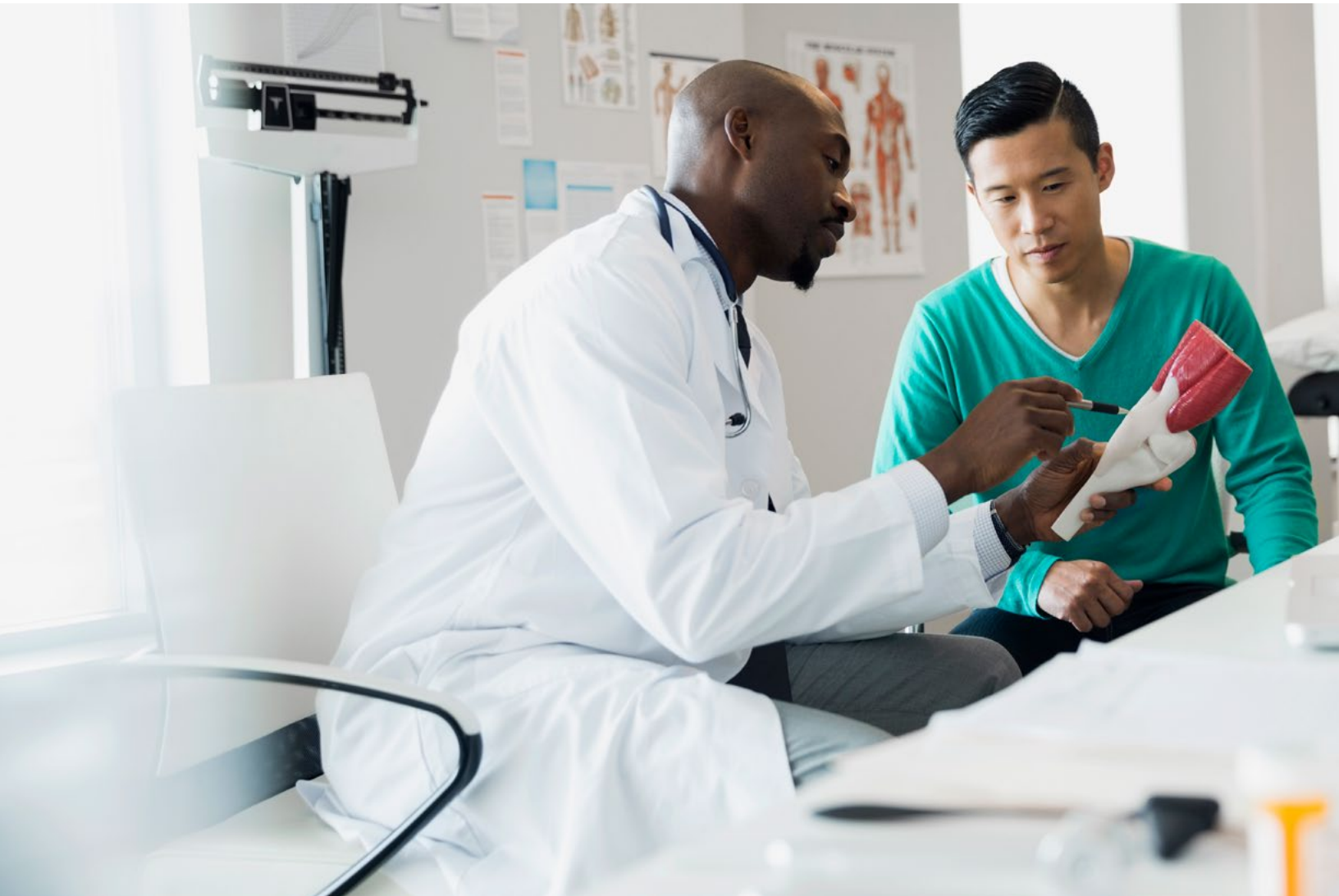
Conduent Healthcare
Government Healthcare Solutions

CONDUENT

CY 2019 Outpatient Prospective Payment System Proposed Rule Summary

A Summary for Medicaid Programs



This white paper summarizes the annual updates and changes to payment rates and policies published by the Centers for Medicare and Medicaid Services (CMS) in its proposed rule for calendar year 2019 (CY 2019) Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule was published in the *Federal Register* on July 31, 2018. All proposed changes and values are subject to public comment period (closed September 24, 2018) and finalization by CMS in November. The final rule is expected in November 2018, for CY 2019, to be effective January 1, 2019. This summary focuses on hospital outpatient services and does not address changes specific to ambulatory surgical centers.

