Issue Brief

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MHA Summary for CY 2020 Proposed OPPS

SUMMARY OF THE MAJOR PROVISIONS

OPPS Update: For CY 2020

The Centers for Medicare & Medicaid Services proposes to increase the payment rates under the Outpatient Prospective Payment System by an Outpatient Department fee schedule increase factor of 2.7 percent. This increase factor is based on the proposed hospital inpatient market basket percentage increase of 3.2 percent for inpatient services paid under the hospital Inpatient Prospective Payment System, minus a proposed multifactor productivity adjustment of 0.5 percentage point.

Based on this proposed update, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization and case-mix) for CY 2020 approximately would be $79 billion, an increase of approximately $6 billion compared to estimated CY 2019 OPPS payments.

CMS will continue to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.980 to the OPPS payments and copayments for all applicable services.

COMMENT

CMS is expected to issue its final FY 2020 hospital PPS update later this week. The final increase to the IPPS rates ultimately will be used to set the OPPS amounts.

2-Midnight Rule (Short Inpatient Hospital Stays)

For CY 2020, CMS proposes to establish a one-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations referrals to Recovery Audit Contractors, and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the inpatient only list under the OPPS beginning on Jan. 1, 2020.

Comprehensive APCs

CMS proposes to create two new comprehensive APCs.These proposed new C-APCs would be C-APC 5182 (Level 2 Vascular Procedures) and C–APC 5461 (Level 1 Neurostimulator and Related Procedures). This proposal would increase the total number of C-APCs to 67.

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Proposed Changes to the Inpatient Only List

CMS proposes to remove one procedure from the IPO list and seeks public comment on the removal of six procedures from the IPO list.

Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments

CMS would complete the phase-in of the reduction in payment for clinic visit services described by HCPCS code G0463 furnished in expected off-campus provider-based departments as a method to control unnecessary increases in the volume of this service.

Device Pass-Through Payment Applications

CMS is evaluating seven applications for device pass-through payments and seeks public comments.

Proposed Changes to Substantial Clinical Improvement Criterion

CMS proposes an alternative pathway to the substantial clinical improvement criterion for devices approved under the FDA Breakthrough Devices Program to qualify for device pass-through status, beginning with applications received on or after Jan. 1, 2020.

Cancer Hospital Payment Adjustment

CMS proposes to continue to provide additional payments to cancer hospitals so that a cancer hospital's payment-to-cost ratio after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data.

However, section 16002(b) of the ***21st Century Cures Act*** requires that this weighted average PCR be reduced by 1.0 percentage point. Based on the data and the required 1.0 percentage point reduction, a proposed target PCR of 0.89 will be used to determine the CY 2020 cancer hospital payment adjustment to be paid at cost report settlement.

Rural Adjustment

For 2020 and subsequent years, CMS would continue the 7.1 percent adjustment to OPPS payments for certain rural sole community hospitals, including essential access community hospitals.

340B-Acquired Drugs

CMS proposes to continue to pay ASP-22.5 percent for 340B-acquired drugs, including when furnished in nonexcepted off-campus PBDs paid under the Physician Fee Schedule pending the outcome of ongoing litigation.

ASC Payment Update

Using the hospital market basket methodology, for CY 2020, CMS proposes to increase payment rates under the ASC payment system by 2.7 percent for ASCs that meet the quality reporting requirements under the Ambulatory Surgical Center Quality Reporting Program. This proposed increase is based on a proposed hospital market basket of 3.2 percent minus a proposed multifactor productivity adjustment required by the ***Affordable Care Act*** of 0.5 percentage point. Based on this proposed update, CMS estimates that total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization and case-mix) for CY 2020 would be approximately $4.89 billion, an increase of approximately $200 million compared

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to estimated CY 2019 Medicare payments.

Proposed Changes to the List of ASC-Covered Surgical Procedures

CMS proposes to add eight procedures to the ASC list of covered surgical procedures. Additions to the list include a total knee arthroplasty procedure, a mosaicplasty procedure and six coronary intervention procedures.

Proposed Changes to the Level of Supervision of Outpatient Therapeutic Services in Hospitals and CAHs

CMS proposes to change the minimum required level of supervision from direct supervision to general supervision for all hospital outpatient therapeutic services provided by all hospitals and critical access hospitals. This proposal would ensure a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician's service.

Hospital Outpatient Quality Reporting Program

CMS proposes to remove "OP-33: External Beam Radiotherapy for Bone Metastases" for the CY 2022 payment determination and subsequent years.

Ambulatory Surgical Center Quality Reporting Program

CMS proposes to adopt one new measure, "ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers," beginning with the CY 2024 payment determination and for subsequent years.

Proposed Requirements for Hospitals to Make Public a List of Their Standard Charges

CMS proposes to add a new Part 180 – Hospital Price Transparency to Title 45 of the Code of Federal Regulations, which would include proposed regulations on price transparency for purposes of section 2718(e) of the ***PHS Act.***

CMS makes proposals related to:

- a definition of "hospital"
- different reporting requirements that would apply to certain hospitals
- definitions for two types of "standard charges" (specifically, gross charges and payer-specific negotiated charges) that hospitals would be required to make public, and a request for public comment on other types of standard charges that hospitals should be required to make public
- a definition of hospital "items and services" that would include all items and services (including individual items and services and service packages) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit
- requirements for making public a machine-readable file that includes a hospital's gross charges and payer-specific negotiated charges for all items and services provided by the hospital
- requirements for making public payer-specific negotiated charges for select hospital-provided items and services that are "shoppable" and that are displayed in a consumer-friendly manner

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- monitoring for hospital noncompliance with public disclosure requirements to make public standard charges
- actions that would address hospital noncompliance, which include issuing a written warning notice, requesting a corrective action plan, and imposing civil monetary penalties on noncompliant hospitals and publicizing these penalties on a CMS website
- appeals of CMPs

Proposed Prior Authorization Process and Requirements for Certain Hospital Outpatient Department Services

CMS proposes a prior authorization process using the authority in section 1833(t)(2)(F) of the act as a method for controlling unnecessary increases in the volume of the following five categories of services: (1) blepharoplasty, (2) botulinum toxin injections, (3) panniculectomy, (4) rhinoplasty and (5) vein ablation.

Organ Procurement Organizations Conditions for Coverage Proposed Revision of the Definition of "Expected Donation Rate"

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

CMS proposes to revise the definition of "expected donation rate" that is included in the second outcome measure to match the Scientific Registry of Transplant Recipients definition.

CMS also proposes to reduce the time period for the second outcome measure and calculate the expected donation rate using 12 out of the 24 months of data (from Jan. 1, 2020, through Dec. 31, 2020) for the 2022 recertification cycle only.

Request for Information Regarding Potential Changes to the Organ Procurement Organization and Transplant Center Regulations

CMS is soliciting public comments regarding what revisions may be appropriate for the current OPO CfCs and the current transplant center Conditions of Participation. In addition, CMS seeks public comments on two potential outcome measures for OPOs.

This is an abbreviated analysis. View the full analysis here.