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2023 Hospital Outpatient Prospective Payment System – Proposed Rule Summary

On Friday, July 15, 2022, the Centers for Medicare & Medicaid Services (CMS) released the 2022 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule, which includes modest payment increases for radiation therapy services effective January 1, 2023. Comments on the proposed rule are due September 13, 2022.

In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from OPPS claims are used to calculate rates. Certain services are considered ancillary, and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment, imaging is not paid separately when reported with treatment delivery services. Below is a summary of key issues impacting radiation oncology.

Proposed Conversion Factor Update

CMS proposes increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.7%. This increase factor is based on the hospital inpatient market basket percentage increase of 3.1% for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a proposed 0.4% productivity adjustment.

Based on this update, CMS estimates that proposed total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2023 will be approximately $86.2 billion, an increase of $6.2 billion compared to 2022 HOPPS payments.

Proposed Use of June 2020 Cost Report and CY 2021 Claims Report Data effort CY 2023 OPPS and ASC Payment System Rate Stetting Due to the PHE

CMS is proposing to use cost report data from the June 2020 Healthcare Cost Report Information System (HCRIS), which only includes cost report data through CY 2019, predating the PHE. This is the same cost report extract used to set OPPS rates for CY 2022. CMS believes using the CY 2021 claims data, with cost reports data through CY 2019 for CY 2023 OPPS rate setting, is the best approximation of expected costs for CY 2023 hospital outpatient services for rate setting purposes. As a result, CMS is proposing to use CY 2021 claims data with cost report data through CY 2019 (prior to the PHE) to set CY 2023 OPPS and ASC payment system rates.

Ambulatory Payment Classifications (APC)

CMS is proposing to make modest changes to the payment rates of traditional radiation oncology APCs in the 2023 HOPPS proposed rule. Below is a list of radiation oncology APCs with their proposed 2023 payment rates:

Radiation Oncology - Ambulatory Payment Classification Proposed 2023 Payment Rates

APC	Descriptor	2022 Rate	2023 Proposed Rate	% Change
5611	Level 1 Therapeutic Radiation Treatment Preparation	$129.59	$135.80	4.79%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$345.85	$365.15	5.58%
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,289.67	$1,365.61	5.89%
5621	Level 1 Radiation Therapy	$122.34	$123.69	1.10%
5622	Level 2 Radiation Therapy	$246.87	$267.74	8.45%
5623	Level 3 Radiation Therapy	$554.12	$583.24	5.26%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$724.50	$731.79	1.01%
5625	Level 5 Radiation Therapy - Proton Therapy	$1,321.12	$1,355.67	2.62%
5626	Level 6 Radiation Therapy - SBRT	$1,771.28	$1,801.19	1.69%

As in each final HOPPS rule, radiation oncology will see fluctuation in weights due to more claims available (about 10%) and the impact of CMS' policy decisions (from the proposed rule). This year, CMS will have to make a decision regarding the cost report proposal, which will also have an impact on weights. Additionally, on June 15, 2022, the Supreme Court issued a decision related to 340B payment rates, which will increase the payment rate to hospitals for 340B drugs. Due to the timing of the Court's decision, CMS did not have time to adjust the HOPPS proposed rule to account for that decision.

Therefore, CMS first will need to recalculate the budget neutrality number based on the claims and policy decisions (noted above). A decision then will need to be made about how much of a 340B give-back to hospitals from earlier years is necessary, whether that give-back will be transitioned over three or four years, and what year the give-back will start (the law does not say what year the give back needs to start).

ASTRO anticipates a reduction in the APC weights in the final rule of approximately 3%.

Comprehensive Ambulatory Payment Classifications (C-APCs)

Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of "J1". All adjunctive services provided to support the delivery of the primary service are included on the claim. While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

For 2023, CMS seeks to expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology with one new C-APC: 5372 (Level 2 Urology and Related Services). This would increase the number of C-APCs to 70. Below is a comparison table of the 2022 payment

rates and proposed 2023 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2022 Rate	2023 Proposed Rate	% Change
77371	SRS Multisource	$7,942.98	$7,881.03	-0.78%
77372	SRS Linear Based	$7,942.98	$7,881.03	-0.78%
77424	IORT delivery by x-ray	$7,942.98	$7,881.03	-0.78%
77425	IORT delivery by electrons	$7,942.98	$7,881.03	-0.78%
C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures				
19298	Place breast rad tube/caths	$5,652.10	$6,027.41	6.64%
C-APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures				
19296	Place po breast cath for rad	$9,106.41	$9,039.52	-0.73%
C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$2,892.28	$3,027.38	4.67%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$5,194.27	$5,377.70	3.53%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$1,658.81	$1,768.53	6.61%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$4,505.89	$4,783.70	6.17%
C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$4,503.49	$4,712.62	4.64%
57155	Insert uteri tandem/ovoids	$4,503.49	$4,712.62	4.64%
58346	Insert heyman uteri capsule	$4,503.49	$4,712.62	4.64%

