Calendar Year (CY) 2020 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Final Rule

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INTRODUCTORY SUMMARY AND BACKGROUND

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgery Centers (ASC) for CY 2020.

CMS is required to annually review and update the payment rates for services payable under the Hospital Outpatient Prospective Payment System (HOPPS) and those payable in ASCs as specified in section 1833 of the Social Security Act. In addition, CMS is required to update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

The prospective payment system (PPS) was developed and implemented to replace the reasonable cost-based payment methodology. The Outpatient Prospective Payment System (OPPS) was implemented for services effective August 1, 2000. Under the OPPS, CMS pays for hospital Part B services on a rate-per-service basis according to the Ambulatory Payment Classification (APC) in which the service is assigned. The Healthcare Common Procedure Coding System (HCPCS), which includes Current Procedural Terminology (CPT®) codes, are used to identify and group the services within each APC.

The OPPS rate is a national unadjusted payment amount which include the Medicare and beneficiary payment. It is divided into a labor-related and nonlabor-related amount, and the labor-related amount is adjusted based on the locality in which the hospital is located.

Special payments for new technology items and services under OPPS may be made by transitional pass-through payments and new technology APCs.

2020 HOPPS/ASC FINAL RULE

The CY 2020 final rule is located in its entirety at the following link:

https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center

This document in PDF form is 1,113 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are an estimated 3,732 facilities paid under OPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and community mental health centers). In response to the CY 2020 proposed rule, CMS received 3,400 timely comments.

For CY 2020, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent under the Outpatient Department (OPD) fee schedule. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to OPPS providers for CY 2020 will be $79 billion. This represents a $6.3 billion increase from estimated CY 2019 OPPS payments.

CMS is also continuing to implement a statutory 2.0 percentage reduction for hospitals failing to meet the hospital outpatient quality reporting requirements set forth by the Hospital Outpatient Quality Reporting (OQR) Program.

CMS is maintaining the rural adjustment factor of 7.1% to the HOPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) for CY 2020 and subsequent years. This will continue until data supports a different factor should be applied. This payment adjustment will continue to exclude separately payable drugs, biologicals and devices paid under the pass-through payment policy.

CMS estimates the increase to the OPD Fee Schedule will result in urban hospitals experiencing approximately an increase of 2.7% and rural hospitals an increase of 2.8%. Comparing those hospitals which are classified as teaching vs. nonteaching, CMS estimates minor teaching hospitals will experience an increase of approximately 2.9%, major teaching hospitals 2.4%, and nonteaching hospitals 2.8% increase.

Ambulatory Payment Classification (APC) Relative Payment Weights

It is required in Section 1833 of the Act to revise the relative payment weight for the APCs at least annually. APCs group services which are considered clinically comparable to each other in terms of resource utilization and associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form. CMS will only pay for those services which are considered not packaged into another service. Under the current C-APC policy, CMS designates a service described by a CPT® or HCPCS code as the primary procedure when the service is identified by OPPS status indicator "J1".

Significance of code G0463

CMS will continue using HCPCS code G0463, hospital outpatient clinic visits for assessment and management of a patient, in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 will continue to be assigned to APC 5012 (code G0463). CMS will use the factor of 1.00 and then dividing the geometric mean cost of each APC by the geometric mean cost of APC 5012 to derive the unscaled relative payment weight for each APC.

CY 2020 will mark the second and final adjustment year based on CY 2019 finalized changes to how the clinic visit, represented by code G0463, is reimbursed in all off-campus provider-based departments. Due to the high volume of reporting for code G0463, CMS finalized reimbursement adjustments to the most widely reported code under HOPPS for what is seen as "unnecessary increases in the volume of outpatient service."

For CY 2019, CMS finalized a site-neutral method for reimbursement for code G0463. In any setting considered off-campus, more than 250 yards from the main buildings of the hospital, either excepted or nonexcepted, CMS set a site neutral rate. This means in either off-campus location the reimbursement for code G0463 would be at 40% of the on-campus outpatient reimbursement. Due to the high rate change, CMS is required to implement this decrease over a two-year period, rather than all at once.

For CY 2019, code G0463 was set to be reimbursed a payment rate of 40% of the HOPPS rate, which is a decrease of 60%. To phase this in, the decreased amount was split in half to be phased in over two years. CY 2019 reimbursement rates for G0463 in all off-campus provider-based departments was decreased by 30%, not the full 60%. The remaining 30% was finalized to be applied in CY 2020, which brings the overall total reimbursement reduction to 60%, or payment of only 40% of the rate. This decision is not without considerable push-back and potential controversy.

There was a lawsuit filed by the American Hospital Association (AHA) which resulting in a decision by the U.S. District Court to remove a portion of the CY 2020 proposed rule related to volume control for these clinic visits, rather than implement the second-year portion of the payment reduction. Moreover, the Advisory Panel on Hospital Outpatient Payment (HOP) unanimously recommended CMS suspend the policy for paying these clinic visits.

CMS will continue to work to ensure CMS will be working to ensure affected 2019 claims for clinic visits are paid in a manner consistent with the court's order, but CMS did not agree it was appropriate at this time to make a change to the second year of the two-year phase-in policy. Within the CY 2020 final rule, CMS expressed their belief the Secretary does have the authority to make changes as a means of controlling unnecessary increases in the volume of OPD services. Specifically, the authority to remove potential reimbursement incentives or differences that may unnecessarily increase the volume of services provided based on location or setting. By implementing a site-neutral payment policy for the clinic visit, CMS believes this appropriately and effectively will impact and adjust any unnecessary services or continued increase in services due to higher reimbursement in a particular setting.

