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2021 Hospital Outpatient Payment System and Ambulatory Surgical Center Payment System Proposed Rule

OVERVIEW

On August 4th, 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) 2021, and updates regulations regarding hospital Star Rating methodology and physician-owned hospitals. The proposed rule would increase both OPPS rates and ASC payment rates by 2.6 percent.

This document summarizes several major provisions of the proposed rule, which is available here. CMS will accept comments on the proposed rule until October 5th.

OPPS PAYMENT UPDATE

CMS is proposing an overall OPPS rate increase of 2.6 percent. This increase is based on the proposed 3 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 0.4 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 2021 would be approximately $83.9 billion, which is an increase of approximately $7.5 billion compared to estimated CY 2020 OPPS payments. This 9.8 percent increase is due in part to projections of temporarily suppressed OPPS spending in 2020 resulting from COVID-19.

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

- *Comprehensive Ambulatory Payment Classifications (C-APCs)* – CMS is proposing to create the following two new C-APCs:
  - C-APC 5378 (Level 8 Urology and Related Services)
  - C-APC 5465 (Level 5 Neurostimulator and Related Procedures)

- *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 additional payments is equal to the weighted average PCR for other OPPS hospitals using the most recently submitted or settled cost report data. However, as required by the 21st Century Cures Act, the weighted average PCR will be reduced by 1.0 percentage point. A proposed PCR target of 0.89 will be used to determine the CY 2021 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 (SCHs), including essential access community hospitals (EACHs).

- *Addressing Wage Index Disparities* – CMS would apply all provisions in the proposed FY 2021 IPPS post-classification wage index for urban and rural areas to the wage index for the OPPS to

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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 continue to use the current Community Mental Health Center (CMHC) and hospital-based PHP geometric mean per diem costs, using updated data for each provider type and a cost floor equal to the CY 2019 final geometric mean per diem costs for each provider type. CMS proposes to calculate the CY 2021 PHP APC per diem rate for hospital-based PHPs based on updated cost data and to calculate the rate for CMHCs based on the proposed cost floor.
- *Inpatient-only (IPO) List* – CMS is proposing to eliminate the IPO list over the course of three calendar years, starting with the removal of approximately 300 musculoskeletal-related services. CMS seeks comment on whether three years is an appropriate timeframe for phasing out the IPO list, whether there are other services that should be removed from the list for CY 2021, and how the removal of additional services should be sequenced.

Payment for 340B Drugs

CMS is proposing to pay 71.3 percent of the average sales price (ASP) for drugs and biologicals acquired through the 340B Drug Pricing Program, which includes a 6 percent add-on amount for overhead and handling costs. CMS seeks comment on an alternative proposal that would continue the current policy of paying 77.5 percent ASP.

CMS proposes that rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals be excepted from either of the proposed 340B payment policies and continue to be paid ASP with a 6 percent add-on.

ASC PAYMENT UPDATE

CMS is proposing to increase payment rates under the ASC payment system by 2.6 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 percent reduced by a proposed 0.4 percentage point adjustment for MFP. CMS estimates that these proposed changes will lead to approximately $5.45 billion in total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix) in CY 2021, an increase of approximately $160 million compared to estimated CY 2020 payments.

CMS is also proposing to add 11 procedures to the ASC list of covered procedures, including total hip arthroplasty, removing them from the inpatient-only list. As a potential alternative to the previous proposal, CMS proposes to modify certain criteria for adding a procedure to the ASC list and to establish a nomination process where stakeholders would use suggested parameters to nominate procedures that can be safely performed in the ASC setting.

As a second alternative, CMS proposes to keep the general standard criteria for the list of covered procedures but eliminate five general exclusion criteria. This alternative proposal would add 266 potential surgery procedures to the covered procedure list that would meet the revised regulatory criteria, including the 11 in the previous list. This would be part of a three year transition of services off the inpatient-only list, resulting in the full elimination of the inpatient-only list by January 1, 2024. CMS is soliciting comments on these three proposals to expand the ASC list of covered procedures.

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QUALITY REPORTING PROGRAM CHANGES

Overall Hospital Quality Star Rating

Starting in 2021, CMS proposes the following changes to the methodology used to calculate the Overall Star Rating:

- Combining three existing process measure groups into one new Timely and Effective Care group as a result of measure removals (thus, the Overall Star Rating would be made up of five groups – Mortality, Safety of Care, Readmissions, Patient Experience, and Timely and Effective Care);
- Using a simple average methodology to calculate measure group scores instead of the current statistical Latent Variable Model;
- Stratifying the Readmission measure group only by hospitals' proportion of dual-eligible patients to align with Hospital Readmissions Reduction Program (HRRP);
- Changing the reporting threshold to receive an Overall Star Rating by requiring a hospital to report at least three measures for three measures groups (one of the groups must specifically be the Mortality or Safety of Care group); and
- Applying peer grouping methodology by number of measure groups where hospitals are grouped by whether they have three or more measures in three, four, or five measure groups (three measure groups is the minimum to receive a rating and five is the proposed number of groups after combining the three process measure groups into one).

CMS proposes to retain some aspects of the current methodology, including annual refresh, included measures, standardization of measure scores, and use of k-means clustering to assign a rating. CMS is also proposing to include critical access hospitals (CAHs) and Veterans Health Administration (VHA) hospitals in the Overall Star Rating.

Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR)

CMS proposes to continue to implement the 2 percentage point reduction in payments for hospitals that fail to meet the Hospital OQR requirements. ASCs will also continue to receive a 2 percentage point reduction if they fail to meet quality reporting requirements. CMS is not proposing any measure additions or removals in this rule; however, CMS proposes to update compliance for measurement and reporting requirements for quality of care provided in outpatient settings for both programs.

LEVEL OF SUPERVISION FOR OUTPATIENT THERAPEUTIC SERVICES

CMS proposes to change the minimum required level of supervision for non-surgical extended duration therapeutic services to general supervision for the entire service, including the initiation of the service which had previously required direct supervision.

CMS also proposes to allow direct supervision for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services to include the virtual presence of the physician through audio/video real-time technology.

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PHYSICIAN-OWNED HOSPITAL EXPANSION EXCEPTION PROCESS

CMS proposes to remove certain provisions in the expansion exception process for hospitals that qualify as "high Medicaid facilities." Those provisions include:

- The cap on the number of additional operating rooms, procedure rooms, and beds that can be approved in an exception; and
- The restriction that the expansion must occur only in facilities on the hospital's main campus.

CMS also proposes to allow high Medicaid facilities to apply for an exception more than once every two years, provided that they submit only one expansion exception request at a time. Additionally, CMS proposes that, for the purposes of determining the number of beds in a hospital's baseline number, a bed is included only if it is considered licensed for the purposes of State licensure.

PRIOR AUTHORIZATION PROCESS SERVICE CATEGORIES

CMS is proposing to add Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators to the list of services that require prior authorization beginning for dates of service on or after July 1st, 2021.