Fact sheet

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CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)

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CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized policies that are consistent with the directives in President Trump's Executive Order, entitled "Protecting and Improving Medicare for Our Nation's Seniors," that aims to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud and abuse to protect seniors and taxpayers.

The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

The CY 2020 OPPS/ASC Payment System final rule with comment period further advances the agency's commitment to strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider burden, and strengthening program integrity so that hospitals and ambulatory surgical centers can operate with better flexibility and

patients have what they need to become active healthcare consumers.

This fact sheet discusses the major provisions of the final rule with comment period (CMS-1717-FC), which can be downloaded from the *Federal Register* at: https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center.

Increasing Choices and Encouraging Site Neutrality

The final rule with comment period includes a policy that continues to eliminate payment differences between certain outpatient sites of service so that patients can benefit from high-quality care at lower costs, and are better able to receive care that is provided safely and is clinically appropriate.

Method to Control for Unnecessary Increases in Utilization of Outpatient Services

As finalized in last year's rule, CMS is completing the two-year phase-in of the method to reduce unnecessary utilization in outpatient services by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting. Clinic visits are the most common service billed under the OPPS. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting. This change would result in lower copayments for beneficiaries and savings for the Medicare program and taxpayers estimated to be $800 million for 2020. With the completion of the two-year phase-in, the cost sharing will be reduced to $9, saving beneficiaries an average of $14 each time they visit an off-campus department for a clinic visit in CY 2020. We acknowledge that the United States District Court for the District of Columbia vacated the volume control policy for CY 2019 and we are working to ensure affected 2019 claims for clinic visits are paid consistent with the court's order. We do not believe it is appropriate at this time to make a change to the second year of the two-year phase-in of the clinic visit policy. The government has appeal rights, and is still evaluating the rulings and considering, at the time of this writing, whether to appeal from the final judgment.

Changes to the Inpatient Only List

This rule finalizes changes to the Inpatient Only (IPO) list including removal of total hip arthroplasty, six spinal surgical procedures and

certain anesthesia services from the list, making these procedures eligible to be paid by Medicare in the hospital outpatient setting in addition to the hospital inpatient setting. The decision on the appropriate site of service is a complex medical judgment made by the physician based on the clinical characteristics of the patient. The 2-midnight rule offers guidance on when payment is generally appropriate under Medicare Part A or Part B.

Also, in response to public comments, we are establishing a two-year exemption rather than the one year we proposed, from certain medical review activities relating to patient status for procedures removed from the inpatient-only list beginning in CY 2020 and subsequent years.

Under this policy, Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) reviews of short-stay inpatient claims for procedures that have been removed from the IPO list within the first two years will be for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule, but claims will not be denied based on patient status (that is, site of service) alone. Furthermore, these procedures will also not be eligible for referral to the Recovery Audit Contractor (RAC) for noncompliance with the 2-midnight rule for a two-year period after their removal from the IPO list. This two-year exemption period will allow providers time to update their billing systems and gain experience with respect to newly removed procedures eligible to be paid under either the Inpatient Prospective Payment System (IPPS) or OPPS, while avoiding potential adverse site of service determinations.

ASC Covered Procedures List
The ASC Covered Procedures List (CPL) is a list of covered surgical procedures that are eligible for payment under Medicare when furnished in an ASC. Covered surgical procedures are those procedures that would not be expected to pose a significant risk to beneficiary safety and for which the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure. For CY 2020, CMS is adding Total Knee Arthroplasty (TKA), Knee Mosaicplasty, six additional coronary intervention procedures, and twelve procedures with new CPT codes to the ASC CPL.

Payment for Procedures Involving Skin Substitutes
For CY 2020, CMS is finalizing its proposal to continue the policy to assign skin substitutes to the low-cost or high-cost group, while we

continue to consider comments received on episode-based payment or a single category of payment for services involving such products for future policy refinement.

Rethinking Rural Health

Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals (CAHs)
CMS is finalizing a change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and CAHs from direct supervision to general supervision. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. This change ensures a standard minimum level of supervision for each hospital outpatient therapeutic service furnished incident to a physician’s service. As stated in the final rule with comment period, this change does not preclude a hospital from requiring a higher level of supervision for certain services, as it determines appropriate.

Addressing Wage Index Disparities
To conform with the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, for CY 2020, CMS will use the post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount. Therefore, the adjustments for the FY 2020 IPPS post-reclassified wage index, including, but not limited to, the policies finalized under the IPPS to address wage index disparities between low and high wage index value hospitals would be reflected in the final CY 2020 OPPS wage index beginning on January 1, 2020. In this final rule with comment period, CMS is also finalizing for the OPPS the other wage index policies adopted in the FY 2020 IPPS final rule. For more detail, see the following link: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

Unleashing Innovation

In the CY 2020 OPPS/ASC final rule, CMS is taking steps to unleash innovation in medical technology and remove obstacles for beneficiaries in accessing new, innovative technologies and treatments. For transformative devices that have an FDA

Breakthrough Device designation, CMS is providing an alternative pathway to qualify for device pass-through payment status, under which the "substantial clinical improvement" criterion would not apply to these devices. The devices would still need to meet the other criteria for pass-through status. This alternative pathway will apply to devices that receive pass-through payment status effective on or after January 1, 2020. The goal of this policy is to give Medicare beneficiaries more timely access to new therapies, and reduce the uncertainty that innovators face regarding payment for these therapies.

Device Pass-through Applications
Effective January 1, 2020, CMS is approving five device pass-through applications that meet the criteria to be granted transitional pass-through status for a period of three years, including AquaBeam® Robotic System, AUGMENT® Bone Graft, Surefire® Spark Infusion System, Optimizer® Smart System, and CustomFlex® ArtificialIris.

