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Special Bulletin

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CMS Issues Hospital Outpatient/ASC Proposed Rule, Including Negotiated Rate Disclosure Proposals

The Centers for Medicare & Medicaid Services (CMS) July 29 released the calendar year (CY) 2020 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) proposed rule. In addition to standard updates, the rule would require hospitals to disclose payer-specific negotiated rates; complete the phase-in of the site-neutral rate for clinic visit services provided in grandfathered off-campus provider-based departments (PBDs); and continue its current policy of cutting the payment rate for certain drugs purchased under the 340B drug savings program. Comments on the proposed rule are due by Sept. 27.

AHA Take: America's hospitals and health systems are dedicated to ensuring patients have the information they need to make informed health care decisions, particularly knowing what their expected out-of-pocket costs will be. However, mandating the disclosure of negotiated rates between insurers and hospitals is the wrong approach. Instead, it could seriously limit the choices available to patients in the private market and fuel anticompetitive behavior among commercial health insurers in an already highly concentrated insurance industry. While we support transparency, the proposal misses the mark, exceeds the Administration's legal authority and should be abandoned.

Further, by continuing payment cuts for hospital outpatient clinic visits and 340B-acquired drugs, CMS has threatened to impede access to care, especially in rural and other vulnerable communities. The AHA has been working to overturn the clinic visit rule through legal action and by working with the Congress. In addition, we, along with other hospital associations and member hospitals, successfully challenged the cuts to the 340B program in court. Now that the court has ruled that those cuts are illegal and exceeded the Administration's authority, we urge CMS to refrain from doing more damage to impacted hospitals with another year of illegal cuts. Instead, as a remedy, CMS should be offering a plan to promptly restore funds to those affected.

Highlights of the OPPS rule follow. A detailed Regulatory Advisory will be issued in the coming weeks.

Key Takeaways

CMS proposes to:

- Update OPPS payment rates by 2.7% in CY 2020;
- Require hospitals to disclose their payer-specific negotiated rates. Hospitals would be required to release these rates for all items and services, as well as provide payer-specific rates for up to 300 "shoppable" bundles of services in a consumer-friendly format.
- Complete the phase-in of the cut in payment for clinic visits provided in grandfathered off-campus PBDs, resulting in a site-neutral rate of 40% of the OPPS rate.
- Continue its payment cut to Average Sales Price (ASP) minus 22.5% for 340B-acquired drugs.
- Change the minimum required level of supervision for all hospital outpatient therapeutic services from direct supervision to general supervision in all hospitals and critical access hospitals, as repeatedly urged by the AHA.
- Require a prior authorization process for five categories of outpatient department services, including: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.
- Remove one quality measure from the Outpatient Quality Reporting Program and adopt one new measure in the ASC Quality Reporting Program.

HIGHLIGHTS OF THE OUTPATIENT PPS PROPOSED RULE

Payment Update: CMS proposes to update OPPS rates by 2.7% for CY 2020. This change includes a market-basket update of 3.2%, as well as a productivity cut of 0.5 percentage points. **These payment adjustments, in addition to other proposed changes in the rule (including the completed clinic visit cut), are estimated to result in a net increase in OPPS payments of 2.0% compared to CY 2018 payments.** For those hospitals that do not publicly report quality measure data, CMS would continue to impose the statutory 2.0 percentage point additional reduction in payment.

Public Disclosure of Negotiated Rates: The proposed rule includes new guidance on the implementation of Section 2718(e) of the Public Health Services Act, which requires hospitals to make their standard charges publicly available, and, if finalized, would incorporate these requirements into regulation for the first time. In the rule, CMS proposes definitions for a number of terms, such as "standard charge," "hospital" and "items and services."