The OPPS rule comprises the requirements and rate updates for outpatient hospital services paid under Medicare fee-for-service based on a prospective payment method using Ambulatory Payment Classifications (APCs), a grouping of certain services and various other Medicare fee schedules (e.g., clinical laboratory and therapy). For CY 2019, CMS estimated that the OPPS rule would apply to 3,695 hospitals (excluding community mental health centers and certain hospitals held harmless such as cancer and children's hospitals).

Medicaid programs paying for outpatient hospital services based on Medicare OPPS or a similar method can use these rules to obtain key payment variables, such as the hospital market basket rate, the conversion factor and bundled payments. States use varying methods to calculate rates, which often involves at least one of the parameters from CMS to set state-level rates. For example, the conversion factor can be used as part of the calculation that determines the dollar payment for services. CMS has posted two different conversion factors, so it's helpful for states to understand the differences to pay providers accurately per their state plan.

Beyond reimbursement topics, it is important for Medicaid programs to be familiar with other CMS initiatives. As with other 2018 rules, CMS proposes streamlining outpatient hospital quality measures and solicits comment on improving hospital pricing transparency and interoperability of electronic healthcare data. In addition, several proposals and requests for information involve improving control over payment for drugs and biologicals, as well as services provided by off-campus provider-based departments. Given some Medicaid agencies have stayed in line with CMS initiatives such as paying for provider-based care, they will once again find themselves considering the pros and cons of the changes Medicare proposes this year.

If you have any questions or need additional information about the OPPS proposed rule or healthcare payment issues, please visit www.conduent.com/medicaid or email govhealthcare@conduent.com.

Highlights

Payment Update. For CY 2019, CMS proposes a rate update increase factor of 1.25 percent, slightly less than last year's update of 1.35 percent. This includes the FY 2019 inpatient hospital market basket increase of 2.8 percent, with legislative-required adjustments.

Payment Impact. CMS estimates the CY 2019 proposed policies to have an overall impact of an $80 million decrease in OPPS payments compared to CY 2018.

Conversion Factor Update. A conversion factor of $79.546 is proposed for hospitals that comply with quality reporting and $77.955 for hospitals that fail to meet such requirements (the annual update factor is reduced by 2.0 percentage points for quality non-compliance).

Relative Weights. The proposed APC relative weights were recalibrated using CY 2017 paid claims data and cost data from CY 2016 cost reports in most cases.

APC Reclassification. For CY 2019, the proposed APC list increases slightly to 719, with 29 APCs being removed and 33 new additions.

Status Indicators. No new payment status indicators are proposed for CY 2019. However, there are several CPT/HCPCS codes that have proposed changes to their assigned status indicators.

Comprehensive APCs (C-APCs). CMS proposes reassigning three APCs (currently assigned to status indicator T) to create new comprehensive APCs (C-APCs). These C-APCs include ear, nose and throat (ENT) and vascular procedures. This would increase the total C-APCs to 64.

C-APC Complexity Adjustment. CMS proposes applying the frequency and cost criteria thresholds to determine if the complexity adjustments are met and reassignment to the next higher cost APC in the clinical family is appropriate.

Packaging Policies. CMS is proposing changes to its packaging policies, resulting in an increase of 27 HCPCS codes to the packaging policy, from 3,702 to 3,729. In particular, CMS proposes increasing the packaging threshold for drugs, biologicals and radiopharmaceuticals from $120 to $125.

