HEALTH CAPITAL Topics ©
Volume 13
Issue 12
December 2020
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CMS Finalizes 2021 Physician & Outpatient Fee Schedules

The *Centers for Medicare & Medicaid Services* (CMS) recently released the final rules for the *calendar year* (CY) 2021 *Medicare Physician Fee Schedule* (MPFS), *Hospital Outpatient Prospective Payment System* (OPPS), and *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 those major changes and the possible impacts of CMS's CY 2021 final rules, which will go into effect on January 1, 2021.

MFPS Final Rule Provisions

On December 1, 2020, CMS finalized the MPFS for 2021, which includes a number of changes to the payment system. A lower conversion factor, *evaluation and management* (E/M) coding and rate changes, and permanent telemedicine expansion were among some of the major changes included in this MPFS final rule.

Major Changes Coming in 2021

The final 2021 MPFS rule includes several significant alterations from the 2020 MPFS rule:

(1) The conversion factor decreased from $36.09 in CY 2020 to $32.41 for CY 2021;[1]
(2) More sustainable telemedicine reimbursement, similar to what was suggested in the proposed rule, was also included. The final rule adds numerous telemedicine procedure codes, either permanently or temporarily, to those currently covered by Medicare. Over 60 of the new codes will be covered temporarily through the end of the current COVID-19 *public health emergency* (PHE), while many others are set to be covered until the end of the PHE;[2]
(3) Direct physician supervision through telecommunications will be allowed through the end of the CY in which the PHE ends, while certain diagnostic tests will be able to be furnished by *nonphysician practitioners* (NPPs) permanently;[3] and,
(4) Payment rates for many surgical and other provider specialties changed significantly. The rates for many surgeries decreased by 6% to 8%,[4] while specialties such as family practice saw their payment rates increase.[5] These noteworthy changes have been the subject of much debate and controversy, both in response to the proposed rule and this final rule, as discussed below.

Changes from the MPFS Proposed Rule

CMS made some minor changes in the MPFS final rule. For example, the final conversion rate is $32.41, a decrease from 2020, but slight increase from the proposed conversion factor of $32.26.[6]

As set forth in the table below, small changes were also made to several payment rates in the final rule, with most changes only decreasing approximately 1% from the proposed rate (if the rate was changed at all).

Comparison of 2020 Payment Rates to 2021 Payment Rates (Proposed and Final)[7]

Physician Specialty	Percent Change from CY 2020 (Proposed Rule)	Percent Change from CY 2020 (Final Rule)
Anesthesiology	-8%	-8%
Cardiac Surgery	-9%	**-8%**
Family Practice	14%	**13%**
Hematology/Oncology	14%	14%
Interventional Radiology	-9%	**-8%**
Neurosurgery	-7%	**-6%**
Ophthalmology	-6%	-6%
Radiology	-11%	**-10%**
Thoracic Surgery	-8%	-8%
Vascular Surgery	-7%	**-6%**

CMS also slightly altered the telemedicine codes to be covered under Medicare: 9 codes were covered permanently and 59 through the year after the PHE ends.[8] However, the main focus on emergency department visits, therapy, and critical care remained the same.

Stakeholder Reactions

Several industry stakeholders, including the *Medical Group Management Association* (MGMA), *American College of Emergency Physicians* (ACEP) and *American College of Surgeons* (ACS), were quick to release statements after CMS published its 2021 MPFS final rule. While some acknowledged CMS's efforts to streamline documentation and reduce paperwork, the majority of reactions were highly critical of the decreased payment rates for many providers.[9] Many asserted that CMS "*ignores [the] impact of [the] pandemic*" in its decisions to lower payments for subspecialties.[10] These organizations cited the financial hardship felt by many providers during the COVID-19 PHE and the immense strain on many areas of the healthcare system.[11] ACS

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even called upon Congress to block the payment rate changes and keep rates the same while the pandemic continues on into 2021.[12]

OPPS & ASC Payment System Final Rule Provisions

On December 2, 2020, CMS finalized the 2021 OPPS and ASC Payment System rule, which includes a number of notable changes to the payment systems. Some of the more notable changes included in the final rule include the elimination of the inpatient only list, expansion of the ASC covered procedures list, and continuation of 340B drug reimbursement cuts. Additionally, the final rule included updates to OPPS and ASC payment rates, as well as to Quality Star Rating calculations.

