Outpatient Prospective Payment System
and
Physician Fee Schedule
CY 2021 Proposed Rules

September 11, 2020

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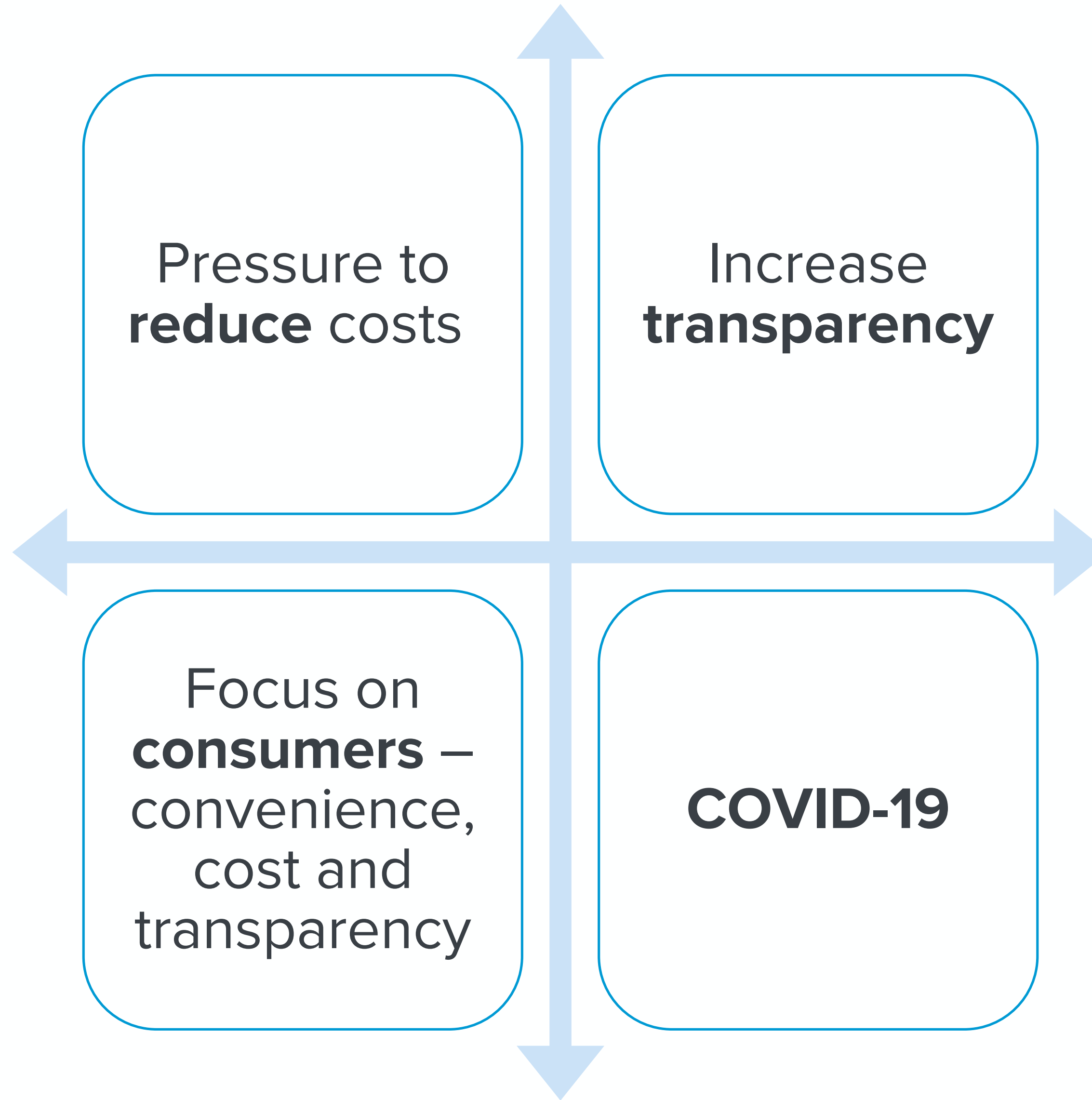
What is OPPS and PFS?

Comments due October 5th

- The OPPS rule sets the reimbursement rate for Medicare **Outpatient** payments, including Ambulatory Surgical Center (ASC) procedures.
- The PFS rule sets the reimbursement rate for Medicare **Physician** payments.
- Final Rules are expected in December.
- Rules become effective January 1, 2021.