Inpatient-Only List. The proposed CY 2019 inpatient-only list consists of 1,745 CPT/HCPCS codes. CMS proposes reassigning one procedure code to an APC code, removing one procedure from the list and adding one procedure to the list. A total of 55 other procedures were added or removed as a result of the CPT/HCPCS annual update.

Device-Intensive Procedures. For CY 2019, CMS proposes including devices regardless of whether the device remains in the body after conclusion of the procedure and lowering the device offset percentage threshold from 40 percent to 30 percent to allow a greater number of procedures to qualify as device-intensive.

Hospital Outpatient Visits and Critical Care Services. No changes were identified for clinic and emergency department hospital outpatient visit payment policies for CY 2019.

Partial Hospitalization Program (PHP). CMS made no changes to its partial hospitalization program policies and ratesetting methodology. Relative weights and payment rates were updated. PHP proposed rates are $216.55 for hospitals and $117.35 for community mental health centers.

Off-Campus Provider-Based Departments (PBDs). CMS proposes applying site-neutral payments for clinic visits in all off-campus provider-based departments (PBDs). Nonexcepted off-campus PBDs already receive a reduced site-specific Medicare Physician Fee Schedule (MPFS) rate for clinic visits (identified by HCPCS code G0463 and APC 5012). This proposal extends the same payment level when the services are provided at an excepted off-campus PBD.

340B Drug Pricing Program. CMS proposes continuing 340B policies started in CY 2018, with a change to the calculation of payment for 340B-acquired biosimilars to average sales price (ASP) minus 22.5 percent when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Excepted off-campus PBDs and nonexcepted PBDs will be paid the same payment rates with the same discounts.

Hospital Outpatient Quality Reporting (OQR) Program. CMS proposes finalizing the removal of 10 Medicare-required quality measures. Half would be removed because the administrative cost outweighs benefits of continued use. CMS again delays implementation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey measures, pending additional data. The use of social risk factors in quality measurement is deferred for future consideration.

CMS Requests for Information. CMS is seeking comment on ways to improve several aspects of outpatient hospital payment, including better quality and reporting measures, addressing opioid abuse, alternative methodologies for PBDs, improving interoperability of sharing healthcare data and others.

Payment Update

CMS is required to review and update the hospital OPPS payment rates annually, which includes the hospital rate update factor or rate of increase with any adjustments required by law.

For CY 2019, CMS proposes a rate update increase factor of 1.25 percent. The proposed increase factor is based on the proposed FY 2019 inpatient hospital market basket increase of 2.8 percent, adjusted by the FY 2019 multi-factor productivity factor of 0.8 percent and an additional 0.75 percentage point reduction required by the Affordable Care Act.

With the proposed update, CMS estimates total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization and casemix) for CY 2019 would be approximately $74.6 billion. CMS indicated that this represents an increase of approximately $4.9 billion compared to CY 2018 OPPS payment estimates.

Table 1 provides a comparison between CY 2018 and the proposed CY 2019 rate update factors and adjustments.

Table 1

CY 19 Proposed Outpatient Rate Update Factor		
Adjustment	Final CY 18	Proposed CY 19
Market basket percentage increase	2.7	2.8
Multi-factor productivity adjustment	-0.6	-0.8
Additional Affordable Care Act adjustment	-0.75	-0.75
Rate update factor	1.35	1.25

Notes:

1. *Federal Register* 82:239 (December 14, 2017), pp. 59256–59258.
2. *Federal Register* 83:147 (July 31, 2018), pp. 37226–37229.
3. Market basket percentage increase is based on the proposed hospital inpatient market basket percentage increase (IHS Global Insight, Inc.'s fourth quarter 2017 forecast).
4. Multi-factor productivity or economy-wide productivity factor reduction required by ACA. The MFP adjustment factor is developed by CMS contractor, IHS Global Insight, Inc., and based on the Bureau of Labor Statistics' official measure of private nonfarm business MFP.
5. Affordable Care Act adjustment = An additional percentage point reduction required by ACA for each of the years 2010 through 2019.

