**Calendar Year 2022 Hospital Outpatient Prospective Payment System Final Rule**

On November 2nd, 2021 the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Hospital Outpatient Prospective Payment System (HOPPS) [final rule.](https://public-inspection.federalregister.gov/2021-24011.pdf) The finalized changes are effective January 1, 2022.

**Conversion Factor Update**

CMS estimates the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.0%. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7% paid under the hospital inpatient prospective payment system (IPPS), minus a 0.7% productivity adjustment. The final conversion factor for hospitals that submit quality data is $84.1770. The conversion factor for hospitals that do not submit quality data is subject to all of the same adjustments except the update is 1.0000 instead of 1.0200. The final conversion factor for hospitals that do not submit quality data is $82.5269.

Due to COVID-19 PHE effects on outpatient service utilization in CY 2020, CMS will utilize CY 2019 data to set CY 2022 OPPS and ASC payment rates. CMS will be using claims data with a date of services between January 1, 2019 and December 31, 2019 to set the 2022 relative weights.

**Estimated Impact on Hospitals**

CMS estimates that OPPS expenditures, including beneficiary cost-sharing will be approximately $82.1 billion, which is approximately $5.9 billion higher than estimated OPPS expenditures in 2021.

**AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES**

**Imaging APCs**

CMS did not make any changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories of which would cause changed pricing for 2022. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

**Proposed CY 2022 Imaging APCs**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| APC | Group Title | SI | Relative Weight | CY 2021 Payment Rate | CY 2022 Payment Rate |
| 5521 | Level 1 Imaging without Contrast | S | 0.9814 | $80.90 | $82.61 |
| 5522 | Level 2 Imaging without Contrast | S | 1.3209 | $108.97 | $111.19 |
| 5523 | Level 3 Imaging without Contrast | S | 2.7917 | $230.13 | $235.00 |
| 5524 | Level 4 Imaging without Contrast | S | 5.8624 | $482.89 | $493.48 |
| 5571 | Level 1 Imaging with Contrast | S | 2.1672 | $178.55 | $182.43 |
| 5572 | Level 2 Imaging with Contrast | S | 4.4678 | $368.12 | $376.09 |
| 5573 | Level 3 Imaging with Contrast | S | 8.6802 | $715.18 | $730.67 |

**\***Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

**CT Lung Cancer Screening**

In the CY 2022 HOPPS Proposed Rule, CMS proposed to place 71271 (Low Dose CT for Lung Cancer

Screening) in the lowest Imaging without Contrast APC (5521), with payment rate of $83.01. The ACR has raised concerns about the inadequate payments for CT lung screening based on flawed hospital data for several years. However, in the CY 2021 Physician Fee Schedule final rule, to preserve longstanding policy, CMS will match CPT code 71271 with predecessor code 71250 and place CPT code 71271 in APC 5522. CMS believes that assignment to APC 5522 for both CPT codes 71250 and 71271 accurately reflects the resources associated with performing these services. In addition, CMS finalized its proposal to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $76.42.

**Medical Physics Dose Evaluation**

In the CY 2022 HOPPS Proposed Rule, CMS proposed to continue to assign CPT code 76145 (Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report (medical physicist/ dosimetrist)) in APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) with a proposed payment rate of $130.19. As a result of comments received by stakeholders, including the ACR, the College is happy with CMS’s decision to reassign CPT code 76145 to APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation) with a payment rate of $345.85.

CMS stated they reviewed the service associated with CPT code 76145, and based on input form their advisors, they believe APC 5612 would be a more appropriate assignment with a proposed payment rate of $347.44. CMS stated that APC 5612 contains CPT code 77307 (Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)), which is clinically similar to CPT code 76145 in that CPT code 77307 describes the work of a medical physicist and dosimetrist. CMS will review APC assignment once claims data have submitted. CMS will then determine whether is it necessary to change APC placement.

**APC Exceptions to the 2 Times Rule**

CMS annually reviews the items and services within an APC group to determine, with respect to comparability of the use of resources, if the highest cost item or service within an APC group is more than 2 times greater than the lowest cost item or service within that same group. CMS made exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments.For 2022, CMS notes that in many cases, the procedure code reassignments and associated APC configurations for 2022 are related to changes in costs of services that were observed in the 2019 claims data. Table 10, found below, lists the 23 APCs that CMS will exempt from the 2 times rule for 2022 based on claims data from January 1, 2019, through December 31, 2019 and processed on or before June 30, 2020.

