



### **Additional Cuts of 10% to Multiple Surgical Procedures, Including TKA and THA**

- The Medicare statute requires that any increases or decreases in RVUs may not cause the amount of Medicare PFS expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. When this threshold is exceeded, CMS makes other increases or cuts in the PFS to maintain “budget neutrality.” In general, this means that increases in RVUs, if not offset by other decreases in RVUs, will be offset by a reduction in all procedures rates through an adjustment to the PFS conversion factor.
- In this case, largely due to increases in 2021 in Medicare expenditures under improved rates for E/M services, CMS is reducing the PFS conversion factor by 10.61% to maintain “budget neutrality” in the PFS.
- *This 10% reduction applies to CPTs 27130 and 27447, in addition to the cuts due to the reduction in work RVUs.*
- As this cut is broadly applicable across surgical specialties, a coalition of such specialty societies is lobbying Congress to waive Medicare's budget neutrality requirements.

### **Major Updates to the Quality Payment Program (QPP) Delayed Beyond 2021**

- In 2019, CMS released a Request for Information to stakeholders related to revising the Medicare QPP Merit-based Incentive Payment System (MIPS) to reduce reported complexities with data submission, confusion surrounding measure selection, and lower barriers to APM participation through a new framework called MIPS Value Pathways (MVPs).
- At the time, AAHKS provided extensive technical commentary and suggestions related to facilitating CMS' intention to create sets of measure options that CMS says “would be more relevant to clinician scope of practice and meaningful to patient care by connecting MIPS measures across the four performance categories specific to specialty or condition.”
- CMS intended to implement MVPs in the Medicare program in 2021. In light of pressures on providers due to the COVID-19 pandemic, CMS will not implement MVPs at this time but will instead work on revising the future program's guiding principles

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## **OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM**

### **Proposed Payment Updates**

- OPPTS: The proposed rule seeks an Outpatient Department (OPD) fee schedule increase factor of 2.6%, which will raise OPPTS rates across the board.
- Medicare ambulatory surgical center (ASC) Payment System: CMS proposes increasing CY 2021 payment rates by 2.6 percent for ASCs that meet the quality reporting requirements under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program using the hospital market basket methodology.
- CMS proposes continuing to implement the statutory 2 percentage point reduction in payments to hospitals failing to meet the hospital outpatient quality reporting requirements.

### **Elimination of the Medicare Inpatient Only (IPO) List by 2024**

- The IPO list was created by CMS in 2000 using its discretionary authority. CMS no longer believes that the IPO list is necessary to identify services that require inpatient care.
  - CMS is persuaded by prior commenters who state that the physician should use his or her clinical knowledge and judgment, together with consideration of the beneficiary's specific needs, to determine whether a procedure can be performed appropriately in a hospital outpatient setting or whether inpatient care is required for the beneficiary, subject to the general coverage rules requiring that any procedure be reasonable and necessary.
  - CMS also believes there have been significant developments in the practice of medicine that allow numerous services to be provided safely and effectively in the outpatient setting.
- CMS will begin by removing approximately 300 musculoskeletal-related services from the IPO list in 2021, including procedures identified by the following CPT codes:
  - 27702 (Arthroplasty, ankle; with implant [total ankle]);
  - 27703 (Arthroplasty, ankle; revision, total ankle);
  - 27445 (Arthroplasty, knee, hinge prosthesis [for example, walldius type]);
  - 27487 (Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component)
  - 27488 (Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee)
  - 27125 (Hemiarthroplasty, hip, partial [for example, femoral stem prosthesis, bipolar arthroplasty]);
  - 27132 (Conversion of previous hip surgery to total hip with or without autograft or allograft);
  - 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft);

- 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft);
  - 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft); and
  - 27140 (Osteotomy and transfer of greater trochanter of femur [separate procedure]).
- CMS is soliciting comments on whether 3 years is an appropriate time frame to eliminate the IPO list, comments regarding other services that might be candidates for removal in 2021, and comments on the sequence of removing additional clinical families and/or specific services in future rulemaking.

### **Interaction between Inpatient Hospital Admissions and the 2-Midnight Rule**

- As procedures are removed from the IPO list, the Medicare 2-Midnight Rule applies, which CMS describes as:
  - “Surgical procedures, diagnostic tests, and other treatments would be generally considered appropriate for inpatient hospital admission *and payment under Medicare Part A* when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based upon that expectation. Conversely, when a beneficiary enters a hospital for a surgical procedure not designated as an IPO procedure . . . , and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally *inappropriate for payment under Medicare Part A*, regardless of the hour that the beneficiary came to the hospital or whether the beneficiary used a bed.”
- CMS proposes that for the first 2 years following a procedure’s removal from the IPO list, that procedure would be exempt from:
  - Automatic site-of-service claim denials;
  - Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to RACs; and
  - RAC reviews for “patient status” (or site-of-service)
- During this 2 year exemption, BFCC-QIO reviews of short-stay inpatient claims could still be reviewed for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule, but claims would not be denied based on site of service alone.

### **Changes to the List of ASC Covered Surgical Procedures**

- CMS proposes adding THA and 10 other procedures to the ASC covered procedures list (CPL). Specifically addressing THA, CMS stated that for CY 2021, it will continue promoting site neutrality where possible between hospital outpatient departments and ASC settings and seeks to expand the ASC-CPL to include as many procedures as reasonably possible. CMS proposed adding THA to the CPL based on their belief that a subset of

Medicare beneficiaries may be suitable candidates to receive THA procedures in ASC setting, physicians should continue exercising clinical judgment for site-of-service determinations, and THA meets existing regulatory requirements for covered surgical procedures in the ASC setting.

