Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

DECEMBER 2020

CY 2021 MEDICARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE – CMS-1736-F

On Dec. 2, the Centers for Medicare & Medicaid Services (CMS) released its annual final rule updating the Outpatient Prospective Payment System (OPPS) effective Jan. 1, 2021 through Dec. 31, 2021 (the final rule is not yet published in the *Federal Register*). CMS finalized an increase in OPPS and Ambulatory Surgical Center (ASC) payments of 2.4% in calendar year (CY) 2021 compared with CY 2020.

COVID-19 Data Reporting (*all page numbers refer to the desk copy, pp. 1190-1197*): With the OPPS final rule, CMS issued an interim final rule expanding the Medicare condition of participation (CoP) requiring hospitals and critical access hospitals (CAHs) to report COVID-19 data as specified by the Secretary of Health and Human Services (HHS). Hospitals and CAHs must track and report their real time inventory supplies and usage rates for COVID-19 related therapeutics distributed and delivered by HHS, as well as the incidence and impact of acute respiratory illnesses (e.g., seasonal influenza, influenza-like illness, and severe acute respiratory infection). Providers must report data in a manner specified by the Secretary of HHS for the duration of the COVID-19 public health emergency. Failure to comply with these data reporting requirements jeopardizes a provider's eligibility to participate in the Medicare and Medicaid programs.

OPPS/ASC Market Basket Update (*pp. 125-134, 905-912)*: CMS finalized a 2.4% market basket update and a 0.0 percentage point Affordable Care Act (ACA) productivity adjustment for the OPPS. Additional proposed adjustments include a wage index budget neutrality factor of 1.0012, a 340B budget neutrality adjustment of 1.0000, and a 0.04 percentage point adjustment to account for the difference in pass-through spending.

The national CY 2021 conversion factor is $82.797 (proposed $83.697). Hospitals that fail to submit quality data will be subject to a 2-percentage point reduction to OPPS payments.

The final ASC market basket update is also 2.4% with a 0.0 percentage point ACA productivity reduction. The proposed CY 2021 ASC conversion factor is $48.952 (proposed $48.984). ASCs that fail to submit quality data will be subject to a 2-percentage point reduction to ASC payments.

340B (*pp. 538-585*): CMS will continue the current payment policy for 340B drugs at Average Sales Price (ASP) minus 22.5%. This payment rate extends to 340B-acquired drugs furnished in non-grandfathered (non-excepted) off-campus provider-based departments. It does not apply to children's hospitals, rural sole community hospitals, or PPS-exempt cancer hospitals.

CMS did not finalize a proposed reimbursement rate of ASP minus 34.7%, plus an add-on payment of 6% of the product's ASP (net payment rate of ASP minus 28.7%).

Inpatient Only List (IPO) (*pp. 678-727, 740-765*): CMS will eliminate the IPO list over the next three calendar years. The first services removed from the IPO list include 266 musculoskeletal services and 32 additional Healthcare Common Procedure Coding System (HCPCS) codes. A full list of procedures CMS removed from the IPO list for CY 2021 is in Table 48 (*pp. 709-727*). CMS will continue its 2-year exemption from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) for noncompliance with the 2-midnight rule, and RAC reviews for "patient status" until procedures removed from the IPO list are more commonly billed in the outpatient setting.

Prior Authorization (*pp. 1109-1134*): CMS added two new service categories to their outpatient prior authorization process starting with dates of service on or after July 1, 2021. The service categories include: (1) cervical fusion with disc removal and (2) implanted spinal neurostimulators. The list of CPT codes requiring prior authorization for 2021 is in Table 74 (*pp. 1132-1134*).

Changes in the Level of Supervision of Outpatient Therapeutic Services (*pp. 727-740*): CMS changed the minimum default level of supervision for non-surgical extended duration therapeutic services (NSEDTS) to general supervision for the entire service, including the initiation portion of the service. This change makes the level of supervision required for NSEDTS consistent with the minimum required level of general supervision that currently applies for most other hospital outpatient therapeutic services.

In the CY 2021 OPPS proposed rule, CMS proposed changing direct supervision requirements for pulmonary, cardiac, and intensive cardiac rehabilitation services. Due to the COVID-19 public health emergency, CMS granted flexibilities in direct supervision of these services via the interim final rule published March 31. In the proposed rule, subject to the clinical judgment of the supervising physician, CMS proposed allowing physicians to provide direct supervision of these services via virtual presence through audio/video real-time communications technology even after the public health emergency ends. However, after consideration of public comments, CMS modified their proposal, allowing direct supervision of these services via audio/video real-time communications technology until the later of the end of the calendar year in which the COVID-19 public health emergency (PHE) ends or Dec. 31, 2021. CMS stated they need more information on the issues involved with direct supervision through virtual presence before implementing this policy permanently.

Hospital Overall Star Ratings (*pp. 963-1108*): CMS finalized several changes to the hospital overall star ratings methodology starting in CY 2021. Changes include:

- Replacement of the latent variable modeling (LVM) with a simple average of measure group scores;
- Decreasing the number of measure groups by consolidating three current groups (Effectiveness of Care, Timeliness of Care, and Efficient Use of Medical Imaging) into one new measure group: Timely and Effective Care;
- Standardization of measure group scores by calculating Z-scores for each measure group;

- Modifying the minimum threshold used for calculating star ratings, requiring hospitals to report at least three measures for three measure groups, with one of the groups being either the Mortality outcome group or the Safety of Care outcome group; and
- Including quality measure data from Veterans Health Administration hospitals beginning CY 2023.

