Issue Brief

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CMS Releases Final Updates to the CY 2019 Hospital Outpatient and ASC Prospective Payment Systems

The Centers for Medicare & Medicaid Services issued a final rule that updates payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments and ambulatory surgical centers beginning Jan. 1, 2019 (CY 2019).

A copy of the 1,182-page document is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24243.pdf. Publication is scheduled in the Federal Register for Wednesday, Nov. 21. The above link will change upon publication.

The addenda relating to the OPPS are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html. The addenda relating to the ASC payment system are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

CMS will, as proposed, "exercise its authority under law to control unnecessary increases in the volume of covered hospital outpatient department services by applying a Physician Fee Schedule-equivalent payment rate for the clinic visit service when provided at an off-campus provider-based department that is paid under the OPPS." This change will be phased in over two years. This policy would result in savings for the Medicare program of an estimated $380 million for 2019.

CMS will extend its 340B drug payment policy at the average sales price minus 22.5. This will affect not only hospital outpatient departments, but excepted off-campus PDPs of a hospital. Note, critical access hospitals are not subject to this policy since they are paid on a cost basis. CMS also accepted rural sole community hospitals, children's hospitals and PPS-exempt cancer hospitals.

UPDATES AFFECTING OPPS PAYMENTS

A. OPPS Update:

For CY 2019, CMS is increasing the payment rates by an outpatient department fee schedule increase factor of 1.35 percent. This increase factor is based on the final FY 2019 hospital inpatient market basket percentage increase of 2.9 percent, minus a multifactor productivity adjustment of 0.8 percentage point, and minus a 0.75 percentage point adjustment required by the ***Affordable Care Act.***

CMS is continuing to implement the statutory 2.0 percentage point reduction in payments for hospital OPDs failing

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4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

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to meet quality reporting requirements by applying a factor of 0.980 to the OPPS payments and copayments for all applicable services.

B. Conversion Factor

The OPD fee schedule increase factor of 1.35 percent for CY 2019, a required wage index budget neutrality adjustment of approximately 0.9984, and an adjustment of -0.10 percentage point of projected OPPS spending for the difference in pass-through spending results in a conversion factor for CY 2019 of **$79.490**.

C. Hospital Outpatient Outlier Payments

CMS will continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. A portion of that 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPPS payments) will be allocated to CMHCs for the Partial Hospital Program outlier payments.

CMS is setting an outlier threshold that exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus **$4,825**. The proposed amount was $4,600. The current threshold is $4,150.

For CMHCs, the threshold would be 3.40 times the payment rate, and the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times APC 5853.

D. Rural Adjustment

CMS will continue its current policy of a 7.1 percent payment adjustment that is done in a budget neutral manner for rural SCHs and essential access community hospitals.

OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS

CMS will pay for separately payable nonpass-through drugs acquired with a 340B discount at a rate of ASP minus 22.5 percent.

CMS is adopting, as proposed, that the pass-through payment status of 23 drugs and biologicals will expire on Dec. 31, 2018.

Forty-nine drugs and biologicals will have continuing pass-through payment status in CY 2019.

CMS is finalizing a packaging threshold for CY 2019 of **$125**, an increase from the current packaging threshold of $120.

PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES

CMS is continuing to use CMHC APC 5853 (Partial Hospitalization (3 or more services per day)) and hospital-based PHP APC 5863 (Partial Hospitalization (3 or more services per day)).

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Payments will be:

5853	Partial Hospitalization (3 or more services per day) for CMHCs	$121.62
5863	Partial Hospitalization (3 or more services per day) for hospital-based PHPs	$222.76

NONRECURRING POLICY

CMS will create an HCPCS modifier (ER — Items and services furnished by a provider-based off-campus emergency department) that is to be reported with every claim line for outpatient hospital services furnished in an off-campus provider-based ED effective Jan. 1, 2019. CAH hospitals are exempt.

CMS is finalizing its proposal to apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463. In addition, CMS is finalizing its proposal to implement this policy in a nonbudget neutral manner. The final payment rates are available in Addendum B.

CMS will pay under the PFS the adjusted payment amount of ASP minus 22.5 percent for separately payable drugs and biologicals (other than drugs on pass-through payment status and vaccines) acquired under the 340B Program when they are furnished by nonexcepted off-campus PBDs of a hospital.

UPDATES TO THE AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

For CY 2019, CMS is utilizing the hospital market basket update of 2.9 percent minus the MFP adjustment of 0.8 percentage point, resulting in an MFP-adjusted hospital market basket update factor of 2.1 percent for ambulatory surgical centers meeting the quality reporting requirements. Those not meeting the quality requirement are subject to a 2.0 percent reduction or an increase of 0.1 percent.

For CY 2019, CMS is adjusting the CY 2018 ASC conversion factor ($45.575) by a wage index budget neutrality factor of 1.0004 in addition to the MFP-adjusted hospital market basket update factor of 2.1. This results in a CY 2019 ASC conversion factor of $46.551 for ASCs meeting the quality reporting requirements. For ASCs not meeting the quality reporting requirements, CMS is adjusting the CY 2018 ASC conversion factor ($45.575) by the wage index budget neutrality factor of 1.0004 in addition to the quality reporting/MFP-adjusted hospital market basket update factor of 0.1 percent, which results in a CY 2019 ASC conversion factor of $45.639.

CMS proposed to permanently designate an office-based four covered surgical procedures for CY 2019. They involved CPT codes 31573, 36513, 36902 and 36905. CMS only is designating codes 31573 and 36513 as office-based. Codes 36902 and 36905 will retain the same payment indicator, “G2.”

REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

CMS proposed to remove a total of 10 measures from the Hospital Outpatient Quality Reporting Program measure set; one in CY 2020 and nine in CY 2021.

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For CY 2020, CMS would remove the following.

1. OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

For CY 2021, CMS would remove the following.

2. OP-5: Median Time to ECG (NQF #0289)
3. OP 31: Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)
4. OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658)
5. OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use (NQF #0659)
6. OP-9: Mammography Follow-up Rates (no NQF number)
7. OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513)
8. 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 (NQF endorsement removed)
9. OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (no NQF number)
10. OP-17: Tracking Clinical Results between Visits (NQF endorsement removed) ***(Page 852)***

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

CMS is removing eight of the 10 proposed. The two that will not be removed are the following.

1. OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF #0658)
2. OP 31: Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)

REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM (PAGE 937)

CMS is finalizing policies to:

1. Remove one quality measure beginning with the CY 2020 payment determination and one quality measure beginning with the CY 2021 payment determination. CMS is not finalizing proposals to remove the Mammography Follow-up Rates (ASC-9) and Thorax Computed Tomography (CT) Use of Contrast Material (ASC-11).
2. Extend the reporting period from one to three years for ASC-12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy beginning with the CY 2020 payment determination and for subsequent years.
3. Update the factors to be considered when removing measures from the program and update the Code of Federal Regulations to better reflect measure removal policies.

This is an abbreviated analysis. View the full analysis here.

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