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A Look At The Proposed Changes For OPPS in 2022

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Proposed Updates to Comprehensive APCs (C-APCs)

Proposed Changes to C-APCs

- **No New C-APCs are being proposed for CY 2022**
  - Number of C-APCs will remain at 69
  - Full list is available in Table 1 of the OPPS Proposed Rule
- **Current packaging exception for COVID-19 treatments will continue through the end of the current PHE**
  - Treatment must be a drug or biological authorized to treat COVID-19
  - Treatment must be authorized for use in the outpatient setting or not be limited to the inpatient setting

Proposed Updates to APC-Specific Policies

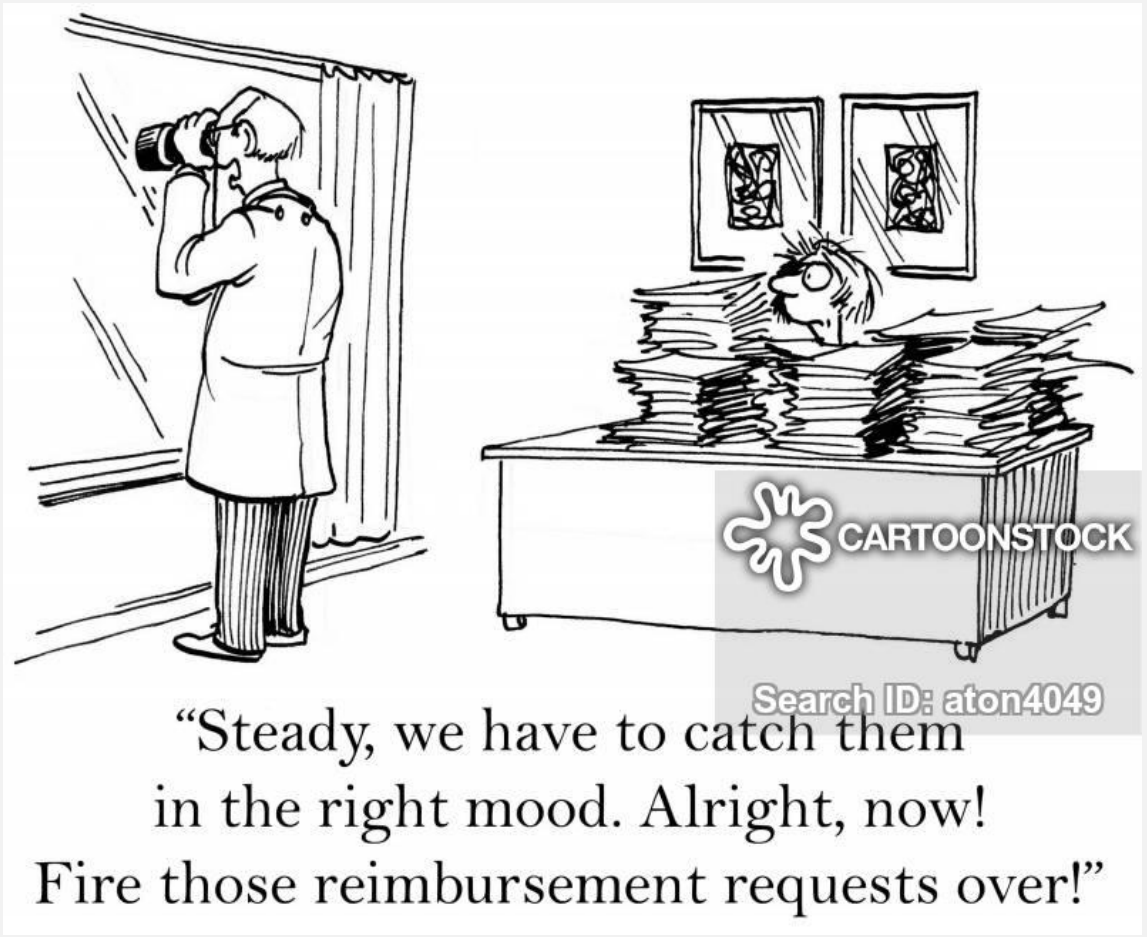
Proposed Changes to New Technology APC Groups

HCPCS	Description	2022 APC	2022 $	2021 APC	2021 $
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	N/A	$0	5733	$56
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	N/A	$0	5441	$261

