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Executive Summary: Proposed 2021 OPPS/ASC Rule

Key Financial and Operational Impacts from the Proposed 2021 Outpatient Prospective Payment System (OPPS) Rule

The 2021 CMS OPPS proposed rule was made available on August 4, 2020. A detailed summary of the rule will be available here shortly. Below is a high-level overview of key changes in the proposed rule.

1) **Conversion Factor**: For CY21, CMS proposed a conversion factor of $83.697. This is an increase from $80.7841 in CY20. Hospitals failing to meet the Outpatient Quality Reporting Program requirements will see a reduced CY21 conversion factor of $82.065.

2) **Wage Index**: The rule proposes to use the FY21 Inpatient Prospective Payment System (IPPS) post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY21. Therefore, any adjustments for the FY21 IPPS post-reclassified wage index, including, but not limited to, any adjustments that CMS may finalize related to the proposed adoption of the revised Office of Management and Budget delineations (such as a cap on wage index decreases and revisions to hospital reclassifications), would be reflected in the final CY21 OPPS wage index beginning on January 1, 2021.

3) **Outlier Threshold:** CMS increases the outpatient fixed loss outlier threshold for CY21 to $5,300 (compared to $5,075 in CY20).

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 multifactor productivity (MFP). CMS estimates that, compared to CY20, OPPS payments in CY21 will increase by approximately $7.5 billion to $83.9 billion. Below is CMS's estimate of how changes in the rule will impact various provider types (see Table 55 in the proposed rule for additional details).

	Projected 2021 Impact
All Facilities*	2.5%
All Hospitals	2.6%
Urban Hospitals	2.5%
Rural Hospitals	3.2%
Major Teaching Hospitals	1.4%
Minor Teaching Hospitals	2.8%
Nonteaching Hospitals	3.2%
Ownership	
Voluntary	2.4%
Proprietary	4.1%
Government	2.2%

*Excludes hospitals permanently held harmless and CMHC

5) **Site-Neutral Payment for Evaluation & Management (E&M) Services**: For CY21, CMS proposes to continue applying a 60% reduction factor for E&M services (described by HCPCS code G0463), when they are provided at non-excepted off-campus hospital outpatient department (HOPD).

6) **Inpatient Only List:** The rule proposes to eliminate the Inpatient Only List (IPO) over three years, beginning with the removal of 300 musculoskeletal-related services.

   The proposed rule continues a 2-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the IPO list under the OPPS beginning on January 1, 2021.

7) **Pass-through Devices**: Currently, there are seven devices eligible for pass-through status. These include:

HCPCS Code	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	1/1/2019	12/31/2021
C1824	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2022
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2022
C1839	Iris prosthesis	1/1/2020	12/31/2022
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2022
C2596	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2022
C1748	Endoscope, single-use (that is, disposable), upper GI, imaging/illumination device (insertable)	7/1/2020	6/30/2023

   For CY21, CMS proposes to add two additional devices to the pass-through list:
   a. CUSTOM*FLEX*® ARTIFICIAL*IRIS*
   b. EXALT™ Model D Single-Use Duodenoscope

8) **Pass-through Drugs**: For 2021, CMS is continuing average sales price (ASP)+6% as payment for pass-through drugs and biologicals.

   There are 28 drugs and biologicals whose pass-through payment status will expire during CY20, as listed in Table 21 in the proposed rule (not included in this summary). Most of these drugs

and biologicals will have received OPPS pass-through payment for 3 years during the period of April 1, 2017 through December 31, 2020.

CMS proposes to end pass-through payment status in CY21 for 26 drugs and biologicals. These drugs and biologicals, which were approved for pass-through payment status between April 1, 2018 and January 1, 2019, are listed in Table 22 in the proposed rule (not included in this summary). The Ambulatory Payment Classifications (APCs) and HCPCS codes for these drugs and biologicals have pass-through payment status that will end by December 31.

The rule proposes to continue pass-through status through CY21 for 46 drugs and biologicals. These drugs and biologicals, which were approved for pass-through payment status beginning between April 1, 2019 and April 1, 2020, are listed in Table 23 in the proposed rule (not included in this summary). The APCs and HCPCS codes for these drugs and biologicals have pass-through payment status that will continue after December 31, 2021.

