CY 2021 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Final Rule (CMS-1736-F)

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INTRODUCTORY SUMMARY AND BACKGROUND

On December 2, 2020, 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 2021.

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 Hospital Outpatient Prospective Payment System (HOPPS) was implemented for services effective August 1, 2000. Under HOPPS, 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. APCs are organized by similar clinical relevance and resource use. Special payments for new technology items and services under OPPS may be made by transitional pass-through payments and new technology APCs.

For ASCs, the surgical procedures on the ASC list for covered procedures are sorted into surgical specialty groups using CPT® and HCPCS code range definitions.

Certain hospitals are excluded from payment under HOPPS including critical access hospitals (CAHs); hospitals located in Maryland and paid under Maryland's All-Payer or Total Cost of Care Model; hospitals located outside the 50 states, the District of Columbia and Puerto Rico; and Indian Service (IHS) hospitals.

2021 HOPPS/ASC Final Rule

The CY 2021 final rule is located in its entirety at the following link:
https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

This document in PDF form is 1,312 pages in length. The format of the information is intended to summarize the finalized changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are approximately 3,665 facilities paid under HOPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and community mental health centers). CMS is increasing payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.4 percent. This increase is based on the final hospital inpatient market basket percentage increase of 2.4 percent. Based on this update, CMS estimates total payments to OPPS for CY 2021 would be approximately $83.8 billion, an increase of approximately $7.5 billion from CY 2020 estimated OPPS payments.

For CY 2021, CMS will recalibrate the APC relative payment weights for services provided on or after January 1, 2021, and before January 1, 2022, using the most recent claims data and cost report data for hospital outpatient department (HOPD) services. Geometric mean costs are used to calculate the APC relative weights, and CMS will use this method for CY 2021.

Conversion Factor

To set the HOPPS conversion factor (CF) for CY 2021, CMS is adjusting the CY 2020 conversion factor of $80.793 by 2.4 percent, while adjusting the conversion factor to ensure any revisions made to the wage index and rural adjustment were made on a budget neutral basis. The finalized overall budget neutrality factor is 1.0012 for wage index changes. CMS is continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPPS payments and copayments for all applicable services. Thus, the proposed CF for CY 2021 for hospitals that meet the hospital OQR program requirements is $82.797 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $82.065.

Proposed Payment Rates

For CY 2021, CMS is finalizing HOPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4 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 HOPPS providers for CY 2021 will be $83.888 billion. This represents a $7.5 billion increase from estimated CY 2020 HOPPS 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.

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.

For CY 2021, CMS will continue to apply 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.

HOPPS wage index updates are finalized by CMS as part of the FY 2021 inpatient prospective payment system (IPPS) wage index adjustments and updated Office of Management and Budget (OMB) delineations applied to the IPPS post-reclassified wage index. The wage indexes for IPPS are used for OPPS rate setting as they are both hospitals and many inpatient hospitals have outpatient services.

The wage index is a key component in determining the specific reimbursement of the services provided as tied to the geographic labor force. These changes are relative to the changes between urban and rural located hospitals. When calculating the reimbursement for a particular service, the APC payment rate is multiplied by 60 percent of the labor related to the service and the wage index assigned per the geographic location of the hospital. This number is then added to the APC rate multiplied by 40 percent of the nonlabor related share of the work.

CMS also proposed and finalized to implement a 5 percent cap on wage index decreases. This cap ensures the changes to be finalized are done to "soften" any decreases that could have an overall impact to a specific value change. This will be a one-year cap effective January 1, 2021.

CMS estimates the proposed rule update of the wage indexes (based on the FY 2021 IPPS proposed rule wage indexes) would result in an increase of 2.6 percent for urban hospitals and an increase of 2.9 percent for rural hospitals under HOPPS.

Rural Adjustments

The rural adjustment factor of 7.1 percent to the HOPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs), established for CY 2020, will be continued for CY 2021 without modification. This will continue until data supports a different factor should be applied. This payment adjustment will continue to exclude separately payable drugs, biologicals, brachytherapy sources, items paid at charges reduced to cost, and devices paid under the pass-through payment policy.

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. Packaging encourages cost effectiveness and resource efficiency. 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. Packaged services are those services that are integral, ancillary, supportive, dependent and adjunctive to the primary service. Under the current Comprehensive APC (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 divide 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.

In CY 2020, CMS implemented changes in reimbursement to code G0463 for all off-campus departments, regardless if they had been excepted for payment of other outpatient services. This was due to the high volume of reporting for the outpatient clinic visit and what CMS believed was *"unnecessary increases in the volume of outpatient service."* To remove any incentivization in billing G0463, the most widely reported outpatient services code, CMS finalized a site-neutral method for reimbursement.