**Table 10. APC Exceptions to the 2 Times Rule for 2022**

|  |  |
| --- | --- |
| **2022 APC** | **APC Title** |
| 5051  | Level 1 Skin Procedures |
| 5055  | Level 5 Skin Procedures |
| 5071  | Level 1 Excision/ Biopsy/ Incision and Drainage |
| 5101 | Level 1 Strapping and Cast Application |
| 5112  | Level 2 Musculoskeletal Procedures |
| 5161 | Level 1 ENT Procedures |
| 5301  | Level 1 Upper GI Procedures |
| 5311  | Level 1 Lower GI Procedures |
| 5521  | Level 1 Imaging without Contrast |
| 5522  | Level 2 Imaging without Contrast |
| 5523  | Level 3 Imaging without Contrast |
| 5524  | Level 4 Imaging without Contrast |
| 5571  | Level 1 Imaging with Contrast |
| 5612  | Level 2 Therapeutic Radiation Treatment Preparation |
| 5627  | Level 7 Radiation Therapy |
| 5673 | Level 3 Pathology |
| 5691  | Level 1 Drug Administration |
| 5721  | Level 1 Diagnostic Tests and Related Services |
| 5731  | Level 1 Minor Procedures |
| 5734 | Level 4 Minor Procedures |
| 5821 | Level 1 Health and Behavior Services |
| 5823 | Level 3 Health and Behavior Services |

**Changes to New-Technology APCs**

*Changes to MRgFUS*

There are currently four CPT/HCPCS codes that describe magnetic resonance image-guided,

high-intensity focused ultrasound (MRgFUS) procedures. For CY 2021, CMS added an additional level to the Neurostimulator and Related Procedures APCs, Level 3 category (APC 5463) with a geometric mean of approximately $10,950. CMS found it reasonable to estimate of the cost of MRgFUS for the treatment of essential tremor in a prospective payment system where some services receive more payment than their

geometric mean cost, while other services receive less payment than their geometric mean cost. For CY 2022, CMS continue to assign CPT code 0398T to APC 5463 with a payment rate of approximately $11,483.38.

**CY 2022 Status Indicator (SI), APC Assignment, And Payment Rate for the MRgFUS Procedures**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CPT/HCPCSCode | Long Descriptor | CY2021OPPSSI | CY2021OPPSAPC | CY 2021OPPSPaymentRate | CY 2022OPPS SI | CY 2022OPPSAPC | CY 2022OPPSPaymentRate |
| 0071T | Focused ultrasoundablation of uterineleiomyomata,including mrguidance; totalleiomyomatavolume less than200 cc of tissue. | J1\* | 5414 | $ 2,623.21 | J1 | 5414 | $2,679.56 |
| 0072T | Focusedultrasoundablation ofuterineleiomyomata,including mrguidance; totalleiomyomatavolume greater orequal to 200 cc oftissue. | J1 | 5414 | $ 2,623.21 | J1 | 5414 | $2,679.56 |
| 0398T | Magneticresonance imageguided highintensity focusedultrasound(mrgfus),stereotacticablation lesion,intracranial formovement disorderincludingstereotacticnavigation andframe placementwhen performed. | J1 | 5463 | $11,236.21 | J1 | 5463 | $11,483.38 |
| C9734 | Focused ultrasoundablation/therapeuticintervention, otherthan uterineleiomyomata, withmagnetic resonance(mr) guidance. | J1 | 5115 | $12,314.76 | J1 | 5115 | $12,593.29 |

\*Hospital Part B Services Paid Through a Comprehensive APC; aid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.

\*\* Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

**Fractional Flow Reserve Derived from Computed Tomography (FFRCT)**

FFRC is a noninvasive diagnostic service that measures coronary artery disease by CT scans with CPT code 0503T. CY 2020 was the first year CMS had Medicare claims data to calculate the cost of HCPCS code 0503T. For 2021, CMS identified 3,188 claims with 465 single frequency claims. Using its standard methodology, CMS determined a geometric mean cost of $804.35 and proposed to assign CPT code 0503T to New Technology APC 1510 (New Technology Level 10 ($801- $900) with a proposed payment rate of $850.50. Based on comments from providers and other stakeholders indicating that the FFRCT service costs $1,100 and the need for providers to learn how to bill for artificial intelligence services, CMS assigned CPT code 0503T to New Technology APC 1511 (New Technology – Level 11 ($901-$1000). For 2022, CMS finalized their proposal to continue to assign CPT code 0503T to New Technology APC 1511 with a payment rate of $950.50

**Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies**

Effective January 1, 2020, CMS assigned three CPT codes (78431- 78433) describing services associated with cardiac PET/CT studies to New Technology APCs (APCs 1522, 1523, and 1523, respectively). CMS will continue this policy for CY 2022.

