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Top 10 Takeaways: 2019 OPPS/ASC Proposed Rule

July 2018

On July 25, 2018, the Centers for Medicare & Medicaid Services (CMS) released proposed policy and payment updates affecting the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment System for calendar year 2019. The proposed updates will be published in the Federal Register on July 31, 2018. Comments are due September 24, 2018.

- *The proposed regulations are available here.*
- *The CMS press release is available here.*
- *The fact sheet is available here.*

Our top 10 takeaways for the OPPS and ASC proposed rule follow.

For more information please Deborah Godes, Sheila Madhani or Christine Song.

On July 25, 2018, the Centers for Medicare & Medicaid Services (CMS) released proposed policy and payment updates affecting the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment System for calendar year 2019. The proposed updates will be published in the Federal Register on July 31, 2018. Comments are due September 24, 2018.

The 2019 OPPS/ASC proposed rule includes proposals that would reduce drug prices, advance site neutral payment policies, increase the number of procedures available to Medicare beneficiaries in the ASC setting, and reduce the burden of quality measure reporting at both hospitals and ASCs. CMS proposes to increase the payment rates under the OPPS by 1.25 percent, but other policy proposals would operate to substantially challenge hospitals with significant payment cuts in two ways: cuts in reimbursement rates for clinic visits provided at certain off-campus provider-based hospital departments (PBDs) and an extension of price cuts on drugs purchased through the 340B Program furnished at non-excepted (non-grandfathered) off-campus PBDs. The American Hospital Association estimates these two proposals would represent close to $1 billion in cuts in Medicare payments for hospitals. Simultaneously, CMS proposes policy changes that generally benefit ASCs, including a change that would increase the number of procedures available for Medicare payment at ASCs and a number of technical changes to better align payments between hospitals and ASCs.

Following are our 10 key takeaways from the proposed rule.

Hospital Outpatient Prospective Payment System

1. CMS Proposes Site Neutral Payments for Clinic Visits at Off-Campus PBDs

Currently, Medicare pays more for a clinic visit when furnished in a hospital outpatient setting than in a physician office setting. In an attempt to control for an observed increase in the volume of outpatient services and costs under OPPS, CMS proposes an expansion of its site neutral policy. Specifically, the agency proposes to apply the site neutral payment policy to clinic visits described by HCPCS code G0463 furnished by excepted (grandfathered) off-campus provider-based outpatient departments.[1] Under this proposed policy, these clinic visit services would be paid the same payment amount used to pay for services furnished by non-excepted off-campus provider-based outpatient departments. Notably, CMS proposes to apply this policy in a non-budget neutral fashion.

[1] In 2017, CMS implemented Section 603 of the Bipartisan Budget Act of 2015, under which, unless an off-campus PBD of a hospital is eligible for grandfather protection (i.e., excepted), Medicare pays for the services furnished at the location, subject to some exceptions, at a rate that is approximately 40 percent of the OPPS rate, known as the Physician Fee Schedule (PFS)-equivalent payment rate.

2. CMS Proposes Collecting Data on Services Furnished in Off-Campus Provider-Based Emergency Departments

CMS proposes to create an HCPCS modifier ("ER – Items and services furnished by a provider-based off-campus emergency department") that must be reported on every claim line on the CMS-1450 for outpatient hospital services furnished in an off-campus provider-based emergency department. This proposal is driven by an observed increase in recent years in the volume of outpatient emergency department visits furnished under the OPPS, and the concern that services may be shifting to the emergency department setting in order to obtain higher payment under OPPS and/or obtain the emergency department exemption from the site neutrality payment policy.

3. CMS Extends 340B Payment Cuts to Non-Excepted Off-Campus PBDs

Earlier in 2018, CMS implemented a controversial change whereby Medicare would pay for drugs covered and paid under the OPPS and purchased through the 340B Program at Average Sales Price (ASP) minus 22.5 percent, instead of the traditional ASP plus 6 percent. CMS now proposes to extend this policy by also paying ASP minus 22.5 percent for 340B-acquired drugs furnished by non-excepted off-campus PBDs. Similarly, CMS proposes to pay for non-pass-through biosimilars acquired under the 340B Program at ASP minus 22.5 percent of the biosimilar's own ASP, rather than ASP minus 22.5 percent of the reference product's ASP. This policy is intended to create an incentive to use biosimilar products by removing the more negative payment differential that was created in last year's rule.