- CMS proposes to define "standard charge" as both gross charges and payer-specific negotiated rates (referred to in the rule as "payer-specific negotiated *charges*").
- CMS proposes to broadly define "hospital" to mean all institutions licensed by a state (or local law as applicable) as a hospital and that serves the general public, including critical access hospitals, inpatient psychiatric facilities and inpatient rehabilitation facilities.
- CMS proposes to define "items and services" as all items and services provided by a hospital, including facility fees, physician and other professional charges if the professional is employed by the hospital, supplies, procedures, and room and board.

CMS would require hospitals to post a list of all of their standard charges – both gross charges and all negotiated rates – for all items and services in a machine-readable format on their websites. Hospitals would be required to create a single, machine readable file with a standard set of five data elements, including a description of each item or service, the gross charge, the payer-specific negotiated charge, any hospital accounting codes and revenue codes, as applicable. Hospitals would be required to post the file on a prominent place on their websites without requiring any form of patient registration or other "barrier" to access.

In addition, CMS proposes requiring hospitals to post the negotiated rates for 300 "shoppable" services, both inpatient and outpatient, in a consumer-friendly way that is both easily understood and searchable. CMS defines "shoppable" as services that are non-urgent, routinely provided, and can be scheduled in advance. For these services, the hospital also would need to provide the payer-specific charge data for any customary ancillary items and services to create charge information for the bundle of services (or "service packages"). CMS identified 70 services that hospitals would need to provide charge data for across the categories of evaluation and management, laboratory and pathology, radiology, and medicine and surgery. These services range from a basic metabolic panel to a CT scan to removing a child's tonsils. Hospitals would need to

identify the remaining 230 shoppable services based on common services for the populations they serve. CMS would provide some flexibility for hospitals to choose services other than the 70 identified by CMS if, for example, the hospital does not provide some of the identified services. However, all hospitals would be required to post bundled charge data for at least 300 shoppable services.

CMS proposes to monitor compliance through review of complaints and audits of hospitals' websites. In the case of noncompliance, CMS proposes to first issue a warning and, if the violation continues, it proposes to require hospitals to submit and follow a corrective action plan. If a hospital does not submit or adhere to the corrective action plan, CMS proposes to impose a civil monetary penalty (CMP) of up to $300 a day.

CMS estimates that it would take hospitals 12 hours, translating to a cost of $1,017.24, to comply with these requirements. Specifically, it estimates that hospitals will need four hours to compile and post charge data for all items and services and eight hours to identify the 300 shoppable services and their corresponding ancillary services, collate the charge data, create a consumer-friendly approach to displaying the data, and post it on their websites.

CMS seeks comment on a number of areas, including the type of charge data hospitals should be required to post; whether requiring 100 shoppable services is more appropriate than 300; and whether CMS should mandate a specific file format, such as Excel; among other areas.

Full Phase-in of Site-neutral Payment Cut for Outpatient Clinic Visits in Off-campus PBDs: For CY 2020, CMS proposes to complete the previously finalized two-year phase-in of the site-neutral reduction in payment for clinic visit services furnished in grandfathered (excepted) off-campus PBDs. Specifically, CMS proposes to pay for hospital outpatient clinic visit (i.e., evaluation and management) services in grandfathered (excepted) PBDs at the "PFS-equivalent" payment rate of 40% of the OPPS payment amount. As it did in CY 2019, the agency proposes to implement this proposal in a non-budget neutral manner, and thus is estimated to cut hospital payments under the OPPS by an estimated $810 million in CY 2020.

Continuation of 340B Drug Payment Policy, Including in Off-Campus PBDs: CMS proposes to continue its current policy under which it pays for separately payable drugs and biologicals (other than drugs on pass-through payment status and vaccines) acquired under the 340B program at Average Sales Price (ASP) minus 22.5%. This policy also extends to 340B-acquired drugs furnished in non-grandfathered (non-excepted) off-campus PBDs. As in the previous OPPS rules, this payment policy would *not* apply to rural sole community hospitals, children's hospital or PPS-exempt cancer hospitals.