Packaging Policies Related to Non-Opioid Pain Management

- Soliciting comments on barriers to accessing non-opioid pain management products and changes to existing policies that would help overcome these
- Seeking comment on how to determine if existing policies are causing access issues to non-opioid pain management drugs/devices
- Seeking information on non-drug products that should be eligible for separate payment as non-opioid pain management alternatives

Proposed OPPS Payment For Devices



Pass-Through Status for Devices

10 Devices with Continuing Pass-Through Status

- Surefire® Spark™ Infusion System – HCPCS Code C1982
- Optimizer® System – HCPCS Code C1824
- AquaBeam® System – HCPCS Code C2596
- AUGMENT® Bone Graft – HCPCS Code C1734
- CustomFlex ARTIFICIALIris® - HCPCS Code C1839
- Exalt™ Model D Single-Use Duodenoscope – HCPCS code C1748
- Hemospray® - HCPCS code C1052
- SpineJack® System – HCPCS code C1062
- Barostim Neo® - HCPCS code C1825
- Shockwave C^2 Coronary Intravascular Lithotripsy catheter – C1761

remedē® System

HCPCS Code C1823

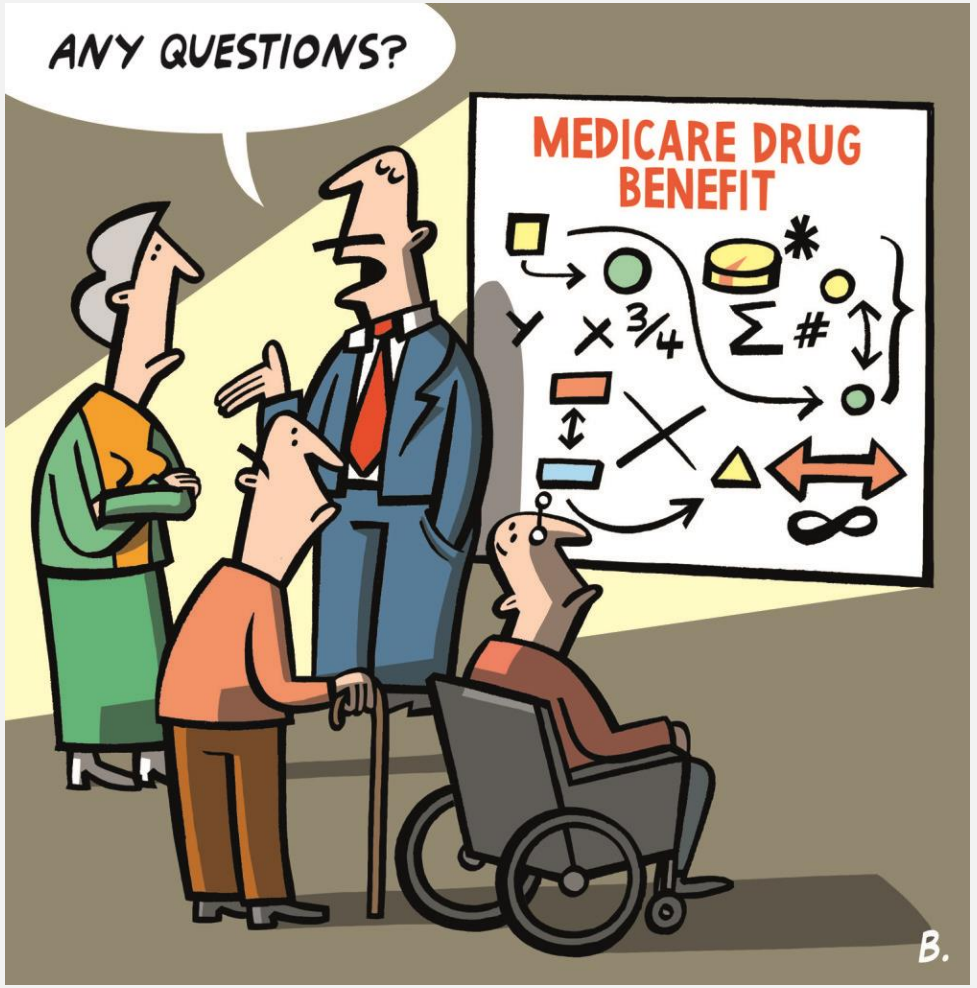
- Proposal to make separate payment for four quarters due to effects of COVID PHE

Pass-Through Status Applications

Eight Applications for Pass-Through Status Received – CMS is requesting public comments on whether devices meet criteria for pass-through status