**LiverMultiscan Service**

The AMA CPT Editorial Panel established two new codes, specifically, Category III CPT codes 0648T and 0649T for LiverMultiScan effective July 1, 2021, and CMS assigned the Category III CPT code 0648T to APC 5523 (Level 3 Imaging without Contrast) with a status indicator of “S” effective July 1, 2021. In the CY 2022 HOPPS proposed rule, CMS proposed to assign CPT code 0648T to APC 5523 (Level 3 Imaging

without Contrast) with a payment rate of $236.14 effective January 1, 2022, and assign the addon code, CPT code 0649T, to OPPS status indicator “N” (packaged) to indicate that payment for the add-on service is included in the primary service. CMS received many comments relating LiverMultiScan. CMS agreed with commenters that LiverMultiScan and HeartFlow share similar characteristics: both require the acquisition of radiologic images as well as analysis of images using proprietary AI algorithms to assist clinicians in appropriately diagnosing a medical condition. CMS estimates the cost associated for this service is between $901 and $1,000. CMS finalizes the assignment of CPT code 0648T to New Technology APC 1511, the same APC assignment for HeartFlow. CMS finalizes CPT code 0649T, an add-on code, as a packaged service (status indicator “N”).

**Brachtherapy**

Since 2010, CMS has used the standard OPPS payment methodology for brachytherapy sources, with payment rates based on source-specific costs as required by statute. CMS proposed no changes to its brachytherapy policy for 2022.

**CT and MR Cost Centers**

In the 2020 OPPS final rule, CMS adopted a policy to apply 50 percent of the payment impact from ending the transition in 2020 and 100 percent of the payment impact from ending the transition in 2021. For 2020, CMS calculated the imaging payment rates based on 50 percent of the transition methodology (excluding square feet CCRs) and 50 percent of the standard methodology (including square feet CCRs). For 2021, CMS proposed to set the imaging APC payment rates at 100 percent of the payment rate using the standard payment methodology under the policy it adopted in the 2020 OPPS final rule. CMS will continue their policy, and will not make any changes for CY 2022.

**Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals**

**Packaged Drugs, Biologicals, and Radiopharmaceuticals**

CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and may not bill beneficiaries separately for any packaged items.

Threshold-packaged drugs under the OPPS are drugs, non-implantable biologicals and therapeutic radiopharmaceuticals whose packaging status is determined by the packaging threshold. If a drug’s average cost per day exceeds the annually determined packaging threshold, it is separately payable and, if not, it is packaged. For 2022, CMS will maintain a packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status of $130..

**Payment Policy for Therapeutic Radiopharmaceuticals**

CMS will continue paying for therapeutic radiopharmaceuticals at ASP+6 percent. For therapeutic radiopharmaceuticals for which ASP data are unavailable, CMS will determine 2022 payment rates based on 2019 geometric mean unit cost.

**Other HOPPS Payment Policies**

**Payment Adjustments to Cancer Hospitals**

The ACA requires an adjustment to cancer hospitals’ outpatient payments to bring each hospital’s payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPPS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis. Consistent with other policies to not use cost report data that span the COVID-19 PHE, CMS will continue using the same cost data to determine the target PCR for 2022 that it used for 2021. Therefore, CMS is using a target PCR of 0.90 reduced by 1.0 percentage point to 0.89.

Table 6 in the final rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals. No additional budget neutrality adjustment is required for the cancer hospital adjustment in 2022 compared to 2021.

**Table 6. The Estimated Percentage Increase in OPPS Payments to Each Cancer Hospital for CY 2022, Due to The Cancer Hospital Payment Adjustment Policy**

|  |  |  |
| --- | --- | --- |
| **Provider Number** | **Hospital Name** | **Estimated Percentage Increase in OPPS Payments for CY 2020 due to Payment Adjustment** |
| 050146 | City of Hope Comprehensive Cancer Center | 39.6% |
| 050660 | USC Norris Cancer Hospital | 31.7% |
| 100079 | Sylvester Comprehensive Cancer Center | 16.5% |
| 100271 | H. Lee Moffitt Cancer Center & Research Institute | 20.8% |
| 220162 | Dana-Farber Cancer Institute | 34.7% |
| 330154 | Memorial Sloan-Kettering Cancer Center | 38.1% |
| 330354 | Roswell Park Cancer Institute | 14.0% |
| 360242 | James Cancer Hospital & Solove Research Institute | 16.4% |
| 390196 | Fox Chase Cancer Center | 11.2% |
| 450076 | M.D. Anderson Cancer Center | 51.4% |
| 500138 | Seattle Cancer Care Alliance | 46.5% |

**Inpatient Only List**

The IPO list was created based on the premise that Medicare should not pay for procedures furnished as outpatient services that are not reasonable and necessary to be performed in any other setting than inpatient. For CY 2022, CMS will stop the elimination of the inpatient only (IPO) list after finalizing policy in CY 2021 to fully eliminate the list. After clinical review of the services removed from the IPO list in CY 2021, CMS will add the 298 services removed from the IPO list. CMS requested comments 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 systemically scale the list back so that inpatient only designations are consistent with current standards of practice. CMS received comments that 120 services not be placed back on the IPO list. Based on evaluation, CMS is keeping several CPT codes off the IPO list in 2022: 22630 (Lumbar spine fusion), 23472 (Reconstruct shoulder joint), and 27702 (Reconstruct ankle joint) and their corresponding anesthesia codes (01638 and 01486).

