Neurological Services
- Physical, Occupational and Speech Therapy
- Cardiac and Pulmonary Rehabilitation
- Office/Outpatient Services

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Tele Mental Health Services

Consolidated Appropriations Act (CAA)

- Eliminated Medicare geographic originating site requirements for the diagnosis, evaluation and treatment of mental health disorders.

Guardrails:

- Face-to-face visit six-months *prior* to the telehealth visit and;
- Face-to-face visit *after* telehealth visit, at a time to be determined by HHS.
- The clinician furnishing the face-to-face visit has to be the same as the one providing the telehealth service.

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Tele Mental Health Services

- Require a face-to-face visit at least 6 months *after* the telehealth visit. CMS seeks comment:
  - Should it be a shorter or longer interval (e.g., 3 months or 12 months)?
  - Should clinicians within the same practice be counted as the same clinician?

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Audio-Only Services Proposals

- Allow use of audio-only communications technology for mental health telehealth services *only if*:

  - Clinician has the capacity to furnish both audio/video telehealth services.
  - Patient either prefers or doesn't have access to audio/video.
  - Patient is receiving the telehealth visit at home.

- Adopt a modifier to distinguish audio-only services.
- **CMS seeks comment:**
  - Should CMS require additional documentation to support the clinical appropriateness of audio-only services?
  - Should CMS *exclude* higher-level services, such as level 4 or level 5 E/M visits?

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CMS also seeks comments on:

Direct Supervision via Telehealth:

- Should CMS permanently allow it? Is it safe?
- Should it be allowed only for a subset of services?
- Should CMS require the use of a modifier if permanently covering it?

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Telehealth - What's Next?

- Limited expansion, based on service line.
- Efforts focused on collecting data to assess appropriateness (e.g., expansion of temporary, Category 3 services).
- Develop guardrails.
- Policymakers to assess program integrity.
- Potential waivers in CMMI models.
- More efforts at the state level.

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Quality Payment Program (QPP)

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Quality Payment Programs: Overview

The Quality Payment Program seeks to reward high-value care through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Merit-based Incentive Payment System (MIPS)

Advanced Alternative Payment Models (APMs)

"To help us progress toward the future state of MIPS, we are focusing the majority of our proposals on MVPs."

– CMS, CY 2022 Proposed Rule

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MIPS: Proposed Scoring Changes

Because of the PHE, CMS will not be scoring the measures in the "Cost" category during PY 2020. Beginning in PY 2022, CMS proposes to update the domain weights as follows:

Merit-based Incentive Payment System (MIPS)	Quality	**40%**	**30%**
	Cost	**20%**	**30%**
	Improvement Activities	**15%**	
	Promoting Interoperability	**25%**	

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MIPS Value Pathways: Proposed Changes

"To help us progress toward the future state of MIPS, we are focusing the majority of our proposals on MVPs." *– CMS, CY 2022 Proposed Rule*

Merit-based Incentive Payment System (MIPS)

- **Adopt seven optional MVPs, beginning in 2023:** Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair and Anesthesia
- **Phase-in the requirement to report the MIPS APM Performance Pathway measure set** over the course of 2022 and 2023
- **Increase the performance threshold from 60 to 75 points** for the CY 2022 performance year (2024's payment year)
- **Adopt an exceptional performance threshold of 89 points**

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MIPS Value Pathways: Proposed Changes

"To help us progress toward the future state of MIPS, we are focusing the majority of our proposals on MVPs." *– CMS, CY 2022 Proposed Rule*

Merit-based Incentive Payment System (MIPS)

- **Freeze the Payment Year (PY) 2023 quality performance standard at 30th percentile of the MIPS quality performance category score.** This would increase to the 40th percentile in PY 2040.
- **Expand the definition of a "MIPS eligible clinician" to include clinical social workers and certified nurse midwives.**

Comment Opportunity: When should CMS mandate MVP participation for all MIPS participants?

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Medicare Shared Savings Program

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MSSP: Overview

The Medicare Shared Savings Program (MSSP) is a voluntary Alternative Payment Model (APM) that gives providers the opportunity to create an Accountable Care Organization (ACO).

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MSSP: Proposed Changes

Extend CMS Web Interface as collection type for MSSP ACOs for PY 2022 and PY 2023.

Freeze PY 2023 quality performance standard at the 30th percentile of MIPS Quality performance category score.

- This would increase to 40% in PY 2024.

Introduce incentives to encourage earlier adoption of eCQMs/MIPS CQMs.

- ACOs that elect to report all three eCQMs/MIPS CQM measures would meet quality performance standard if they rank at a minimum in the 30th percentile of the performance benchmark on at least one measure.

