HEALTHCARE REGULATORY ROUND-UP EPISODE #33

Top Insights From the 2023 Hospital OPPS Proposed Rule

Including Rural Emergency Hospitals

August 17, 2022

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WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

Introductions

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Agenda

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1. OPPS and ASC payment rate updates
2. Payment for 340B drugs
3. Changes to the Inpatient Only List
4. Additional services requiring prior authorization
5. Clinic visits provided in rural sole community hospitals
6. Billing for discarded single-dose/single-use packaged drugs
7. Organ acquisition costs
8. Payment for surgical N95 respirators
9. Rural Emergency Hospital Program
10. RFI – Use of CMS Data to Drive Competition

REMINDER:
Comments due
September 13

1. OPPS and ASC Payment Rate Updates

- Proposed 2.7 percent rate increase
  - Update based on market basket increase of 3.1 percent and -0.4 percent productivity reduction
  - Uses claims data from CY2021; June 2020 HCRIS cost report data
  - IPPS proposed 2.6 percent increase; final rule reflected 4.3 percent
  - Hospitals failing to meet quality reporting requirements subject to additional 2 percent reduction to OPPS conversion factor
- OPPS conversion factor = $86.79 (currently $84.18)
- ASC conversion factor = $51.32 (currently $49.91)

2. Payment for 340B Drugs

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- Impact of Supreme Court decision in *American Hospital Association v. Becerra*
  - Cannot vary payment rates for drugs/biologicals among groups of hospitals without first surveying acquisition costs
  - Decision focused on CYs 2018 and 2019
- Proposed rule at OMB when court decision issued
  - CMS noted that final rule would reflect decision of the Court
    - ASP + 6 percent
    - When will CMS use findings from 2020 survey of acquisition costs??
    - Impact on base rate due to budget neutrality??
      - Paying 340B drugs at same level as other separately payable drugs “will have an effect on the payment rates for other items and services due to the budget-neutral nature” of the system

3. Changes to the Inpatient Only List

PYA

- IOL represents medically complex/invasive services and not appropriate as an outpatient service
- Removal of 10 maxillofacial procedures
- Addition of 8 services to IOL, including –
  - Total disc arthroplasty
  - Implantation of absorbable mesh or other prothesis for delayed closure due to soft tissue infection or trauma
  - Certain repairs of anterior abdominal hernias (4) and parastomal hernias (2)
- Adds lymph node biopsy to ASC covered procedure list

4. Prior Authorization

- Proposes to add facet joint interventions
  - Would be effective on or after March 1, 2023
- Current services requiring prior authorization –
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation
  - Cervical fusion with disc removal
  - Implanted spinal neurostimulators

5. Clinic Visits in Rural SCHs

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- Current policy uses PFS to determine rates for clinic visits at off-campus provider-based departments
  - PFS-equivalent determined as 40 percent of OPPS rate
- Proposes to exempt rural sole community hospitals from the site-neutral clinic visit cuts
  - Services would be paid at full OPPS rate
- Soliciting comments on applicability to other rural hospitals, such as those under 100 beds

6. Discarded Single-Dose/Single-Use Packaged Drugs

- Proposed methodology initially introduced in 2023 MPFS proposed rule
  - Outpatient hospital and ASC claims would report –JW modifier to identify discarded amounts of *refundable* separately payable single-dose/single-use packaged drugs
  - Also proposes use of –JZ modifier in instances of no discarded amounts for these same drugs

7. Organ Acquisition Costs

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- Proposes to exclude “research” organs from the calculation of Medicare’s share of organ acquisition costs
  - Intended to assure that Medicare does not share in the cost of research
- Proposes to cover as organ acquisition costs certain hospital costs incurred when donor dies from cardiac death

8. Payment for Surgical N95 Respirators

PYA

- Payments intended to offset additional marginal resource costs associated with procuring domestically-produced NIOSH-approved respirators
- Proposes biweekly interim lump-sum payments reconciled at cost report settlement
  - Rule outlines needed information for cost reporting periods beginning on or after January 1, 2023

9. Rural Emergency Hospital Program

- Addressed in OPPS
  A. REH Quality Reporting Program
  B. Payment policies
  C. Enrollment process
  D. Stark Law exceptions
- Proposed CoPs addressed previously; comments due August 29