**Changes to Beneficiary Coinsurance for Certain Colorectal Cancer Screening Tests**

Medicare pays 100 percent of the payment amount for certain colorectal cancer screening tests that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Thus, a beneficiary pays no cost-sharing for these screening tests.

When the colorectal cancer screening test benefit category was enacted into law, the statute specifically provided that if, during the course of a screening flexible sigmoidoscopy or screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under Medicare Part B shall not be made for the screening flexible sigmoidoscopy, but rather shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal. The result was that beneficiaries faced unexpected coinsurance charges because the procedure was classified as a diagnostic test instead of a preventive service screening test.

Section 4104 of the ACA addressed this issue with respect to the deductible but not for any coinsurance that may apply. Section 122 of the CAA addresses this issue for the coinsurance by successively reducing, over a period of years, the percentage amount of coinsurance for which the beneficiary is responsible so that for services furnished on or after January 1, 2030, the coinsurance will be zero. The phased-in increases in the amount the Medicare program pays for these services on or after January 1, 2022 are as follows:

|  |  |  |
| --- | --- | --- |
| **Year** | **Medicare Payment Percent** | **Beneficiary Coinsurance Percent** |
| 2022 | 80 | 20 |
| 2023 – 2026 | 85 | 15 |
| 2027 – 2029 | 90 | 10 |
| 2030 and subsequent years | 100 | 0 |

CMS stated they will examine the claims data, and monitor for any increases in surgical services unrelated to the colorectal cancer screening test performed on the same date as the screening test for a notable increase or abuse of this policy.

**Comment Solicitation on Temporary COVID-19 Policies**

In response to the COVID-19 pandemic, CMS issued waivers and undertook emergency rulemaking to implement a number of temporary policies to address the pandemic, including policies to prevent spread of the infection and support diagnosis of COVID-19. CMS sought on whether any of the temporary policies should be made permanent.

**Direct Supervision by Interactive Communications Technology**

During the PHE, CMS waived the requirement for direct supervision to be provided through the physical presence of a physician or non-physician practitioner for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services. CMS found that commenters supported allowing direct supervision of cardiac rehabilitation and pulmonary rehabilitation, and intensive cardiac rehabilitation services through two-way, audio/video communication technology on a permanent basis, or, for a period of time following the conclusion of the PHE, such as until the end of 2022. CMS will consider further comments for further rule making.

**Request for Information on Rural Emergency Hospitals (REHs)**

Section 125 of the CAA of 2021 establishes rural emergency hospitals (REHs) as a new Medicare provider type that will furnish emergency department services and observation care. The REH must have a staffed emergency department 24 hours a day, 7 days a week. In addition, an REH may elect to furnish other medical and health services on an outpatient basis as the Secretary may specify through rulemaking. REHs may not provide acute care inpatient services, except for skilled nursing facility services that are furnished in a distinct part unit. CMS sought public comments through this RFI to inform its policy making. CMS plans to consider the public comments for possible future rulemaking.

**Measure Changes within the Hospital OQR Program**

*Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Outpatient Quality Programs – Request for Information**(p.836)*

In the Hospital Outpatient Prospective Payment System proposed rule for calendar year 2022, CMS sought stakeholder input through a formal Request for Information (RFI) on the transition of digital quality measurement (dQM) across Medicare quality performance programs by 2025. CMS states this effort is to maintain the alignment and harmonization outlined in the 2020 Department of Health and Human Services (HHS) Health Quality Roadmap, CMS is approaching HHS’ priorities with other federal entities, like the Office of the National Coordinator on Health Information Technology (i.e., 21st Century Cures Act), to promote data interoperability and access.

In response to the RFI, CMS received a large volume of that they state will be used to inform future rule making on the 2025 transition to FHIR.

**Hospital Outpatient Quality Reporting Program** *(p. 860)*

CMS previously established policies for selecting, retaining, and removing Hospital Outpatient Quality Reporting Program (OQR) quality measures. There are no changes to any of these policies at this time.

*Finalized Removals Beginning with the CY 2023 Reporting Period/CY 2025 Payment*

*Determination (p. 867)*

CMS has finalized their proposal to remove OP-2 (Fibrinolytic Therapy Received within 30 Minutes of ED Arrival) and OP-3 (Median Time to Transfer to Another Facility for Acute Coronary Intervention) and replace them with the ST-Segment Elevation Myocardial Infarction (STEMI) eCQM (newly designated as OP-40), which reduces burden with electronic reporting. More information on OP-40 can be found further in this detailed summary.

