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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, CVA, ASA, FACHE, Publisher
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CMS Finalizes 2020 Physician & Outpatient Fee Schedules

The *Centers for Medicare & Medicaid Services* (CMS) recently finalized the calendar year (CY) 2020 *Medicare Physician Fee Schedule* (MPFS), the *Hospital Outpatient Prospective Payment System* (OPPS), and the *Ambulatory Surgical Center* (ASC) Payment System. The final rules generally remained unchanged from their proposed versions, with a couple of exceptions. This *Health Capital Topics* article will briefly review each of these final rules.

MPFS Final Rule Provisions

On November 1, 2019, CMS finalized the 2020 MPFS rule, which includes a number of changes to the payment system.[1] The final 2020 MPFS conversion factor was set at $36.09 (the same amount as set forth in the proposed rule), which it noted was a "*slight increase of $0.05 above the CY [M]PFS conversion factor of $36.04*."[2]

Subsequent to its July 29, 2019 proposed rule, CMS changed course, and collaborated with the *American Medical Association* (AMA) on making changes to the evaluation and management (E/M) services payments.[3] In its final rule, CMS implemented significant changes, based on the AMA Current Procedural Terminology (CPT) Editorial Panel's adopted revisions, for office/outpatient E/M visits, which is set to be implemented in 2021.[4] Part of CMS's reason for the change derives from the goal of reducing the burden on providers of healthcare so the providers may be able to "*focus on what is clinically relevant and medically necessary*."[5]

Importantly, the final rule reduces the number of levels of office/outpatient E/M visits for *new patients* to four, but preserves five levels of coding for *established patients*.[6] Of note, CMS is not applying any of the E/M changes to the global surgery codes.[7] Further, CMS is adopting new time ranges within the CPT codes, as revised by the CPT Editorial Panel.[8] CMS states the rule change with regard to E/M visits "*would further our ongoing effort to reduce administrative burden, improve payment accuracy, and...better reflect the current practice of medicine*."[9]

CMS made modifications in the final rule to the documentation policy to which providers must adhere "*[i]n an effort to reduce mandatory and duplicative medical record evaluation and management*."[10] The final rule allows providers to review and sign notes made by other medical team members, which can include physicians, residents, nurses, and students.[11] No longer will providers be required to re-document notes made by other medical team members, greatly simplifying providers' documentation burden.[12] CMS "*intentionally did not propose to specify who can be included as a member of the medical team*," meaning the definition could include scribes and nutritionists (as noted by CMS).[13]

OPPS Final Rule Provisions

On November 1, 2019, CMS finalized the 2020 OPPS and ASC Payment System rule, which, similar to the MPFS, includes a number of notable changes to the payment systems.[14]

CMS finalized the OPPS payment rates by 2.6%, based on the 3% hospital market basket increase minus a 0.4 percentage point multifactor productivity (MFP) adjustment.[15] The increased payment rates only apply to those hospitals that meet quality reporting requirements.[16] Importantly, CMS is continuing the 2.0% reduction in payment to hospitals failing to meet quality reporting requirements.[17]

Of note, CMS is continuing to proceed with the 340B rate cuts that were previously ruled unlawful, as discussed in the September 2019 *Health Capital Topics* article entitled, "*Judge Strikes Down Site-Neutral Payments Rule*."[18] Medicare will continue to pay an adjusted amount of *average sale price* (ASP) minus 22.5% for separately payable drugs or biologicals that a hospital acquires through the 340B Program.[19] Further, CMS will collect 340B hospital drug acquisition cost data to better assess the implementation of the rate cut.[20] CMS acknowledges that if they are ultimately unsuccessful in litigation regarding the rate cut, this cost data survey may be used to help make plaintiffs whole for the period of time the rate cut was in place and determine a lesser rate reduction that may prevail if litigated.[21]

The OPPS final rule emphatically endorses the idea of "*site-neutrality*,"[22] the policy of eliminating payment differences between various outpatient healthcare facilities, based on the premise that the move would "*control unnecessary increases in the volume of covered outpatient department services*."[23] CMS refrained from making any changes to the two-year phase-in of its site-neutrality policy.[24] CMS estimates that Medicare savings under this policy would total $800 million in 2020, with Medicare beneficiaries saving an average of $14 each time they visit an off-campus hospital clinic in 2020.[25]

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Additionally, the OPPS final rule changes the minimum level of supervision necessary for hospital outpatient therapeutic services from *direct supervision* to *general supervision*.[26] The change dictates that a physician must have overall direction and control, but their physical presence is not necessary.[27] However, CMS does state that "*[o]ur policies on supervision, along with hospital conditions of participation*" are dictated by state law, especially state scope of practice laws.[28]