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CMS Proposed Quality Reporting Transition

			PY 2021	PY 2022	PY 2023	PY 2024
ACO Quality Reporting Requirements	ACO's must report through one of the following pathways:	10 Measures within the CMS Web Interface	Yes	Yes	Yes; With the addition of 3 eCQMs/MIPS CQM	No; planned sunset of CMS Web Interface
		3 eCQM/MIPS CQM Measures	Yes	Yes	Yes	Reporting becomes required
	CAHPS for MIPS Survey		Yes	Yes	Yes	Yes
	Claims-based measures (HWR and MCC)		Yes	Yes	Yes	Yes
ACO Quality Performance Standard	Stands as the threshold ACOs must achieve to avoid quality-related compliance actions.		30th Percentile	30th Percentile	30th Percentile	40th Percentile

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Medicare Shared Savings Program

Proposed APM Performance Pathway (APP) Measures Sets

Meaningful Measure Area	Measure Title	Quality ID #	Collection Type
Patient's Experience	CAHPS for MIPS	321	CAHPS for MIPS Survey
Admissions & Readmissions	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	479	Administrative Claims
	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS	TBD	Administrative Claims
Mgt. of Chronic Conditions	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	001	eCQM/MIPS CQM/ CMS Web Interface*
	Controlling High Blood Pressure	236	eCQM/MIPS CQM/ CMS Web Interface*
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	438	CMS Web Interface*
Treatment of Mental Health	Preventive Care and Screening: Screening for Depression and Follow-up Plan	134	eCQM/MIPS CQM/ CMS Web Interface*
	Depression Remission at Twelve Months	370	CMS Web Interface*
Preventable Healthcare Harm	Falls: Screening for Future Fall Risk	318	CMS Web Interface*
Preventive Care	Preventive Care and Screening: Influenza Immunization	110	CMS Web Interface*
	Breast Cancer Screening	113	CMS Web Interface*
	Colorectal Cancer Screening	112	CMS Web Interface*
Prevention/Treatment of Opioid & Substance Use Disorders	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	CMS Web Interface*

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Medicare Shared Savings Program: Additional Proposals

Additional Proposals

- Changes to streamline the MSSP program, including:
  - Reducing frequency and circumstances of certain submissions to CMS
  - Simplifying the application process

- Update Extreme and Uncontrollable Circumstances (E&UC) policy for PY 2023 to align with proposed performance standard freeze.

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Opioid Use Disorder (OUD) Treatment Services

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Opioid Use Disorder Treatment Services: Overview

CMS implemented Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.

The Rules Established:

- A methodology for determining bundled payments for episodes of care;
- Codes for payments for weekly episodes of care that include prescription drugs and non-drug episodes of care;
- Add-on codes for intake and periodic assessments, take-home dosages for prescription drugs.

Prescription Drugs Include: methadone, oral buprenorphine, implantable buprenorphine, injectable buprenorphine or naltrexone

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OUD Treatment Services: Proposed Changes

Temporary Flexibility

During the COVID-19 PHE, CMS permitted counseling and therapy to be provided using audio-only telephone calls.

Proposed Permanence

Now, CMS proposes to permanently allow audio-only calls where two-way audio/video communication technology is not available.

Documentation

After the PHE, CMS proposes to require OTPs to document in patients' medical records the use of audio-only calls and the rationale for doing so.

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Electronic Prescribing of Controlled Substances (EPCS) For Part D Drugs

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EPCS for Part D Drugs: Overview

Section 2003 of the (SUPPORT) Act mandated that, beginning January 1, 2021, the prescribing of a Schedule II, III, IV or V controlled substance under Medicare Part D needed to be done electronically.

Initially, CMS finalized this provision with an effective date of January 1, 2021, and a compliance date of January 1, 2022.

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EPCS for Part D Drugs: Proposed Changes

- Due to the COVID-19 PHE, CMS proposes to delay the compliance date for the EPCS requirement until January 1, 2023.

- For Part D controlled substance prescriptions written for beneficiaries in long-term care facilities, the compliance date would be delayed until January 1, 2025.

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EPCS for Part D Drugs: Compliance Threshold

Proposed Compliance Threshold

- CMS is proposing to establish a compliance threshold of 70% of prescribing under Part D.
  - Must be done electronically per calendar year.

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Evaluation and Management (E/M) Visits

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Evaluation and Management (E/M) Visits

CMS proposes to refine the E/M visit code set by:

- "Splitting" or sharing visits, which is an E/M visit that is performed by both a physician and a Non-Physician Practitioner (NPP), as long as the visit meets the conditions for services furnished.
  - Only the physician or NPP who performs the substantive portion of the split can bill for the visit.
  - CMS seeks feedback on their substantive portion definitions and if there should be a list of qualifying activities.
- Adopt the CPT language for critical care services.

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Indirect Compensation Arrangements (ICAs)

- CMS proposes to change the definition of ICAs to include any unbroken financial relationships in which the compensation closest to the physician involves compensation for anything other than services that they personally perform.

- This includes arrangements for the rental of office space or equipment that meet the other conditions of the regulations.

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RFI on Vaccine Administration Services

CMS seeks comments on:

- **The costs involved in furnishing preventative vaccines (e.g., pneumonia, flu and hepatitis B)**
  - The different types of health care providers who administer vaccines and how that has changed since the beginning of the pandemic.
  - How the costs of furnishing flu, pneumococcal and hepatitis B vaccines compare to the cost of furnishing COVID-19 vaccines.
  - How the PHE may have impacted costs, including whether those costs will continue beyond the PHE.
- **The $35 add-on payment for certain vulnerable beneficiaries who received the COVID-19 vaccine at home.**

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Questions?

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