*New Measures for the Hospital OQR Program (p.867)*

CMS has adopted three new measures: COVID-19 Vaccination Coverage Among Health Care Personnel, Breast Cancer Screening Recall Rates, and STEMI eCQM.

*COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) (p. 867)*

Due to the public health emergency (PHE) COVID-19, CMS has adopted a vaccination measure among HCP (newly designated as OP-38) beginning with the CY 2022 reporting period. This measure will help the CDC to track COVID-19 vaccination coverage among HCP in non-LTC facilities, including outpatient hospitals. CMS emphasizes that this measure does not require a hospital to enforce staff vaccination in order for the hospital to successfully participate in the Hospital OQR Program; instead, the hospital must report the rate of its staff that have completed a complete vaccination course. In collaboration with the CDC, facilities will report data to the National Healthcare Safety Network (NHSN) by enrolled facility (also known as OrgID); the CDC will then translate and submit the data to CMS. OP-38 will be publicly reported, beginning with the October 2022 Care Compare refresh, or as soon as technically feasible.

The measure denominator is the number of HCP eligible to work in the hospital for at least 1 day during the self-selected week, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. The numerator for the HCP measure is the cumulative number of HCP eligible to work in at the hospital for at least 1 day during the self-selected week and who received a complete vaccination course against COVID-19.

*Breast Cancer Screening Recall Rates (p. 895)*

CMS will adopt the Breast Cancer Screening Recall Rates measure (newly designated as OP-39) beginning in the CY 2022 reporting period. This measure fills the gap that was left in the Hospital OQR Program measure portfolio with the removal of the Mammography Follow Up Rates measure (OP-9), which did not address digital breast tomography (DBT). OP-39 calculates the percentage of Medicare fee-for-service (FFS) beneficiaries from claims at the facility level for whom a traditional mammography or DBT screening study was performed that was then followed by a diagnostic mammography, DBT, ultrasound of the breast, or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting on the same day or within 45 days of the index image. There are no exclusions for this measure, and it is not risk-adjusted. The goal for this measure is a recall rate between 5-12 percent, as a high cumulative dose of low-energy radiation could signify high false-positives, and a significantly low recall rate could lead to delayed or undetected cases of cancer. The recall rate range is not based on specific clinical guidelines but does use peer-reviewed consensus documents, including the ACR BI-RADS Manual 2013, that support the importance of appropriate recall rates.

*ST-Segment Elevation Myocardial Infarction (STEMI) eCQM (p. 908)*

CMS will adopt the STEMI eCQM (OP-40) beginning with the CY 2024 reporting period. This eCQM measures the percentage of ED patients with a diagnosis of STEMI who received timely delivery of guideline-based reperfusion therapies appropriate for the care setting and delivered in the absence of contraindications. As mentioned previously in this summary, OP-40 replaces OP-2 and OP-3, which were manually chart-abstracted. OP-40 broadens the group of measured STEMI patients and better supports compliance with the full group of patients covered in the 2013 ACCF and AHA guidelines for the management of STEMI by measuring timeliness and appropriateness of care for STEMI patients in the ED. This measure also assists the transition towards the use of EHR data in the HOQR program.

*Finalized Measures in the Hospital OQR Program**(p. 939)*

The following table depicts the previously finalized measures in the HOQR program that are related to imaging:

**Table 63: Hospital OQR Program Measure Set for the CY 2023 Payment
Determination Related to Imaging**

|  |  |
| --- | --- |
| **Number** | **Measure Name** |
| 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-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-39 | Breast Cancer Screening Recall Rates\*\*\*\**Newly finalized in 2021* |

*Hospital OQR Program Measures and Topics for Future Considerations* *(p. 942)*

*Introduction and Expansion of the CMS Disparity Methods to Hospital OQR Program (p. 955)*

Consistent with the executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, in conjunction with the CMS Quality Strategy and Meaningful Measures Framework, CMS invited stakeholder comments regarding achieving health equity for all patients by implementing new health equity-focused policies in the Hospital Outpatient Quality Reporting program within the Hospital Outpatient Prospective Payment System proposed rule for calendar year 2022.

