



# CY 2019 OPPS/ASC Final Rule

## HFMA Executive Summary

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# OPPS Payment Updates

- For CY 2019, the outpatient prospective payment system (OPPS) conversion factor will be **\$79.490**, up from \$78.636 in CY 2018.
- The calculation is shown in the table below:

2018 Conversion Factor	\$78.636
Update	1.0135
Cancer Hospital Adj.	1.0000
Wage Index Budget Neutrality	0.9984
Pass-Through Budget Neutrality	0.9990
2019 Conversion Factor	\$79.490

- The update of 1.35% equals the market basket increase of 2.9%, minus the 0.8% multifactor productivity adjustment (MFP), and 0.75% outpatient department reduction required by the ACA.
- Hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) program requirements will see a reduced conversion factor of **\$77.900**.
- However, due to conflicting calculations, it is unclear how CMS determined this reduced conversion factor.

# OPPS Payment Updates

- For 2019, CMS is continuing to set aside 1.0% of the estimated aggregate total payments under the OPPS for outlier payments.
- CMS is continuing to set the outlier payment equal to 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the ambulatory payment classification (APC) payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold (\$4,600) are met.
- For 2019, the outlier threshold will be met when a hospital's cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount, and also exceeds the APC payment rate, plus a \$4,825.00 fixed-dollar threshold (compared to \$4,150 in 2018).

# 340B Drug Pricing Program

- Effective January 1, 2019, CMS will pay, under the physician fee schedule (PFS) the adjusted payment amount of average sales price (ASP) -22.5% for separately payable drugs and biologicals acquired under the 340B Program when they are furnished by non-excepted off-campus provider-based departments (PBDs) of a hospital.
- CMS believes this policy would better reflect the resources and acquisition costs that non-excepted off-campus hospital outpatient departments (HOPDs) incur for drugs and biologicals acquired under the 340B program.
- These payments will differ from the ASP+6% payment for drugs and biologicals made in physicians' offices and other nonhospital settings.
- For CY 2019, rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals are excepted from this payment adjustment.
  - These hospitals will continue to be paid ASP+6%.
- CMS estimates that the Medicare program and beneficiaries would save approximately \$49 million under the PFS.
- The site-specific PFS payment for these drugs and biologicals represents new utilization under the PFS, and would not be subject to the PFS budget neutrality.

# 340B Drug Pricing Program

- Under section 603 of the Bipartisan Budget Act of 2015, CMS is precluded from paying off-campus PBDs that opened after November 2, 2015, (with limited exceptions) under the OPPS.
  - These sites are referred to as “non-excepted off-campus HOPDs” to distinguish them from other HOPDs that may still be paid under the OPPS.
- In the 2018 OPPS final rule, CMS discussed concerns that not applying the 340B drug payment policy to non-excepted off-campus HOPDs creates an incentive for hospitals to move drug administration services for 340B-acquired drugs to non-excepted off-campus HOPDs to receive a higher payment.

# Controlling Increases in Volume of Outpatient Services

- To control unnecessary increases in the volume of covered HOPD services, CMS will pay for HCPCS code G0463 in all HOPDs at 70% of the full OPPS rate in 2019, and 40% of the full OPPS rate in 2020.
- The final payment amount will equal the site neutral PFS payment rate for services furnished at off-campus PBDs, subject to section 603 of the Bipartisan Budget Act of 2015.
- This policy will result in estimated 2019 savings of approximately \$380 million, with:
  - \$300 million of accrued savings to Medicare
  - \$80 million saved by Medicare beneficiaries in the form of reduced copayments
- The application of the payment reduction for code G0463 will be phased-in over a two-year period.
- This payment rate change will not be implemented in a budget-neutral manner.

# Off-Campus Provider-Based Department Data Collection

- Effective January 1, 2019, CMS will implement new HCPCS modifier, *ER-Items and services furnished by a provider-based off-campus emergency department (ED)*, to collect data to assess the extent to which OPPS services are shifting to off-campus provider-based EDs.
- The modifier must be reported with every claim line for outpatient hospital services furnished in off-campus provider-based EDs.
  - The modifier will be reported on the UB-04 form (CMS Form1450) for hospital outpatient services.
- Critical access hospitals will not have to report this modifier.
- CMS shares the concerns of the Medicare Payment Advisory Commission (MedPAC) and other entities that higher payment rates for services furnished in off-campus provider-based EDs may be a significant factor in the growth of the number of these departments.
- CMS believes it must collect data to assess the extent to which OPPS services are shifting to off-campus provider-based EDs.

# Hospital Outpatient Quality Reporting Program

- CMS finalizes changes to the factors it uses to determine whether to remove a measure from the OQR Program and codifies the list.
- While the first seven factors were previously used (with some wording differences), factor 8, “*the costs associated with a measure outweigh the benefit of its continued use in the program*”, is newly adopted.
  - It has also been finalized for use in other quality reporting programs.
- Because stakeholders may have different perspectives on the costs and benefits associated with a measure, CMS plans to consider input from a variety of stakeholders in evaluating the costs and benefits of measures.
- CMS clarifies its calculations for factor 1 regarding “topped out” measures.
- Two measures (OP-11 and OP-14) are removed as “topped out” using a modified calculation of truncated coefficient of variation, which is discussed in the rule.