Payment Impact

For CY 2019, CMS estimates an overall impact of an $80 million decrease in OPPS payments compared to CY 2018. This includes only the changes in the rule. When taking into account all the changes and adjustments, the overall impact to all OPPS providers is estimated at -0.1 percent. The impact is estimated to be the same when it excludes cancer hospitals, children's hospitals and community mental health centers.

Table 2 summarizes the estimated impact of the proposed payment policies and updates and the number of facilities affected by the proposed changes compared to estimated payments in CY 2018. The changes include the rate update factor, the proposed off-campus provider-based department visits policy, the outlier payment decrease and other factors.[1]

Table 2

Overall Impact of CY 19 OPPS Proposed Changes		
	Number of Providers	Impact on Payments
All providers	3,806	-0.1
All hospitals	3,695	-0.1
Urban hospitals	2,900	-0.1
Rural hospitals	795	-0.1
CMHCs	44	-17.9

Notes:

1. *Federal Register* 83:147 (July 31, 2018), pp. 37228–37229.
2. "All providers" includes children and cancer hospitals and Community Mental Health Centers (CMHCs).
3. "All hospitals" excludes children and cancer hospitals and CMHCs.

Conversion Factor Update

Under the hospital OPPS payment method, CMS pays for most services using a conversion factor, or base price, multiplied by a relative weight for the APC, which reflects the degree of complexity as well as the cost of the service. The conversion factor turns the APC relative weight into the dollar payment for the services. In addition, a portion of the conversion factor is adjusted by the hospital wage index to account for geographic differences in labor costs. Medicare annually updates the conversion factor, relative weights and wage indexes.

For CY 2019, CMS proposes a conversion factor of $79.546 for hospitals that comply with quality reporting and $77.955 for hospitals that fail to meet such requirements (the annual update factor is reduced by 2.0 percentage points for quality non-compliance).

As in previous years, CMS proposes using the hospital wage indexes (after re-classifications finalized under the hospital IPPS rule) to adjust the conversion factor. The labor-related share (the portion of service costs attributable to wage costs) remains at 60 percent.

Table 3 compares the final CY 2018 and the proposed CY 2019 conversion factors.

Table 3

Conversion Factor Comparison		
	Final CY 18	Proposed CY 19
National CF for hospitals that meet quality reporting requirements	$78.636	$79.546
National CF for hospitals that fail to meet quality reporting requirements	$77.064	$77.955
Rate update factor	1.35	1.25
Quality reporting requirement percentage point reduction	-2.0	-2.0

Notes:
1. *Federal Register* 82:239 (December 14, 2017), pp. 59256, 59445.
2. *Federal Register* 83:147 (July 31, 2018), pp. 37072–37073.
3. National CF = national conversion factor.

Relative Weights

CMS proposes recalibrating the APC relative weights that will be used to pay for services in CY 2019, using the same basic methodology from previous years. In general, the methodology is based on paid claims data and most recently available cost report data. For CY 2019, CMS proposes updating the APC relative weights using CY 2017 claims data (approximately 86 million claims) and cost data from the most recent available data, CY 2016 cost reports in most cases.

For CY 2019 OPPS, CMS proposes extending the policy for providers to transition from a square feet cost allocation method to another cost allocation method (e.g., direct assignment or dollar value). As a result, CMS would continue to remove claims from these providers when calculating CCRs used to estimate costs for the imaging APCs (CT and MRI). This would extend the transition to a sixth year; CMS indicated that for CY 2020, it expects to use cost data from all providers to calculate the imaging relative weights, irrespective of the cost allocation method.

APC Reclassification

Ambulatory Payment Classifications (APCs) were established as a method to classify covered groups of outpatient hospital services that are comparable both clinically as well as resources required to provide the services. Payment is typically packaged to include not only the primary procedure performed or service provided, but also include the costs of related ancillary and supportive services considered integral to the primary service.

For CY 2019, CMS proposes a few changes to APCs. In CY 2018, a total of 716 APCs were available for payment under the OPPS. For CY 2019, the proposed list increases slightly to 719, with 29 APCs being removed and 33 new additions. The majority of deletions and additions pertain to injection-related APCs and the proposed deletion of C-APC 5495 Level 5 Intraocular Procedures.