The proposed rule stated that "Significant and persistent inequities in health care outcomes exist in the United States." And that "belonging to a racial or ethnic minority group; living with a disability; being a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; living in a rural area, or being near or below the poverty level" is associated with worse health outcomes. Unfortunately, the COVID-19 pandemic highlights many of these longstanding health inequities with higher infection rates, hospitalization, and mortality among Black, Latino, and Indigenous and Native American individuals relative to their white counterparts. Although different factors result in disparate health outcomes, CMS cited that limited access to high-quality care is a significant contributor. Therefore, CMS proposed improving data collection of the elements influencing inequities within their quality programs. CMS perceives that this would present opportunities for providers to receive the resources necessary to improve their care quality. Having received a large volume of comments on this high priority area, CMS notes that commenters’ feedback will be taken into consideration during

future policy development.

*Administrative Requirements**(p. 578)*

While there are no proposed changes to the rules regarding the security official who is responsible for the security and account management requirements for the hospital’s QualityNet account, CMS does wish to clarify in this proposed rule that failure to maintain an active QualityNet security official will result in a finding that the hospital did not successfully participate in the Hospital OQR Program.

*Claims-Based Measure Data Requirements for CY2024 Payment Determination and Subsequent Years**(p. 582)*

There are no proposed changes to the claims-based measure requirements. The following claims-based measures are required for CY2023 and subsequent years:

* OP-8: MRI Lumbar Spine for Low Back Pain (NQF #0514)
* OP-10: Abdomen CT – Use of Contrast Material
* OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low Risk Surgery (NQF #0669)
* OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (NQF #2539)
* OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
* OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687); and Breast Screening Recall Rates

*Proposed eCQM Reporting and Submission Requirements**(p. 591)*

CMS has stated in previous rules that they intend to include electronic clinical quality measures (eCQMs) in the Hospital OQR Program. As previously stated, CMS proposed to adopt the STEMI eCQM measure beginning in CY2023. In this proposed rule, CMS suggested a progressive increase in the number of quarters for which hospitals will be required to report eCQM data.

For 2023, CMS proposes a voluntary submission period in which hospitals submitting STEMI eCQM data report any quarter(s) of data. For 2024, CMS proposes to require that hospitals report one self-selected calendar quarter of data. This pattern will continue with two quarters required in 2025, three in 2026, and finally all four quarters required in 2027. CMS requests comments related to this proposal.

**Radiation Oncology Model**

*Background*

Under the Radiation Oncology (RO) Model, Medicare would pay participating providers and suppliers a site-neutral, episode-based payment for specified professional and technical radiation therapy (RT) services furnished during a 90-day episode to Medicare fee-for service (FFS) beneficiaries diagnosed with certain cancer types. The RO Model will be mandatory and encompass 30% of all eligible RO episodes, including 950 physician group practices (PGPs), hospital outpatient departments (HOPDs), and freestanding radiation therapy centers in 204 core-based statistical areas (CBSAs). In the Specialty Care Models final rule published in September 2020, CMS expected savings of $230 million from the RO Model. CMS updated saving expectations, CMS expects savings will be reduced to $150 million due to the changes to the model including: the removal of brachytherapy, the removal of liver cancer, and revised performance period and baseline periods. The Consolidated Appropriations Act (CAA), 2021, included a provision that prohibits implementation of the RO Model before January 1, 2022.

*Performance Period*

CMS modified the RO Model performance period to January 1, 2022 through December 31, 2026. Each performance period will be a 12-month period, unless the initial model performance period starts mid-year, in which case performance year (PY) 1 will begin on that date and end on December 31 of that year.

CMS will define the “baseline period” specifying which episodes are used in the pricing methodology. The baseline period will be January 1, 2017 through December 31, 2019, unless the RO Model is prohibited by law from starting in 2022. CMS modified the definition of “model performance period” to mean the five PYs during which RO episodes must initiate and terminate.

*Participant Exclusions*

CMS will exclude from the RO Model only the HOPDs that are participating in the Pennsylvania Rural Health Model (PARHM), rather than excluding both HOPDs in the PARHM and those that are eligible to participate in the PARHM. CMS will also exclude the HOPD of any participating hospital in the Community Transformation Track of the Community Health Access and Rural Transformation (CHART) Model from the RO Model.

In prior rulemaking, CMS finalized that a PGP, freestanding radiation therapy center, or HOPD, which would otherwise be required to participate in the RO Model, may choose to opt out if it has fewer than 20 episodes of RT services across all CBSAs selected. CMS clarified that the dates of data used to determine eligibility for low volume opt-out are the most recent year with claims data available, which is 2 years prior to the PY. At least 30 days prior to the PY start date, CMS will notify RO participants eligible for the low volume opt-out.

CMS also updated the definition for legacy CMS certification number (CCN) and legacy taxpayer identification number (TIN) in the final rule. CMS defines a legacy CCN as a CMS certification number (CCN) that an RO participant that is a hospital outpatient department (HOPD) or its predecessor(s) previously used to bill Medicare for included radiotherapy (RT) services but no longer uses to bill Medicare for included RT services. CMS will define legacy TIN as a taxpayer identification number (TIN) that an RO participant that is a PGP, or a freestanding radiation therapy center, or its predecessor(s) previously used to bill Medicare for included RT services but no longer uses to bill Medicare for included RT services.