- CMS proposes two methods to change the way procedures are added to the ASC CPL:
  - CMS would establish a nomination process and external stakeholders, including professional specialty societies, would use suggested parameters to nominate procedures that can be safely performed in ASC settings and that meet all other regulatory standards.
  - Or, CMS would revise the criteria for covered surgical procedures for ASCs by keeping the general standards and eliminating 5 of the general exclusions, which would add approximately 270 surgery or surgery-like codes to the CPL that are not on the CY 2020 IPO list. CMS also solicits comments on whether the conditions for coverage for ASCs should be revised under this approach.

### **Physician-Owned Hospitals**

- CMS proposes removing certain restrictions on the expansion of physician-owned hospitals that qualify as “high Medicaid facilities.” Specifically, CMS proposes removing the restriction that only permitted expansion of facility capacity if the expansion would not result in the number of operating rooms, procedure rooms, and beds for which the hospital was licensed to exceed 200% of the hospital's baseline number of operating rooms, procedure rooms, and beds. CMS also proposes removing the restriction that permitted expanded facility capacity only in facilities on the hospital's main campus.
- CMS proposes permitting “high Medicaid facilities” to request an exception to the prohibition on expansion of facility capacity more frequently than once every two years, provided that the hospital submits only one expansion exception request at a time.
- A “high Medicaid facility” is defined as a hospital that:
  - is not the sole hospital in a county;
  - with respect to each of the 3 most recent 12-month periods for which data are available, has an annual percent of total inpatient admissions under Medicaid that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and
  - does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries
- CMS proposes that, for purposes of determining the number of beds in a physician-owned hospital's baseline number of operating rooms, procedure rooms, and beds, a bed is included if the bed is considered licensed for purposes of State licensure, regardless of the specific number of beds identified on the physical license issued to the hospital by the State.

Code (DRG/CPT)	2017		2018		2019		2020		2021		% Change from 2020
	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	
<b>IPPS<sup>1,2</sup></b>											
<b>469</b>	3.2906	\$19,756.47 <sup>3</sup>	3.201	\$17,837.66	3.1742	\$17,921.78	3.1399	\$18,200.84	3.0989	\$18,530.61	+1.8%
<b>470</b>	2.0671	\$11,777.82 <sup>4</sup>	2.0543	\$11,447.64	1.9898	\$11,234.56	1.9684	\$11,410.09	1.9104	\$11,423.69	+0.1%
<b>521<sup>5</sup></b>	--	--	--	--	--	--	--	--	3.0652	\$18,329.99	--
<b>522<sup>6</sup></b>	--	--	--	--	--	--	--	--	2.1943	\$13,121.34	--
<b>OPPS</b>											
<b>27130</b>	--	--	--	--	--	--	147.2988	\$11,899.38	150.0479	\$12,558.56	+5.5%
<b>27447</b>	--	--	128.7225	\$10,122.22	134.7827	\$10,713.88	147.2988	\$11,899.38	150.0479	\$12,558.56	+5.5%
<b>27429*</b>	110.4967	\$4,974.12	128.7225	\$10,122.22	134.7827	\$10,713.88	147.2988	\$11,899.38	150.0479	\$12,558.56	+5.5%
<b>ASC</b>											
<b>27130</b>	--	--	--	--	--	--	--	--	182.1815	\$8,923.98	--
<b>27447</b>	--	--	--	--	--	--	180.3081	\$8,609.17	180.9903	\$8,865.63	+2.9%
<b>27429*</b>	110.4967	\$4,974.12	111.2415	\$5,069.83	151.2694	\$7,041.74	224.0958	\$10,717.80	215.2574	\$10,544.176	-1.7%
<b>PFS</b>											
<b>27130<sup>7</sup></b>	35.8887	\$1,403.61	35.9996	\$1,409.74	36.039	\$1,408.77	36.0896	\$1,415.07	32.2605	\$1,222.02	-13.7%
<b>27447<sup>8</sup></b>	35.8887	\$1,402.89	35.9996	\$1,408.30	36.0391	\$1,408.05	36.0896	\$1,413.27	32.2605	\$1,220.41	-13.7%

<sup>1</sup> **National Payment Amount** – Projected by CMS of the baseline amount that will be paid nationally for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. *With the exception of 2017, see footnote 2.*

<sup>2</sup> Assumes hospital reported quality data and is a meaningful EHR user.

<sup>3</sup> **National Average Amount** – Amount calculated in later years that represents that average amounts actually paid to facilities for Medicare's share of the MS-DRG. This calculation **INCLUDES** the MS-DRG amount, teaching, disproportionate share, capital, and outlier payments for all cases. Medicare payments DO NOT include beneficiary co-payments and deductible amounts nor any additional payments from third parties for coordination of benefits. Data is available through 2017.

<sup>4</sup> National Average Amount.

<sup>5</sup> **New DRG code proposed for 2021** "hip replacement with principal diagnosis of hip fracture with MCC"

<sup>6</sup> **New DRG code proposed for 2021** "hip replacement with principal diagnosis of hip fracture without MCC"

<sup>7</sup> **Total RVUs** – 2020 (39.21); 2021 (37.88)

<sup>8</sup> **Total RVUs**: 2020 (39.16); 2021 (37.83)

\* For comparison purposes the CPT code for Reconstruction Knee is included