- RECELL® System
- AngelMed Guardian® System
- BONEBRIDGE Bone Conduction Implant System
- Eluvia™ Drug-Eluting Vascular Stent System
- Cochlear™ Osia® 2 System
- Pure-Vu® System
- Xenocor Xenoscope™

Drugs, Biologicals & Radio-pharmaceuticals



Drugs, Biologicals, & Radiopharmaceuticals

There are 72 drugs and biologicals proposed for new or continuing pass-through status for Q1 of 2022

- Status Indicator “G”
- Paid at ASP + 6% for at least two years but not more than three years OR at WAC + 3% if ASP data is not available
- Biosimilars paid at ASP + 6% of reference product’s ASP
- Therapeutic radiopharmaceuticals and blood clotting factors continue to be paid at ASP + 6%
- Payment rates updated on a quarterly basis
- See VitalKnowledge or Tables 28/29 for complete list of drugs with pass-through status for Q1 of 2022

Drugs, Biologicals & Radio-pharmaceuticals

- Proposed packaging threshold for CY 2022 is $130, which is the same as CY 2020/2021

Alternative Payment Methodology for 340B Drugs

Non-pass-through drugs purchased under 340B program are proposed to be paid at ASP minus 22.5% for 2022 (No Change)

- Modifier JG should be assigned to 340B drugs by OPPS facilities
- Modifier use will trigger payment reduction
- Modifier TB should be assigned to 340B drugs by facilities that are not subject to the payment reduction
  - No payment reduction will result from modifier use
  - For use by rural SCHs, children's hospitals and PPS-exempt cancer hospitals

Alternative Payment Methodology for 340B Drugs

- Modifier requirements and payment reduction applies only to drugs with status indicator of “K”
- Vaccines and pass-through drugs are excluded
- Non-OPPS facilities are excluded such as critical access hospitals and Maryland hospitals
- Does apply to non-excepted HOPDs as of 2019
- US Supreme Court has agreed to hear the case during its upcoming session

Pass-Through Status Extended

There are 27 drugs with expiring pass-through status that will receive 1-4 quarters of continued separate payment due to effects of COVID PHE

A9590 (4)	C9046 (3)	C9047 (2)	J0121 (2)	J0222 (4)
J0291 (4)	J0642 (3)	J1095 (3)	J1096 (2)	J1303 (2)
J1943 (4)	J2798 (4)	J3031 (3)	J3111 (1)	J3245 (3)
J7169 (3)	J7208 (3)	J9036 (2)	J9119 (3)	J9204 (4)
J9210 (2)	J9269 (2)	J9313 (3)	J9356 (1)	Q5108 (3)
Q5110 (3)	Q5111 (3)			

Partial Hospitalization Program

Partial Hospitalization Program

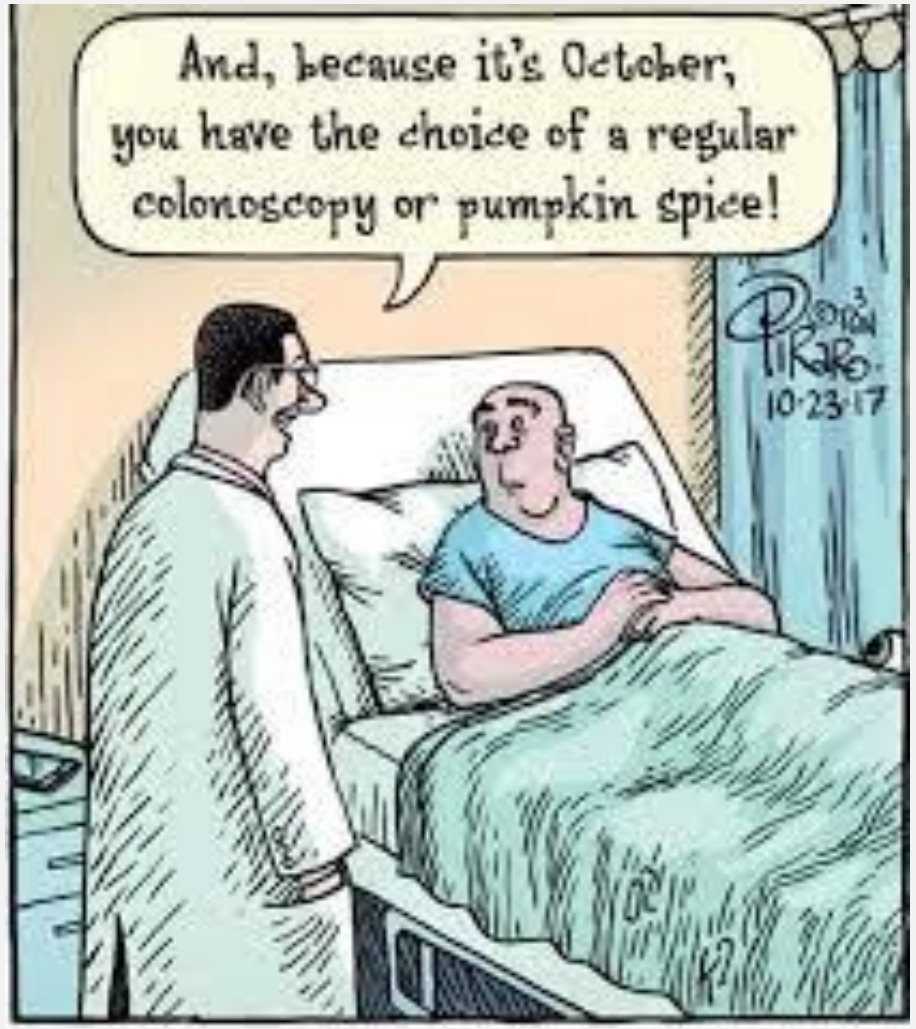
CMHCs providing 3 or more services per day will continue to be reimbursed under APC 5853