The agency discusses at length the status of the successful litigation the AHA, along with other hospital associations and member hospitals, waged challenging the nearly 30% cuts. CMS, in the proposed rule, affirms its commitment to appeal the U.S. District court's decision. The agency asks for public comment on potential remedies for the CY 2018 and CY 2019 payments and for use in CY 2020 payments in the event the agency

receives an adverse ruling by the U.S. Court of Appeals. Specifically they are soliciting public comment on the implications of a remedy that would pay for 340B acquired drugs at ASP plus 3% for CY 2020 and for determining a remedy for the CY 2018 and 2019 reductions. They also ask for comments on whether the remedy should be retrospective (on a claim-by-claim basis) in nature, or prospective (e.g., upward adjustment to future claims to account for past underpayments). In addition, CMS ask for comments on how the OPPS budget-neutrality requirements should be treated. Finally, CMS declares that they will propose a specific remedy, in the event the agency loses their appeal. Such a remedy would be proposed in the next available payment rule, which would be the CY 2021 OPPS/ASC.

Comprehensive APCs: CMS proposes to create two new comprehensive APCs (C-APCs) for Level 2 Vascular Procedures and for Level 1 Neurostimulator and Related Procedures. This proposal would increase the total number of C-APCs to 67.

Inpatient-only List: CMS proposes to remove CPT code 27130 (Total hip arthroplasty) from the inpatient-only list, making it eligible to be paid in both an inpatient and outpatient setting. In addition, the agency proposes to establish a one-year exemption from medical review activities for procedures removed from the inpatient-only list beginning in 2020. Specifically, CMS proposes to establish a one-year exemption from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs), and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the inpatient-only list beginning on Jan. 1, 2020.

Wage Index: CMS proposes to use the FY 2020 hospital inpatient PPS post-reclassification wage index for the outpatient PPS. This would encompass any proposed inpatient PPS wage index policies that are finalized in the FY 2020 inpatient PPS final rule. For more detail about CMS's wage index policy proposals, see the FY 2020 inpatient PPS proposed rule Regulatory Advisory.

Changes in the Level of Supervision of Outpatient Therapeutic Services: 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. 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. The Hospital Outpatient Payment Panel would continue to provide advice on the appropriate supervision levels for individual hospital outpatient services, and CMS would retain its authority to make changes to the level of supervision required for individual services through notice-and-comment rulemaking. **The AHA supports this proposal, as we have repeatedly pushed CMS for a solution to this critical issue for rural hospitals.**

Proposed Prior Authorization Requirements for Certain Outpatient Services: Citing "unnecessary increases in the volume" of certain covered outpatient department services, CMS proposes to implement a prior authorization requirement for five categories of services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation. The agency claims this will help to ensure these services, which are often cosmetic, are only billed when medically necessary.

Hospital Outpatient Quality Reporting Program (OQR): CMS proposes to remove one quality measure from the OQR starting with the CY 2022 payment determination. The measure, External Beam Radiotherapy (EBRT) for Bone Metastases (OP-33), assesses the percentage of patients, regardless of payer, with bone metastases and no history of previous radiation who receive EBRT with an acceptable dosing schedule. Since its adoption in the CY 2016 OPPS final rule, stakeholders (including the measure's steward) have noted concerns regarding the CPT codes used to report the measure, complicated measure calculations, and burdensome patient record reviews necessary to report data for the measure. Because the burdens of this measure outweigh its benefits to the OQR, CMS proposes to remove the measure beginning with October 2020 encounters.

In addition to this proposal, CMS seeks feedback on potentially adopting four patient safety measures in the OQR in the future. These four measures were previously adopted for the ASC Quality Reporting Program (ASCQR), and include ASC-1: Patient Burn; ASC-2: Patient Fall; ASC-3: Wrong Site, Wrong Side, Wrong Procedure, Wrong Implant; and ASC-4: All-Cause Hospital Transfer/Admission. However, reporting of these measures was suspended in the ASCQR program in last year's final rule due to concerns regarding the accuracy of data reporting for these measures and because they all lost endorsement by the National Quality Forum (NQF). In this rule, CMS states that it would pursue new, HOPD-relevant measure specifications and an updated submission method using a CMS online data submission tool (e.g., QualityNet) if the measures were proposed for adoption in future rulemaking.