Any setting considered off-campus, more than 250 yards from the main buildings of the hospital, either excepted or nonexcepted, CMS finalized to reimburse for code G0463 at 40 percent of the on-campus outpatient reimbursement rate. Due to the high rate change, CMS implemented the decrease over a two-year period (2019 and 2020), rather than all at once.

In September 2019 a lawsuit was filed in the United States District Court for the District of Columbia, stating Health and Human Services Secretary, Alex Azar, overstepped his authority to set a site neutral policy for reimbursement of the clinic visit services. In the CY 2020 final rule, CMS indicated they were working to ensure 2019 claims were paid consistent with the court's ruling but continued with the reduction in 2020. On July 17, 2020, the United State Court of Appeals for the District of Columbia ruled in favor of CMS. Indicating the changes made by CMS were reasonable in their interpretation of adopting methods for controlling unnecessary increases in the volume of relevant services.

For CY 2021, code G0463 will continue to be reimbursed at a payment rate of 40 percent of the HOPPS rate for all off-campus outpatient departments. The finalized national rate for G0463 in 2021 is $118.74. The national rate for any off-campus provider, excepted and nonexcepted, will be $47.50 for code G0463, while the national rate for on-campus outpatient departments will be $118.74 in 2021.

APC "2 Times Rule"

All services (codes) associated with an APC are paid the exact same amount. 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".

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. In the final rule, CMS is finalizing their proposal to except the 18 APCs identified with an additional 5 APCs. The following table lists those APCs identified in violation of the 2 times rule in which CMS is making an exception for CY 2021:

TABLE 9.— APC EXCEPTION TO THE 2 TIMES RULE FOR CY 2021	
Final CY 2021 APC	**Final CY 2021 APC Title**
5051	Level 1 Skin Procedures
5055	Level 5 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5101	Level 1 Strapping and Cast Application
5112	Level 2 Musculoskeletal Procedures
5161	Level 1 ENT Procedures
5301	Level 1 Upper GI 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
5627	Level 7 Radiation Therapy
5673	Level 3 Pathology
5691	Level 1 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

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 classify devices as device-intensive were only those 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:

- Procedure must involve implantable device assigned to a CPT® or HCPCS code;
- Device must be surgically inserted or implanted (including single-use devices);
- Device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (down from 40 percent);
- Device has received FDA marketing authorization and investigational device exemption (IDE), and meets exemption from premarket review;
- Device is integral to the procedure performed;
- Device is used for one patient only; and
- Device comes into contact with human tissue.

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 will 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.

For CY 2021, CMS is finalizing their proposal to not make any changes to the device-intensive policy. In addition, CMS has not identified any specific procedures as exceeding the 30 percent threshold that would qualify as device-intensive procedures in the proposed rule.

Elimination of Inpatient Only List

Procedures and services typically provided in an inpatient setting and not paid by Medicare under HOPPS are identified on the inpatient only (IPO) list. This list was created to identify procedures that *"require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time, or the underlying physical condition of the patient who would require the surgery and, therefore, the service would not be paid by Medicare under the OPPS. For example, the list includes certain surgically invasive services on the brain, heart, and abdomen, such as craniotomies, coronary-artery bypass grafting, and laparotomies."*

The complete IPO list can be found as Addendum E to the CY 2021 HOPPS final rule. Currently there are approximately 1,740 services on the IPO list. Annual review of this list identifies services which should be removed or added based on the most recent data and medical evidence available. The current criteria used to determine if a procedure or service should be removed from the IPO and assigned to an APC group for payment under HOPPS includes:

- Most outpatient departments are equipped to provide the services to the Medicare population;
- Simplest procedure described by the code may be furnished in most outpatient departments;
- Procedure is related to codes that have already been removed from the IPO list;
- Determination made that the procedure is being furnished in numerous hospitals on an outpatient basis;
- Determination made that the procedure can be appropriately and safely furnished in an ASC, and is on the list of approved ASC services or has been proposed by us for addition to the ASC list.

Since the IPO list was developed in 2000, CMS has stated regardless of how a procedure is classified for purposes of payment, the expectation is of the surgeon and hospital assessing the risk of the procedure or service to the patient and acting in the patient's best interest – taking the site of service into account. CMS also recognized the emergence of new technologies, advancements in surgical techniques, and enhancements of surgical protocols would allow removal of some procedures and services from the IPO list. CMS clarified removal of procedures from the IPO list allows for payment in either the inpatient or outpatient setting.

