**CMS proposes Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System changes for 2019 (CMS-1695-P)**

On July 25, 2018, the Centers for Medicare & Medicaid Services (CMS) proposed changes that would encourage site-neutral payment between sites of services and make healthcare prices more transparent for patients so that they can be more informed about out-of-pocket costs. The proposed rule proposes updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

The proposed polices in the CY 2019 OPPS and ASC Payment System proposed rule would further advance the agency's priority of creating a patient-centered healthcare system by achieving greater price transparency, interoperability, and significant burden reduction so that hospitals and ambulatory surgical centers can operate with better flexibility and patients have what they need to become active healthcare consumers.

This fact sheet discusses the major provisions of the proposed rule. The deadline for submitting comments on the proposed rule is September 24, 2018. The proposed rule (CMS-1695-P) can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-15958.pdf.

**Increasing Choices and Encouraging Site Neutrality**

The proposed rule proposes a number of policies that reduce payment differences between sites of service so that patients can benefit from high quality care at lower costs, and are able to receive care that is provided safely and is clinically appropriate.

*Proposal and Comment Solicitation on Method to Control for Unnecessary Increases in Utilization of Outpatient Services*
CMS is proposing to exercise authority under the law to control unnecessary increases in the volume of covered hospital outpatient department services by applying a Physician Fee Schedule (PFS)-equivalent payment rate for the clinic visit service when provided at an off-campus provider-based department (PBD) that is paid under the OPPS. The clinic visit is the most common service billed under the OPPS and is often furnished in the physician office setting.

This proposed change would result in lower copayments for beneficiaries and savings for the Medicare program which are estimated to be $760 million for 2019. For an individual Medicare beneficiary, current Medicare payment for the clinic visit is approximately $116 with $23 being the average beneficiary copayment. The proposal to adjust this payment to the PFS equivalent rate would reduce the OPPS payment rate for the clinic visit by the PFS relativity adjuster of 40 percent to an amount of $46 and a beneficiary copayment of $9, thus saving beneficiaries an average of $14 each time they visit an off-campus department.

*ASC Covered Procedures List*
The ASC Covered Procedures List (CPL) is a list of covered surgical procedures that are payable by Medicare when furnished in an ASC. Covered surgical procedures are those procedures that would not be expected to pose a significant risk to beneficiary safety and would not typically be expected to require active medical monitoring and care at midnight following the procedure. Under current policy, covered surgical procedures may include those described by certain Common Procedural Terminology (CPT) codes that are within the surgical code range or

other types of codes that directly crosswalk or are clinically similar to CPT codes within the surgical code range.

For CY 2019, CMS is proposing to allow certain CPT codes outside of the surgical code range that directly crosswalk or are clinically similar to procedures within the CPT surgical code range to be included on the CPL and is proposing to add certain cardiovascular codes to the ASC CPL as a result. Additionally, CMS is proposing to review all procedures added within the past three years) to reassess recent experience with the procedures in the ASC and to determine whether such procedures should continue to be on the ASC CPL.

*High Cost/Low Cost Threshold for Packaged Skin Substitutes*
CMS is proposing to continue our policy established in CY 2018 to assign skin substitutes to the low cost or high cost group. In addition, CMS presents several payment ideas to change how skin substitute products are paid under the OPPS and solicits comments on these ideas and welcomes new ideas on how to pay for skin substitute products.

*New Technology Payment Policy for Low-Volume Services*
CMS is proposing that services assigned to New Technology Ambulatory Payment Classifications (APCs) with fewer than 100 claims annually would be paid under one of several alternative payment methodologies. Specifically, CMS is proposing to use up to four years of data to calculate the geometric mean, the median, and the arithmetic mean and to solicit comment on which method should be used to establish payment for the new technology service for the upcoming year. The goal of such a policy is to promote transparency and predictability in the payment rates for these low-volume new technology procedures and to mitigate wide variation from year to year for such services.

*Device Intensive Policy*
Device intensive procedures are those where the device cost exceeds a certain threshold of the total cost of the procedure. Currently, that threshold is 40 percent. In the ASC setting, the device portion of the payment is the same as it is under the OPPS. For CY 2019, we are proposing to lower the device threshold to thirty (30) percent. This will allow procedures that use relatively high cost devices to be better recognized in the ASC setting.