4. CMS Requests Information on Price Transparency, Drugs and Biologicals, and Interoperability

CMS posted three Requests for Information (RFIs) soliciting input on the following topics:

- Part B drugs: In an effort to reduce drug prices, CMS is seeking feedback on a potential model design to bring the principles of value-based payment to Part B drugs by building upon the Competitive Acquisition Program (CAP), which was suspended several years ago. Such a model would allow CMS to negotiate prices for Part B drugs versus just accepting the price offered by the vendor. CMS is also interested in how best to handle Medicare payment for the new high-cost therapies, and whether a potential CAP-like model could be an appropriate payment and delivery structure for these drugs and biologicals. This RFI, while included in the OPPS proposed rule, is not specific to the hospital outpatient setting, but would apply to Part B drug payments broadly.
- Price Transparency: CMS is soliciting comments on whether providers should be required to inform patients about charges and payment information for health care services and out-of-pocket costs, what data elements the public would find most useful, and what other changes are needed to empower patients. This RFI

follows other recent similar inquiries and proposals by CMS intended to better empower beneficiaries with more actionable information.

- Interoperability: In light of the widespread adoption of electronic health records, CMS is seeking feedback on how they can better use health and safety standards that are required for Medicare/Medicaid participation to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

5. CMS Solicits Comments on Alternative Payment Methodologies for Skin Substitutes

Since 2014, CMS has packaged skin substitutes to either high-cost or low-cost categories, and CMS proposes to continue to do so for CY 2019. In response to stakeholder concerns about the current packaging policy, however, CMS is soliciting comments on four potential changes to the packaging methodology for skin substitutes:

- Establish a lump-sum "episode based" payment for a wound care episode
- Eliminate high-cost/low-cost categories for skin substitutes and only have one payment category and set of procedure codes for all skin substitute products
- Allow for the payment of current add-on codes (for incrementally large wound sizes) or create additional procedure codes to pay for skin graft services between 26 cm^2 and 99 cm^2 and substantially over 100 cm^2
- Keep the high-cost/low-cost skin substitute categories but change the threshold used to assign skin substitutes in the high- or low-cost groups

CMS indicates that it is proposing to continue the established policy for CY 2019, but that the agency may make some changes in CY 2020. Additionally, CMS proposes that any skin substitute that was assigned to a high-cost group in 2018 would be assigned to a high-cost group in 2019.

Ambulatory Surgical Center Payment System

6. CMS Proposes 2 Percent ASC Payment Update Based on Hospital Market Basket

For CY 2019, CMS proposes a 2 percent update for ASC services. While historically CMS has updated ASC rates based on the consumer price index-urban (CPI-U), CMS now proposes to use the hospital market basket, which the agency uses to update OPPS rates. CMS proposes to make this switch for a five-year period, 2019 through 2023, while the agency studies the relationship between hospital and ASC costs and payments. This change is generally favorable to ASCs, since the CPI-U historically trends lower than the hospital market basket update, which means ASC payments generally are inflated less than hospital payments.

7. CMS Proposes to Increase Procedures on Device Intensive List

The Medicare device intensive policy helps offset the cost of expensive devices where payment is packaged into the procedure payment by making a separate payment for the device cost portion. For 2019, CMS proposes two changes to the device intensive policy. First, CMS is allowing high-cost, single-use surgically inserted or implanted devices that meet the device offset percent threshold to qualify even if the device does not remain in the patient's body at the conclusion of the procedure. Second, CMS proposes to lower the device offset percentage threshold to 30 percent from the current 40 percent. With the proposed change based on current claims data, an additional 155 procedures are proposed to be device intensive and eligible for supplemental payment in CY 2019.

8. CMS Proposes Broadening the Definition of Surgical Procedures Eligible for Medicare Payment

In an effort to provide greater flexibility and range in the type of services provided in the ASC environment, CMS proposes to broaden its definition of surgical procedures eligible for Medicare payment to account for "surgery-like" procedures that are assigned codes outside of the CPT surgical range (defined as 10000–69999). Pursuant to this broader definition of surgical procedures, CMS proposes to add 12 cardiac catheterization procedures (CPT codes 93451–93462) to the ASC Covered Procedures List (CPL).

9. CMS Proposes to Re-Review Newly Added Procedures to the ASC Covered Procedures List

CMS proposes to review procedures recently added to the ASC CPL to determine if the procedures continue to meet the criteria required to be added to the ASC CPL. Specifically, CMS will review procedures to determine if the procedures do not (1) pose a significant safety risk to Medicare beneficiaries when performed in an ASC and (2) require active medical monitoring at midnight following the procedure. In its first review under this proposed policy, CMS would review clinical information and utilization data for the 38 procedures added to the ASC CPL in 2015 through 2017.

Quality Reporting Programs

10. CMS Proposes to Reduce the Quality Measure Reporting Burden for Hospitals and ASCs

CMS proposes to reduce the number of measures hospitals and ASCs would be required to report for their respective quality programs: the Hospital Outpatient Quality Reporting (OQR) Program and the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. Both programs require participants 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.

For both the Hospital and ASC OQRs, CMS proposes to remove in total two quality measures beginning with the CY 2020 payment determination and 16 quality measures beginning with the CY 2021 payment determination.

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