New Technology APCs. New technology APCs are typically new procedures that do not have sufficient claims history to establish an accurate payment. An APC is assigned once enough claims data is gathered. This is usually done within two years. In CY 2018, there were 112 New Technology APCs encompassing 52 levels of payment.

For CY 2019, CMS proposes retaining services within New Technology APC groups until sufficient claims data have been collected to justify reassignment of the service to a clinically appropriate APC. CMS also proposes using up to four years of data to calculate the geometric mean, median and arithmetic mean, and to solicit comment on which method should be used to establish payment for the new technology service.

Maximum new technology payment will continue to be capped at $160,000 (New Technology-Level 52). In CY 2018, CMS expanded the high payment APCs and reduced the payment intervals for each APC to provide more granularity of payments for use of expensive equipment. New technology payments are made as the average payment for the payment interval. For example, under the current APC list, a piece of equipment with costs of $117,000 would be considered New Technology Level 50 for payments between $115,000 and $130,000 and receive payment of $122,500.50.

Imaging APCs. In CY 2016 and CY 2017, CMS restructured and consolidated the imaging APCs to provide broader grouping and remove excessive granularity. This restructuring resulted in a decrease from 17 imaging APCs in CY 2016 to seven in CY 2017 – four imaging without contrast APCs and three imaging with contrast APCs.

For CY 2019, CMS proposes reassigning CPT 0398T MRgFUS stereotactic ablation, intracranial from APC 1576 New Technology-Level 39 ($15,001–$20,000) to APC 1575 New Technology-Level 38 ($10,001–$15,000) with a proposed payment rate of $12,500.50, based on available claims data.

Intraocular Procedure APCs. For CY 2019, CMS proposes reassigning the Argus II procedure from APC 1904 New Technology-Level 50 ($115,001–$130,000) to APC 1906 New Technology-Level 51 ($130,001–$145,000), which would result in a proposed payment rate for the Argus II procedure of $137,500.50.

CMS also proposes excluding payment for all procedures assigned to New Technology APCs from being bundled into the payment for procedures assigned to a C-APC. This would allow for separate payment for the Argus II procedure when it is performed with another comprehensive service.

For APC 5495 Level 5 Intraocular Procedures, CMS proposes reassigning CPT 0308T Insertion ocular telescope prosthetic from APC 5495 to APC 5493, which are comprehensive APCs (C-APCs). C-APC 5495 would be deleted, based on the available claims data. (See the Comprehensive APCs section for additional information.)

Two Times Rule. The Two Times Rule relates to the costs of items and services within an APC. The rule states that the highest cost of an item or service in a given APC must not be more than two times greater than the lowest cost item or service within the same APC. This rule aims to maintain the clinical and resource homogeneity within APCs.

For CY 2019, CMS is proposing to make changes to the procedure codes assigned to specific APCs that contain services that are similar with regard to both their clinical and resource characteristics. The proposed rule identifies 16 APCs for the exception to the Two Times Rule (Table 4).

Table 4

CY 19 Proposed APC Exceptions to the Two Times Rule	
APC	APC Title
5071	Level 1 Excision/Biopsy/Incision and Drainage
5113	Level 3 Musculoskeletal Procedures
5521	Level 1 Imaging Without Contrast
5522	Level 2 Imaging Without Contrast
5523	Level 3 Imaging Without Contrast
5571	Level 1 Imaging With Contrast
5612	Level 2 Therapeutic Radiation Treatment Preparation
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5724	Level 4 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5732	Level 2 Minor Procedures
5735	Level 5 Minor Procedures
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Notes:
1. *Federal Register* 83:147 (July 31, 2018), p. 37090.

Status Indicators

Under Medicare OPPS, every procedure code is assigned a status indicator (SI). Status indicators dictate whether Medicare pays for a service under the OPPS or another payment system (e.g., separate fee schedules), and whether policy rules would apply (e.g., packaging and discounting). Each year, CMS modifies status indicator assignments to CPT/HCPCS codes which provide information on how a particular service is paid (or not paid) under OPPS.