*Device Pass-through Applications*
There were seven device pass-through applications that were reviewed for the CY 2019 proposed rule. There were no proposals to approve or deny any of the applications in the CY 2019 proposed rule. CMS is soliciting comments before making final determinations on the applications in the final rule.

*Proposal to Apply 340B Drug Payment Policy to Nonexcepted Off-Campus Provider-Based Departments (PBDs)*
Section 340B of the Public Health Service Act (Section 340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs at discounted prices from manufacturers. CMS reexamined the appropriateness of the Average Sale Price (ASP) plus 6 percent payment methodology for 340B drugs in the CY 2018 OPPS/ASC final rule. Beginning January 1, 2018, Medicare pays an adjusted amount of the ASP minus 22.5 percent for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS that is not excepted from the payment adjustment policy. For CY 2018, rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment.

In the CY 2018 OPPS/ASC final rule with comment period, a few commenters raised that the 340B reduction would not apply to non-excepted off-campus PBDs and shared their view that this could result in behavioral changes that may undermine CMS' policy goals of reducing beneficiary cost-sharing liability. This year, CMS is proposing to adopt a policy to pay ASP minus 22.5 percent for 340B-acquired drugs furnished by non-excepted off-campus provider-based departments.

**Meaningful Measures/Patients Over Paperwork**

This proposed rule would reduce the number of measures ASCs and hospital outpatient departments are required to report under the Ambulatory Surgical Center Quality Reporting and Hospital Outpatient Quality Reporting Programs. These proposed removals are arrived at after a careful and holistic review of all current, required quality measures. Measures are being proposed for removal after consideration under certain "removal factors": if they are duplicative, they are "topped out" (meaning that the overwhelming majority of providers are performing highly on them), or if their costs are greater than benefits in reporting. The proposed removals are aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. Overall, the proposed rule would eliminate a significant number of measures ASCs and hospital outpatient departments are currently required to report; a total of 15 measures would be removed from these quality programs.

*Hospital Outpatient Quality Reporting (OQR) Program*
The Hospital OQR Program is a pay-for-reporting quality program for services rendered in the outpatient hospital setting. The Hospital OQR Program requires hospital outpatient facilities to meet quality reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update if they fail to meet these requirements. In the CY 2019 OPPS/ASC Proposed Rule, CMS is proposing to remove certain measures from the Hospital OQR Program. The proposals to remove these measures are consistent with the CMS' commitment to using a smaller set of more meaningful measures and focusing on patient-centered outcomes measures, while taking into account opportunities to reduce paperwork and reporting burden on providers. In the CY 2019 OPPS/ASC proposed rule, CMS is proposing to:

1. Remove one quality measure beginning with the CY 2020 payment determination and nine quality measures beginning with the CY 2021 payment determination.
2. Extend the performance period from one to three years for OP-32: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
3. Update the factors to be considered when removing measures from the program.
4. Change the frequency of the Hospital OQR Program Specifications Manual release beginning with CY 2019 and for subsequent years.
5. Update requirements related to participation status, including removal of the Notice of Participation form.

| Measure Name | Removal Rationale |
|---|---|
| Chart-Abstracted Measures | |
| Median Time to ECG (OP-5) | The burden associated with the measure outweighs the benefit of its continued use. |
| Claims-Based Measures | |
| Mammography Follow-up Rates (OP-9) | Measure does not align with current clinical guidelines or practice. |
| Thorax Computed Tomography (CT) Use of Contrast Material (OP-11) | Measure performance is “Topped-Out”. |
| Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (OP-14) | Measure performance is “Topped-Out”. |
| Web-based Tool Measures | |
| The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data (OP-12) | Performance or improvement on a measure is not strongly linked to better patient outcomes. |
| Tracking Clinical Results between Visits (OP-17) | Performance or improvement on a measure is not strongly linked to better patient outcomes. |
| Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (OP-29) | The costs associated with the collection of this measure outweighs the benefit of its continued use. |
| Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use (OP-30) | The costs associated with the collection of this measure outweighs the benefit of its continued use. |
| Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (OP-31) | The costs associated with the collection of this measure outweighs the benefit of its continued use. |
| Federal Data Registry Preventative Care Measures | |
| Influenza Vaccination Coverage Among Healthcare Personnel (OP-27) | The burden associated with the collection of this measure outweighs the benefit of its continued use. |