- CY 2022 proposed reimbursement rate of $136.14
- Reported costs from CMHCs have continued to decrease
- Cost floor continued for CY 2022 to avoid another reimbursement decrease
- CMHCs urged to review cost-reporting instructions as there appears to be a number of errors in the data submitted

Hospital-based PHP providers providing 3 or more services per day will continue to be reimbursed under APC 5863

- CY 2022 proposed reimbursement rate of $253.76

Proposed Changes to Inpatient Only List



Proposed Changes to Inpatient Only List

Reversal of decision to phase out the Inpatient Only (IPO) List over a 3-year period

- All IPO procedures removed in 2021 will be added back to the IPO list for CY 2022 (298 services)
- No procedures are proposed to be removed from the IPO for CY 2022

Don’t forget – Procedures that aren’t on the inpatient only list aren’t REQUIRED to be performed on an outpatient basis

Proposed Changes to Inpatient Only List

CMS is soliciting comments in the following areas:

- Should any of the 298 services that were removed from the IPO list in 2021 NOT be added back?
- Should CMS continue to maintain the IPO list but scale it back to allow procedures to be performed where clinically appropriate based on current standards of practice?
- What is a reasonable timeframe to eliminate the IPO list, if that is the route taken?
- Is CMS using the right approach to remove procedures from the IPO list, or should other criteria be considered?
- What effect will any changes have on Medicare beneficiaries and on providers?

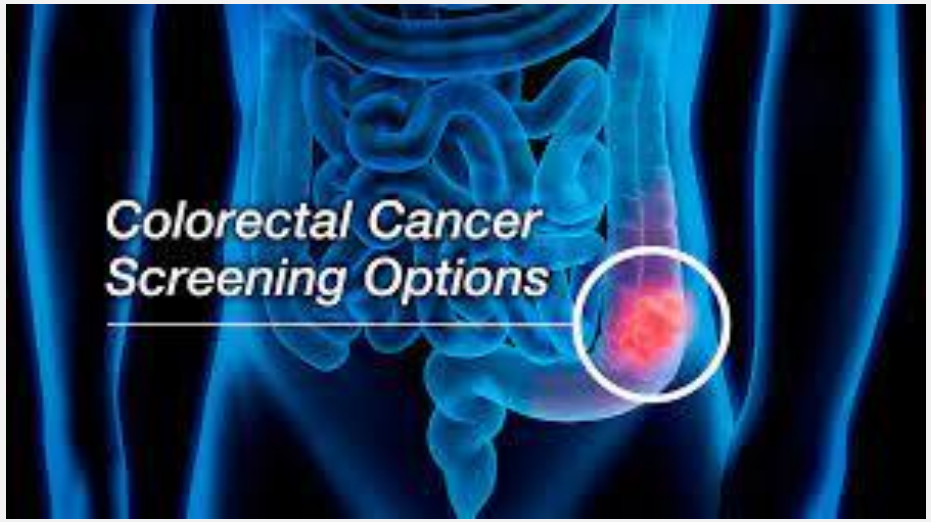
Two-Midnight Rule

RAC Review Exemption

- Procedures on the IPO list are appropriate for IP hospital admission **regardless of expected length of stay**
- Procedures removed from the IPO list will be exempt from “patient status” review for 2 years rather than indefinitely
  - Can still be reviewed by BFCC-QIO or RAC for medical necessity
  - Not to be used to determine a hospital’s compliance with the 2-midnight rule

