HMA Summary of 2021 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule

On August 4, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2021 proposed rule for the hospital outpatient department (HOPD) and ambulatory surgical center (ASC) prospective payment systems (PPS). This Proposed Rule includes payment rate and policy changes for the upcoming calendar year. The comment deadline for the Proposed Rule is October 5, 2020.

Overall, this proposed rule includes favorable payment rate updates for hospitals and ASCs. Among the most notable policy changes are: 1) transitioning services to lower cost settings by eliminating the inpatient-only list to enable more services to be provided in the outpatient settings and increasing the scope of procedures that can be provided in ASCs, 2) further reducing payments for the 340B drug program, and 3) modifying the formula for calculating Hospital Star Ratings, and expanding the use of prior authorization for outpatient services.

HMA continues to analyze these proposed rules and will provide more detailed analyses evaluating the impacts of its key proposals in the coming weeks. For more information or questions about the proposed rule please contact Zach Gaumer (zgaumer@healthmanagement.com) or Eric Hammelman (ehammelman@healthmanagement.com).

Hospital Outpatient and Ambulatory Surgical Center Payment

CMS proposes to update the Hospital Outpatient Prospective Payment System (OPPS) payment rates by 2.6 percent, which is projected to increase OPPS payments to providers by more than $7.5 billion. This is a similar increase to the 2.7 percent update implemented for CY 2020.

CMS also proposes to update ASC payment rates by 2.6 percent, which is projected to increase ASC payments by $160 million. This is a similar increase to the 2.7 percent update implemented for CY 2020.

Inpatient-only (IPO) List

CMS proposes to eliminate the Inpatient Only (IPO) list, which lists procedures that are typically only provided in the inpatient setting, over a three-year transitional period with the list completely phased out by CY 2024. For CY 2021, CMS proposes to remove 266 musculoskeletal-related services. If this proposal is finalized, these procedures would be eligible to be paid by Medicare in the hospital outpatient setting when "reasonable and necessary". CMS also proposed to continue the two-year exemption from certain medical review activities related to the 2-midnight rule for procedures newly removed from the IPO list.

CMS requests comment on whether the three-year period is appropriate for this transition, whether there are particular procedures the agency should prioritize for removal from the IPO list, and how the agency should sequence the removal of additional clinical families and/or services from the IPO list in future rulemaking.

ASC-covered Procedures List

CMS proposes to add 11 procedures to the ASC-covered procedures list (ASC-CPL), a list of procedures eligible for coverage and payment when furnished in an ASC. This includes total hip arthroplasty as well as several coronary procedures and reproductive system procedures. In addition, CMS proposes two alternatives to the ASC-CPL to further expand services payable in ASCs. Under the first alternative, CMS would modify criteria for adding a procedure to the ASC-CPL and establish a process under which relevant stakeholders would nominate procedures that can be safely performed in the ASC setting. Under the second alternative, CMS would revise the ASC-CPL criteria by eliminating five general exclusion criteria. CMS estimates 270 additional procedures would be added to the ASC covered procedures list in CY 2021.

340B Drugs

CMS proposes to adopt a rate of the average sales price (ASP)-34.7 percent with a 6 percent add-on amount for overhead and handling costs for a net proposed rate of ASP-28.7 percent for separately payable drugs or biologics that are acquired through the 340B Program. CMS seeks comment on an alternative proposal of continuing the current Medicare payment policy of paying ASP-22.5 percent for 340B-acquired drugs for CY 2021 and subsequent years. In addition, CMS proposed that rural sole community hospitals, children's hospitals, and cancer hospitals exempt from the Medicare prospective payment system be excepted from either of the proposed 340B payment policies and that these hospitals would continue to report informational modifier "TB" for 340B-acquired drugs, and continue to be paid ASP+6 percent.

Hospital Quality Star Ratings

CMS proposes to establish, update, and simplify the methodology that would be used to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) in 2021. Proposed modifications include:

- Combining three existing process measure groups into one new Timely and Effective Care group to make the Overall Star Ratings based on just 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;
- Stratifying the Readmission measure group only by hospitals' proportion of dual-eligible patients to align with Hospital Readmissions Reduction Program (HRRP);
- Requiring hospitals to report at least three measures for three measures groups; and
- Applying a peer grouping methodology by number of measure groups where hospitals are grouped by whether they have three or more measures in three, four, or five measure groups.

In addition, CMS proposes to include critical access hospitals (CAHs) and Veterans Health Administration (VHA) hospitals in the Overall Star Ratings program.

Prior authorization requirements

For the second consecutive year CMS proposes to implement prior authorization requirements for certain outpatient services. For CY 2021, CMS proposes to require prior authorization for Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators. CMS asserts that prior authorization policy

for these services will be effective for controlling increases in volume in instances when these cases are not medically necessary. Prior authorization requirements would not apply to these procedures when performed in the inpatient setting.

Hospital Outpatient Device Pass-through Payments

CMS received five device pass-through applications for the CY 2021 proposed rule. Three of the applications have an FDA Breakthrough Device designation, two of which were preliminarily approved for device pass-through payment during the quarterly review process: CUSTOM*FLEX*® ARTIFICIAL*IRIS* and EXALT™ Model D Single-Use Duodenoscope. CMS is soliciting public comment on all five applications.

Physician-owned hospitals

CMS proposes to remove the cap on the number of additional operating rooms, procedure rooms, and beds that can be approved as a part of the exceptions process for certain physician-owned hospitals applying to CMS to increase their service capacity beyond their original provider agreement. In addition, CMS proposes to remove the restriction that the expansion of these facilities must occur only within a hospital's main campus.