CMS also finalized their proposal that during the model performance period, an entity would not be eligible for the low volume opt-out if its legacy TIN or legacy CCN was used to bill Medicare for 20 or more episodes or RO episodes, as applicable, of RT services in the 2 years prior to the applicable PY across all CBSAs selected for participation. CMS believes this change removes any incentive for RO participants to change their TIN or CCN in an effort to become eligible for the low volume opt-out.

*Changes to RO Model Episodes*

CMS amended the criteria to include cancer types in the RO Model, so that: a cancer type must be commonly treated with radiation per nationally recognized, evidence-based clinical treatment guidelines; associated with current ICD-10 codes that have demonstrated pricing stability, which is determined by analyzing interquartile ranges of the episode prices across cancer types; and the Secretary must not have determined the cancer type is not suitable for inclusion in the RO Model. As a result of the amended criteria, CMS removed liver cancer from the list of cancer types included.

CMS removed brachytherapy as an included modality in the RO Model. CMS stated that it does not seek to incentivize or discourage the use of one modality over another, but to encourage providers to choose the RT services that are the most clinically appropriate. CMS will monitor the utilization of brachytherapy as a single modality and multimodality among RO participants compared to non-participants, and consider whether there is opportunity to adjust pricing for multimodality episodes and potentially add brachytherapy to the model in the future.

Episode payment rates in the RO Model are modality-agnostic, and CMS does not have separate national base rates per included cancer type based on a specific modality. Because the evidence base for Intraoperative Radiotherapy (IORT) is limited to certain cancer types, and it is a modality that is not site neutral, it does not meet the qualifications for inclusion in the model. CMS sought comments on whether and how they may include IORT in the model pricing methodology in future years. CMS did not respond to comment, but states that comments will inform potential changes to the RO Model.

*Pricing Methodology*

CMS had previously finalized that for sequestration, they would deduct 2% from each episode payment after applying the trend factor, geographic adjustment, case mix and historical experience adjustments, discount, withholds, and coinsurance to the national base rates. However, the requirements for sequestration may be modified by legislation or regulation, and as a result, CMS will remove the percentage amount and indicating that sequestration will be applied in accordance with applicable law.

CMS is excluding all Maryland, Vermont, and US Territory claims, and all CAH, inpatient, ASC and PPS-exempt claims from episode construction, attribution, and pricing. Furthermore, CMS will exclude all claims of an HOPD participating in PARHM, as well as episodes that are attributed to an RT provider or RT supplier that is located in a ZIP Code not assigned to a CBSA for model participation.

For PY 1, under the EUC policy, Professional participants and Dual participants have the option to submit data for three pay-for-performance measures: 1) Plan of Care for Pain; 2) Screening for Depression and Follow Up Plan; and 3) Advance Care Plan. A fourth measure, Treatment Summary Communication – Radiation Oncology, will be established as a pay-for-reporting measure. CMS clarified that the number of national base rates will vary based on how many cancer types are included in the model. CMS also clarified that Part B expenditures during the baseline period would be used to establish separate professional component (PC) and technical component (TC) national base rates for each of the included cancer types, the historical experience adjustments, and the case mix adjustments for PY1. The case mix adjustments for PY2-PY5 would be calculated using the case mix model from the baseline period with inputs from beneficiary characteristics from the most recent 3-year period.

As previously finalized, CMS will apply a trend factor, an adjustment applied to the national base rates that updates those rates to reflect current trends in the OPPS and PFS rates for services, to each of the national base rates. For each performance year, CMS will calculate separate trend factors for the PC and TC of each cancer type using data from HOPDs and freestanding radiation therapy centers not in the model. CMS clarified that the number of separate trend factors will vary depending on the number of cancer types included in the model. The trended national base rates will be made available on the RO Model website prior to the start of the applicable performance year.

CMS previously finalized a stop-loss limit of 20% for RO participants that had fewer than 60 episodes from 2016-2018. Under this policy, CMS would use no-pay claims to determine what these RO participants would have been paid under FFS compared to the model, and CMS would pay these participants retrospectively for losses in excess of 20% of what they would have been paid under FFS. Payments under the stop-loss policy will be determined under reconciliation, which occurs in August after the end of each performance year, and a true-up of the reconciliation would take place one year later. CMS changed the definition of “stop-loss reconciliation amount” to mean the amount owed by CMS for the loss included under the Model to RO participants that have fewer than 60 episodes during the baseline period and were furnishing included RT services any time before the start of the model performance period in the CBSAs selected for participation. The model’s discount factor payment cuts remain at 3.5% off the professional component (PC) payment and 4.5% off of the technical component (TC) payment.