Elimination of the Inpatient Only (IPO) List

CMS finalized its proposal to eliminate the IPO list over a three-year transitional period.[13] The IPO list is comprised of 1,740 services for which Medicare will only reimburse when performed in an inpatient setting.[14] The phasing-out of the IPO list will begin with the removal of 266 musculoskeletal-related services, plus an additional 32 HCPCS codes.[15] Beginning January 1, 2021, the services removed from the IPO list will be eligible for Medicare reimbursement in an outpatient setting, when outpatient care is deemed medically appropriate.[16]

Expansion of the ASC Covered Procedure List (CPL)

The final rule also added eleven procedures to the ASC CPL.[17] Additionally, the final rule included changes to the criteria under which procedures can be added to the ASC CPL, with the intention of expanding the ASC CPL in future years. Currently, which procedures can be added to the ASC CPL is determined by a set of general standard criteria (which applies to all potential ASC CPL procedures)[18] and a set of general exclusion criteria (which apply to certain potential ASC CPL procedures).[19] The 2021 OPPS final rule specifies that the new criteria governing which procedures can be added to the ASC CPL will keep the general standard criteria, while eliminating five of the general exclusion criteria.[20] It is believed that the advancements in technology and medical procedures has enhanced the safety of procedures performed in ASCs and justifies the removal of the five of the general exclusion criteria.[21]

Notably, this method of allowing for the expansion of the ASC CPL was one of two methods proposed in the 2021 OPPS proposed rule. Alternatively, it was proposed that the criteria for procedures to be added to the ASC CPL would be modified, and stakeholders would be permitted to nominate procedures to be added to the ASC CPL.[22] After a commenting period, CMS ultimately decided that eliminating the exclusion criteria while upholding the general standards would allow for more immediate expansion of the ASC CPL.[23] Revisions to this criteria will allow for an additional 267 surgical procedures to be added to the ASC CPL in 2021.[24]

Continuation of 340B Drug Reimbursement Cuts

Currently, 340B hospital and provider participants pay an adjusted amount of *average selling price* (ASP) minus 22.5% for drugs purchased under the 340B program.[25] This adjusted amount was originally set forth in the CY 2018 OPPS final rule.[26] Since the rule was finalized, CMS's authority to adjust 340B payment rates to ASP - 22.5% from the previous payment rate of ASP +6% has been highly contested and has been the subject of ongoing litigation.[27] However, on July 31, 2020, CMS's authority to move forward with these cuts was upheld by the U.S. Court of Appeals for the D.C. Circuit.[28]

The final rule maintains the adjusted payment amount of ASP -22.5%, which differs from the adjusted payment amount originally proposed. The OPPS proposed rule originally suggested a net adjusted payment amount of -28.7%, based on results from the *Hospital Acquisition Cost Survey for 340B-Acquired Specified Covered Drugs*.[29] The proposed rule also suggested a continuation of the current adjusted payment amount of ASP -22.5% as an alternative.[30] While this decision is favorable to hospitals compared to the originally proposed adjusted payment amount, it has nonetheless been met with significant backlash from stakeholders.[31]

Increased Flexibility Physician-Owned Hospitals

The 2021 OPPS final rule removes "*unnecessary regulatory restrictions*" on high Medicaid facilities,[32] originally set forth by the *Patient Protection and Affordable Care Act* (ACA).[33] The ACA included a provision that prohibits pre-existing physician-owned hospitals from expanding the number of operating rooms, procedure rooms, or beds in their facilities.[34] The final rule includes a revision to this restriction that will now: allow physician-owned hospitals classified as "*high Medicaid facilities*" to apply for an expansion exception once every two years; no longer cap the number of beds that can be approved in that exception; and, no longer limit expansion to only facilities that are located on the hospital's main campus.[35]

Payment Rate Updates

CMS finalized an increase in both OPPS and ASC payment rates. Payment rates will increase by 2.4% in 2021 for hospital outpatient departments (HOPDs) that meet the requisite quality reporting criteria.[36] This payment increase is based on a projected hospital market basket increase of 2.4%, with a 0% adjustment for *multi-factor productivity* (MFP).[37] This payment rate increase is slightly lower than the proposed payment increase of 2.6%, which was based on a projected hospital market basket increase of 3.0% with a 0.4% MFP adjustment.[38] Additionally, payment rates for HOPDs that do not meet the requisite quality reporting criteria will be reduced by 2% through the application of a 0.9805 factor to OPPS payments and copayments for all applicable services.[39]

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Based upon these updates, payments to OPPS providers during CY 2021 are expected to total approximately $83.888 billion.[40] This projection is approximately $7.541 billion greater than the estimated CY 2020 OPPS payments and is consistent with the projections included in the proposed rule.[41]

