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CMS Issues Physician, Outpatient/ASC, Home Health, and ESRD Final 2023 Payment Rules

Last week, the Centers for Medicare and Medicaid Services (CMS) finalized four provider payment rules: Calendar Year (CY) 2023 Physician Fee Schedule (PFS); CY 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System; CY 2023 Home Health Prospective Payment System (PPS); and CY 2023 End-Stage Renal Disease (ESRD) Prospective Payment System.

Through the rules, CMS is boosting payments for hospital outpatient services by 3.8%, home health services by 0.7%, and ESRD services by 3.1% while reducing payments under the physician fee schedule by 4.47%.

Provider groups are calling on Congress to step in and mitigate the payment cuts under the Medicare physician fee schedule, as they have in recent years, noting that the cuts are particularly harmful amid financial headwinds due to inflation, increased supply costs, and an unprecedented shortage in the health care workforce. While there is some momentum in Congress to address the fee schedule cuts, as well as other statutory cuts impacting the Medicare provider population in a year-end spending package, the prospects of any relief will become clearer after the mid-term election. Hospital groups and home health groups, separately, have raised concerns about their CY 2023 payment rates, with hospital groups warning that the finalized outpatient payment rate increase does not keep pace with inflation and home health providers warning that the final rule still retains large permanent payment adjustments that will be detrimental to the industry, despite delaying some to future years.

In addition to setting payment rates, the final rules implement policy changes to key provider programs, and there are several common themes throughout each rule, including an emphasis on equity and access to behavioral health, a continued re-examination of policies enacted during the COVID-19 pandemic, and a desire to increase participation in accountable care models.

- For more information on the PFS final rule: Press release, PFS fact sheet, MSSP fact sheet, blog post on behavioral health changes and final rule.
- For more information on the OPPS/ASC final rule: Press release, OPPS/ASC fact sheet, Rural Emergency Hospitals fact sheet and final rule.
- For more information on the Home Health PPS final rule: Fact sheet and final rule.
- For more information on the ESRD PPS final rule: Fact sheet and final rule.

Physician Fee Schedule Final Rule: Key Provisions

Conversion factor and E/M changes: For CY 2023, the PFS conversion factor will be $33.06, a decrease of $1.55, or 4.47%, compared with the CY 2022 PFS conversion factor of $34.61. The final conversion factor is two cents lower than the initial rate and accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units. CMS also delayed until CY 2024 the split (or shared)

visits policy finalized in CY 2022 to define the "substantive portion" of a split (or shared) visit based on the amount of time spent by the billing practitioner.

Telehealth: For CY 2023, CMS added five new services to the Medicare Telehealth List on a permanent basis. CMS also added more than 50 services, such as psychophysiological therapy, to the temporary Category 3 list, which CMS stated will expire at the end of 2023, or 151 days post-PHE, whichever is later. CMS said it could revisit the Category 3 list extension in the future as the agency has sought to determine which services could continue to be provided via telehealth beyond the PHE. CMS in the rule finalized a delay to the in-person requirements for telehealth services for mental health until 151 days post-PHE. Other telehealth policies that were added to the Medicare telehealth list on a temporary interim basis but were not given Category 3 status, such as telephone E/M services, also will remain in place for 151-days post PHE, in line with telehealth extensions. CMS reiterated it does not plan to pay for telephone E/M services beyond their expiration, stating that "statute requires that telehealth services be so analogous to in-person care," which the agency interprets as using two-way, audio-visual communications technology. Under the rule, providers will continue to bill with the place of service indicator that would have been reported had the service been furnished in person. The claims will require modifier 95 to identify them as services furnished as telehealth services.

Mental and behavioral health. CMS finalized policies aimed at bolstering the mental and behavioral health workforce, including creating a new General Behavioral Health Integration (BHI) code for instances in which clinical psychologists (CPs) or licensed clinical social workers (CSWs) furnish mental health services and serve as the focal point of care integration. CMS also expanded other non-physician practitioners' ability to treat patients by allowing licensed marriage and family therapists, licensed professional counselors, addiction counselors, certified peer recovery specialists, and others to provide behavioral health services under general supervision rather than "direct" supervision of a physician or non-physician practitioner. CMS said it will address payment for new codes related to caregiver behavioral management training in CY 2024 rulemaking.

