Key Proposals in Medicare's 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule [CMS-1772-P]

CMS PROPOSAL
Updating the ASC Conversion Factor (Starts on page 556 of 886) • CMS proposes to update the ASC conversion factor using the hospital market basket (HMB) (together with the multi-factor productivity adjustment) through 2023. • **Migration Data:** CMS reiterated its intent to assess whether there is a migration of the performance of procedures from the hospital setting to the ASC setting because of the use of a hospital market basket update, as well as whether there are any unintended consequences, such as less than expected migration of the performance of procedures from the hospital to the ASC setting. • For CY 2023, the conversion factor is proposed to be increased by 2.7 percent under the OPPS and ASC Payment System (for facilities that meet the quality reporting requirements) (calculated as 3.1 percent HMB update minus the MFP of 0.4 percent). • **Cost Data:** CMS also reiterated the Agency's request to "assess the feasibility of collaborating with stakeholders to collect ASC cost data in a minimally burdensome manner and could propose a plan to collect such information. Such cost data would be beneficial in establishing an ASC-specific market basket index for updating payment rates under the ASC payment system." The proposed conversion factor is **$51.315** for ASCs and **$86.785** for HOPDs. The ratio of these conversion factors is 59.13 percent, which is lower than the ratio in 2022 (59.3 percent).
Updating the ASC Relative Payment Weights for CY 2023 (Starts on page 554 of 886) • CMS proposes an ASC weight scalar of 0.8474 which is lower than the 2021 final ASC weight scalar of 0.8552. • CMS did acknowledge: "where the estimated ASC expenditures for an upcoming year are higher than the estimated ASC expenditures for the current year, the ASC weight scalar is reduced to bring the estimated ASC expenditures in line with the expenditures for the baseline year. ***This frequently results in ASC relative payment weights for surgical procedures that are lower than the OPPS relative payment weights for the same procedures for the upcoming year.*** Therefore, over time, even if procedures performed in the HOPD and ASC receive the same update factor under the OPPS and ASC payment system, payment rates under the ASC payment system would increase at a lower rate than payment for the same procedures performed in the HOPD because of applying the ASC weight scalar to ensure budget neutrality**.**"
Device-Intensive ASC Covered Surgical Procedures (Starts on page 507 of 886) • As of the 2022 payment rule, the device offset percentage is calculated using ASC rates and not HOPD rates. This means that any procedure in in which the device cost is 30 percent of the overall ASC procedure rate receives device intensive status. • There are currently 460 device-intensive codes in 2022. If finalized as proposed, there would be 491 device-intensive codes in 2023.

Key Proposals in Medicare's 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule [CMS-1772-P]

CMS PROPOSAL
• Complexity Adjustments: Also as discussed in more detail in section XIII.D.1.c of the proposed rule, CMS proposes to create a special payment policy under the ASC payment system adding 52 new C codes to the ASC-CPL to provide a special payment for code combinations eligible for complexity adjustments under the OPPS.
Proposed Additions to the List of ASC Covered Surgical Procedures (Starts on page 513 of 886) • CMS is proposing to add one code to the ASC-CPL for 2023, 38531 (Open bx/exc inguinofem nodes). • CMS states, "We continue to focus on maximizing patient access to care by adding procedures to the ASC CPL when appropriate. While expanding the ASC CPL offers benefits, such as preserving the capacity of hospitals to treat more acute patients and promoting site neutrality, we also believe that any additions to the CPL should be added in a carefully calibrated fashion to ensure that the procedure is safe to be performed in the ASC setting for a typical Medicare beneficiary. We expect to continue to gradually expand the ASC CPL, as medical practice and technology continue to evolve and advance in future years. We encourage stakeholders to submit procedure recommendations to be added to the ASC CPL, particularly if there is evidence that these procedures meet our criteria and can be safely performed on the typical Medicare beneficiary in the ASC setting."
Proposed Name Change and Start Date of Nominations Process (Starts on page 516 of 886) • CMS proposes to change the name of the process finalized last year in the CY 2022 OPPS/ASC final rule from "Nominations" to the "Pre-Proposed Rule CPL Recommendation Process." CMS believes the current name of the process may suggest an unintended formality or limitation – one that implies the nominations process is the preferred, primary, or only means by which interested parties may submit recommendations. CMS believe this proposed new name would not. • In addition, CMS is in the process of developing the technological infrastructure and Paperwork Reduction Act (PRA) package for the recommendations process. Because they were unable to complete the infrastructure development and PRA processes in time for commenters to recommend procedures to be added to the ASC-CPL prior to the CY 2023 proposed rule, they propose to revise the start date of the recommendation process in the regulatory text. They propose to change January 1, 2023, to January 1, 2024, so that the text at § 416.166(d) would specify that on or after January 1, 2024, an external party may recommend a surgical procedure by March 1 of a calendar year for the

