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2020 Hospital Outpatient Payment System and Ambulatory Surgical Center Payment System Proposed Rule

OVERVIEW

On July 29th, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule regarding the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2020. The proposed rule would increase both OPPS rates and ASC payment rates by 2.7 percent.

In addition to proposing several payment and policy changes, the proposed rule would require hospitals to post standard charges for all items and services, including gross charges and payer-negotiated charges, online and in a machine-readable format. Hospitals would also be required to publicly post standard charge data for a limited set of "shoppable" services that can be scheduled by the health care consumer in advance.

This document summarizes several major provisions of the proposed rule, which is available here. CMS will accept comments on the proposed rule until September 27th.

OPPS PAYMENT UPDATE

CMS is proposing an overall OPPS rate increase of 2.7 percent. This increase is based on the proposed 3.2 percent hospital inpatient market basket increase for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by the proposed multifactor productivity (MFP) adjustment of 0.5 percentage point. Based on these proposed changes, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) in CY 2020 would be approximately $79 billion, which is an increase of approximately $6 billion, or nearly 8%, compared to estimated CY 2019 OPPS payments.

Other proposed payment policy changes include, but are not limited to:

- *Comprehensive Ambulatory Payment Classifications (C-APCs)* – CMS is considering developing an episode-of-care for skin substitutes and is seeking public comments regarding a future C-APC for procedures using skin substitute products. CMS is proposing to create two new C-APCs, including:
    - C-APC 5182 (Level 2 Vascular Procedures)
    - C-APC 5461 (Level 1 Neurostimulator and Related Procedures)
- *Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)* – In CY 2020, CMS is planning to complete the second year of the two-year phase-in for evaluation and management clinic visits when performed in excepted off-campus PBDs. During the second year of the transition, PBDs would continue to be paid the site-specific physician fee schedule (PFS) rate for the clinic visit service.
- *Cancer Hospital Payment Adjustment* – CMS is proposing to continue to provide additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio (PCR) after the

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additional payments is equal to the weighted average PCR for other OPPS hospitals using the most recently submitted or settled cost report data. A proposed PCR target of 0.89 will be used to determine the CY 2020 cancer hospital payment adjustment to be paid at cost report settlement.

- *Rural Adjustment* – CMS is proposing to continue the 7.1 percent adjustment to OPPS payments for certain rural sole community hospitals, including essential access community hospitals.
- *Addressing Wage Index Disparities* – CMS would apply all provisions in the proposed FY 2020 IPPS post-classification wage index for urban and rural areas to the wage index for the OPPS to determine the wage adjustment for both the OPPS payment rate and the copayment standardized amount.
- *Partial Hospitalization Program (PHP) Per Diem Rates* – CMS proposes to use the current Community Mental Health Center and hospital-based PHP geometric mean per diem costs, but with a cost floor equal to the CY 2019 final geometric mean per diem costs as the basis for developing CY 2020 PHP APC per diem rates.
- *Inpatient-only (IPO) List* – CMS is proposing to remove Total Hip Arthroplasty from the IPO list, making it eligible to be paid by Medicare in both the hospital inpatient and outpatient setting. CMS is also proposing to establish a one-year exemption from medical review activities for procedures removed from the IPO list starting in CY 2020 and continuing in subsequent years.

Payment for 340B Drugs

CMS is proposing to continue to pay 77.5% of the average sales price (ASP) for drugs acquired through the 340B Drug Pricing Program, including when furnished in nonexcepted off-campus PBDs paid under the PFS. CMS intends to appeal a district court case which concluded that the U.S. Secretary of Health exceeded his statutory authority by adjusting the Medicare payment rates for drugs acquired under the 340B Drug Pricing Program to this amount.

CMS is soliciting public comments on the appropriate OPPS payment rate for 340B-acquired drugs, if a change is necessary based on the outcome of the appeal, including whether a rate of ASP plus 3 percent could be an appropriate payment amount for these drugs for both CY 2020 and for establishing a remedy for CYs 2018 and 2019 payment rates.

ASC PAYMENT UPDATE

CMS is proposing to increase payment rates under the ASC payment system by 2.7 percent for ASCs that meet the Ambulatory Surgical Center Quality Reporting (ASCQR) requirements. This proposed increase is based on a proposed hospital market basket of 3.2 percent reduced by a proposed 0.5 percentage point adjustment for MFP as required by the Affordable Care Act. CMS estimates that these proposed changes will lead to approximately $4.89 billion in total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) in 2020, an increase of approximately $200 million compared to estimated 2019 payments.

CMS is also proposing to add 8 procedures to the ASC list of covered procedures, including a total knee arthroplasty procedure, a mosaicplasty procedure, and six coronary intervention procedures. CMS seeks

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public comments as to whether other surgical procedures related to the cardiovascular system should be added to the ASC list of covered surgical procedures.