HIGHLIGHTS OF THE MEDICARE ASC PROPOSED RULE

ASC Payment Update: For CYs 2019 through 2023, CMS set a policy to update the ASC payment system using the hospital market-basket update instead of the Consumer Price Index for all urban consumers. As such, for CY 2020, CMS proposes to increase payment rates under the ASC payment system by 2.7% for ASCs that meet the ASC quality reporting requirements. This proposed increase is based on a proposed hospital market-basket percentage increase of 3.2% minus a proposed productivity adjustment of 0.5 percentage point. CMS estimates that payments to ASCs would increase by $100 million in CY 2020.

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 would include a total knee arthroplasty procedure, a mosaicplasty procedure, as well as six coronary intervention procedures.

ASC Quality Reporting Program (ASCQR): CMS proposes to adopt one new quality measure in the ASCQR starting with the CY 2024 payment determination. The measure, Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers (ASC-19), is a risk-adjusted outcome measure of acute, unplanned hospital visits (including emergency department visit, observation stay, or unplanned inpatient admission) within 7 days of a procedure that is "within the scope of general surgery training." The measure is claims-based (meaning that ASCs would not need to submit any data to CMS) and would be based on two years of data ending two years prior to the applicable payment determination year; if adopted, the first data collection period would be CYs 2021 to 2022 for CY 2024 payment. The measure received endorsement from NQF in 2018, and was developed in conjunction with two other measures that were adopted in the ASCQR beginning with the CY 2022 payment determination (ASC-17 and ASC-18, Hospital Visits after Orthopedic and Urology ASC procedures, respectively).

Similar to the proposal for the OQR, CMS also seeks comment on potentially re-starting data collection for the four patient safety measures (ASC 1-4) previously adopted for the ASCQR, but whose reporting was suspended due to concerns regarding data accuracy. In this rule CMS states that it would use an updated submission method using a CMS online data submission tool (e.g., QualityNet) if the measures were proposed for use again in the ASCQR. The agency seeks comment on whether using such a data submission method would result in undue burden for ASCs.

OTHER HIGHLIGHTS

Request for Comment on Medicare Cost Reporting Processes and Hospital Chargemaster: Hospitals are required to submit to CMS an annual cost report, which typically includes charges derived from the hospital chargemaster. CMS requests comment on several aspects of the cost reporting process and use of the chargemaster, including:

- the continued value of the chargemaster charges in setting hospital payment;
- the costs associated with maintaining the chargemaster for Medicare cost reporting and reimbursement;
- the potential to modernize or streamline the Medicare cost reporting process;
- the potential impact on submitting charge data to CMS if the chargemaster were modified or replaced; and
- alternative sources that could provide the information necessary to calculate Medicare payments.

CMS also requests comment on the frequency of updating the hospital chargemaster, including the rationale for updating the chargemaster more frequently than on an annual basis and the impact that more frequent updates could have on costs for patients.

NEXT STEPS

CMS will accept comments on this rule through Sept. 27. The final rule will be published around Nov. 1, and the policies and payment rates will take effect Jan. 1, 2020. Watch

for a more detailed analysis of the proposed rule in the coming weeks, as well as an invitation to an AHA members-only call to discuss the proposed rule.

If you have further questions, contact Roslyne Schulman, AHA director of policy, at rschulman@aha.org for questions on payment, Caitlin Gillooley, AHA senior associate director of policy, at cgillooley@aha.org for questions on quality reporting, and Ariel Levin, senior associate director of policy, at alevin@aha.org for questions on price transparency.