Key Proposals in Medicare's 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule [CMS-1772-P]

CMS PROPOSAL
ASC-CPL for the following calendar year. CMS continue to welcome all procedure submissions through the public comment process, as they have in previous years.
Proposed Changes to the Inpatient Only (IPO) List (Starts on page 411 of 886) • CMS proposes to remove ten codes from the IPO list for 2023: 16036 (Escharotomy addl incision); 21141 (Lefort i-1 piece w/o graft); 21142 (Lefort i-2 piece w/o graft); 21143 (Lefort i-3/> piece w/o graft); 21194 (Reconst lwr jaw w/graft); 21196 (Reconst lwr jaw w/fixation); 21347 (Opn tx nasomax fx multiple); 21366 (Opn tx complx malar w/grft); 21422 (Treat mouth roof fracture); 22632 (Arthrd pst tq 1ntrspc lm ea)
Proposed ASC Payment for Combinations of Primary and Add-On Procedures Eligible for Complexity Adjustments under the OPPS (Starts on page 521 of 886) • CMS proposes a policy to provide increased payment to ASCs for combinations of certain service codes and add-on procedure codes that are eligible for a complexity adjustment under the OPPS. • While add-on codes (N1) do not come with additional reimbursement (packaged into primary code), the addition of the add-on codes to a primary procedure code often changes the complexity of the procedure, making it more costly to perform. • CMS identified **52** different complexity adjustment code combinations for codes that are payable in the ASC setting and would be eligible for a complexity adjustment if the procedure were performed in an HOPD. • CMS is proposing to assign each eligible code combination a new C code that describes the primary and the add-on procedure(s) performed. C codes are unique temporary codes and are only valid for claims for HOPD and ASC services and procedures. Under this proposal, CMS would add these C codes to the ASC-CPL and when ASCs bill this C code, they would receive a higher payment rate that reflects that the code combination is more complex and costlier than the primary procedure alone. • CMS generally estimates that ASC services were paid approximately 55 percent of the HOPD rate for similar services in CY 2021. When they compared the HOPD complexity-adjusted payment rate of these primary procedure and add-on code combinations to the ASC payment rate for the same code combinations, they found that the average rate of ASC payment as a percent of HOPD payment for these code combinations was 25 to 35 percent.

Key Proposals in Medicare's 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule [CMS-1772-P]

CMS PROPOSAL
ASC Payment System Policy for Non-Opioid Pain Management Drugs and Biologicals that Function as Surgical Supplies (Starts on page 535 of 886) • In 2022, CMS finalized a policy to unpackage and pay separately at ASP plus 6 percent for the cost of non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS under proposed new § 416.174. • Using their criteria, CMS proposes four products that are eligible for this reimbursement for 2023: C9290 (Inj, bupivacaine liposome); J1097 (Phenylep ketorolac opth soln); J1096 (Dexametha opth insert 0.1 mg); and C9089 (Bupivacaine implant, 1 mg)
Requirements for the ASC Quality Reporting Program (Starts on page 596 of 886) • CMS is proposing to delay mandatory reporting of *ASC-11 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* and maintain reporting for this measure as voluntary. • No changes were made to *ASC-20: COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)*, which requires data collection and reporting through NHSN. • A Potential Future Specialty Centered Approach for the ASCQR Program: CMS seeks comment on a potential future direction of the ASCQR Program that would allow ASCs to report quality-related data on a customizable measure set that more accurately reflects the care delivered in this setting and accounts for the services provided by individual facilities. • ASC Facility Volume Data: CMS seeks comment on the potential inclusion of a volume measure in the ASCQR Program, either by bringing back *ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures* or adopting another volume indicator.
Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces (Starts on page 768 of 886) CMS is seeking information from the public on how data that CMS collects could be used to promote competition across the health care system or protect the public from the harmful effects of consolidation within healthcare. Specifically, CMS seeks comment from the public on the following: • What additional data collected on form 855A (PECOS) would be helpful to release to the public and researchers, to help identify the impact of provider mergers, acquisitions, consolidations, and changes in ownership on the affordability and availability of medical care, and why?

Key Proposals in Medicare's 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule [CMS-1772-P]

CMS PROPOSAL
• Do commenters suggest that CMS release data on any mergers, acquisitions, consolidations, and changes in ownership that have taken place for any additional types of providers beyond nursing facilities and hospitals? If so, for which types of providers? • What additional information collected by CMS would be useful for the public or researchers who are studying the impacts of mergers, acquisitions, consolidations, or changes in ownership? • Section 6401 (a) of the ACA established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information in PECOS under new enrollment screening criteria. In 2016, CMS completed its initial round of revalidations and resumed regular revalidation cycles in accordance with 42 CFR 424.515.335 Would data for transactions occurring before the 2016 CMS revalidation effort be useful for the public or researchers, even if such data may be less complete?