Previously, CMS had proposed that RO participants submit quality measure data starting in PY1, and that starting in PY1, the 2% quality withhold for the PC will be applied. CMS will not be finalizing this policy due to the EUC policy.

CMS finalizes its proposal to align the model performance period so that the final year of the baseline period would be used to calculate the implied RVU shares. CMS is not considering the exclusion of 2020 data from the case mix adjustment.

*Advanced APM/MIPS APM*

Criterion to be an Advanced APM includes: 1) use of certified EHR technology (CEHRT), 2) payment based on quality measures, and 3) financial risk. RO Model participants must annually certify their use of CEHRT, have their payment adjusted by a 2% quality withhold with the chance of earning some or all back based on their AQS, and have discount factors applied to RO Model payments. The RO Model also meets the criteria to be a MIPS APM, and any MIPS eligible clinician who is included on the individual practitioner list may report and be scored for MIPS as part of an APM Entity through the APM Performance Pathway. In previous rule making, CMS established that RO Model participants must use CEHRT and annually certify to its use during the model performance period within 30 days of the start of each PY. CMS will continue this policy so that if an RO participant begins participation in the RO Model at any time during an ongoing PY, they must certify their use of CEHRT by the last determination snapshot date.

CMS modified the Track One and Track Two proposal, as established in the proposed rule, by splitting the Track One component into two tracks, establishing Tracks One, Two and Three. Track One will be for RO participants who comply with all RO requirements, including CEHRT. Track One RO Participants will be considered either Advanced APMs and MIPS APMs. Track Two will be for those RO participants who comply with all RO Model requirements except for CEHRT, therefore making these participants MIPS APMs. Track Three will be for all other RO participants who will not be considered either an Advanced APM or MIPS APM.

CMS states that by establishing the new Track Two category, those RO participants who do not certify their use of CEHRT can be eligible for MIPS APM reporting and scoring pathways. CMS believes this lessens the burden of the CEHRT requirement.

In prior rulemaking, CMS established that an incomplete episode occurs when: 1) a Technical or Dual participant does not furnish TC to a beneficiary within 28 days following a treatment planning service or 2) when traditional Medicare stops being the primary payer, or 3) a beneficiary stops meeting all the beneficiary criteria. CMS modified this policy for all incomplete episodes in such a way that will allow CMS to reconcile the episode payment for the PC and TC that was paid to the RO participant with what the FFS payments would have been for those RT services using no-pay claims. After reviewing incomplete episode data, CMS determined that the data did not support paying RO participants only the first installment of an episode for incomplete episodes, which was the previous policy. CMS modified the coinsurance associated with incomplete episodes so that it is set at 20 percent of the FFS amount applicable to the RT services provided.

*Extreme and Uncontrollable Circumstances*

In the final rule, CMS establishes an EUC policy that provides Professional and Dual participants with the option of submitting quality measures data starting with PY1 (January 1, 2022). For PY 1, under the EUC policy, Professional participants and Dual participants have the option to submit data for three pay-for-performance measures: 1) Plan of Care for Pain; 2) Screening for Depression and Follow Up Plan; and 3) Advance Care Plan. A fourth measure, Treatment Summary Communication – Radiation Oncology, will be established as a pay-for-reporting measure. To help identify RO participants that are experiencing EUC, CMS would consider: 1) whether the RO participants are furnishing services within a geographic area considered to be within an “emergency area” during an “emergency period”, 2) whether the geographic area within a county, parish, U.S. territory, or tribal government served as a condition precedent for 1135 waiver authority, or the National Emergencies Act, and 3) whether a state of emergency has been declared in the geographic area.

In instances where an EUC is nation-wide and impacts RO participants’ ability to implement the requirements of the RO Model at the start of the model performance period, CMS will delay the start date of the model performance period by up to one calendar year. RO Participants would be notified of any changes to the model performance period on the RO Model website no later than 30 days prior to the original start date. In the case where a delay to the RO Model performance period is required due to an EUC, other aspects of the RO Model may be impacted, including status as an Advanced APM and the years that would be included in the baseline period. In the case of a regional EUC, CMS will not change the model performance period, but instead only to delay or exempt requirements for RO participants in the impacted region. If an EUC impacts a RO participants’ ability to comply with the RO Model’s quality measure or clinical data elements reporting requirements, CMS may delay or exempt the affected RO participants from reporting requirements, make the requirements optional, and/or extend the time for RO participants to report data to CMS, as applicable. If CMS decides to remove quality and clinical data submission requirements for affected RO participants due to a national, regional, or local event, CMS may choose to repay the quality withhold during the next reconciliation period and award all possible points in the subsequent AQS calculation for affected RO participants.