CMS Stays the Course

BY CHRISTIAN G. DOWNS, MHA, JD

The Centers for Medicare and Medicaid Services (CMS) released the final Medicare payment rules for calendar year (CY) 2020 in tandem this year on Nov. 1, 2019. Subsequently, on Nov. 15, the agency finalized hospital price transparency proposals originally included in the proposed CY 2020 Outpatient Prospective Payment System (OPPS) with the release of the 2020 Price Transparency Requirements for Hospitals to Make Standard Changes Public final rule. As usual, the OPPS and Medicare Physician Fee Schedule (MPFS) final rules brought both good and not-too-good news for oncology. Though most provisions under these final rules became effective Jan. 1, 2020, the significant new requirements mandated under the price transparency rule do not go into effect until Jan. 1, 2021.

2020 OPPS Final Rule

In comments to the proposed 2020 OPPS rule, ACCC urged CMS not to finalize its proposal to complete phase-in of the payment reduction for clinic visits at excepted off-campus departments. CMS's phased-in decrease in payments to these off-campus departments began under the 2019 OPPS final rule. In 2019, reimbursement for clinic visits at excepted off-campus departments dropped to 70 percent of the standard OPPS rate. Despite a decision by the U.S. District Court of the District of Columbia that CMS's cost-cutting method in this instance is not permissible and violates the agency's statutory obligations, for 2020 CMS chose to stay the course, finalizing the reduction in payment to 40 percent of the OPPS rate.

On Dec. 11, 2019, news service Inside Health Policy reported that CMS plans to "repay hospitals that sued over 2019 pay cuts from the agency's so-called site-neutral policy. The agency has also updated the 2019 pay rates for clinic visits at certain off-campus hospital facilities to remove the cut in light of a federal court decision that said the agency didn't have the authority to implement it." However, CMS has not changed its plans to continue to implement the cuts in 2020 that have been previously vacated by the Federal District Court. Read more at **accc-cancer.org/12-11-2019**.

ACCC also urged the agency not to finalize its proposal to continue to pay for separately payable drugs without pass-through status purchased under the 340B Program at ASP −22.5 percent. This payment reduction is also the subject of ongoing litigation. The U.S. District Court of the District of Columbia found that the secretary of the U.S. Department of Health and Human Services exceeded his authority with these reimbursement cuts; CMS has appealed the decision, and the Court of Appeals has yet to make a final ruling. For 2020, CMS finalizes its proposal to continue to pay for 340B-acquired drugs at ASP −22 percent.

For 2020, CMS finalized the establishment of prior authorization for certain designated hospital outpatient department services. Although the list of covered services that will require prior authorization includes 38 CPT codes and two HCPCS codes, procedures that could be cosmetic—blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation—the introduction of prior authorization may signal the potential broader utilization of this cost containment measure in Medicare.

On the good news front, ACCC, along with other stakeholders, urged that CMS not finalize its proposals to revise the exception to the day of service rule (14-day rule) for molecular pathology tests and certain advanced diagnostic laboratory tests. The proposed changes would have (1) required the ordering physician to determine whether the results of these tests would be intended to guide treatment during any future hospital outpatient encounters and (2) removed molecular pathology tests from the exception completely, so that ordering of these tests would have to comply with the 14-day rule for the laboratory to bill for tests. CMS did not finalize these proposals for 2020. Despite the comments of ACCC and others, however, the agency finalized exclusion of blood banks and centers from the exception.

CMS also finalized its proposal regarding level of supervision of outpatient therapeutic services in hospitals and critical access hospitals. For 2020 the agency finalizes its change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for all hospitals and critical access hospitals. General supervision means that the procedure is furnished under the physician's

overall direction and control but the physician is not required to be present during the performance of the procedure. CMS notes that under this policy the requirement for general supervision is the same for all outpatient therapeutic services, including chemotherapy and radiation therapy services. The agency further comments that this policy does not change the Conditions of Participation, other federal or state regulations, or state scope-of-work standards that might also apply to supervision requirements for certain services.

2020 MPFS Final Rule

The good news from the 2020 MPFS final rule? The impact of changes under the final rule will be negligible for physicians involved in cancer care. Reimbursement for Medicare Part B drugs and biologicals will remain at ASP +6 percent. Non-excepted provider-based departments will continue to be paid at 40 percent of the OPPS rate.

In the 2020 final MPFS rule, CMS drops its plan to create a single payment rate for E/M level 2 through 4 visits that was slated to go into effect Jan. 1, 2021. Instead for 2021, CMS will establish separate work relative value units for level 2 through 4 E/M visits for new and established patients, similar to the current values. CPT code 99201 (Level 1 office/outpatient visit, new patient) will be eliminated, because 99201 and 99202 are both straightforward medical decision making, only distinguished by history and exam elements. Instead Level 1 visits will only describe or include visits performed by clinical staff for established patients (CPT code 99211). For a comprehensive look at coding and billing changes under the CY 2020 OPPS and MPFS, see pages 8-22.

2020 Price Transparency Requirements for Hospitals to Make Standard Changes Public Final Rule

Arguably the most significant change finalized by CMS in November was not under the OPPS or the MPFS but under the 2020 Price Transparency Requirements for Hospitals to Make Standard Changes Public final rule. CMS finalized its proposed new price transparency requirements that originally appeared in the proposed 2020 OPPS rule. Though these new requirements do not go into effect until Jan. 1, 2021, they are substantial. Under the Hospital Price Transparency final rule, nearly all hospitals, including those that do not bill OPPS or are not enrolled in Medicare (excluding federally owned or operated facilities), will be required to:

- **Publicly disclose their "standard charges" for virtually all items and services provided by the hospital.** CMS defines standard charges broadly to include many types of charges; for example, gross charges, payer-specific negotiated charges (as delineated by payer and by plan), discounted cash price charges (i.e., uninsured patient discounted charges), and de-identified maximum and minimum charges. Further, hospitals must display the list of standard charges prominently on the hospital's website and make it easily accessible; that is, free of charge and without login or password requirements.
- **Provide a "consumer-friendly" list of pricing information for 300 "shoppable" services.** CMS defines these as services that can be scheduled in advance by consumers. The list must include 70 CMS-selected shoppable services (if they are provided by the hospital). Hospitals can identify the remaining 230 services.

The agency states that it will use a combination of methods to monitor compliance with these new price transparency requirements. Enforcement will be through civil monetary penalties of up to $300 per day. If hospitals have multiple violations of the price transparency requirements, the maximum penalty remains $300 per day.

On Dec. 4, the American Hospital Association, along with the Association of American Medical Colleges, the Children's Hospital Association, and the Federation of American Hospitals, filed suit in U.S. District Court in Washington, D.C., asserting that the price transparency rule's requirement that hospitals disclose rates negotiated with insurers violates the First Amendment.

During ACCC's Dec. 5 policy webinar with legal experts from Hogan Lovells, presenters urged ACCC members to share their policy concerns now—in January and February before CMS starts to work on next year's proposed rules. ACCC is here to support your advocacy voice. Let us hear from you at policy@accc-cancer.org. OI

Christian G. Downs, MHA, JD, executive director, Association of Community Cancer Centers, Rockville, Md.