*Ambulatory Surgical Center Quality Reporting (ASCQR) Program*

The ASCQR Program is a pay-for-reporting quality program for ASC services. The ASCQR Program requires ASCs to meet quality reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update for failure to meet these requirements. In the CY 2019 OPPS/ASC Proposed Rule, CMS is proposing to remove certain measures from the ASCQR Program. The proposals to remove these measures are consistent with the CMS’ commitment to using a smaller set of more meaningful measures and focusing on patient-centered outcomes measures, while taking into account opportunities to reduce paperwork and reporting burden on providers. In the CY 2019 OPPS/ASC proposed rule, CMS is proposing to:

1. Remove one quality measure beginning with the CY 2020 payment determination and seven quality measures beginning with the CY 2021 payment determination.
2. Extend the performance period from one to three years for ASC-12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
3. Update the factors to be considered when removing measures from the program.

| **Measure Name** | **Removal Rationale** |
|---|---|
| Claims-Based Measures | |
| Patient Burn (ASC-1) | Measure performance is “Topped-Out”. |
| Patient Fall (ASC-2) | Measure performance is “Topped-Out”. |
| Wrong Site, Wrong Side, Wrong Procedure, Wrong Implant (ASC-3) | Measure performance is “Topped-Out”. |
| All-Cause Hospital Transfer/Readmission (ASC-4) | Measure performance is “Topped-Out”. |
| Web-based Tool Measures | |
| Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (ASC-9) | The costs associated with the collection of this measure outweighs the benefit of its continued use |
| Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use (ASC-10) | The costs associated with the collection of this measure outweighs the benefit of its continued use |
| Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (ASC-11) | The costs associated with the collection of this measure outweighs the benefit of its continued use. |
| Federal Data Registry Preventative Care Measures | |
| Influenza Vaccination Coverage Among Healthcare Personnel (ASC-8) | The costs associated with the collection of this measure outweighs the benefit of its continued use |

## Proposed Updates to OPPS Payment Rates

In accordance with Medicare law, CMS is proposing to update OPPS payment rates by 1.25 percent. This update is based on the projected hospital market basket increase of 2.8 percent minus both a 0.8 percentage point adjustment for multi-factor productivity (MFP) and a 0.75 percentage point adjustment required by law. The increase of this rate update is largely offset by the proposal to pay for visits at excepted off-campus PBDs at a PFS equivalent rate, which is projected to reduce OPPS payments by 1.2 percent.

*Partial Hospitalization Program (PHP) Rate Setting*
The CY 2019 OPPS/ASC proposed rule updates Medicare payment rates for PHP services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). The PHPs are structured intensive outpatient programs consisting of a group of mental health services paid on a per diem basis under the OPPS, based on PHP per diem costs.

*Update to PHP Per Diem Rates*
The CY 2019 OPPS/ASC proposed rulemaintains the methodology established in CY 2017. In CY 2017, CMS implemented a unified rate structure with a single PHP APC for each provider type for days with 3 or more services per day. In establishing the proposed rates for CY 2019, CMS used CY 2017 preliminary claims data to calculate the CMHC and hospital-based PHP (HB PHP) geometric mean per diem costs, consistent with existing regulations.

## Proposed Updates to ASC Payment Rates

CMS currently updates ASC payment rates annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). In the CY OPPS/ASC 2017 proposed rule, CMS solicited recommendations and ideas on ASC payment system reform. For the CY 2019 OPPS/ASC proposed rule, in response to the comments received, CMS is proposing to update ASC payment rates using the hospital market basket rather than the consumer price index-urban (CPI-U) for 2019-2023. We also seek comment on an alternative proposal to maintain CPI-U while collecting evidence to justify a different payment update, or adopting the new proposed payment update based on the hospital market basket permanently. We request comment on what type of evidence should be used to justify a different payment update and how CMS should go about collecting that information in the least burdensome way possible.