Although most radiation oncology services see a modest increase in the proposal, ASTRO remains concerned that these services are still undervalued due to the C-APC methodology. Despite efforts to encourage the Agency to value these services more accurately, CMS remains committed to the methodology and does not intend to modify it for radiation oncology services. ASTRO will continue to educate CMS on the impact the C-APC methodology has on radiation oncology services, particularly brachytherapy.

Two-Times Rule Exception

CMS established two-times rule criteria within the APC methodology that requires that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest-costing procedure categorized to that same APC. However, the Agency can exempt any APC from the two-times rule for any of the following reasons:

- Resource homogeneity
- Clinical homogeneity
- Hospital outpatient setting utilization
- Frequency of service (volume)
- Opportunity for upcoding and code fragments

Based on CY 2021 claims data, CMS proposes to apply the two-times rule exception to APC 5611 *Level 1 Therapeutic Radiation Treatment Preparation.* This is in addition to APC 5612 *Level 2 Therapeutic Radiation Treatment Preparation* and APC 5627 *Level 7 Radiation Therapy* which were on the two-times rule exception list in previous years.

Brachytherapy Sources

In the 2023 HOPPS proposed rule, CMS is proposing to continue to base the payment rates for brachytherapy sources on the geometric mean costs for each source, which is consistent with the methodology used for other services under HOPPS. Additionally, the Agency will use the costs derived from 2021 claims data to set the proposed 2023 payment rates for brachytherapy sources because that is the claims data used for most other items in the proposed rule. However, C2645 *Brachytherapy planar source, palladium-103, per square millimeter* had insufficient claims data, so the Agency proposes to continue the CY 2019 payment rate of $4.69 per mm^2 in CY 2023.

CMS proposes to pay for HCPCS codes C2698 *Brachytherapy source, stranded, not otherwise specified* and C2699 *Brachytherapy source, non-stranded, not otherwise specified,* at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively on a per source basis. For 2023, the proposed rates are $39.07 for C2698 and $34.96 for C2699. This is a 2.30% change in payment for C2698 and an 0.40% change for C2699 from the 2022 rates.

In the 2022 HOPPS final rule, CMS established a Low Volume APC policy for brachytherapy APCs (also for New Technology APCs and clinical APCs—it is universal). For those APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, CMS uses up to four years of claims data to establish a payment rate for each item or service, which is a similar methodology that the Agency applies to low volume services assigned to New Technology APCs. Further, the Agency calculates the cost based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost.

CMS is proposing to designate 4 brachytherapy APCs as Low Volume APCs for CY 2023 (See Table 24 below). These are the same APCs that were proposed in the 2022 proposed rule, except APC 2647, *Brachytherapy, non-stranded, Gold-198,* did not meet the claims threshold for the CY 2023 proposed rule.

Table 24: Cost Statistics for Proposed Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2023

APC	APC Description	CY 2021 Claims	Geometric Cost	Proposed Median	Proposed Arithmetic	Proposed Geometric	CY 2023 Proposed

		Available for Ratesetting	without Low Volume APC Designation	Cost	Mean Cost	Mean Cost	APC Cost
2632	Iodine I-125 sodium iodide	9	$141.23	$31.74	$44.35	$37.26	$44.35
2635	Brachytx, non-str, HA, P-103	26	$125.24	$34.04	$51.09	$42.77	$51.09
2636	Brachy linear, nonstr, P-103	0	---*	$49.65	$53.38	$38.80	$53.38
2645	Brachytx, non-str, Gold-198	14	$144.37	$184.49	$377.65	$141.18	$377.65

*For this proposed rule, there are no CY 2021 claims that contain the HCPCS code assigned to APC 2636 (HCPCS code C2636) that are available for CY 2023 OPPS/ASC ratesetting.

OPPS Payment for Software as a Service

Algorithm-driven services that assist practitioners in making clinical assessments can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). CMS refers to these technologies as software as a service (SaaS). For CY 2023, CMS is seeking comments on the specific payment approach they might use for these services under the OPPS as SaaS-type technology becomes more widespread. CMS is concerned about the potential for bias in algorithms and predictive modeling and is seeking comments on how they could encourage software developers to prevent or mitigate the possibility of bias in new applications of this technology.

Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

Transitional pass-through payments are provided for certain "new" drugs and biologicals that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payments for the procedures or services associated with the new drug or biological. In the proposed rule, CMS clarifies that for pass-through payment purposes, radiopharmaceuticals are included as "drugs." Transitional pass-through payments for a drug can be made for a period of at least 2 years, but not more than 3 years, after the payment was first made for the drug as a hospital outpatient service under Medicare Part B.

Proposed Payment Policy for Therapeutic Radiopharmaceuticals

For CY 2023 and subsequent years, CMS proposes to continue the payment policy for therapeutic radiopharmaceuticals that began in CY 2010. Medicare pays for separately payable therapeutic radiopharmaceuticals under the Average Sales Price (ASP) + 6% methodology adopted for separately payable drugs and biologicals. If ASP information is unavailable for a therapeutic radiopharmaceutical, they base therapeutic radiopharmaceutical payment on mean unit cost data derived from hospital claims.

CMS believe that this rationale continues to be appropriate for nonpass-through, separately payable therapeutic radiopharmaceuticals in CY 2023. Therefore, they propose for CY 2023 and subsequent years to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals at ASP+6%. Where there is no ASP, they will use mean unit cost data derived from hospital claims.

New HCPCS Codes Effective July 1, 2022

For the July 2022 update, 63 new HCPCS codes were established and made effective on July 1, 2022. Through the July 2022 OPPS quarterly update, CMS recognized several new codes for separate payment and assigned them to appropriate interim OPPS status indicators and APCs.

In this proposed rule, CMS is soliciting comments on the proposed APC and status indicator assignments for the codes implemented on July 1, 2022 (the two relevant to radiation oncology are listed in Table 6 below).

Table 6: New HCPCS Codes Effective July 1, 2022

CY 2023 HCPCS Code	CY 2023 Long Descriptor	Proposed CY 2023 Comment Indicator	Proposed CY 2023 Status Indicator	Proposed CY 2023 APC
0174T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance		N	
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	NP	N	

Applications Received for Device Pass-Through Status for CY 2023

CMS establishes specific criteria for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in treatment of Medicare beneficiaries. Devices must meet the following criteria: 1) receive FDA approval or clearance; 2) the device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part; and 3) the device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. Finally, the device must

not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

In addition to meeting criteria for pass-through payment, a device must meet specific criteria for CMS to establish a new category of devices. The criteria for establishing a new category of devices require that the device is not appropriately described by any other category; and that it has an average cost that is not insignificant relative to the payment amount for the procedure or service with which the device is associated by demonstrating:

1) The estimated average reasonable costs of devices in the category exceeds 25% of the applicable APC payment amount for the service related to the category of devices;
2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment about for the related service by at least 25%; and
3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10% of the APC payment amount for the related service.

The following are pass-through applications received that are of interest to radiation oncology.

NavSlim™ and NavPencil
Elucent Medical, Inc. submitted an application for a new device category for transitional pass-through payment status for CY 2023 for the NavSlim™ and NavPencil (referred to collectively as "the Navigators"). The applicant described the Navigators as single-use (disposable) devices for real-time, stereotactic, 3D navigation for the excision of pre-defined soft tissue specimens.

With respect to the newness criterion, on March 22, 2019, the applicant received 510(k) clearance from FDA to market the EnVisio™ Navigation System (which includes the Navigators) for the non-imaging detection and localization (by navigation) of a SmartClip™ (see below) that has been implanted in a soft tissue biopsy site or a soft tissue site intended for surgical removal. The applicant submitted its application for consideration as a new device category for transitional pass-through payment status for the Navigators on February 28, 2022, which is within 3 years of the date of the initial FDA marketing authorization.

With respect to second eligibility criterion, according to the applicant, the Navigators are an integral part of the service furnished and are used for one patient only. However, they did not specifically indicate whether the Navigators come in contact with human tissue, and are surgically implanted or inserted or applied in or on a wound or other skin lesion. The FDA 510(k) Summary (K183400) states that the Navigator is a sterile, non-patient contacting, single-use device.

The applicant also did not indicate whether the Navigators meet the criteria that the device must not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

CMS also noted issues with the evidence submitted with the application. One study submitted

was unpublished, another was undated and unpublished, and none of the articles submitted provided conclusive evidence that the use of the Navigators reduces surgical site infection rates or the risk of tissue marker migration, as claimed by the applicant. In addition, the articles and case reports provided by the applicant described the use of the subject devices only in breast cancer surgery cases. As reported by the applicant, the Navigators can also be used for patients that have biopsy proven cancers in other organs that lack anatomic landmarks like the abdomen and head and neck. CMS welcomes additional evidence of substantial clinical improvement in cases related to nonbreast cancer related procedures.

