Illinois Health and Hospital Association

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ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Other Finance Staff

FROM: A.J. Wilhelmi, President & CEO
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SUBJECT: **CMS Final Payment Rule for CY 2020: Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System**

Executive Summary

On Nov. 12, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register (FR)* the final annual update regarding the Medicare outpatient prospective payment system (OPPS) and ambulatory surgical center payment system (ASC) for calendar year (CY) 2020. A correction notice was subsequently published on Jan. 3, 2020, updating certain wage index and budget neutrality factors, in addition to several of the addenda. The provisions of this final rule are effective Jan. 1, 2020.

Assuming that all hospitals comply with the quality reporting criteria, we estimate a net increase in OPPS payments to Illinois hospitals of approximately 0.8% in CY 2020, or $23.6 million. This includes adjustments for budget neutrality, wage index updates, wage index disparity reductions, and other ambulatory payment classification factors and updates. This does not include the impact of the 2% sequestration reduction to all Medicare payments.

Additionally, CMS released a final rule addressing new hospital price transparency requirements on Nov. 15, 2019. The hospital price transparency final rule is effective Jan. 1, 2021. IHA's summary of the hospital price transparency final rule can be found on the IHA website.

Highlights of this final rule include:

- Complete phase-in of the site-neutral rate for clinic visits provided at excepted off-campus provider-based departments (PBDs), despite a court order to vacate this policy as implemented in CY 2019;
- Continued reimbursement of 340B-acquired drugs at average sales price (ASP) minus 22.5%, despite ongoing litigation regarding CMS' authority to implement this reimbursement cut;

- Changes to the Outpatient Quality Reporting (OQR) and ASC Quality Reporting (ASCQR) Programs;
- Removal of several services including total knee arthroplasty from the inpatient-only (IPO) list; and
- Changes to the minimum required level of supervision for hospital outpatient therapeutic services from direct to general supervision at all hospitals and critical access hospitals (CAHs).

Available in the IHA C-Suite are hospital-specific reports comparing the estimated financial impact of the CY 2020 OPPS changes on your hospital, Illinois and the U.S. Following is a more detailed description of the final rule:

Medicare OPPS

The final CY 2020 OPPS conversion factor is $80.793, a 1.64% increase from the CY 2019 conversion factor of $79.490. This conversion factor reflects a market basket update of 3%, the Affordable Care Act (ACA)-mandated productivity market basket reduction of 0.4 percentage points, and additional budget neutrality adjustments. Hospitals that do not comply with OQR reporting requirements are subject to a 2.0 percentage point payment reduction.

Wage Index: CMS will use the federal fiscal year (FFY) 2020 inpatient prospective payment system (IPPS) post-reclassification wage index for CY 2020 OPPS payments. CMS applies the wage index to the labor-related share of the OPPS conversion factor, which will remain at 60%. All finalized IPPS wage index policies are also recognized for OPPS payments, including an increase in the wage index for hospitals in the bottom quartile, a transitional 5% cap in which a hospital's FFY 2020 wage index cannot be less than 95% of its final FFY 2019 wage index, and the removal of wage index data from urban hospitals that reclassify as rural when calculating each state's rural floor and rural wage index. For more details on these changes, see IHA's summary of the FFY 2020 IPPS final rule. For OPPS hospitals that are not paid under IPPS, CMS will assign a wage index value based on geographic location and any applicable wage index arguments.

FFY 2020 Illinois Wage Index by CBSA

Area Name	Wage Index, FFY 2020	Reclassified Wage Index, FFY 2020	Reclassified Geographic Adjustment Factor, FFY 2020	Rural Floor
Illinois	0.8259	0.8259	0.8772	0.8270
Bloomington	0.9160	0.8948	0.9267	
Cape Girardeau	0.8270			
Carbondale-Marion	0.8270			
Champaign-Urbana	0.8848	0.8703	0.9093	

Chicago-Naperville-Arlington Heights	1.0337	1.0197	1.0134	
Danville	0.9291	0.9291	0.9509	
Decatur	0.8566			
Elgin	1.0465	1.0312	1.0213	
Kankakee	0.9025	0.8746	0.9123	
Lake County	1.0395	1.0395	1.0269	
Peoria	0.8623			
Rock Island	0.9047	0.8832	0.9185	
Rockford	0.9751	0.9526	0.9673	
St. Louis	0.9260	0.9260	0.9487	
Springfield	0.9350	0.9185	0.9434	

Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs): CMS will continue applying a 7.1% payment increase for rural SCHs and EACHs. This payment add-on excludes separately payable drugs and biologicals, brachytherapy sources, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

Outlier Payments: The final CY 2020 outlier fixed-dollar threshold is $5,075, an increase from $4,825 in CY 2019. Outlier payments are paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the Ambulatory Payment Classification (APC) payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold are met.