The Broader Policy Landscape



Key Themes In OPPS and PFS

Continued Push to Control Utilization and Costs

- Prior Authorization
- Site-neutral payments
- 340B payment reductions
- Reduced payment for physician specialists

Effort to Accelerate Shift to the Outpatient Setting

- Removal of Inpatient Only List
- Addition of 11 procedures to the ASC setting

Increase Access to Telehealth

- Addition of nine permanent and 13 temporary services to the telehealth list.
- Comment solicitation on telehealth flexibilities.

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Outpatient Prospective Payment System (OPPS) Proposed Rule

OPPS Overview

- Payment Update
- Prior Authorization
- Site-Neutral Payments
- 340B Drug Program
- IPO List
- ASC List
- Levels of Supervision
- Hospital Star Ratings
- HCPCS Codes
- Physician-Owned Hospitals

Outpatient and ASC Payments

Contributing Factor	Outpatient	ASC
Net Update	+ 2.6% ($7.5 billion)	+2.6% ($160 million)

Prior Authorization

Prior Authorization

- Beginning July 1, 2021, CMS proposes to add two services to the prior authorization list:
  - Cervical Fusion with Disc Removal
  - Implanted Spinal Neurostimulators

Site-Neutral Payments

Site-Neutral Payments

- Continued reduction for clinic visits (G0463) provided in off-campus, Hospital Outpatient Provider-Based Departments (HOPDs) - $46 visit instead of $116 visit.

340B Drug Program

Overview

2017

CMS reduces reimbursement for 340B drugs from ASP +6% to ASP -22.5%, effective 2018.

2018

The AHA and other hospital groups file lawsuit. Court rules in favor of hospitals.

2019

Pending an appeal, CMS proposes alternate reimbursement methodology, including ASP+ 3%.

CMS announces intent to collect data on hospitals' 340B acquisition costs.

2020

In May, CMS launches survey to determine hospitals' costs for 340B purchases.

In July, Court of Appeals overturns the 2018 ruling.

In August, CMS proposes steeper payment reductions in OPPS CY 2021 proposed rule.

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340B Drug Program

- CMS proposes two payment “alternatives:”
  - ASP -28.7%
    - Decreases payments by $427 million for 340B drugs.
    - Increases payments for all non-drug OPPS services by 0.85%.
  - ASP -22.5%

Inpatient Only (IPO)
and
Ambulatory Surgical Center (ASC) Lists

Overview

CMS uses these lists to regulate the site of service for various health care procedures. Inclusion or omission is determined by many factors, including patient safety, quality of care and cost.

Inpatient Only (IPO) List

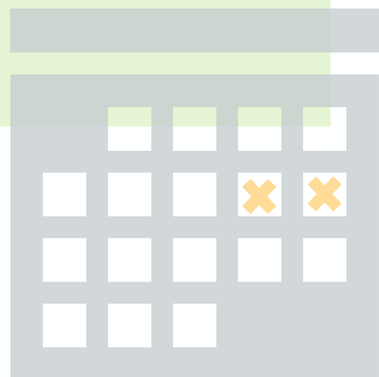
These procedures are only reimbursable if performed in an inpatient setting.

Ambulatory Surgical Center (ASC) List

These procedures may be performed at an ASC, to reduce cost.

IPO List: Phased Removal

CMS proposes to eliminate the IPO list over the course of three years.



IPO Phased Removal Period: CY2021 – CY2023

- Remove 266 musculoskeletal-related services in 2021.
- Continue the two-year exemption from medical review activities for site-of-service for all procedures removed from the IPO list.

"Any service that was once listed on the IPO list would be subject to the 2-midnight benchmark and presumption."

IPO List: Phased Removal

2021
- CMS launches phase-out with the removal of 266 musculoskeletal services.

2022
- Which services are most appropriate for removal in 2022?

2023
- Which services are most appropriate for removal in 2023?

2024
- CMS completes phase-out IPO list.

"We no longer believe there is a need for the IPO list in order to identify services that require inpatient care."

Proposed Additions to the ASC List

CPT/HCPCS Code	Procedure Descriptor	Indicator
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system.	G2
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only	J8
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	G2
21365	Open treatment of complicated fracture(s) for 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/allograft	J8
27412	Autologous chondrocyte implantation, knee	G2
57282	Colpopexy, vaginal; extra-peritoneal approach	G2
57283	Colpopexy, vaginal; intra-peritoneal approach	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.	J8

Options for Updating the ASC List

CMS also seeks comment on two alternative processes for updating the ASC covered procedures list.

Option 1:

Establish an external-stakeholder nomination process, which would allow trade organizations and professional specialty societies to nominate procedures that can be safely performed in an ASC.