LEVEL OF SUPERVISION OF OUTPATIENT THERAPEUTIC SERVICES

CMS proposes to change the minimum required level of supervision for all therapeutic services provided by all hospitals. The minimum required level of supervision would be changed from direct supervision to general supervision. Previously, only critical access hospitals and rural hospitals under 100 beds were allowed to use general supervision for therapeutic services. Under direct supervision, the clinical supervisor must be on site or in an adjacent physician office in order to permit immediate in-person response to an emergency if needed during the performance of the procedure. General supervision requires that services are provided under the supervising physician's or other qualifying practitioner's direction and control, but the clinical supervisor's presence is not required on campus.

QUALITY REPORTING PROGRAM CHANGES

Hospital Outpatient Quality Reporting (OQR)

CMS proposes to continue to implement the 2 percentage point reduction in payments for hospitals that fail to meet the Hospital OQR requirements. CMS is proposing to remove the Hospital OQR measure, *External Beam Radiotherapy for bone Metastases (OP-33)*, beginning with the CY 2022 payment determination and for subsequent years. CMS is seeking public comments on potentially adding the following four patient safety measures previously adopted for the ASC Quality Reporting in future rulemaking:

- ASC-1: Patient Fall
- ASC-2: Patient Burn
- ASC-3: Wrong Site, Wrong Side, Wrong Procedure, Wrong Implant
- ASC-4: All-Cause Hospital Transfers/Admissions

Ambulatory Surgical Center Quality Reporting (ASCQR)

ASCs will continue to receive a 2 percentage point reduction if they fail to meet quality reporting requirements. CMS is proposing to add one new measure, *Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers (ASC-19)*, to the ASCQR Program beginning with the CY 2024 payment determination and for subsequent years. CMS is not proposing to remove any measures from ASCQR in this rule.

PUBLIC LIST OF STANDARD CHARGES

The proposed rule would build upon prior agency guidance that required hospitals to make public their standard charges upon request in 2015, and subsequent agency guidance that required hospitals to publicly post their standard charges online in a machine-readable format in 2019. The proposed rule would require hospitals to make public all standard charges, which include the hospital's gross charges and payer-specific negotiated charges, for all items and services provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit. The public list must include the following corresponding information, as applicable, for each item or service:

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- Description of each item or service (including both individual items and services and service packages);
- The corresponding gross charge;
- The corresponding payer-specific negotiated charge that is clearly associated with the name of the third party payer; and
- Any code used by the hospital for purposes of accounting or billing, such as CPT, DRG or Revenue codes.

Public lists of all hospital standard charges would have to be available in a digital and machine-readable file posted online. CMS is seeking public comments on adopting a requirement that hospitals make public their standard charges through an open application programming interface (API), which would allow health care consumers to use the application of their choice to access health care service price estimates.

Consumer-Friendly Standard Charges for Shoppable Services

CMS is also proposing that hospitals make public the payer-specific negotiated charge for a limited set of "shoppable" services that are displayed and packaged in a consumer-friendly manner. Shoppable services are those that can be scheduled by the health care consumer in advance. Under the proposed rule, hospitals would be required to:

- Display payer-specific negotiated charges for at least 300 shoppable services, including 70 CMS-selected services and 230 hospital-selected services;
- Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code;
- Make sure that the charge information is displayed prominently on a publicly available webpage, clearly identifies the hospital (or hospital location), is easily accessible and without barriers, and is searchable; and
- Update the information at least annually.

Monitoring and Enforcement

Under the proposed rule, CMS would have the authority to monitor hospital compliance with these regulations by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites. If a hospital is deemed noncompliant with one or more of the requirements for public standard charges, CMS may provide a warning notice to the hospital and request a corrective action plan from the hospital. If a hospital fails to respond to this request or comply with the requirements of the corrective action plan, CMS may impose a civil monetary penalty on the hospital of up to $300 per day and may publicize the noncompliance on a CMS website. CMS also proposes to establish an appeals process for hospitals regarding the civil monetary penalty.

DEVICE PASS-THROUGH APPLICATIONS

CMS is proposing an alternative pathway to qualify for device pass-through payment status for devices that meet the Food and Drug Administration (FDA) Breakthrough Device Designation. The FDA Breakthrough Devices Program expedites the development of, and provides priority review of, medical devices that meet certain criteria and subsequently receive this designation. Under the proposed

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alternative pathway to pass-through status, the "substantial clinical improvement" criterion would not apply for such devices.

PROPOSED PRIOR AUTHORIZATION PROCESS

CMS cites a higher than expected volume increase for the following five services in recent years that far exceeds the average increase in the number of Medicare beneficiaries:

- Blepharoplasty;
- Botulinum toxin injections;
- Panniculectomy;
- Rhinoplasty; and
- Vein ablation.

To address this higher than expected volume increase, CMS proposes to implement a required prior authorization process for these services.