Clinical Laboratory Fee Schedule (CLFS) (*pp. 111-121*): CMS will exclude cancer-related protein-based Multianalyte Assays with Algorithmic Analyses (MAAAs) from the OPPS clinical laboratory packaging policy, paying for MAAAs separately under the CLFS. CMS added MAAAs to the laboratory date of service exception, requiring laboratories to bill Medicare directly for such tests instead of seeking payment from the hospital.

APC-Specific Policies (*pp. 18*): CMS created two new comprehensive APCs (C-APCs): (1) Level 8 Urology and Related Services (C-APC 5378), and (2) Level 5 Neurostimulator and Related Procedures (C-APC 5465). If finalized, there will be 69 C-APCs.

Updates to ASC Covered Surgical Procedures (*pp. 789-867*): CMS added 11 procedures to the ASC Covered Procedures List, including (Table 59, *pp. 851-852*):

- CPT code 0266T (Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed));
- CPT code 0268T (Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed);
- CPT code 0404T (Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency);
- CPT code 21365 (Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches;
- CPT code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft;
- CPT code 27412 (Autologous chondrocyte implantation, knee);
- CPT code 57282 (Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus));
- CPT code 57283 (Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy);
- CPT code 57425 (Laparoscopy, surgical, colpopexy (suspension of vaginal apex));
- CPT code C9764 (Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed; and
- CPT code C9766 (Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed.

CMS also finalized 12 ASC covered surgical procedures as temporarily office-based for CY 2021 (Table 57, *pp. 798*-799), and an additional 11 ASC covered surgical procedures as permanently office-based for CY 2021 (Table 58, *p.* 799).

CMS finalized a change to the process used to add surgical procedures to the ASC Covered Procedures List. Specifically, CMS will assess surgical procedures on four criteria, including the procedure: (1) is separately paid under the OPPS; (2) not designated as requiring inpatient care under §419.22(n) as of Dec. 31, 2020; (3) not only able to be reported using a CPT unlisted surgical procedure code; or (4) not otherwise excluded under §411.15. CMS added §§416.166(d) and (e) to allow physicians to consider certain safety factors when determining the most appropriate site of care for a specific patient, and describe how CMS will add a surgical procedures to the ASC Covered Procedures List. These changes result in the addition of 267 procedures to the ASC Covered Procedures List (Table 60, *pp. 852-865*).

Hospital Outpatient and ASC Quality Reporting Programs (OQR/ASCQR) (*pp. 915-963*): CMS did not finalize any new measures for the OQR or ASCQR programs. Table 62 (*p. 920*) contains the finalized OQR measure set for payment determination in CY 2023 and subsequent years. CMS finalized CY 2021 ASCQR measures in the CY 2021 OPPS/ASC final rule. Table 64 (*pp. 943-944*) contains the finalized ASCQR measure set for payment determination in CY 2024 and subsequent years.

CMS finalized several updates to regulatory language related to administrative requirements for both programs, most of which are related to previously finalized provisions. CMS also expanded the review and corrections policy for the OQR to apply to data submitted via the agency's web-based tool starting with data submitted for the CY 2023 payment determination (*pp. 930-931*). CMS will create a similar policy for the ASCQR.

The CY 2023 submission deadlines are as follows (*p. 925*):

Patient Encounter Quarter	Clinical Data Submission Deadline
Q2 2021 (April 1 – June 30)	Nov. 1, 2021
Q3 2021 (July 1 – Sept. 30)	Feb. 1, 2022
Q4 2021 (Oct. 1 – Dec. 31)	May 1, 2022
Q 1 2022 (Jan. 1 – Mar. 31)	Aug. 1, 2022

Wage Index (*pp. 135-153*): CMS finalized an OPPS labor-related share of 60%. CMS adopted updated OMB delineations and related inpatient prospective payment system (IPPS) wage index adjustments to calculate the CY 2021 OPPS wage indexes (see IHA's fact sheet on the federal fiscal year (FFY) 2021 IPPS final rule for more information).

Outlier Payments (*pp. 166-170*): To ensure CY 2021 aggregate outlier payments equal 1.0% of estimated total OPPS payments, CMS finalized a fixed-dollar threshold of $5,300 combined with the multiple-threshold of 1.75 times to Ambulatory Payment Classification (APC) payment rate.

Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH) (*pp. 155-158*): CMS will continue its current policy of a 7.1% budget neutral payment adjustment for rural SCHs and EACHs for all OPPS services and procedures. This proposal excludes separately payable

drugs and biologicals, brachytherapy sources, items paid at charges reduced to cost, and devices paid under the pass-through payment policy.

Proposed Partial Hospitalization Program (PHP) and Community Mental Health Center (CMHC) Updates (*pp. 637-678*): Using the most recent updated claims and cost data to calculate CY 2021 geometric mean per diem costs, CMS finalized a hospital-based PHP geometric mean per diem cost of $253.76 and a CMHC geometric mean per diem cost of $136.14.

Contact:
Contact IHA

Sources:

Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report COVID-19 Therapeutic Inventory and Usage and to Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19) [CMS-1736-F]. December 2, 2020. Available from: https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf. Accessed December 2, 2020.