Option 2:

Retain the general standard criteria and eliminate five of the general exclusion criteria. **If chosen, this option would add 270 additional codes to the ASC list.**

Levels of Supervision

- Change the minimum level of supervision to *general* for non-surgical extended duration therapeutic services.
- Allow *direct* supervision for pulmonary, cardiac and intensive cardiac rehabilitation services.

Star Ratings

- CMS created the 5 – Star Quality Rating System to help consumers compare health care facilities using reported metrics.

- Retain the following elements of the current system:
  - An Annual Publication Cycle.
  - Publicly display measure group level information along with the overall rating.
  - Use K-means clustering to assign a rating between one and five stars.
  - Apply z-standardization to measure scoring prior to being combined into an aggregate measure score.

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Star Ratings

- CMS proposes to:
  - Stratify the readmission measure group by the proportion of Medicare and Medicaid dually eligible patients served.
  - Peer group hospitals by the number of measure groups a hospital has been scored on.
  - Apply a minimum threshold for ratings.
  - Use a simple average of measure scores to calculate measure group scores.

Star Ratings

- CMS proposes to:
  - Consolidate measures from seven to five measure groups:
    - Mortality
    - Safety of Care
    - Readmission
    - Patient Experience
    - Timely and Effective Care
  - Use publicly reported data from one of the four quarterly refreshes to the Hospital Compare data within the prior year.

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Physician-Owned Hospitals

- CMS proposed to:
  - Remove the following regulatory restrictions on high Medicaid facilities that limit the expansion of the facility.
    - Limitation of one expansion request every two years.
    - Limitation of restricting the expansion of a facility to 200% of its baseline.
  - Revise the definition of “beds” in a physician-owned hospital to include all beds considered licensed for purposes of State licensure.

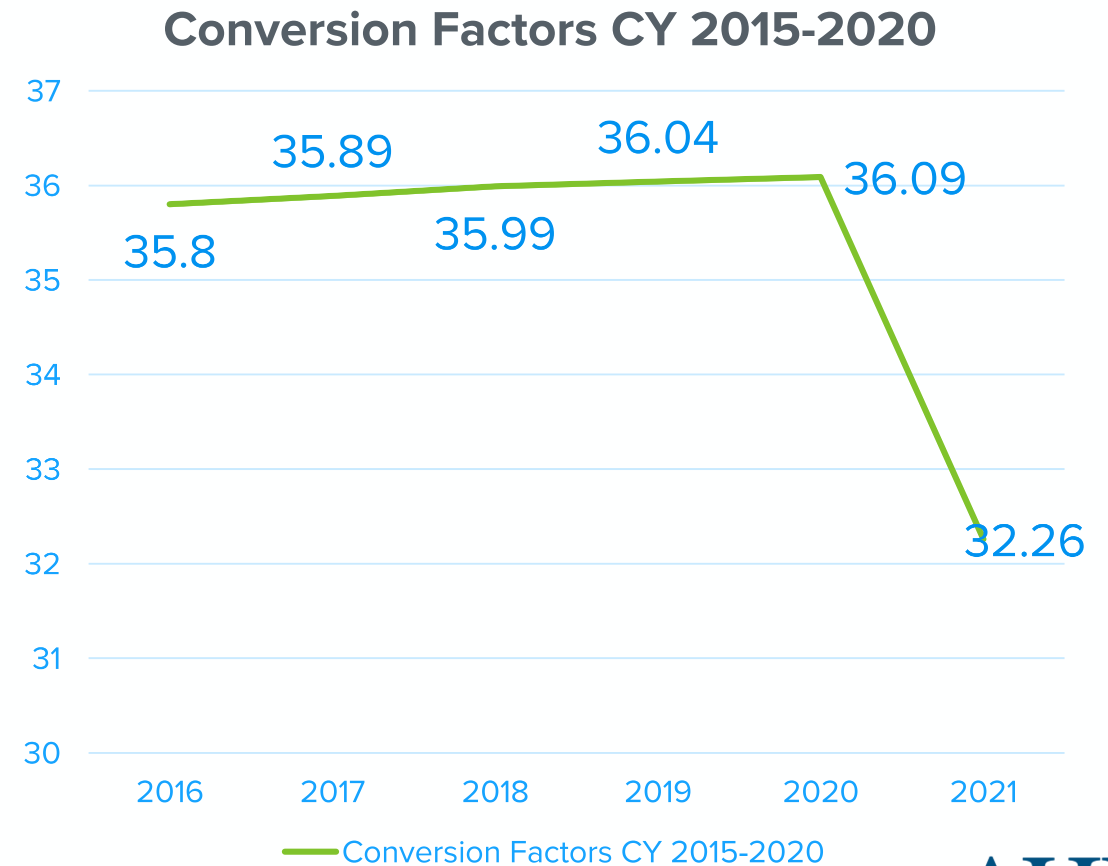
Physician Fee Schedule (PFS) Proposed Rule

PFS Overview

- Conversion Factor Update
- Evaluation and Management (E/M) Office/Outpatient Visits
- Telehealth
- Scope of Practice
- Quality Payment Programs
- Medicare Shared Savings Program

Conversion Factor Update

- CMS proposes to reduce the conversion factor to $32.26 for CY 2021.