Opioid Treatment Programs (OTPs). CMS finalized changes to the methodology for pricing the drug component of the methadone weekly bundle and add-on code for take-home supplies for CY 2023. In addition, CMS will allow OTPs to begin buprenorphine treatment via telehealth, (including audio-only in certain circumstances) and to be reimbursed for services performed by mobile units, such as vans.

Medicare Shared Savings Program (MSSP): CMS finalized several changes included in the proposed rule that are aimed at advancing CMS' overall value-based care strategy of growth, alignment, and equity. For example, CMS finalized several changes to its benchmarking methodology to help sustain long-term participation. In addition, CMS finalized the creation of advanced investment payments to new, low-revenue ACOs that serve underserved populations. The advance investment payments, which CMS plans to recoup as ACOs generate shared savings, can be used to make upfront investments in staff and address the social needs of beneficiaries, such as food and housing. Other finalized policies include a new health equity adjustment to quality performance scores and a new requirement, effective Jan. 1, 2023, requiring ACOs to inform beneficiaries of the agreement period prior to or at the first primary care service, instead of annually, as well as provide a follow-up notice within 180 days of the initial notification.

Quality Payment Program (QPP): Beginning in CY 2023, CMS will add five new, optional MIPS Value Pathways. CMS also finalized several policies aimed at reducing burden and facilitating participation in Alternative Payment Models (APMs), including permanently establishing the 8% minimum Generally Applicable Nominal Risk standard for Advanced APMs, which is currently set to expire in 2024.

Dental, Oral and Audiology Services: CMS finalized policies to broaden Medicare's dental coverage definitions and expand access to audiology services. Beginning in CY 2023, CMS will pay for dental services not currently

covered by Medicare, such as dental examination and treatment, when those services are delivered prior to an organ transplant or certain cardiac procedures. Beginning in CY 2024, Medicare will pay for dental services delivered as part of treatment for head and neck cancers. CMS said effective CY 2023 it will establish an annual process to review public feedback on other instances in which Medicare should cover dental services. In addition, CMS finalized proposals that will give beneficiaries direct access, when appropriate, to an audiologist without a physician referral. In response to comments, audiologists will use a new modifier, as opposed to the new HCPCS code (GAUDX) proposed, to bill for those services.

Colorectal screening. CMS finalized its expanded definition of a colorectal cancer screening test to include a follow-up colonoscopy to a positive at-home test, which means Medicare cost-sharing would be waived. In addition, Medicare will cover the service for individuals 45 years of age and above, in line with the newly lowered age recommendation (down from 50) from the United States Preventive Services Task Force.

Vaccine administration: CMS finalized proposals to annually update payments for vaccine administration services to take into account the Medicare Economic Index and the geographic location in which the vaccine is administered. The agency also will continue payments for at-home COVID-19 vaccinations for CY 2023.

Hospital OPPS/ASC Final Rule: Key Provisions

Payment rates: CMS will increase OPPS and ASC payment rates for hospitals and ASCs that meet applicable quality reporting requirements by 3.8%, compared with CY 2022. CMS estimated it will pay a total of $86.5 billion to OPPS providers in CY 2023. The payment rate update accounts for a 4.1% hospital market basket percentage increase and a -0.3-percentage point productivity adjustment. Due to the COVID-19 pandemic's impact on CY 2020 cost data, CMS applied the same methodology for determining CY 2023 payment rates as it did for CY 2022, relying on certain data from before the PHE.

340B payment: In response to the Supreme Court's ruling in American Hospital Association v. Becerra, CMS will return the hospital pay rate for 340B drugs to 106% of the average drug sales price for CY 2023. Since those payments must be made in a budget neutral manner, CMS finalized a -3.09% reduction to payment rates for non-drug services for CY 2023. CMS estimated that under the updated 340B payment rates, urban hospitals will see a 1.2% increase in payments, while rural hospitals will see payments decline by 1%. CMS said it is still reviewing comments on the best way to address 340B payments for CYs 2018-2022 and said it will issue separate rulemaking ahead of the CY 2024 OPPS/ASC proposed rule, which is typically published in July.