ASC payment rates will also increase by 2.4%, based on the same calculation applied to OPPS payment rates, for an estimated total of $5.42 billion to ASCs in CY 2021, an increase of approximately $120 million from the CY 2020 ASC payment projection.[42]

Quality Reporting Updates

In an effort to reduce administrative burden and improve operational efficiencies as a part of the *Patients over Paperwork Initiative*,[43] the 2021 OPPS final rule includes changes to the methodology used to calculate the Overall Hospital Quality Star Rating.[44] The changes to the Overall Star Rating methodology aim to simplify the calculation process and improve the predictability of a provider's Overall Star Rating over time.[45] In addition to these methodology updates, critical access hospitals (CAHs) and Veterans Health Administration (VHA) hospitals will be added to the Overall Star Rating program in CY 2021.[46]

In contrast, no measures were added or removed from the Hospital Outpatient Quality Reporting (OQR) or the Ambulatory Surgical Center Quality Reporting (ASQR) Program reporting requirements.[47] However, the 2021 OPPS final rule does detail changes to update and refine the administrative and reporting requirements for the OQR and ASQR programs in order to emphasize quality care and improve measurements.[48]

Response from Stakeholders

Stakeholders responded favorably to some of policies detailed in the OPPS and ASC final rule, while expressing discontentment with other policies. Industry groups such as Premier and the American Hospital Association (AHA) spoke out against the elimination of the IPO list, arguing that this decision, "*without clinical guidance or best practices for determining site of service*," could negatively impact the safety of patients.[49] Meanwhile, the *Ambulatory Surgery Center Association* (ASCA) praised CMS's revision to the ASC CPL criteria, stating that "*CMS should be commended for recognizing that ASCs are increasingly able to safely provide a greater range of services as medical practice evolves*."[50]

As previously mentioned, there was significant backlash from stakeholders in response to the finalized 340B drug reimbursement rates. Tom Nikels, Executive Vice President of the AHA, released a statement criticizing the final rule for placing financial burden on 340B hospitals who have already faced significant financial hardships as a result of COVID-19. Other industry groups echoed Nikels's concerns.[51]

Additional criticism was propagated by industry groups in response to the easing of restrictions on qualified physician-owned hospitals. A statement released by the AHA cited its long standing opposition of loosening restrictions on physician-owned hospitals and criticized physician-owned hospitals for "*cherry-picking patients*" and contributing to higher utilization of healthcare services and higher costs.[52]

Conclusion

While these finalized rules continue the overarching initiative of CMS and the Trump Administration to "*Improv[e] Price and Quality Transparency in American Healthcare to Put Patients First*," [53] the ultimate impact of this agenda on providers is still indeterminate. As previously mentioned, many stakeholders remain concerned over the impact these new policies will have on providers in light of the financial strain many are experiencing as a result of COVID-19. However, these rules reflect a growing effort to increase options patients have over treatment location and continue to prioritize and reduce the administrative burden placed on providers.

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1 "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc." Federal Register Vol. 85, No. 159 (August 17, 2020), p. 50373; "Medicare Program; CY 2020 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc." Federal Register Vol. 84, No. 221 (November 15, 2019), p. 63152; "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; etc." Table 104.

2 "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients" Centers for Medicare and Medicaid Services, December 1, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment (Accessed 12/2/20).

3 "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021" Centers for Medicare and Medicaid Services, December 1, 2020, https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1 (Accessed 12/2/20).

4 "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; etc." Table 106.

5 *Ibid.*

6 Federal Register Vol. 85, No. 159, p. 50373.

7 Note that this is not an exhaustive list of payment rate changes, but rather some examples of the largest increases/decreases; bolded values represent a change from the proposed rule to final rule for the MPFS 2021. "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; etc." Table 106.

8 *Ibid.*

9 "December 1, 2020: MGMA statement on the 2021 Physician Fee Schedule Final Rule" Medical Group Management Association, December 1, 2020, https://www.mgma.com/advocacy/advocacy-statements-letters/advocacy-statements/december-1,-2020-mgma-statement-on-the-2021-physi (Accessed 12/2/20); "American College of Surgeons calls on Congress to prevent CMS Medicare Physician Fee Schedule from taking effect" American College of Surgeons, December 1, 2020, https://www.facs.org/media/press-