A. REH Quality Reporting Program

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- Recommended by National Advisory Committee
  1. Fibrinolytic therapy received within 30 minutes of ED arrival
  2. Median time to transfer to another facility for acute coronary intervention
  3. Aspirin on arrival
  4. Median time from ED arrival to ED departure for discharged ED patients
  5. Door to diagnostic evaluation by qualified medical personnel
  6. Left without being seen
- MBQIP – Emergency department transfer communication
- Claims-based measures
  1. Abdomen CT – use of contrast material
  2. Hospital visit rate after outpatient colonoscopy
- Other areas of interest
  1. Telehealth
  2. Maternal health
  3. Mental health
  4. ED services
  5. Equity
- Methodological challenges with measurement in low-volume settings

B. REH Payment Policies

- REH services reimbursed at 105% OPPS rate
  - Co-payment based on standard rate
  - Includes services furnished in REHs' off-campus provider-based departments
  - Utilize OPPS claims processing system with REH-specific payment flag; but REH claims not used for OPPS rate setting purposes
  - CMS interprets section 1834(x)(1) to define "REH services" as those services reimbursed under OPPS
    - "We are soliciting comments on whether CMS should adopt a narrower definition of REH services…"
- Payment for non-REH services
  - Clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography paid at applicable fee schedule rate (no 5% increase)

REH Facility Payment

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- CY 2019 total estimated CAH spending = $12,083,666,636
  - Include copayments
  - Use claims data (interim rates?) (CMS = $450M more than cost report data; 42 more CAHs included in claims data than cost report data)
- CY 2019 total estimated PPS payments for CAHs: $7,679,358,171
  - Model PPS payments by processing CAH claims through IPPS, IRF-PPS, IPF-PPS, OPPS, and SNF-PPS* (rejected MedPAC's recommendation to adjust for "missing" primary diagnoses)
  - Calculate/estimate supplemental payments for new technology, outlier claims, clotting factor, IME, DSH, UCC, and low-volume hospitals (but not value-based purchasing adjustments)
- Difference of $4,404,308,465 divided by 1,368 (number of CAHs enrolled in Medicare in CY 2019) = **$3,219,528** (or $268,294 per month)
- For subsequent years, increase by hospital market basked percentage increase

Potential Issues

PYA

- Under-count 2019 CAH payments
  - Use of CAH claims data = interim rates or final settlements?
  - Include payments for professional services under Method II?
- Inconsistent numbers for estimated PPS payments
  - Page 44786: "Total Projected Amount of Medicare Spending for CAHs if Paid Prospectively in CY 2019: $7.68 billion"
  - Page 44780: "Total estimated prospective payment for CAHs in CY 2019 with copayments: $7,033,248,418"
  - $472,298 difference in annual facility payment
- For swing bed to SNF conversion, CMS uses swing bed days, not accounting for the fact swing bed LOS < SNF LOS (even when control for severity of condition)
- Include 6 CAHs that closed in 2019 in total count of CAHs (no adjustment)

C. REH Enrollment Process

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- What we know
  - Submit change of information application (as opposed to initial enrollment application)
  - MAC screening for entities with lowest level of risk
  - Billing privileges effective on date of survey completion
  - Not required to provide Medicare Outpatient Observation Notice
- Transition process
  - Continue to receive payment as CAH/PPS hospital up until REH billing privileges effective?

D. REH Stark Law Exceptions

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- REHs do not provide hospital services but do provide other designated health services
- Expand hospital-specific compensation arrangements to include REHs (except medical staff incidental benefits)
- Propose new REH ownership exception (vs. reliance on rural provider exception)
  - Ownership interest in entire REH (vs. specific department)
  - Ownership not directly or indirectly conditioned on referrals or other business generated
  - Physicians not offered more favorable terms
  - Restrictions on financing and guarantees
  - Distributions proportional to ownership interest
  - No guaranteed additional investment opportunities or other opportunities on more favorable terms

10. RFI – Use of CMS Data to Drive Competition

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- Executive Order 14036 and accompanying fact sheet regarding impacts of hospital consolidation based on analysis of CMS data
- CMS now exploring other ways in which data could be used to drive competition
  - What additional data collected by CMS would be helpful to the public and researchers to evaluate the impact of provider mergers, acquisitions, consolidations, and changes in ownership on the affordability and availability of medical care?
  - Should CMS release data on mergers, acquisitions, consolidations, and changes in ownership for provider types other than hospitals and nursing facilities?

Our Next Health Care Regulatory Round-Up

FY2023 Final Rules

August 31, 2022

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How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services