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CY 2019 Hospital Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) Payment System Proposed Rule

OVERVIEW

On July 25th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update Medicare payment rates for hospital outpatient departments and ASCs for CY 2019. The rule would increase OPPS rates by 1.25%. However, proposed changes to off-campus Provider-Based Department (PBD) payment policies are expected to effectively offset the OPPS rate increase resulting in a net decrease of 0.1% ($80 million nationwide). The rule would increase ASC payment rates by 2.0% or $32 million in 2019. This document summarizes key payment and policy changes proposed by the rule.

CMS will accept comments on the proposed rule until September 24th. The text of the proposed rule is available here.

PAYMENT UPDATES

Off-Campus Provider-Based Department (PBD) Payments

The rule proposes a number of payment policies that are designed to encourage site-neutral payments for services. Under the proposed rule, clinic visit services rendered at off-campus PBDs would receive a Physician Fee Schedule (PFS)-equivalent payment rate, rather than an OPPS rate. CMS anticipates that this change would generate $760 million in savings for the Medicare program in 2019.

Beginning in CY 2019, CMS is also proposing to pay for certain new services (Table 32 on p.401) delivered by excepted off-campus PBDs under the PFS, rather than the OPPS. Services delivered by excepted off-campus PBDs that previously billed for these services between November 1, 2014 and November 1, 2015 would be exempt from this change and would continue to be paid under the OPPS.

ASC Covered Procedure List (CPL)

The rule would expand the list of covered surgical procedures that are payable at an ASC. Currently, the ASC CPL includes covered surgical procedures described by certain Common Procedural Terminology (CPT) codes that are *within* the surgical code range or other types of codes that are similar to CPT codes within the surgical code range. The proposed rule would allow certain new "surgery-like" CPT codes *outside* of the surgical code range to also be included on the ASC CPL.

CMS is proposing to review all 38 procedures added to the ASC CPL between 2015 and 2017 to determine whether such procedures should remain on the list.

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Drug Payment Cuts

The 2018 OPPS final rule decreased payment rates for most hospitals purchasing certain covered outpatient drugs through the 340B Drug Pricing Program from the Average Sales Price (ASP) plus 6% to ASP minus 22.5%. The 2019 rule would expand the 340B payment cut to non-excepted off-campus PBDs. Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals would still be exempt from 340B cuts.

CMS also proposes to pay certain drugs and biological products that do not have pass-through payment status and are not acquired under the 340B Program at wholesale acquisition cost (WAC) plus 3% instead of WAC plus 6%.

Opioid Provisions

To address the opioid crisis, CMS proposes to:

- Pay for non-opioid pain management drugs at ASP plus 6% to encourage the use of non-opioid pain management drugs; and
- Remove pain communication questions from the Hospital Inpatient Quality Reporting Program in an effort to avoid opioid overprescribing. This change would not take place until 2022.

New Technology Ambulatory Payment Classifications (APCs)

The rule proposes that services assigned to New Technology APCs with fewer than 100 claims per year be excluded from bundling into Comprehensive APCs in order to gather more accurate data, and that they be paid under an alternative payment methodology to establish more stable and representative rates. CMS is soliciting comment on methodologies that would use up to four years of data to calculate the geometric mean, the median, or the arithmetic mean.

ASC-Covered Device-Intensive Procedures

Currently, CMS defines device-intensive procedures as those in which the device cost exceeds 40% of the total cost of the procedure. To allow a greater number of ASC procedures to qualify as device-intensive, the proposed rule would lower the threshold to 30% of the cost of the procedure. The rule would also require that the device be implanted or inserted and allow procedures that involve single-use devices to qualify as device-intensive, regardless of whether or not they remain in the body after the conclusion of the procedure.

Under the ASC payment system, surgically-inserted device-intensive procedures would receive a payment for the service portion of the procedure using the ASC standard rate setting methodology and a payment amount of the device portion of the procedure based on the OPPS device offset percentages.

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Threshold for Packaged Skin Substitutes

CMS is soliciting comment on an alternative methodology for assigning skin substitute products to high or low cost groups.

QUALITY REPORTING PROGRAMS

Under the Hospital Outpatient Quality Reporting (OQR) and ASC Quality Reporting (ACQR) Programs, outpatient hospital departments and ASCs receive a 2% payment reduction for failure to meet certain requirements. The proposed rule would decrease the number of measures that must be reported under the OQR and ASCQR Programs. Measures were proposed for removal based on a new review methodology that considers whether the measures are duplicative, irrelevant because the overwhelming majority of providers perform highly on them, or inefficient because the costs of reporting the measure outweighs the benefits.

Hospital OQR Program

CMS is proposing to remove the Influenza Vaccination Coverage Among Healthcare Personnel measure for 2020 payment determinations and the following measures for 2021 payment determinations:

- Median Time to ECG;
- Mammography Follow-up Rates;
- Thorax Computed Tomography Use of Contrast Material;
- Simultaneous Use of Brain Computed Tomography and Sinus CT;
- Ability for Providers with Health Information Technology to Receive Laboratory Data Electronically Directly to Their Qualified/Certified Electronic Health Record System as Discrete Searchable Data;
- Tracking Clinical Results between Visits;
- Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients;
- Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use; and
- Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery.

The proposed rule would also extend the performance period for the Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy measure from one year to three years.

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ASCQR Program

CMS is proposing to remove Influenza Vaccination Coverage Among Healthcare Personnel measure for 2020 payment determinations and the following measures for 2021 payment determinations:

- Patient Burn;
- Patient Fall
- Wrong Site, Wrong Side, Wrong Procedure, Wrong Implant;
- All-Cause Hospital Transfer/Readmission;
- Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients;
- Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use; and
- Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

The proposed rule would also extend the performance period for the Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy measure from one year to three years.

REQUEST FOR INFORMATION (RFI)

The proposed rule contains three RFIs related to promoting interoperability of electronic health information, price transparency, and leveraging existing authority to negotiate payment amounts for Part B drugs. For the latter, CMS is considering whether the model could include Medicare Advantage organizations, state Medicaid agencies, and Medicaid managed care organizations.