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Evaluation and Management Changes

- CMS proposes to increase the payment rate for office/outpatient E/M visits to more accurately reflect physician time.
  - Changes favors office-based care

- Increases/decreases for certain specialties
  - Winners:
    - Family Practice (9%), Hematology/Oncology (9%), Endocrinology (11%)
  - Losers:
    - Vascular Surgery (-7%), Radiology (-11%), Emergency Medicine (-6%)

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Increasing/Decreasing Specialty Payments

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$246	5%	4%	0%	9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Audiologist	$74	-4%	-2%	0%	-7%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Cardiology	$6,849	1%	0%	0%	1%
Chiropractor	$759	-7%	-3%	0%	-10%
Clinical Psychologist	$824	-1%	1%	0%	0%
Clinical Social Worker	$851	-1%	1%	0%	0%
Colon And Rectal Surgery	$168	-4%	-1%	0%	-5%
Critical Care	$376	-6%	-2%	0%	-8%
Dermatology	$3,758	-1%	-1%	0%	-2%
Diagnostic Testing Facility	$813	-1%	-5%	0%	-6%
Emergency Medicine	$3,065	-5%	-1%	0%	-6%
Endocrinology	$506	11%	6%	1%	17%
Family Practice	$5,982	9%	4%	1%	13%

Telehealth

Telehealth

EXECUTIVE ORDERS

Executive Order on Regulatory Relief to Support Economic Recovery

ECONOMY & JOBS | Issued on: May 19, 2020

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In December 2019, a novel coronavirus known as SARS-CoV-2 (“the virus”) was first detected in Wuhan, Hubei Province, People’s Republic of China, causing an outbreak of the disease COVID-19, which has now spread globally. The Secretary of Health and Human Services declared a public health emergency on January 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19. In Proclamation 9994 of March 13, 2020 (Declaring a

Executive Order on Improving Rural Health and Telehealth Access

HEALTHCARE | Issued on: August 3, 2020

★ ★ ★

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. My Administration is committed to improving the health of all Americans by improving access to better care, including for the approximately 57 million Americans living in rural communities. Americans living in rural

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Proposed Permanent Telehealth Services

2021 Proposed Additions to the Medicare Telehealth Services List on a Category Basis	
HCPCS Code	**Code Description**
GPC1X	Visit complexity inherent to E/M (Add-on code)
90853	Group psychotherapy
96121	Neurobehavioral status exam (List in addition to primary procedure)
99XXX	Prolonged office or other outpatient E/M service (List in addition to E/M service)
99483	Care planning for a patient with cognitive impairment
99334*	Domiciliary or rest home E/M visit for an established patient (15 minutes)
99335*	Domiciliary or rest home E/M visit for an established patient (25 minutes)
99347*	Home visit for E/M of an established patient (15 minutes)
99348*	Home visit for E/M of an established patient (25 minutes)
*These services can be billed when furnished as a telehealth service only for treatment of a substance use disorder or occurring mental health disorder.[8]	

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Proposed Temporary Telehealth Services

Service Type	CPT Codes	Code Description
Domiciliary, Rest Home or Custodial Care Services, Established patients*	99336	Domiciliary or rest home E/M visit for an established patient (40 minutes)
	99337	Domiciliary or rest home E/M visit for an established patient (60 minutes)
Home Visits, Established patients*	99349	Home visit for E/M of an established patient (40 minutes)
	99350	Home visit for E/M of an established patient (60 minutes)
Emergency Department (ED) Visits	99281	ED visit for E/M for a self-limited or minor problem
	99282	ED visit for E/M for a low of moderately severe problem
	99283	ED visit for E/M for a moderately severe problem
Nursing Facilities Discharge Day Management	99315	Nursing facility discharge, 30 minutes or less
	99317	Nursing facility discharge, more than 30 minutes
Psychological and Neuropsychological Testing	96130	Psychological testing evaluation, first hour
	96131	Psychological testing evaluation, additional hour
	96132	Neuropsychological testing evaluation, first hour
	96133	Neuropsychological testing evaluation, additional hour

*These services can be billed when furnished as a telehealth service only for treatment of a substance use disorder or occurring mental health disorder.