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10 American College of Surgeons, December 1, 2020.
11 Medical Group Management Association, December 1, 2020; American College of Surgeons, December 1, 2020; "ACEP Responds to Finalized 2021 Physician Fee Schedule Cuts" American College of Emergency Physicians, December 1, 2020, https://www.emergencyphysicians.org/press-releases/2020/12-1-20-acep-responds-to-finalized-2021-physician-fee-schedule-cuts (Accessed 12/2/20).
12 American College of Surgeons, December 1, 2020.
13 "CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC)," Centers for Medicare and Medicaid Services, December 1, 2020, https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 12/8/20).
14 "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report COVID-19 Therapeutic Inventory and Usage and to Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19)", CMS-1736-FC, 1736-IFC (December 2, 2020), p.678-679
15 *Ibid*, p.17-18
16 Centers for Medicare and Medicaid Services, December 1, 2020.
17 *Ibid.*
18 As set forth in 42 C.F.R. § 416.166(b), procedures on the ASC CPL must not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC and must not require, under standard medical practice, that a beneficiary be actively monitored by medical personnel or require care at midnight following the procedure.
19 Currently, services that meet any of the general exclusion criteria set forth in Section 42 C.F.R. § 416.166(c), cannot be added to the ASC CPL. These exclusion criteria include surgical procedures that: (1) generally result in extensive blood loss; (2) require major or prolonged invasion of body cavities; (3) directly involve major blood vessels; (4) are generally emergent or life threatening in nature; or (5) commonly require systemic thrombolytic therapy.
20 CMS-1736-FC, 1736-IFC (December 2, 2020), p. 814.
21 *Ibid*, p.841
22 *Ibid*, p.831
23 *Ibid*, p.833
24 Centers for Medicare and Medicaid Services, December 1, 2020.
25 *Ibid.*
26 *Ibid.*
27 CMS-1736-FC, 1736-IFC (December 2, 2020), p.541-542
28 Centers for Medicare and Medicaid Services, December 1, 2020.
29 CMS-1736-FC, 1736-IFC (December 2, 2020), p.581
30 Federal Register Vol. 85, No. 156 (August 12, 2020), p. 48775.
31 "Hospitals Criticize Major Policy Moves in 2021 OPPS Final Rule," by Jacqueline LaPointe, Revcycle Intelligence, December 4, 2020, https://revcycleintelligence.com/news/hospitals-criticize-major-policy-moves-in-2021-opps-final-rule (Accessed 12/8/20).
32 High Medicaid hospitals are those that: (1) are located in a county with a 5-year population growth rate that is at least 150% of the state 5-year population growth rate; (2) serve an equal to or greater percentage of Medicaid patients than the average of all hospitals in the county; (3) do not discriminate against beneficiaries of federal health care programs; (4) are located in a state with an average be capacity in the state less than the national average bed capacity; and (5) has an average bed occupancy rate greater than the state average bed occupancy rate. CMS-1736-FC, 1736-IFC (December 2, 2020), p. 1160.
33 *Ibid*, p. 22.
34 *Ibid*, p.1160
35 *Ibid*, p.1165
36 Centers for Medicare and Medicaid Services, December 1, 2020.
37 *Ibid.*
38 Federal Register Vol. 85, No. 156 (August 12, 2020), p. 48774.
39 CMS-1736-FC, 1736-IFC (December 2, 2020), p.17
40 *Ibid*, p.17
41 *Ibid.*
42 *Ibid*, p.20
43 "Patients Over Paperwork Fact Sheet," Centers for Medicare and Medicaid Services, August 2019, https://www.cms.gov/About-CMS/Story-Page/Patients-Over-Paperwork-fact-sheet.pdf (Accessed 12/17/20).
44 Centers for Medicare and Medicaid Services, December 1, 2020.
45 *Ibid*.
46 *Ibid.*
47 *Ibid.*
48 *Ibid.*
49 "Statement on the Outpatient Prospective Payment System Final Rule," Premier, Inc., December 2, 2020, https://www.premierinc.com/newsroom/policy/statement-on-the-outpatient-prospective-payment-system-final-rule (Accessed 12/8/20); "AHA Statement on CY 2021 OPPS Final Rule," Tom Nickels, American Hospital Association, December 2, 2020, https://www.aha.org/press-releases/2020-12-02-aha-statement-cy-2021-opps-final-rule (Accessed 12/8/20); LaPointe, December 4, 2020.
50 "2021 Final Medicare Payment Rule Released" Ambulatory Surgery Center Association, December 2, 2020, https://www.ascassociation.org/asca/aboutus/latestnews/newsarchive/newsarchive2020/december2020/202012-2021cmsfinalrule (Accessed 12/8/20); "LaPointe, December 4, 2020.
51 Tom Nickels, December 2, 2020; LaPointe, December 4, 2020.
52 *Ibid.*
53 "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First," The White House, June 24, 2019, https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/ (Accessed 12/17/20).

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