Payment for Clinic Visits Provided at Excepted Off-Campus Provider-Based Departments (PBDs): In CY 2019, CMS began phasing-in the use of the Medicare Provider Fee Schedule (MPFS) payment methodology for HCPCS code G0463 (hospital outpatient clinic visit) at excepted off-campus PBDs. In September, the U.S. District Court for D.C. ruled that CMS exceeded its authority in lowering payments for clinic visits at excepted off-campus PBDs. Despite this decision, this final rule completes the phase-in, with CMS indicating that they may appeal the court's decision. Thus, for CY 2020, clinic visits at excepted off-campus PBDs will be paid at 40% of the OPPS rate.

We estimate that this policy will lower payments to Illinois hospitals by $12.3 million. This cut will be implemented in a non-budget neutral manner.

Updates to the Hospital OQR Program: CMS finalized the removal of OP-33: External Beam Radiotherapy (NQF #1822) for the CY 2022 payment determination, beginning with Jan. 1, 2020 encounters. The final submission of data collected for CY 2019 encounters is required by May 15, 2020 for use toward CY 2021 payment determinations. Table 61 on *FR* pages 61413-61414 lists the 18 measures for CY 2022 payment determination.

Updates to APC Groups and Weights: CMS recalibrated the relative APC weights using CY 2018 hospital claims. Final CY 2020 payment rates and weights are available in Addenda A and B of the final rule on the CMS website. CMS removed five HCPCS codes from the CY 2020 bypass list, including: G0436, 71010, 71015, 71020, and 93965. For more information on these removed codes, see *FR* pages 61149-61150.

CT and MRI Cost-to-Charge Ratios (CCRs): CMS finalized its decision to use all claims with valid CT and MRI cost center CCRs, including those that use a "square foot" cost allocation method, to estimate costs for applicable APCs. CMS will phase-in this methodological approach over two years, applying 50% of the payment impact from including "square feet" claims in CY 2020 and 100% of the payment impact in CY 2021. Table 4 on *FR* page 61153 shows the estimated cost impact for CT and MRI APCs under this proposed phase-in for CY 2020.

New Comprehensive APCs: CMS will continue to exclude payment for procedures assigned to a New Technology APC from Comprehensive APCs (C-APC) when included on a claim with a "J1" indicator. CMS will also exclude payment for any procedures assigned to a New Technology APC from being packaged into the payment for comprehensive observation services assigned to status indicator "J2" when they are included on a claim with "J2" procedures. CMS also finalized two new C-APCs for CY 2020, C-APC 5182: Level 2 Vascular Procedures, and C-APC 5461: Level 1 Neurostimulator and Related Procedures. Table 5 on *FR* pages 61164-61166 displays all 67 C-APCs for CY 2020.

Composite APCs: CMS will continue paying for mental health services provided by a hospital through composite APC 8010 when those services are provided to a single beneficiary on a single date of service, and those services exceed the maximum per diem payment rate for partial hospitalization services. CMS will set the payment rate for composite APC 8010 for CY 2020 at the same payment rate as the maximum partial hospitalization per diem payment rate for a hospital (APC 5863). CMS will also continue using multiple imaging composite APCs to pay for services providing more than one imaging procedure from the same imaging family on the same date. Table 6 on *FR* pages 61169-61173 displays CY 2020 OPPS imaging families and multiple imaging procedure composite APCs.

Low-Volume New Technology APCs: CMS will continue allowing the use of up to four years of claims data, rather than the most recent available year of claims data, to establish a payment rate for services assigned to a New Technology APC with fewer than 100 claims annually.