Proposed Non-recurring Policy Changes

Changes to Coinsurance



Phased elimination of coinsurance for screening tests that become diagnostic services

- Append HCPCS modifier PT to the diagnostic procedure code
  - Coinsurance of 20% for CY 2022
  - Coinsurance of 15% for CY 2023
  - Coinsurance of 10% for CY 2027- CY 2029
  - Coinsurance of 0% for CY 2030 and beyond

Flexibilities Related to COVID PHE

CMS is soliciting information on flexibilities due to waivers that will end when the PHE is declared over

- Volume of audio/video mental health services provided
- Virtual presence of supervising physician
- HCPCS code C9803 for specimen collection
- Use of 2019 claims data/cost reports for CY 2022 rate setting

Method to Control Unnecessary Increases in Hospital OP Services

Clinic visits provided in excepted off-campus provider-based clinics will continue to be reimbursed at the Physician Fee Schedule (PFS) rate

- Will apply to HCPCS code G0463, Outpatient clinic visit, when reported with modifier PO
  - For 2022, reimbursement rate will be equal to 40% of reimbursement under OPPS
  - Non-budget neutral change
  - CMS prevailed on appeal to the D.C. District Court
  - US Supreme Court declined to hear the case

Requirements for Hospitals to Make Public a List of Their Standard Charges

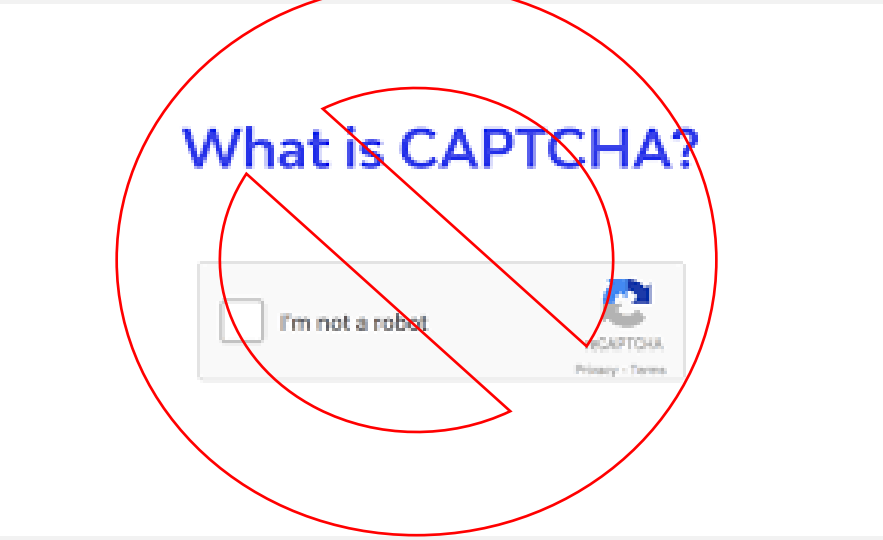
Proposal to Increase Civil Monetary Penalties for Noncompliance

- Hospitals with <= 30 beds - CMP amount will be $300 per day
- Hospitals with more than 31 beds– CMP amount will be $10 per bed per day
  - Amount caps at $5,550 per day
  - Number of beds will be determined based on most recent cost report

Proposal to Exclude Facility from Rules

- State forensic hospitals will qualify for exemption
  - Defined as a public psychiatric hospital that provides treatment for individuals who are in the custody of penal authorities
  - Will not apply unless treatment is exclusively provided to those patients

Proposals Prohibiting Barriers to Access



- Pricing information must be accessible to automated searches and direct file downloads
- Link must be posted on a publicly available website
- No blocking codes or CAPTCHA allowed

Hospital outpatient quality reporting program

Proposed Changes to Hospital OQR Program

Removal of Measures

- OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (2023)
- OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention (2023)

New Measures

- COVID-19 Vaccination Coverage Among Health Care Personnel (2022)
- Breast Screening Recall Rates (2022)
- STEMI eCQM (2024)
- OP-37a-e – Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (2024)