The Agency also seeks comments on whether the Navigators meet the device pass-through payment criteria discussed in this section, including the cost criterion for device pass-through payment status.

SmartClip™

Elucent Medical, Inc. also submitted an application for a new device category for transitional pass-through payment status for CY 2023 for the SmartClip™ Soft Tissue Marker (SmartClip™). They described the SmartClip™ as an electromagnetically activated, single-use, sterile soft tissue marker used for anatomical surgical guidance. According to the applicant, the SmartClip™ is the only soft tissue marker that delivers independent coordinates of location when used in conjunction with the applicant's EnVisio™ Navigation System (which includes the Navigators discussed previously).

With respect to the newness issue, the applicant received 510(k) clearance from the FDA on June 4, 2018, but they did not submit an application for consideration as a new device category for transitional pass-through payment status for the SmartClip™ until February 28, 2022, which is more than 3 years from the date of the initial FDA marketing authorization.[1] The applicant has asked CMS to use the FDA clearance date for the Navigators (discussed above) as the applicable date for the SmartClip™'s initial marketability since these devices are used in conjunction.

The Agency seeks comments on whether SmartClip™ meets the device pass-through payment criteria discussed in this section, including the cost criterion for device pass-through payment status.

Proposed New Technology APCs

Services that are assigned to New Technology APCs are typically new services that do not have sufficient claims history to establish an accurate payment for the services. One of the objectives of establishing New Technology APCs is to generate sufficient claims data for a new service so that it can be assigned to an appropriate clinical APC. Some services that are assigned to New Technology APCs have very low annual volume, which CMS considers to be fewer than 100 claims. They consider services with fewer than 100 claims annually to be low-volume services because there is a higher probability that the payment data for a service may not have a normal statistical distribution, which could affect the quality of their standard cost methodology that is

[1] The pass-through payment application for a medical device must be submitted within 3 years from the date of the initial FDA approval or clearance, unless there is a documented, verifiable delay in U.S. market availability after FDA approval or clearance is granted

used to assign services to an APC. In addition, services with fewer than 100 claims per year are not generally considered to be a significant contributor to the APC rate setting calculations and, therefore, are not included in the assessment of the 2-times rule.

Where utilization of services assigned to a New Technology APC is low, it can lead to wide variation in payment rates from year to year, resulting in even lower utilization and potential barriers to access to new technologies, which ultimately limits the Agency's ability to assign the service to the appropriate clinical APC. To mitigate these issues, CMS decided it was appropriate to use its equitable adjustment authority to adjust how it determined the costs for low-volume services assigned to New Technology APCs. For New Technology APCs with fewer than 100 single claims at the procedure level that can be used for rate setting, CMS would apply its proposed methodology for determining a low volume APC's cost (as previously mentioned in the section on *Brachytherapy Services*), choosing the "greatest of" the median, arithmetic mean, or geometric mean at the procedure level, to apply to the individual services assigned to New Technology APCs and provide the final New Technology APC assignment for each procedure.

A procedure of interest to radiation oncology within the proposed New Technology APCs is *Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy*. Effective January 1, 2019, CMS established HCPCS code C9751 (Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (for example, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)). This microwave ablation procedure utilizes a flexible catheter to access the lung tumor via a working channel and may be used as an alternative procedure to a percutaneous microwave approach. Based on its review of the New Technology APC application for this service and the service's clinical similarity to existing services paid under the OPPS, the Agency estimated the likely cost of the procedure would be between $8,001 and $8,500.

In claims data available for CY 2019 for the CY 2021 OPPS/ASC final rule with comment period, there were four claims reported for bronchoscopy with transbronchial ablation of lesions by microwave energy. Given the low volume of claims for the service, CMS proposed for CY 2021 to apply the policy it adopted in CY 2019, under which it utilizes its equitable adjustment authority to calculate the geometric mean, arithmetic mean, and median costs to calculate an appropriate payment rate for purposes of assigning bronchoscopy with transbronchial ablation of lesions by microwave energy to a New Technology APC. The Agency found the geometric mean cost for the service to be approximately $2,693, the arithmetic mean cost to be approximately $3,086, and the median cost to be approximately $3,708. The median was the statistical methodology that estimated the highest cost for the service and provided a reasonable estimate of the midpoint cost of the three claims that have been paid for this service. The payment rate calculated using this methodology fell within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501– $4000)). Therefore, CMS assigned HCPCS code C9751 to APC 1562 for CY 2021.