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COVID-19 Telehealth Services Not Added

- Initial nursing facility visits, all levels (Low, Moderate, andHigh Complexity) (CPT 99304-99306)
- Psychological and Neuropsychological Testing (CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- Initial hospital care and hospital discharge day management (CPT 99221- 99223; CPT 99238- 99239)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT 99468- 99472; CPT 99475- 99476)
- Initial and Continuing Neonatal Intensive Care Services (CPT 99477- 99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT90952, 90953, 90956, 90959, and 90962)
- Radiation Treatment Management Services (CPT 77427)
- Emergency Department Visits, Levels 4-5 (CPT 99284-99285)
- Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324- 99328)
- Home Visits, New Patient, all levels (CPT 99341- 99345)
- Initial and Subsequent Observation and Observation DischargeDay Management (CPT 99217- 99220; CPT 99224- 99226; CPT 99234-99236)

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COVID-19 Telehealth Waivers

- CMS seeks comments on whether to make permanent the following waivers:
  - Allow nursing home visits to be done via telehealth.
  - Allow the use of audio-only services.
  - Allow direct supervision to be provided using audio/video technology.

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CMS Solicits Input on...

- What other telehealth services should be added on a temporary or permanent basis?
- What specific health outcomes are being gathered to demonstrate the clinical benefit of a telehealth service?
- What safeguards can be employed to maintain safety and effectiveness of services?
- How are practices efficiently transitioning patients from telehealth to in-person care?
- Are frequency limitations burdensome and do they limit beneficiary access to necessary care?
- What training is required for effective use of audio/video communications technology?
- How to address concerns around induced utilization and fraud, waste, and abuse?

Telehealth - What's Next?

Establish Payment Rates
"We need to assess the Medicare payment rates for telehealth services."

Develop Guardrails
"First, it is important to assess whether the mode of telehealth service delivery is clinically appropriate and safe for patients, as compared to an in-person visit."

Ensure Program Integrity
"We are monitoring program integrity implications such as practitioners who may be offering shorter telehealth visits with patients to maximize payment or billing more visits than are possible in a day."

Scope of Practice

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Scope of Practice

- Make permanent the supervision of diagnostic tests by Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse-Midwives (CNMs) and Certified Nurse Specialists (CNS).
- Clarifies that pharmacists can provide incident-to services, including medication management services under Medicare Part B.
- Allow the delegation of maintenance therapy services as clinically appropriate.

Quality Payment and Medicare Shared Savings Programs

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Overview

The Quality Payment Program seeks to reward high-value care through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

- CMS will **not** be introducing the MIPS Value Pathways (MVPs) during the 2021 performance period, as originally finalized in the CY 2020 PFS Rule.

Merit-based Incentive Payment System

CMS proposes to continue to modify the performance category weights for the 2021 performance period.

Proposed Weights

- **Quality: 40%** *(decreased by 5%)*
- **Cost: 20%** *(increased by 5%)*
- **Promoting Interoperability: 25%** *(unchanged)*
- **Improvement Activities: 15%** *(unchanged)*

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Merit-based Incentive Payment System

CMS is considering replacing the MIPS APM scoring standard with the MIPS APM Performance Pathway (APP).

- Participating clinicians would not be scored on the cost category. Instead, they would automatically receive credit in the MIPS Improvement Activity category.
- To qualify, clinicians would have to report on a common set of six quality measures.

Merit-based Incentive Payment System

For CY 2021, CMS also proposes to:

- Defer the development of specific MVPs, instead adding principles to guide their development.
- Align the Promoting Interoperability measures with the Hospital Promoting Interoperability program, including the implementation of a new health information exchange measure.

Medicare Shared Savings Program

Overview

The Medicare Shared Savings Program (MSSP) is a voluntary APM that gives providers the opportunity to create an Accountable Care Organization (ACO).

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Medicare Shared Savings Program

Quality Measurement Proposed Changes

- Reduce the number of measures in the ACO measure set from 23 to six.
- Require ACOs to receive quality scores in or above the 40th percentile to quality for shared savings.
- Terminate ACO participation agreements that fail to meet the minimum quality score standard for two consecutive performance periods.

Medicare Shared Savings Program

Additional Proposals

- Include new E/M and care management CPT and HCPCS codes in the ACO assignment methodology.
- Give automatic full credit for CAHPS patient experience of care surveys.

Seeking Comment: CMS is also seeking comment on an alternative scoring methodology approach for the “extreme and uncontrollable circumstances” of performance year 2020.

Questions?

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