New Proposed Quality Measures

- **COVID-19 Vaccination Coverage Among HCP**
  - Denominator: Number of HCP eligible to work for at least 1 day of self-selected week
  - Numerator: Number of HCP who have received complete vaccination course
  - Reported quarterly through the CDC's NHSN web-based surveillance system
- **Breast Screening Recall Rates**
  - Denominator: Number of Medicare patients who received breast screening service (mammogram or DBT) at an OPPS facility
  - Numerator: Number of patients who received a diagnostic mammogram, ultrasound, DBT, or MRI within 45 days of screening service
  - Data will be collected from final claims data

New Proposed Quality Measures

- **ST-Segment Elevation Myocardial Infarction eCQM**
  - Denominator: Number of ER patients 18 years and older diagnosed with STEMI who do not have contraindications to fibrinolytic, antithrombotic, and anticoagulation therapies
  - Numerator: Number of patients who received fibrinolytic therapy within 30 minutes of arrival; or number of patients who received percutaneous coronary intervention (PCI) within 90 minutes of arrival; or number of patients who were transferred to a PCI-capable hospital within 45 minutes of arrival at the non-PCI-capable hospital
  - Reported by the hospital's CEHRT using chart data and submitted to CMS, voluntarily in 2023 with mandatory reporting in 2024

Measures Retained for CY 2022 Reporting

Measure Name
OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-8: MRI Lumbar Spine for Low Back Pain
OP-10: Abdomen CT – Use of Contrast Material
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-22: Left Without Being Seen

Measures Retained for CY 2022 Reporting

Measure Name
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
OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Reporting)
OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
OP-35: Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy
OP-36: Hospital Visits after Hospital Outpatient Surgery
Breast Screening Recall Rates

Changes to Quality Improvement Programs – Request for Information

CMS has a goal to move to digital quality measurement for all quality reporting and value-based purchasing programs by 2025 and is seeking feedback

- Proposed definitions of digital quality measures
- Proposed use of FHIR (publicly-available standard for health data exchange, published by HL7®)
- Burdens caused by current quality reporting programs
- Benefits that may be obtained from having access to real-time quality information
- Importance of standardized and interoperable data
- Policy considerations needed when aggregating data from multiple sources
- Initial priority areas when developing digital quality measures

Radiation Oncology Model

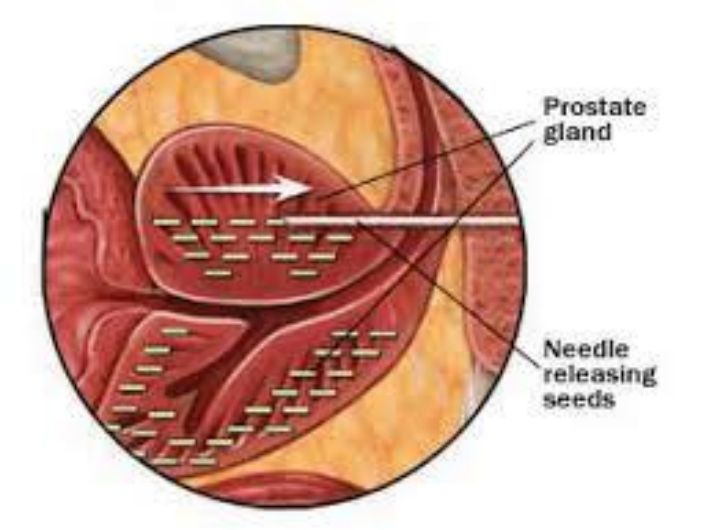
Proposed Radiation Oncology Model Updates

- Performance period will be from January 1, 2022 through December 31, 2026
- Program will NOT apply to RT providers in Maryland, Vermont, or US Territories; ASCs; CAHs; exempt cancer hospitals; facilities participating in the Pennsylvania Rural Health Model (PARHM) https://innovation.cms.gov/initiatives/pa-rural-health-model ; HOPDs participating in the Community Transformation Track of the Community Health Access and Rural Transformation (CHART) model https://innovation.cms.gov/innovation-models/chart-model
- Facilities may opt out due to low volume (fewer than 20 episodes in the most recent year with available claims data)

Included Cancer Types

- Must be commonly treated with radiation
- Must be associated with current ICD-10 codes that have pricing stability
- Must NOT be determined to be inappropriate for inclusion in model
- Liver cancer proposed for removal

Included Therapies



- Proposal to remove brachytherapy from list of included RT services
- Request for ideas on how to pay for multi-modality therapy in the future

Stay Tuned

Next Up

1:55 pm CDT	**Break** 1:55 pm – 2:05 pm CDT
2:05 pm CDT	**Preparing for the CY 2022 CPT® Code Changes** 2:05 pm – 2:50 pm CDT