Using the hospital market basket, CMS proposes to update ASC rates for CY 2019 by 2.0 percent. The change is based on the projected hospital market basket increase of 2.8 percent minus a 0.8 percentage point adjustment for multi-factor productivity (MFP). This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

## New Clinical Families of Services at Off-Campus PBDs Excepted from Section 603 of the Bipartisan Budget Act of 2015

In CY 2017 OPPS rulemaking, CMS proposed, but did not finalize, a policy that off-campus PBDs excepted from Section 603 of the Bipartisan Budget Act of 2015 could continue to be paid at OPPS rates for items and services in each of the 19 proposed “clinical families of services” if that PBD furnished and billed for a service in that clinical family of services prior to November 2, 2015. While CMS did not finalize this policy in CY 2017, CMS noted that it would continue to monitor the volume of services at excepted PBDs to determine if future rulemaking should

address service-line expansion. In the CY 2019 OPPS/ASC proposed rule, CMS is proposing to pay for services in new clinical families of services furnished at excepted off-campus PBDs under the PFS instead of the OPPS.

**Combating the Opioid Crisis**

In response to recommendations from the *President's Commission on Combatting Drug Addiction and the Opioid Crisis,* out of an abundance of caution and to avoid any potential unintended consequences of possible opioid overprescribing, under the Hospital Inpatient Quality Reporting (IQR) Program, CMS is proposing to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey measure by removing the three recently revised pain communication questions starting with January 1, 2022 discharges.

In addition, the *President's Commission on Combating Drug Addiction and the Opioid Crisis* also recommended that CMS review its payment policies for certain drugs that function as a supply, specifically non-opioid pain management treatments. Drugs that function as a supply in surgical procedures or diagnostic tests are packaged under the OPPS and ASC payment systems. In response to this recommendation as well as stakeholder requests, for CY 2019, we are proposing to pay separately at ASP plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC. Further, we are seeking feedback on whether other non-opioid alternatives for acute or chronic pain have evidence demonstrating that they lead to a decrease in opioid prescriptions and addiction and may, therefore, warrant separate payment under the OPPS and ASC payment systems.

**Price Transparency: Request for Information**

CMS is seeking comment through a Request for Information (RFI) within the proposed rule asking whether providers and suppliers can and should be required to inform patients about charges and payment information for healthcare services and out-of-pocket costs, what data elements the public would find most useful, and what other changes are needed to empower patients.

**Advancing My HealthEData: Request for Information**

In addition to payment and policy proposals, CMS is releasing an RFI to obtain feedback on positive solutions to better achieve interoperability or the sharing of healthcare data between providers. Specifically, CMS is requesting public feedback through a RFI on the possibility of revising Conditions of Participation related to interoperability as a way to increase electronic sharing of data by providers. This will inform next steps to advance this critical initiative.

In responding to the RFIs, commenters should provide clear and concise proposals that include data and specific examples. CMS will not respond to RFI comment submissions in the final rule, but rather will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

**Potential Model to Leverage the Authority under the Competitive Acquisition Program for Part B Drugs and Biologicals: Request for Information**

CMS is soliciting public comment on how best to develop a model leveraging authority provided to the agency under the Competitive Acquisition Program (CAP) in order to reduce expenditures while maintaining or improving the quality of care furnished to beneficiaries. CMS seeks feedback ways to design a potential model that tests private-sector vendor-administered payment arrangements for certain separately payable Part B drugs and biologicals, including high cost therapies. The RFI solicits public comments on potential model parameters such as a potential model's scope, which types of providers and suppliers should be included or excluded from a potential model, the types of Medicare Part B drugs and biologicals that should be included or excluded from a model, the role of private-sector vendors selected to negotiate and administer vendor-based payment arrangements with manufacturers under the model, the defined population of beneficiaries to be addressed by a potential model, appropriate beneficiary protections, possible inclusion of other payers, options for model payments, and other design features.