Based on evaluation of all the comments, legal action, and recommendations by the HOP Panel, as indicated above, CMS is moving forward with the reduction. This means the full reduction in payments will be applied, a 60% reduction to the on-campus reimbursement for code G0463 for those services provided in off-campus excepted provider-based departments. These departments also bill services with modifier PO to identify the classification of setting. CMS will continue to monitor the service and volumes provided as well as the ongoing litigation and judicial decisions.

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using a market basket update. For CY 2020 ASCs will see an increase of 2.6% for centers that meet quality reporting under the Ambulatory Surgical Center Quality Reporting (ASCQR) program, slightly lower

than proposed. CMS projects expenditures for beneficiaries in ASCs will be approximately $4.96 billion, an increase of approximately $230 million from CY 2019 payments.

Wage Index

Under HOPPS, the wage index is an assigned value that is used when determining the reimbursement amount for any given code (CPT® or HCPCS) in a specific hospital or ASC. This value will vary depending on the geographic location of the hospital or ASC and whether it is designated as an urban or rural location. The wage index is then valued with the labor adjustments and the APC assigned values to calculate the overall reimbursement rate for the service in a specific geographic location.

CMS finalized to continue applying a wage index of 1.000 for frontier state hospitals (Montana, Wyoming, North Dakota, South Dakota, and Nevada), this policy has been in place since CY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low number of people per square mile when compared to other states.

Wage index updates were finalized as part of the inpatient prospective payment system (IPPS) FY 2020 final rules. These changes were relative to the changes between urban and rural located hospitals. Due to this, CMS did implement a budget neutrality factor applied to the conversion factor and a 5% cap on wage index decreases. This cap ensures the changes finalized were done in a budget neutral fashion and "soften" any decreases that could have an overall impact to a specific value change.

APC "2 Times Rule"

Items and services within an APC group cannot be considered resource utilization comparable if the highest mean cost for an item or service within the same APC group is more than 2 times greater than the lowest median cost. This is called the "2 times rule".

In the proposed rule, CMS identified 18 APCs in which the 2 times rule violation was found. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the HOP Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation.

Within the final rule, CMS was able to remedy two of the APC violations but identified an additional one APC 5593 (Level 3 Nuclear Medicine and Related Services). After consideration of comments and data, CMS is making exceptions to 17 of the 2 times rule violation APCs, this means no adjustments or movement of codes to other APCs to balance the highest and lowest costing codes. Several APCs which include imaging services for endovascular procedures are included on the list for CY 2020. The following table lists the APCs identified as in violation of the 2 times rule but will not be adjusted:

TABLE 11: APC Exceptions to the 2 times rule for CY 2020

CY 2020 APC	CY 2020 APC Title
5112	Level 2 Musculoskeletal Procedures
5161	Level 1 ENT Procedures

5181	Level 1 Vascular Procedures
5311	Level 1 Lower GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5593	Level 3 Nuclear Medicine and Related Services
5612	Level 2 Therapeutic Radiation Treatment Preparation
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

New Comprehensive Ambulatory Payment Classifications (C-APCs)

As a result of the annual review of existing C-APCs, CMS is creating two new C-APCs for CY 2020. This now brings the total number of C-APCs to 67. Of interest is C-APC 5182 (Level 2 Vascular Procedures). These C-APCs were in the proposed rule, and finalized after the comment period.

Device-Intensive Procedures

In the CY 2019 final rule and for subsequent years, CMS modified criteria for device-intensive procedures to potentially allow a greater number of procedures to qualify as device-intensive. In years' past, one of the main criteria used to consider devices for device-intensive criteria only devices that remained in the patient (even temporarily) after the procedure. This is no longer a consideration. The modified criteria for device-intensive procedures is now in force:

1) Procedure must involve implantable device assigned to a CPT® or HCPCS code;

2) Device must be surgically inserted or implanted; and

3) Device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (down from 40 percent).

CMS applied a 31 percent default offset to new HCPCS codes which describe procedures requiring a medical device implant but does not yet have claims data. Once claims data is available, CMS would be able to establish the HCPCS code-level device offset for procedures. The exception to this is in the case of a high cost implantable device, which would be temporarily assigned a higher offset percentage if warranted by additional information. For example, pricing data could possibly come from the device manufacturer.

After the comment period, CMS determined the device offset percentage for CPT® code **36904** exceeds the 30 percent threshold and is therefore assigned device-intensive status for CY 2020:

36904 - Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)

Levels of Supervision for OP Therapeutic Services

According to the Medicare Benefit Policy Manual Chapter 6, Direct supervision means the physician *"must be present and on the premises of the location (the provider-based department of the hospital) and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed."* General supervision means *"the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure."*

In the CY 2020 final rule, CMS is changing the minimum required level of supervision from **direct** supervision to **general** supervision for all hospital outpatient therapeutic services provided by hospitals and Critical Access Hospitals (CAHs).

CMS did stress that changing to general supervision this will not prevent any of the hospitals from providing services under direct supervision when the physician administering that service determines it is appropriate to do so. There are many therapeutic services provided in the outpatient setting that are highly complex and need the direct supervision of the qualified physician. Hospitals and physicians will now have the ability to set the supervision level as they believe is appropriate, this could result in direct or personal supervision for some outpatient therapeutic services.

Hospitals and physicians must also consider hospital policies, CAH Medicare Conditions of Participation (CoPs), state scope of work regulations, as well as state and federal laws which may and do define supervision requirements for certain services which would supersede the changes in supervision level as indicated by CMS.

CMS also noted, failure of a physician to provide the adequate supervision in accordance with hospital and CAH CoPs would not cause payment to be denied for that service, but consistent violations of the supervision requirements would result in corrective action plans, and finally in termination of the hospital or CAH from Medicare participation for ongoing failure to comply.