ASC Payment System Final Rule Provisions

For 2020, the final rule raised the ASC payment rate to 2.6%, based on the 3% hospital market basket increase minus a 0.4 percentage point MFP adjustment.[29] CMS did not change its relatively new policy to use the hospital market basket update for ASC payment rates for CYs 2020-2023.[30] CMS openly endorses the idea of shifting services from the inpatient hospital setting to the lower-cost ASC setting and will evaluate whether their policies facilitate this shift.[31] CMS will "*assess whether there is a migration of the performance of procedures from the hospital setting to the ASC setting as a result of the use of a hospital market basket update*" in five years to ensure there are no "*unintended consequences, such as less than expected migration*."[32] Moreover, the final rule adds new procedures to its list of the procedures that Medicare will cover in an ASC setting, including total knee arthroplasty, a mosaicplasty procedure, and six coronary intervention procedures.[33]

Importantly, CMS did not propose any cost reporting requirements for ASCs, indicating that ASCs have put off the obligation for yet another year despite the recommendations of the *Medicare Payment Advisory Commission* (MedPAC) to institute ASC cost reporting requirements.[34] ASC cost reporting and reimbursement trends are further explored in the November 2019 *Health Capital Topics* article title, "*Valuation of Ambulatory Surgery Centers (ASC): Reimbursement*."

Conclusion

While these finalized rules continue the overall healthcare initiative of CMS and the Trump Administration to "*Improv[e] Price and Quality Transparency in American Healthcare to Put Patients First*," the ultimate impact of this agenda on providers is still indeterminate. However, it is fair to assume that this regulatory push to slow increasing healthcare costs is just the beginning.

1 "Finalized Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020" Centers for Medicare & Medicaid Services, November 1, 2019, https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar (Accessed 11/15/19).
2 *Ibid.*
3 After receiving pushback the AMA on the proposed E/M revisions, CMS collaborated with the AMA on revising these proposals for the final rule. "Medicare Program: CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc.: Proposed Rule" Federal Register Vol. 84, No. 157 (August 14, 2019), p. 40673-40674.
4 "Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule" Federal Register Vol. 84, No. 221 (November 15, 2019), p. 62846-62847.
5 *Ibid*, p. 62846.
6 *Ibid*, p. 62847.
7 *Ibid*, p. 62858.
8 *Ibid*, p. 62848.
9 *Ibid*, p. 62847.
10 *Ibid*, p. 62681.
11 *Ibid*, p. 62682.
12 *Ibid.*
13 *Ibid*, p. 62684.
14 "CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)" Centers for Medicare & Medicaid Services, November 1, 2019, https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 11/15/19).
15 "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots" Federal Register, Vol. 84, No. 218 (November 12, 2019), p. 61145.
16 Centers for Medicare & Medicaid Services, November 1, 2019.
17 Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61145.
18 "Judge Strikes Down Site-Neutral Payments Rule" Health Capital Topics, Vol. 12, Issue 9 (September 2019), https://www.healthcapital.com/hcc/newsletter/09_19/HTML/MODEL/convert_site_neutral_model_hc_topics_draft-9.24.19.php (Accessed 11/15/19).
19 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. Centers for Medicare & Medicaid Services, November 1, 2019; Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61145.
20 Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61145.
21 *Ibid.*
22 *Ibid*, p. 61386.
23 CMS points to MedPAC research showing an average increase of 8.6% per year of OPPS spending. Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61337, 61366.
24 *Ibid*, p. 61337.
25 Centers for Medicare & Medicaid Services, November 1, 2019.
26 Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61363.
27 Centers for Medicare & Medicaid Services, November 1, 2019.
28 Federal Register, Vol. 84, No. 218, November 12, 2019, p. 61362.
29 *Ibid*, p. 61145.
30 *Ibid*, p. 61408.
31 *Ibid.*
32 *Ibid.*
33 *Ibid*, p. 61145.
34 *Ibid*, p. 61370.

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Todd A. Zigrang, MBA, MHA, CVA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President & General Counsel of HCC, where she focuses on project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. She has presented before associations such as the American Bar Association and NACVA.

John R. Chwarzinski, MSF, MAE, is Senior Vice President of HCC, where he focuses on the areas of valuation and financial analysis of healthcare enterprises, assets and services. Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's of Science in Finance Degree from the John M. Olin School of Business at Washington University in St. Louis. He has presented before associations such as the National Association of Certified Valuators and Analysts; the Virginia Medical Group Management Association; and, the Missouri Society of CPAs. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, and economic and quantitative financial analysis.

Daniel J. Chen, MSF, CVA, focuses on developing Fair Market Value and Commercial Reasonableness opinions related to healthcare enterprises, assets, and services. In addition he prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams. Mr. Chen holds the Certified Valuation Analyst (CVA) designation from NACVA.

Paul M. Doelling, MHA, FACMPE, has over 25 years of healthcare valuation and operational management experience and he has previously served as an administrator for a number of mid to large-sized independent and hospital-owned physician practice groups. During that time, he has participated in numerous physician integration and affiliation initiatives. Paul has authored peer-reviewed and industry articles, as well as served as faculty before professional associations such as the Medical Group Management Association (MGMA) and the Healthcare Financial Management Association (HFMA). He is a member of MGMA, as well as HFMA where he previously served as President of the Greater St. Louis Chapter.

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