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Executive Summary: Final 2020 OPPS/ASC Rule

Key Financial and Operational Impacts from the Final 2020 Outpatient Prospective Payment System (OPPS) Rule

The 2020 OPPS final rule was made available on November 1, 2019. A detailed summary of the rule will be available here shortly. Below is a high-level overview of key changes in the final rule.

1) **Conversion Factor**: For CY20, in a December 31, 2019, final rule correction notice, CMS updated the conversion factor from $80.784 to $80.793. This is an increase from $79.490 in CY19. Hospitals failing to meet the Outpatient Quality Reporting Program requirements will see a reduced CY20 conversion factor of $79.2501.

2) **Wage Index**: The wage index changes to address "disparities" between high- and low-wage hospitals finalized in the 2020 IPPS rule also apply to the OPPS final rule for CY20. These changes include:

   - Increasing the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals. The policy would be effective for at least four years to allow employee compensation increases implemented by these hospitals enough time to be reflected in the wage index calculation. To offset the cost of increasing payments to low-wage index hospitals, the rule applies a uniform budget neutrality adjustment to the standardized amount.

   - Removing urban-to-rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY20.

   - Implementing a 5% cap on any decrease in a hospital's wage index in a budget-neutral manner. This is designed to protect hospitals from significant decreases in wage index (and therefore payments). This will also result in a budget neutrality adjustment to the standardized amount.

3) **Outlier Threshold:** CMS increases the outpatient fixed loss outlier threshold for CY20 to $5,075 (compared to $4,825 in CY19).

4) **Overall Impact**: CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6%. This update is based on the projected hospital market basket increase of 3.0% minus a 0.4 percentage point adjustment for multi-factor productivity (MFP). CMS estimates that, compared to CY19, OPPS payments in CY20 will increase by approximately $6.3 billion. This estimate excludes CMS's estimated changes in enrollment, utilization and case mix. Below is a breakdown of how the final rule will impact specific types of hospitals.

1. Down from $79.770 as proposed.

	Projected 2020 Impact
All Facilities*	1.3%
All Hospitals	1.3%
Urban Hospitals	1.3%
Rural Hospitals	1.1%
Major Teaching	0.9%
Minor Teaching	1.3%
Nonteaching	1.5%
Ownership	
Voluntary	1.1%
Proprietary	2.1%
Government	1.3%

*Excludes hospitals permanently held harmless and CMHCs

5) **Site-Neutral Payment for E&M Services**: In CY19, CMS applied a 30% reduction factor for E&M services (described by HCPCS code G0463), when they were provided at an excepted off-campus hospital outpatient department (HOPD). This was half of the payment differential between E&M services provided in the HOPD and freestanding settings under a two-year phase-in policy to implement site-neutral payment. For 2020, CMS will implement the full 60% reduction to payments for E&M services described by HCPCS code G0463 provided in exempted HOPDs. Similar to CY19, this will be implemented in a nonbudget-neutral manner. CMS estimates this policy results in CY20 savings of approximately $800 million, with approximately $640 million of the savings accruing to Medicare, and approximately $160 million saved by Medicare beneficiaries in the form of reduced copayments.

   The final rule acknowledges the district court decision vacating the site-neutral cuts for CY19 and states CMS is working to ensure affected 2019 claims for clinic visits are paid consistent with the court's order. The rule further states that CMS does not believe it is appropriate at this time to make a change to the second year of the two-year phase-in of the clinic visit policy. The government is currently considering whether wants to appeal the final judgment.

6) **Price Transparency**: The price transparency requirements have been separated into a separate rule that will be finalized at a later date and may include policies related to health plans, based on media coverage of Administrator Verma's comments. HFMA's detailed summary of the proposed price transparency provisions is available here.

   In response to the President's executive order on price transparency, CMS expands its prior interpretations of section 2718 of the Public Health Service Act. The proposed rule would require all hospitals to make a list of both gross charges and negotiated rates for all services in

the hospital charge description master as well as a set of shoppable services publicly available. The rule specifies the manner and format in which the lists are to be made publicly available. Hospitals that do not comply with the requirement may be subject to a civil monetary penalty (CMP) of up to $300 per day.

7) **Inpatient Only List - Total Hip Arthroplasty (THA)**: The CY20 final rule removes total hip arthroplasty (CPT Code 27130) from the inpatient only list in CY20, allowing these procedures to be performed in hospital outpatient departments. It will be assigned to C-APC 5115 with a status indicator of J1. The final rule prohibits Quality Improvement Organizations from referring THA cases performed in the inpatient setting to Recovery Audit Contractors for patient status (site of service) reviews for two years (increased from one year in the proposed rule). The rule does not add THA to the Ambulatory Surgery Center (ASC) covered procedure list.

8) **Pass-Through Devices**: Currently, there is one device eligible for pass-through status: HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system), with an eligibility date of January 1, 2019. The pass-through status of the device category for C2624 expires on December 31, 2021 and C1822 will continue to receive device pass-through payments in 2020.

