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

OVERVIEW

On December 2nd, the Centers for Medicare and Medicaid Services (CMS) released a final rule that updates 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 final rule increases both OPPS rates and ASC payment rates by 2.4 percent.

In addition to finalizing a number of payment and policy changes, the rule includes a comment period on the new reporting requirements for hospitals during the COVID-19 Public Health Emergency (PHE) and the revisions to the Radiation Oncology (RO) Model. CMS will accept comments until January 31, 2021.

This document summarizes several major provisions of the final rule, which is available here.

OPPS PAYMENT UPDATE

CMS's overall OPPS rate increase of 2.4 percent is based on the hospital market basket increase for inpatient services paid under the hospital inpatient prospective payment system (IPPS). 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 or 9.8% compared to estimated CY 2020 OPPS payments, due in part to temporarily suppressed outpatient payments in 2020 resulting from COVID-19.

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

- *Comprehensive Ambulatory Payment Classifications (C-APCs)* – CMS is creating the following two new C-APCs:
  - C-APC 5378 (Level 8 Urology and Related Services)
  - C-APC 5465 (Level 5 Neurostimulator and Related Procedures)
- *Inpatient-only (IPO) List* – CMS is eliminating the IPO list over the course of three calendar years, starting with the removal of 266 musculoskeletal-related services. CMS is also removing 32 additional HCPCS codes from the IPO list based on public comments. Services removed from the IPO list will be exempt from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organization referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and RAC reviews for "patient status" (i.e., site-of-service) until such services are more commonly billed in the outpatient setting.
- *Cancer Hospital Payment Adjustment* – CMS is continuing 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

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weighted average PCR will be reduced by 1.0 percentage point. A 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 maintaining the current 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 will use the FY 2021 IPPS post-reclassified wage index and applicable IPPS wage index adjustments to determine the wage adjustments for both the OPPS payment rate and the copayment rates.
- *Partial Hospitalization Program (PHP) Per Diem Rates* – CMS is continuing 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. CMS is calculating the CY 2021 PHP APC per diem rate for hospital-based PHPs and CMHC PHPs based on updated cost and claims data.
- *Unified Rate Structure* – CMS will maintain the unified rate structure of a single PHP Ambulatory Payment Classification for each provider type for days with three or more services per day (however, CMS is not finalizing the proposed cost floors).

Payment for 340B Drugs

CMS is continuing the current policy of paying 77.5 percent Average Sales Price (ASP) for drugs and biologicals acquired through the 340B Drug Pricing Program. Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals continue to be exempt from 340B payment policies. Exempt hospitals and physician's office settings continue to be paid ASP with a 6 percent add-on.

ASC PAYMENT UPDATE

CMS is increasing payment rates under the ASC payment system by 2.4 percent for ASCs that meet the Ambulatory Surgical Center Quality Reporting (ASCQR) requirements. This finalized increase is based on a hospital market basket increase of 2.4 percent. CMS estimates that these changes will lead to approximately $5.42 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 $120 million compared to estimated CY 2020 payments.

CMS is adding 11 procedures to the ASC list of covered procedures, including total hip arthroplasty, as part of the standard review process. CMS is modifying the criteria for adding a surgical procedure to the ASC list and establishing a process for the public to notify CMS regarding surgical procedures that should be added to the ASC list. Under these revised criteria, CMS is adding an additional 267 surgical procedures to the ASC list. Certain criteria used in the past will now be factors for physicians to consider when deciding whether a beneficiary should receive a covered surgical procedure in an ASC.

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QUALITY REPORTING PROGRAM CHANGES

Overall Hospital Quality Star Ratings

Starting in 2021, CMS is adopting 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;
- Standardizing measure group scores (i.e., making varying scores directly comparable by putting them on a common scale);
- 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 into whether they have three or more measures in three, four, or five measure groups (three measure groups is the minimum to receive a rating).

CMS is retaining 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 including Critical Access Hospitals (CAHs) and Veterans Health Administration hospitals in the Overall Star Rating.

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

CMS is continuing 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 implementing any measure additions or removals in this rule; however, CMS is updating and refining measurement and reporting requirements for quality of care provided in outpatient settings for both programs.

LEVEL OF SUPERVISION FOR OUTPATIENT THERAPEUTIC SERVICES

CMS is changing the minimum 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 is also permitting 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 until either the end of the calendar year in which the COVID-19 PHE ends or December 31, 2021, whichever is later.

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PHYSICIAN-OWNED HOSPITAL EXPANSION EXCEPTION PROCESS

CMS is removing 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 is also allowing 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. 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 adding 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 1, 2021.

RADIATION ONCOLOGY (RO) MODEL

Due to the COVID-19 PHE, CMS is revising the RO Model's performance period to begin on July 1, 2021 and end on December 31, 2025, delaying the implementation of the model by six months and reducing the total performance period from five years to four and a half years. This will require CMS to revise other components of the RO Model, including:

- How episodes and RO episodes are used to determine eligibility for the low volume opt-out for Performance Year (PY) 3 and RO episodes are used to determine eligibility for the low volume opt-out for PY4 through PY5;
- Certified Electronic Health Record Technology (CEHRT) requirements;
- Submission of quality measures and clinical data elements;
- The quality withhold;
- Quality reconciliation amount; and
- The status of the RO Model as an Advanced Alternate Payment Model (APM) and Merit-based Incentive Payment System (MIPS) APM.

HOSPITAL AND CRITICAL ACCESS HOSPITAL REPORTING

CMS is requiring hospitals and CAHs to report information about their usage and inventory of therapeutics to treat COVID-19. Hospitals and CAHs will also be required to provide information regarding the incidence and impact of acute respiratory illnesses, including seasonal influenza, during the ongoing COVID-19 PHE.