Protecting Taxpayer Dollars

CMS is focused on establishing new methods to reduce unnecessary increases in the volume of covered outpatient department services. Prior authorization has already proven to be an effective method for controlling improper payments and decreasing the volume of potentially improperly billed services for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Recently, CMS has observed significant increases with regard to certain outpatient department (OPD) services that are primarily cosmetic. CMS reviewed internal data, and developed a list of OPD services for which it is requiring prior authorization as a method to control unnecessary increases in volume for these services. Specifically, CMS is implementing a prior authorization requirement for Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation to help ensure these services, which are often cosmetic, and only covered by Medicare in limited circumstances, are billed only when medically necessary.

Meaningful Measures/Patients Over Paperwork

CMS is finalizing changes to the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs to further meaningful measurement and reporting for quality of care in the outpatient surgical setting while limiting burden.

Hospital Outpatient Quality Reporting (OQR) Program
The Hospital OQR Program is a pay-for-reporting quality program for the hospital outpatient department setting. The Hospital OQR Program requires hospitals to meet quality reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update if these requirements are not met.

CMS is finalizing to remove one web-based measure for the CY 2022 Program Year from the Hospital OQR Program, External Beam Radiotherapy (EBRT) for Bone Metastases (OP-33). This removal is on the basis that the costs associated with the measure outweigh the benefit of its continued use in the program; the complexity of reporting this measure places substantial administrative burden on hospitals.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program
The ASCQR Program is a pay-for-reporting quality program for the ASC setting. The ASCQR Program requires ASCs to meet quality reporting requirements or receive a reduction of 2.0 percentage points in their annual fee schedule update if these requirements are not met.

CMS did not propose to remove any measures in this rulemaking as our analysis of the current ASCQR Program measure set indicates that there are no measures that meet the measure removal factors following last year's comprehensive removal initiative. CMS is adopting one claims-based measure beginning with the CY 2024 payment determination, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers (NQF #3357).

CY 2020 OPPS Payment Methodology for 340B Purchased Drugs

Section 340B of the Public Health Service Act (340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs at discounted prices from manufacturers. In the CY 2018 OPPS/ASC final rule, CMS reexamined the appropriateness of the prior Average Sale Price (ASP) plus 6 percent payment methodology for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, Medicare adopted a policy to pay an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS that is not excepted from the payment adjustment policy.

For CY 2020, CMS is finalizing its proposal to continue to pay an adjusted amount of ASP minus 22.5 percent for separately payable drugs or biologicals that are acquired through the 340B Program. In the proposed rule, CMS acknowledged that the CY 2018 and 2019 OPPS payment policies for 340B-acquired drugs are the subject of ongoing litigation, and the agency is currently appealing the decision in the United States Court of Appeals for the District of Columbia Circuit. We solicited comments for a potential remedy for CYs 2018 and 2019 in the event of an unfavorable decision. Those comments are summarized in the final rule. We also announced in our intent to conduct a 340B hospital survey to collect drug acquisition cost data for CY 2018 and 2019, and data from that survey may be used to craft a remedy. In the event the 340B hospital survey data are not used to devise a remedy, we intend to consider the public input to inform the steps we would take to propose a remedy for CYs 2018 and 2019 in the CY 2021 rulemaking.

Updates to OPPS Payment Rates

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent. 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).

Partial Hospitalization Program (PHP) Rate Setting
The CY 2020 OPPS/ASC final rule updates Medicare payment rates for Partial Hospitalization Program (PHP) services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). The PHPs are structured intensive outpatient programs consisting of a group of mental health services paid on a per diem basis under the OPPS, based on PHP per diem costs.

Update to PHP Per Diem Rates
CMS is finalizing this policy as proposed and will maintain the unified rate structure established in CY 2017, with a single PHP APC for each provider type for days with three or more services per day. CMS is using the CMHC and hospital-based PHP (HB PHP) geometric mean per diem costs, consistent with existing policy, using updated data for the hospital-based PHP geometric mean per diem cost and a cost floor for CMHCs equal to the CY 2019 CMHC final geometric mean per diem cost

Updates to ASC Payment Rates

In the CY 2019 OPPS/ASC final rule with comment period, we finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). CMS did not propose any changes to its policy to use the hospital market basket update for ASC payment rates for CY 2020-2023.

Using the hospital market basket, CMS is finalizing an update to the ASC rates for CY 2020 equal to 2.6 percent. The update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for MFP. This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

Revision to the Organ Procurement Organization Conditions for Certification

Organ Procurement Organizations (OPOs) are currently required to meet two out of three outcome measures. CMS is finalizing the proposal to revise the definition of “expected donation rate” that is included in the second outcome measure to match the Scientific Registry of Transplant Recipient (SRTR) definition. This change will clarify the regulatory standard so that we may properly enforce the second outcome measure, eliminate any provider confusion, and further support our goals of accurately and reliably measuring OPO performance.

To give OPOs adequate time to comply with the change to the definition of “expected donation rate,” CMS is temporarily suspending the requirement that OPOs meet two of three outcome measures for the 2022 recertification cycle only. Therefore, all OPOs are not required to meet the standards of the second outcome measure for the 2022 recertification cycle only. OPOs must instead meet one of two outcome measures (the donation rate of eligible donors measure or the aggregate donor yield measure).

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Contact us

CMS News and Media Group
Johnathan Monroe, Director
Kelly Ceballos, Deputy Director

press@cms.hhs.gov
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