   CMS added five more devices in the CY 2020 final rule under the traditional process:
   - Surefire® Spark™ Infusion System
   - Optimizer® System
   - AquaBeam and
   - AUGMENT® Bone Graft

   Additionally, the ARTIFICALIris® was approved for pass-through status under the new, "Breakthrough Device Alternative Pathway:"

9) **Pass-Through Drugs**: For 2020, CMS is continuing ASP+6% as payment for pass-through drugs and biologicals. As separately payable drugs and biologicals will be paid at ASP+6% with or without pass-through payment (except when acquired through the 340B drug discount program), no Ambulatory Payment Classification (APC) offset is required for the pass-through payment.

   Table 40 of the final rule lists 6 drugs and biologicals with expiring pass-through status on December 31, 2019. Each of the products will have received the full 3 years of pass-through payments once the additional payments expire.

   Table 41 of the final rule lists 80 drugs and biologicals for which CMS is continuing pass-through payment status in 2020. Table 43 lists the APCs where an offset will be applied for policy packaged drugs paid on pass-through.

10) **Payment for Part B Drugs Acquired under the 340B Program**: Despite its loss in court related to inappropriate reductions in payment for CY18 and CY19, CMS will continue paying for separately payable Part B drugs acquired under the 340B program at Average Sales Price minus 22.5%.

    CMS solicited comments on appropriate remedies for CY18 and CY19 claims, should the ruling in the case be upheld on appeal. In the final rule, CMS notes that it may use data collected from providers related to their acquisition costs of 340B drugs in CY18 and CY19 to both develop a remedy, in the event it loses its appeal of CY18 and CY19, and set rates for separately payable drugs acquired under the 340B program, moving forward. CMS anticipates proposing a remedy for CY18 and CY19 in the CY21 OPPS rule, in the event the appeals court upholds the lower court's ruling.

11) **Nonexempt Provider-based Clinics**: CMS will continue to pay for services provided in nonexempted hospital outpatient departments (new clinics that were not in process by November 2, 2015) at 40% of the OPPS rate.

12) **General Supervision of Hospital Outpatient Therapeutic Services**: For CY20, CMS finalizes a change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and Critical Access Hospitals (CAH) from direct supervision to general supervision. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. This change does not preclude a hospital from requiring a higher level of supervision for certain services, as it determines appropriate.

13) **Additional Comprehensive APCs**: CMS creates two new comprehensive APCs (C-APCs). The new C-APCs include the following: C-APC 5182 (Level 2 Vascular Procedures) and C–APC 5461 (Level 1 Neurostimulator and Related Procedures). This increases the total number of C-APCs to 67.

14) **Prior Authorization Process for Certain OPD Services:** Beginning in CY20, CMS will require hospitals to submit a prior authorization request for any service on its list of outpatient department services requiring prior authorization. The five categories of services are: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation. However, there is not a similar prior authorization requirement for these services when they are provided in an ASC.

    CMS provides a list of specific CPT codes in Table 64 of the final rule (not included in this summary). Additionally, any claims associated with or related to a service included on the prior authorization list that is denied will also be denied since these services are deemed unnecessary. These associated services include, but are not limited to, services such as anesthesiology services, physician services and/or facility services.

This requirement begins for dates of service on or after July 1, 2020, to allow more time for provider education and process implementation.

15) **Outpatient Quality Reporting Program**: For the Hospital Outpatient Quality Reporting Program, the final rule does not add new measures. The rule (beginning with January 2020 encounters) removes OP-33: External Beam Radiotherapy for Bone Metastases, for the CY22 payment determination and subsequent years, due to the cost associated with the measure relative to its benefits.

16) **ASC Conversion Factor**: CMS increases the CY20 ASC conversion factor to $47.747 for ASCs meeting the quality reporting requirements from the CY19 conversion factor of $46.532. CMS is finalizing an update to the ASC rates for CY20 equal to 2.6%. The update applies to ASCs meeting relevant quality reporting requirements.

17) **Additions to the ASC Surgical Covered Procedures List:** CMS adds total knee replacement (TKA), a mosaicplasty procedure, as well as six coronary intervention procedures, and 12 procedures with new CPT codes to the list of surgical procedures covered when performed in an ASC (see Table 1 at the end of the document).

18) **ASC Quality Reporting Program:** For the Ambulatory Surgery Center Quality Reporting Program, CMS finalizes the addition of one new measure, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at ASCs, beginning with the CY24 payment determination and for subsequent years. CMS is not removing any quality measures from the ASCQR program.

19) **ASC Impact**: Including beneficiary cost sharing and estimated changes in enrollment, utilization and case-mix and changes in the final rule, Medicare ASC payments for CY20 are projected to be $4.96 billion, an increase of approximately $230 million, compared to estimated CY19.

Table 1: Additions to the List of ASC Covered Surgical Procedures for CY20

CY20 CPT Code	CY20 Long Descriptor	CY20 ASC Payment Indicator
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)	G2
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; 50 cc or less injectate	G2
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	G2
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	J8
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	J8
33016	Pericardiocentesis, including imaging guidance, when performed	G2
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	G2
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	G2
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	G2
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	G2
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	G2
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	J8
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	J8
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	G2
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8

CY20 CPT Code	CY20 Long Descriptor	CY20 ASC Payment Indicator
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	J8
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1