Hospital Outpatient/ASC Quality Reporting Programs: In response to comments, CMS said it will maintain voluntary reporting status of the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure for both the Hospital Outpatient and ASC Quality reporting programs for CY 2023.

Rural Emergency Hospitals: CMS finalized conditions of participation, payment rates, and enrollment requirements for Rural Emergency Hospitals (REH), a new provider type, which will go into effect on Jan. 1, 2023. CMS will pay for REH services at 105% of the OPPS rate for equivalent services. In response to comment asking about REH eligibility for the 340B program, CMS noted that decision is under the authority of Health Resources and Services Administration (HRSA).

Telehealth: CMS made permanent a COVID-19 flexibility that enabled clinical staff of hospital outpatient departments to provide telehealth behavioral care. In order for CMS to cover behavioral health services furnished remotely, the beneficiary must have an in-person service at least 6 months before the initial telehealth visit and have an in-person visit within 12 months of their virtual appointment. CMS said it will make exceptions to the in-person requirements in certain cases.

Site neutral payment updates: CMS finalized a proposal to exempt Rural Sole Community Hospitals from site-neutral clinic visit payments and will pay provider-based departments associated with those hospitals at the full OPPS rate.

COVID-19: CMS finalized bi-weekly lump sum payments for domestically produced National Institute for Occupational Safety and Health (NIOSH)-approved surgical N95 respirators.

RFI on M&A. In the proposed rule, CMS included a request for information related to the potential impact of mergers and acquisitions, consolidations and changes in ownership on competition and transparency. While CMS did not address the feedback received in this final rule, we expect to see more in future rulemaking.

Home Health PPS Final Rule: Key Provisions

Payment rates: CMS finalized a 0.7%, or $125 million, payment increase for Home Health Agencies for CY 2023. The payment rate update reflects a 4.1% market basket update, a productivity cut of 0.1 percentage points, an increase of 0.2 percentage points for outlier payments, as well as a 3.5 percentage point cut related to the prospective permanent behavioral assumption adjustment, which is a 7-percentage point cut now being phased in over a two-year period.

Wage index: CMS finalized a permanent, budget neutral 5% cap on negative wage index changes.

Telehealth: On Jan. 1, 2023, CMS will begin collecting claims data on the use of telecommunications technology on a voluntary basis. Home health agencies beginning July 1, 2023, will be required to report those data.

Home Health Value-based Purchasing Program: CMS finalized several updates to the value-based purchasing program, including new definitions for baseline years.

Home Health Quality Reporting Program: CMS finalized its proposal to require home health agencies to report all-payer patient assessment data beginning with the CY 2027 program year. CMS will consider Jan. 1, 2025-June 30, 2025, a phase-in period during which home health agencies will not be penalized for failing to submit data.

ESRD PPS Final Rule: Key Provisions

Payment rates: CMS finalized a base rate of $265.57 for the CY 2023 ESRD PPS, which is an increase of $7.67 from CY 2022 rates. CMS estimated total payments to ESRD facilities will reach $7.9 billion for CY 2023.

Wage index: CMS finalized a proposal to raise the wage index floor 0.1 percentage point, from 0.5 to 0.6. In addition, CMS finalized a permanent, budget neutral 5% cap on negative wage index changes.

ESRD Quality Incentive Program: CMS finalized proposals to pause the collection of certain measures that the agency determined have been significantly impacted by the COVID-19 pandemic for performance year 2023, including the Standardized Hospitalization Ratio (SHR) clinical measure, the Standardized Readmission Ratio (SRR) clinical measure, the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) clinical measure, the Long-Term Catheter Rate clinical measure, the Percentage of Prevalent Patients Waitlisted (PPPW) clinical measure, the Kt/V Dialysis Adequacy Comprehensive clinical measure, and the Standardized Fistula Rate clinical measure.

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