# Hospital Outpatient Quality Reporting Program

- Applying the newly finalized measure removal criteria, and considering the goals of the Meaningful Measures Initiative, CMS removes 8 measures from the Hospital OQR Program.
- Beginning with the CY 2020 payment determination, *OP-27: NHSN Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)* will be removed from the Hospital OQR Program.
- For the CY 2021 payment determination, CMS will remove the following measures:
  - OP-5: Median Time to ECG (NQF #0289)
  - OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (NQF #0659)
  - OP-9: Mammography Follow-up Rates
  - OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513)
  - OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT
  - OP-12: The Ability for Providers with HIT (Health Information Technology) to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data
  - OP-17: Tracking Clinical Results between Visits
- CMS estimates that the removal of one chart abstracted measure (OP-5) and three measures submitted by HOPDs using a web-based tool (OP-12, OP-17, and OP-30) will reduce reporting burden and save a total of \$24.9 million nationally for CY 2021

# Hospital Outpatient Quality Reporting Program

- Two additional measures, one voluntary, were proposed for removal under factor 8, but are retained in the final rule:
  - OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658)
  - \*OP 31: Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (NQF #1536)
- CMS requested and received public comment on possible measure topics for the OQR Program, which it will consider for the future.

\*voluntary measure

# Hospital Outpatient Quality Reporting Program

- The total number of mandatory measures is reduced from 21 previously adopted for the 2020 and 2021 payment determinations, to 20 measures for 2020 payment, and 13 measures for 2021 payment.
- The final Hospital OQR Program measures for CY 2020 and 2021 payment determinations appear in a table in the final rule.
- CMS says that its changes to the OQR Program are intended to improve the usefulness and usability of quality program data by streamlining how facilities report and access data, while maintaining or improving consumer understanding of publicly reported data.

# Ambulatory Surgical Center Updates

- Instead of using the Consumer Price Index for All Urban Consumers (CPI-U) to measure the update factor for ambulatory surgical centers (ASCs) as it has done in the past, CMS finalized its proposal to apply a hospital-market basket update to ASCs for an interim period of five years.
- CMS will use the hospital market basket update of 2.9%, minus the MFP adjustment of 0.8%, which yields an update of 2.1% (\$46.551) for ASCs meeting quality reporting requirements.
- If the CPI-U had been used, the update would have been 1.8%.
- CMS continues its policy of reducing the update by 2.0% for ASCs not meeting the quality reporting requirements, yielding an update of 0.1%, or \$45.639.
- This computation is displayed in the following chart:

	ASCs reporting quality data	ASCs not reporting quality data
2018 ASC conversion factor	\$45.575	
Wage adjustment for budget neutrality	x 1.0004	
Net MFP-adjusted update	x <u>1.021</u>	x <u>1.001</u>
2019 ASC conversion factor	\$46.551	\$45.639

# Ambulatory Surgical Center Quality Reporting Updates

- CMS finalized and codifies changes to the factors it will use when considering removal of measures from the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.
  - The final eight factors are the same as those finalized for the OQR Program
- Applying the finalized measure removal criteria, and considering the goals of the Meaningful Measures Initiative, CMS removes two measures from the ASCQR Program:
  - ASC-8: Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)
  - ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use (NQF #0659)
- CMS retained the following measures that were proposed for removal, but suspends data collection for the first four measures, beginning with 2021 payment:
  - ASC-1: Patient Burn (NQF #0263)
  - ASC-2: Patient Fall (NQF #0266)
  - ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (NQF #0267)
  - ASC-4: All-Cause Hospital Transfer/Admission (NQF #0265)
  - ASC-9: Endoscopy/Polyp Surveillance Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658)
  - ASC-11: Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (NQF #1536)
- ASCs must report nine measures for the 2020 payment determination, and four for the 2021 payment determination.
- Two additional measures were previously finalized for addition to the program, beginning with the 2022 payment determination, for which a total of six measures will be required.

# Ambulatory Surgical Center Covered Surgical Procedures

- CMS will add 12 cardiac catheterization procedures to the list of ASC covered surgical procedures.
- In response to comments, CMS also added five procedures performed during cardiac catheterization procedures to this list (CPT codes 93566, 93567, 93568, 93571, and 93572).
- The 17 procedures that CMS adds to the list of ASC covered surgical procedures is shown in Table 60 of the final rule.

# Final Rule Impact

- CMS estimates that the total 2019 increase in Federal government expenditures due only to changes in the 2019 OPPS final rule is approximately \$440 million.
- Including estimated changes in enrollment, utilization, beneficiary cost-sharing and case-mix, CMS estimates that the 2019 increase in OPPS expenditures will be approximately \$5.8 billion.
- Total OPPS expenditures are estimated to be about \$74.1 billion in 2019.

# Request for Information

- In the 2019 OPPS proposed rule, CMS included a Request for Information related to promoting interoperability and electronic health care information exchange.
- The agency received over 60 timely pieces of correspondence.
- CMS neither summarizes, nor responds to these comments, or indicates whether it will act on them in the future.



# For More Information

- Read a [full summary](#) of the final rule.
- Read the full text of the [final rule](#) in the November 21, 2018, *Federal Register*.

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