Payment for Medical Devices with Pass-Through Status: CMS will allow new medical devices that are (1) part of the U.S. Food and Drug Administration (FDA) Breakthrough Devices Program and (2) have received FDA marketing authorization to forgo meeting the new medical devices substantial clinical improvement criterion. This policy is effective for devices receiving pass-through payments on or after Jan. 1, 2020. The device must still meet other requirements in

order to qualify for pass-through payment status; for more information on these criteria see *FR* page 61273.

- One device category is currently eligible for pass-through payment: C1823: Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads. However, in the proposed rule CMS indicated this device category was C1822: Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system. We await final clarification on which category is currently eligible for pass-through payment.
- Five additional devices were approved for device pass-through payment beginning Jan. 1, 2020: Surefire® Spark™ Infusion System; Optimizer® System; AquaBeam® System; Augment® Bone Graft; ARTIFICIAL*IRIS*® (approved under the FDA Breakthrough Devices Program).

Updates to the IPO List: CMS removed total hip arthroplasty (CPT 27130) from the IPO list, assigning the procedure to C-APC 5115 Level 5 Musculoskeletal Procedures with status indicator "J1." Anesthesia CPT 01214 was also removed from the IPO list, as this service accompanies open procedures involving hip joints and total hip arthroplasty. An additional six spinal procedures and four anesthesia procedures were also removed from the IPO list. See Tables 48 and 49 on *FR* pages 61358-61359 for CPT codes, C-APC assignments, and CY 2020 OPPS status indicators.

In addition to these changes, CMS established review activity exemptions for procedures removed from the IPO list beginning CY 2020. Procedures that are removed from the IPO list are exempt from site-of-service claim denials under Medicare Part A, eligibility for Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) for noncompliance with the two-midnight rule, and RAC reviews for patient status. These exemptions last for two years. During that time, BFCC-QIOs may review claims in order to educate practitioners and providers regarding compliance with the two-midnight rule, but noncompliant claims will not be denied payment with respect to site-of-service under Medicare Part A.

Partial Hospitalization Program (PHP) Services: For APC 5853 provided via community mental health centers (CMHCs), the final CY 2020 PHP APC geometric mean per diem cost is $121.62, and the final CY 2020 PHP payment rate is $124.29. For APC 5863 provided via hospital-based PHPs, the final CY 2020 PHP APC geometric mean per diem cost is $233.52, and the final CY 2020 PHP payment rate is $238.64.

CMS remains concerned about the underutilization of individual therapy in both CMHCs and hospital-based PHPs, particularly on days with three services. CMS reiterated that it expects days with only three services to be the exception, not the rule for PHP days.

Supervision of Outpatient Therapeutic Services: CMS changed the minimum level of supervision required for hospital outpatient therapeutic services from direct to general supervision for hospitals and CAHs beginning Jan. 1, 2020. Having advocated for this change for many years, IHA applauds CMS' decision. Allowing general supervision will positively impact access to and utilization of outpatient therapeutic services in our hospitals, particularly our rural hospitals, which have expressed difficulty in meeting direct supervision requirements for years.

Medicare ASC Payment System

The final CY 2020 ASC conversion factor is $47.747. This conversion factor reflects a market basket update of 3% and the ACA-mandated productivity market basket reduction of 0.4 percentage points. ASCs that do not comply with ASCQR reporting requirements are subject to a 2.0 percentage point payment reduction.

Packaged Services – Non-Opioid Pain Management: CMS will continue to unpackage and pay separately at ASP + 6% the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in ASCs. In CY 2020, Exparel® is the only FDA-approved drug that meets this criteria. CMS did not extend this policy to additional OPPS settings.

ASCQR Program Changes: For the CY 2024 payment determination, CMS finalized adoption of ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedure Performed at Ambulatory Surgical Centers (NQF #3357). This measure is claims-based, meaning ASCs will not be required to submit additional data to inform this measure. For more information, see *FR* pages 61421-61428. For the full list of ASCQR Program measures for CY 2024 payment determination, see *FR* page 61429.

ASC-Covered Surgical Procedures: CMS added eight procedures to the ASC list of covered surgical procedures for CY 2020. These include six coronary intervention and associated add-on procedures (CPTs 92920, 92921, 92928, 92929, C9600, and C9601), and two total knee arthroplasty procedures (CPTs 27447 and 29867).