For CY 2023, the only available claims for HCPCS code C9751 are from CY 2019. Therefore, CMS is proposing, given the low number of claims for this procedure, to again utilize its equitable adjustment authority. Because they are using the same claims as they did for CY 2021 and 2022, they found the same values for the geometric mean cost, arithmetic mean cost, and the median cost for CY 2022. Therefore, the payment rate calculated falls again within the cost band for New Technology APC 1562 (New Technology—Level 25 ($3501–$4000)), and the Agency proposes to continue to assign HCPCS code C9751 to APC 1562 (New Technology—Level 25 ($3501–$4000)), with a proposed payment rate of $3,750.50 for CY 2023. Details regarding HCPCS code C9751 are included in Table 11.

Table 11: CY 2022 Proposed OPPS APC and Status Indicator for HCPCS Code C9751 Assigned to New Technology APC

CY 2023 HCPCS Code	Long Descriptor	Proposed CY 2023 OPPS SI	Proposed CY 2023 OPPS APC	Proposed CY 2023 OPPS Payment Rate
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]	T	1562	$3,750.50

Cancer Hospital Payment Adjustment

Since the inception of OPPS, Medicare has paid the 11 hospitals that meet the criteria for "cancer hospitals" under OPPS for covered outpatient hospital services to reflect their higher outpatient costs. CMS proposes to continue to provide additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. However, the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0%. Based on the data and the required 1.0% reduction, CMS is proposing that a target PCR of 0.89 would be used to determine the CY 2023 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.89 for each cancer hospital.

Table 4 shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2023, due to the cancer hospital payment adjustment policy.

Table 4: Estimated CY 2023 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2023 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	45.5%
050660	USC Norris Cancer Hospital	31.7%
100079	Sylvester Comprehensive Cancer Center	24.1%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.1%
220162	Dana-Farber Cancer Institute	42.7%
330154	Memorial Sloan-Kettering Cancer Center	69.2%
330354	Roswell Park Cancer Institute	15.2%
360242	James Cancer Hospital & Solove Research Institute	12.9%
390196	Fox Chase Cancer Center	23.5%
450076	M.D. Anderson Cancer Center	49.4%
500138	Seattle Cancer Care Alliance	46.1%

Health Equity

Similar to proposals put forth in the Agency's other proposed rules, CMS is seeking input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. One approach being considered to measure equity across CMS programs is the expansion of efforts to report quality measure results stratified by patient social risk factors and demographic variables.

Rural Emergency Hospital Quality Reporting (REHQR) Program

CMS is proposing to require a QualityNet account and Security Official (SO) requirement in line with other quality programs for purposes of data submission and access of facility level reports. The Agency is also requesting information on: (1) measures recommended by the National Advisory Committee on Rural Health and Human Services and additional suggested measures for the REHQR Program, and (2) and comments on rural telehealth, behavioral and mental health, and maternal health services.

Rural Emergency Hospital (REH) Payment Policy

Section 125 of the Consolidated Appropriations Act of 2021 (CAA) established a new provider type called Rural Emergency Hospitals (REHs), effective January 1, 2023. REHs are facilities that convert from either a critical access hospital (CAH) or a rural hospital (or one treated as such under section 1886(d)(8)(E) of the Social Security Act) with less than 50 beds, and that do not provide acute care inpatient services with the exception of post-hospital extended care services furnished in a unit of the facility that is a distinct part licensed as a skilled nursing facility.

By statute, REH services include emergency department services and observation care and, at the election of the REH, other outpatient medical and health services furnished on an outpatient

basis, as specified by the Secretary through rulemaking. By statute, covered outpatient department services provided by REHs will receive an additional 5% payment for each service. Beneficiaries will not be charged a copayment on the additional 5% payment.

CMS is proposing to consider all covered outpatient department services, other than inpatient hospital services as described in section 1833(t)(1)(B)(ii), that would otherwise be paid under the OPPS as REH services. REHs would be paid for furnishing REH services at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service increased by 5%. They are also proposing that REHs may provide outpatient services that are not otherwise paid under the OPPS (such as services paid under the Clinical Lab Fee Schedule) as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services would not be considered REH services and therefore would be paid under the applicable fee schedule and would not receive the additional 5% payment increase that CMS proposes to apply to REH services.

Finally, CMS is proposing that REHs would also receive a monthly facility payment. After the initial payment is established in CY 2023, the payment amount will increase in subsequent years by the hospital market basket percentage increase.

Additional information about the 2023 HOPPS proposed rule can be found at the following links:

A display copy of the proposed rule can be found at:
https://public-inspection.federalregister.gov/2022-15372.pdf

The addenda relating to the HOPPS proposed rule are available at:
https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-p

A fact sheet on this proposed rule is available at:
https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center