All drugs and biologics with pass-through status for CY21, are assigned status indicator "G" in Addenda A and B to the proposed rule (available online).

9) **Payment for Separately Payable Part B Drugs Acquired under the 340B Program**: CMS proposes to pay for separately payable, non-pass-through drugs acquired under the 340B Program at ASP minus 34.7%, plus an add on of 6% of the product's ASP for a net payment rate of ASP minus 28.7% based on the results of the "Hospital Acquisition Cost Survey for 340B-Acquired Specified Covered Drugs." Similar to the 340B drug payment policy implemented in CY18, CMS also proposes that rural sole community hospitals, PPS-exempt cancer hospitals and children's hospitals would be exempted from the 340B payment policy for CY21 and subsequent years.

   CMS notes this is proposed as an alternative to continuing its current policy of paying ASP minus 22.5% for 340B-acquired drugs.

10) **General Supervision of Hospital Outpatient Therapeutic Services**: For CY21 and subsequent years, CMS proposes to change the minimum default level of supervision for nonsurgical extended duration therapeutic services to general supervision for the entire service, including the initiation portion of the service, for which CMS had previously required direct supervision. This would be consistent with the minimum required level of general supervision that currently applies for most outpatient hospital therapeutic services.

    The rule also proposes that, for CY21 and subsequent years, direct supervision for pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services would include virtual presence of the physician through audio/video real-time communications technology subject to the clinical judgment of the supervising physician.

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11) **Additional Comprehensive APCs**: CMS creates two new comprehensive APCs (C-APCs). The new C-APCs include the following: C-APC 5378 (Level 8 Urology and Related Services) and C–APC

    5465 (Level 5 Neurostimulator and Related Procedures). This increases the total number of C-APCs to 69.

12) **Prior Authorization Process for Certain OPD Services:** The rule proposes two additional categories of service — cervical fusion with disc removal and implanted spinal neurostimulators — to the list of services that will require prior authorization. The requirement would be effective beginning with services provided on or after July 1, 2021.

13) **Outpatient Quality Reporting Program**: For the Hospital Outpatient Quality Reporting Program, the proposed rule does not add or remove measures.

14) **Overall Hospital Quality Star Ratings**: Starting in CY21, CMS is proposing to update and simplify how the star ratings are calculated, reduce the total number of measure groups and stratify the readmission measure group based on the proportion of dual-eligible patients.

15) **ASC Conversion Factor**: CMS increases the CY21 ASC conversion factor to $48.984 from the CY20 conversion factor of $47.747 for ASCs meeting the quality reporting requirements. CMS proposes an update to the ASC rates for CY21 equal to 2.6%. For ASCs not meeting the quality reporting requirement, the proposed conversion factor is $48.029.

16) **Additions to the ASC Surgical Covered Procedures List:** CMS adds total hip replacement (THA, CPT Code 27130) and ten other procedures (listed in Exhibit 1) to the list of services covered when provided in an ASC.

    Additionally, the rule proposes an alternative for changing the way procedures are added to the ASC covered services list. This would result in 270 additional procedures covered when provided in an ASC. Table 41 in the proposed rule provides a list of these procedures.

17) **ASC Quality Reporting Program:** For the ASC Quality Reporting Program, the proposed rule does not add or remove measures.

18) **ASC Impact**: The proposed rule increases payment rates under the ASC payment system by 2.6% for ASCs that meet the quality reporting requirements. This proposed increase is based on a hospital market basket percentage increase of 3.0% minus a proposed multifactor productivity adjustment required by the Affordable Care Act of 0.4 percentage points. Based on this proposed update, CMS estimates the total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization and case mix) for CY21 would be approximately $5.45 billion, an increase of approximately $160 million as compared with estimated CY20 Medicare payments.

Exhibit 1: Proposed Additions to the List of ASC-Covered Surgical Procedures for CY21

CY21 CPT Code	CY21 Long Descriptor	CY21 ASC Payment Indicator
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)	G2
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	J8
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, Radiofrequency	G2
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	G2
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	J8
27412	Autologous chondrocyte implantation, knee	G2
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	G2
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	G2
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	G2
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	G2
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	J8