Payments for Drugs, Biological and Radiopharmaceuticals

CY 2020 340B Drug Payment Policy: CMS will continue reimbursing for separately payable drugs and biologicals acquired under the 340B program at ASP minus 22.5%. CMS is expanding this reimbursement cut to 340B-acquired drugs provided at non-excepted off-campus PBDs. This payment policy is part of an ongoing lawsuit: *American Hospital Association et al. v. Azar et al.* In May, the U.S. District Court concluded that CMS exceeded its authority with its large reduction to Medicare payments for 340B-acquired drugs for CY 2018 and CY 2019. CMS is pursuing an appeal, and on Nov. 8, the U.S. Circuit Court of Appeals for the D.C. Circuit heard extended oral arguments. AHA's counsel asked the court for an expedited ruling to either prevent additional cuts in CY 2020, or remediate them promptly.

Regardless of the outcome of current litigation, CMS plans to collect acquisition cost data from 340B providers, indicating that they believe current reimbursement at ASP minus 22.5% overcompensates 340B providers. If they move forward with the collection of these data, they may use such information to set 340B reimbursement rates moving forward. IHA submitted comments on this proposed data collection on Nov. 29.

Threshold-Packaged and Policy-Packaged Drugs: Payment rates for drugs, biologicals and radiopharmaceuticals (i.e., drugs) without pass-through status are based on third quarter 2019 ASP data. Payment for non-pass-through drugs is either packaged with the procedure payment or paid separately, depending on the cost of the drug. The CY 2020 packaging threshold is $130, an increase of $5 from CY 2019. Drugs that cost more than $130 will be paid separately through their own APC.

The cost of certain drugs are packaged with procedure payments regardless of their individual cost. These are referred to as policy-packaged drugs. The payment status of such drugs are listed in Addendum B of the final rule located on CMS' website.

CY 2020 Payment for Separately Payable, Non-Pass-Through Drugs: CMS will continue to pay for such drugs at ASP plus 6% (note, these are drugs that are not 340B-acquired drugs and biologicals). If ASP data are not available (i.e., the drug is new), CMS will pay for such drugs at wholesale acquisition cost (WAC) plus 3%. This payment amount does not apply to single source drugs that must be paid at 106% of ASP or WAC, whichever is less.

Pass-Through Drugs: Pass-through status for six drugs and biologicals expired Dec. 31, 2019 (see Table 40, *FR* page 61303). CY 2020 pass-through status will continue or was established for 80 additional drugs and biologicals (see Table 41, *FR* pages 61305-61310).

High Cost/Low Cost Threshold for Packaged Skin Substitutes: If skin substitutes were assigned to the high-cost group in CY 2019, CMS will continue assigning them to the high-cost group in CY 2020 regardless of whether they exceed the geometric mean unit cost or a products per day cost threshold. CMS will also assign skin substitutes with pass-through payment status to the high-cost category. The list of packaged skin substitutes and their group assignments is in Table 45 on *FR* pages 61333-61335.

Prior Authorization Requirements

CMS will require prior authorization for certain outpatient department services beginning on July 1, 2020. These services fall into five categories: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. The full list of services requiring prior authorization are in Table 65 on *FR* pages 61457-61458. For more details on the final prior authorization process, see *FR* pages 61446-61451.

Changes to the Laboratory Date of Service Policy

Medicare claims for laboratory services include a Date of Service (DOS) field which determines whether a hospital or performing laboratory bills Medicare for the test. CMS established a DOS exception in the CY 2018 OPPS final rule, indicating that the DOS of molecular pathology tests and tests designated by CMS as Criterion (A) advanced diagnostic laboratory tests is the date that the test was performed only if:

- The test was performed following the date of a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

Beginning CY 2020, CMS will exclude molecular pathology tests performed by a laboratory that is a blood bank or center from the laboratory DOS exception, meaning hospitals will bill Medicare for these tests and blood banks and centers must seek payment from the hospital.

Changes Impacting Organ Procurement Organizations (OPOs) and Transplant Centers

CMS revised the definition of "expected donation rate." Beginning with the CY 2022 recertification cycle, CMS will use the following: The expected donation rate per 100 eligible deaths is the rate expected for an OPO based on the national experience for OPOs serving similar eligible donor populations and donation service areas. CMS will adjust this rate for age, sex, race, and cause of death.