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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: August 1, 2019

Re: Summary of the CY 2020 Medicare Hospital Outpatient Prospective Payment System Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) published the 2020 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule on July 29, 2019. The following is a summary of proposals relevant to AAHKS members' surgical practices, as well as other initiatives significant to providers more broadly. CMS is seeking feedback and comments on its proposals no later than September 27, 2019.

Total Hip Arthroplasty and the Inpatient-Only List (IPO)

- CMS proposes to remove CPT code 27130 (THA) from the IPO list. As such, providers would be able to bill Medicare for THA performed during a hospital outpatient stay. Medicare would continue to reimburse providers for THA as an inpatient procedure if the patient's admission spans at least two midnights.[1]

- CMS believes that CPT 27130 meets two of the criteria used in considering the removal of procedures from the IPO: (1) "the simplest procedure described by the code may be performed in most outpatient departments" and (2) the procedure is related to codes that CMS has already removed from the IPO list. CMS invites public comments on whether THA meets these two criteria.

- CMS notes comments received by stakeholders since 2018 that THA could be provided on an outpatient basis for *some* Medicare beneficiaries given thorough preoperative screening by medical teams with significant experience and expertise in hip replacement. These comments noted "significant success involving same day discharge for patients who met the screening criteria and whose experienced medical teams were able to perform the procedure early enough in the day for the patients to achieve postoperative goals, allowing home discharge by the end of the day."

[1] An exception to the 2-midnight rule may be made on a case-by-case basis if the admitting physician reasonably believes the admission will span 2 midnights, or if the admitting physician believes inpatient admission status is otherwise medically necessary for a stay of less than 2 midnights.

- For THA and any other procedures removed from the IPO in 2020, CMS proposes such procedures would be exempt for one year from referrals by Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) to Recovery Audit Contractors (RACs) for "patient admission status" reviews. BFCC-QIOs would still review select claims and "educate" providers on compliance with the 2-midnight rule. CMS invites comments on the appropriate time period for such an exemption. CMS proposes that the present exemption from RAC referrals for TKA admission status would expire in 2020.

- CMS proposes to assign reimbursement for outpatient THA to the Level 5 Musculoskeletal Procedures Ambulatory Payment Classification (C-APC) 5115 with status indicator J1, which has a geometric mean cost of $11,879.66.[2]

Total Knee Arthroplasty and Ambulatory Surgical Centers (ASCs)

- CMS seeks to add TKA to the ASC Covered Surgical Procedures List (CPL) in CY 2020.

- CMS notes its ongoing policy to promote site neutrality and its agreement "that that there is a *small subset* of Medicare beneficiaries who may be suitable candidates to receive TKA procedures in an ASC setting *based on their clinical characteristics*." CMS further notes:
    - In 2016, more than 800 TKAs were successfully performed in ASCs on Medicare Advantage patients
    - Following removal of TKA from the IPO, only 18% of TKAs moved from the inpatient to outpatient settings in 2018

- CMS solicits public comment on methods to ensure Medicare beneficiaries receive surgical procedures in the ASC setting only as clinically appropriate.

Proposed Payment Updates

- Outpatient Prospective Payment System: The proposed rule seeks to increase the 2020 payment rates by 2.7% compared to CY 2019.

- ASC payment system: For CYs 2019 through 2023, CMS proposes to update the ASC payment system using the updated hospital market basket instead of the Consumer Price Index for all urban consumers (CPI- U). CMS projects a rate increase of 2.7% in 2020.

[2] CMS compares this to the 50th percentile IPPS payment level for DRG 470 of approximately $11,900 for 2020.

Making Hospital Standard Charges Transparent

- CMS proposes to require hospitals to make public their standard charges (both gross charges and payer-specific negotiated charges) *for all items and services* online in a machine-readable format. CMS believes the information and format is most useful for developers who could use these data in consumer-friendly price transparency tools, or who may integrate the data into electronic medical records and shared decision making tools at the point of care.

- CMS further proposes "consumer-friendly" transparency for gross standard charges and payer-specific negotiated charges for a limited set of "shoppable services." Those are services that can be scheduled by a health care consumer in advance, such as joint arthroplasty.

- CMS's proposal includes monitoring and enforcement capabilities to ensure hospital compliance with the price transparency requirements. CMS would assess a monetary penalty after providing a warning notice to the hospital, or after requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

- CMS is not proposing to remove any ASCOR Program measures this year as its analysis of the current measure set indicates that there are no measures that meet the measure removal factors following last year's comprehensive removal initiative.

- CMS is proposing to adopt 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).

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