Over the years, some stakeholders have requested to maintain the IPO list as a tool in which to ensure quality of care for Medicare beneficiaries. Other stakeholders have requested to eliminate the IPO list and defer to the clinical judgment of physicians for decisions regarding patient care and site of service. CMS has recently reevaluated the need to restrict payment for certain procedures and services in the hospital outpatient setting.

CMS believes physician judgment, state and local regulations, accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and other CMS quality and monitoring initiatives will continue to ensure the safety of beneficiaries in both the inpatient and outpatient settings in the absence of the IPO list.

Removal of procedures would be the based on new technologies, enhanced postoperative processes, and quicker rehabilitation protocols.

To that end, CMS has finalized to eliminate the IPO list over a 3-year transitional period starting in CY 2021. This transition of procedures and services from the IPO list would begin January 1, 2021, with the full list eliminated by January 1, 2024. The first group of services to be removed will be 266 musculoskeletal services and procedures, and 16 recommended services/anesthesia codes by the Advisory Panel on Hospital Outpatient Payment (HOP Panel) for a total of 298 services. CMS finalized to remove all 298 services from the IPO list. Of interest is the TIPS procedure:

TABLE 47.— HOP PANEL-RECOMMENDED PROCEDURE REMOVED FROM IPO LIST BEGINNING IN CY 2021

CPT Code	Long Descriptor	Related Services	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)	37183	J1	5193

Changes to Supervision for Non-Surgical Extended Duration Therapeutic Services

In the CY 2020 final rule, CMS changed 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). In response to COVID-19 and as part of the Public Health Emergency (PHE), CMS adopted a policy to reduce the minimum default level of supervision for non-surgical extended duration therapeutic services (NSEDTS) to general supervision for the entire service, including the initiation of the service which direct supervision was required. This policy was adopted on an interim final basis for the duration of the PHE to give providers flexibility to handle burdens created by the PHE.

CMS believes this policy is appropriate outside the PHE and should apply permanently for the duration of the NSEDTS. These have a significant monitoring component which can extend for a period of time, not surgical in nature, and typically have a low risk of complications after the assessment. Therefore, CMS finalized to establish **general** supervision as the minimally required supervision level for all NSEDTS provided on or after January 1, 2021. This would be consistent with the minimum required level or general supervision that currently applies for most outpatient hospital therapeutic services.

CMS stressed that changing NSEDTS to general supervision would 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.

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using the hospital market basket update to calculate rates. For CY 2021, CMS is finalizing an adjustment to wage indexes utilizing the Office of Management and Budget (OMB) updated delineations applied to the IPPS post-reclassified wage index. The wage indexes for IPPS are used for OPPS ratesetting as they are both hospitals and many inpatient hospitals have outpatient services.

CMS finalized an increase of 2.4% for ASCs that meet quality reporting under the Ambulatory Surgical Center Quality Reporting (ASCQR) program. This update is based on the projected hospital market basket increase of 2.4 percent minus a 0.0 percentage point adjustment for multi-factor productivity (MFP). In addition, CMS is finalizing to adjust the conversion factor (CF) by the proposed wage index budget neutrality factor of 0.9999 in addition to the hospital market basket update of 2.4 percent, which results in a CY 2021 ASC CF of $48.952 for ASCs meeting the ASCQR program. For those ASCs who do not meet the ASCQR program, the finalized CF is $47.996. CMS projects expenditures for beneficiaries in ASCs will be approximately $5.42 billion, an increase of approximately $120 million compared to CY 2020 payments.

Surgical Procedures Designated as Temporarily Office-Based

CMS annually reviews and updates the covered procedures for which ASC payment is made, including those procedures which may be appropriate for ASC payment and those procedures which may be designated as office-based. Of those procedures designated as office-based, they can either be permanent (being performed predominately in physicians' offices, i.e. more than 50 percent of the time); or temporary (designated as such in the CY 2019/CY 2020 final rules or fewer than 50 claims for procedure in data reviewed). CMS uses payment indicators as part of this designation: G2, P2, P3 or R2.

Of interest are codes 92985 and 93986, which have a payment indicator of P2*: Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight*.

TABLE 57.— ASC COVERED SURGICAL PROCEDURES TO BE DESIGNATED AS TEMPORARILY OFFICE-BASED FOR CY 2021

CY 2021 CPT/HCPCS Code	CY 2021 Long Descriptor	CY 2021 ASC Payment Indicator**
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	P2**
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	P2**

**Payment indicators are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the PFS final rates.

For these two codes, payment is based on their OPPS relative weight rather than MPFS nonfacility PE RVU-based amount.

Stay tuned for additional updates and changes for CY 2021.