For CY 2019, CMS proposes no changes to the list of status indicators finalized in CY 2018. While no new status indicators were defined, CMS proposes to re-assign, delete and create new assignments for services.

- 253 new CPT/HCPCS codes received status indicator assignments.
- 326 CPT/HCPCS code had a status indicator change for CY 2019.
- 65 CPT/HCPCS codes were deleted for CY 2019.

Comprehensive APCs (C-APCs)

Comprehensive APCs (C-APCs) can be considered "mini DRGs," such that a single APC payment is made for the majority of billed items on a claim. Each service has a corresponding C-APC assignment and all services are ranked, with payment being made for the highest ranking primary service. C-APCs were first introduced in CY 2015, when CMS created 25 C-APCs. An additional 10 C-APCs were established in CY 2016 and 25 were added in CY 2017, bringing the total C-APC count to 62 as of January 1, 2017. No additional C-APCs were created in CY 2018, maintaining the total of 62 C-APCs across 21 clinical families.

For CY 2019, CMS proposes adding three new comprehensive APCs to the list of C-APCs finalized in CY 2018. These APCs are currently assigned to status indicator T Multiple Procedure Reduction Applies. The proposed changes were identified as including primary, comprehensive services that are typically reported with other ancillary and adjunctive services. In addition, C-APC 5495 (Level 5 Intraocular Procedures) would be deleted. With the new C-APCs, the clinical family count would be up to 22, for a total of 64 C-APCs proposed for CY 2019. The three new APCs are:

- C-APC 5163 (Level 3 ENT Procedures)
- C-APC 5183 (Level 3 Vascular Procedures)
- C-APC 5184 (Level 4 Vascular Procedures)

In the preamble, CMS proposes deleting C-APC 5495. However, this APC is listed in the rule table of proposed C-APCs without further comment on its status. APC 5495 is not displayed on the Addenda tables (Addendum A, B and J).

Please refer to Appendix A for details on the C-APC list proposed for CY 2019.

C-APC Complexity Adjustments

Complexity adjustments are used to provide increased payment for certain comprehensive services. CMS ranks all procedures assigned to the J1 status indicator based on their comprehensive geometric mean costs in order to define primary procedures, with a rank of 1 being the highest rank. The complete list of all procedures assigned to the J1 status indicator as well as the corresponding ranking is located in Addendum J on the CMS webpage for the OPPS rules. Complexity adjustments are warranted if two or more J1 procedure code combinations occur on more than 25 claims and the cost is more than two times the least expensive procedure with the original APC.

Expanding the complexity adjustment combinations is an attempt by CMS to account for the large number of new codes to be paid by C-APC and the additional costs the C-APC payments must take into consideration. To accommodate for the rapid expansion of C-APCs, CMS expanded the qualifying complexity adjustment code combinations in CY 2017.

For CY 2019, CMS proposes applying the frequency and cost criteria thresholds to determine if the complexity adjustment is met and reassignment to the next higher cost APC in the clinical family is appropriate.

Packaging Policies

Packaging of ancillary, supportive or adjunctive services into primary services has been a major priority for CMS since 2008. Packaging payments for interrelated services creates incentives for hospitals to furnish services efficiently and use resources flexibly. Since 2015, there have been drastic changes in the number of services being packaged as well as the manner in which they are packaged (conditional, unconditional). For CY 2019, CMS proposes 3,729 HCPCS codes be considered for packaging (status indicators N, Q1, Q2 or Q4); 3,702 HCPCS codes were packaged in CY 2018.

Vaccine Administration. CMS proposes no changes in policy.

Skin Substitutes. Currently, skin substitutes are packaged into payment for the related primary procedure. Payment is determined based on assignment to a high cost or low cost group. Assignment to the high cost group is currently made for skin substitutes with a geometric mean unit cost or per day cost that exceeds either the mean unit cost or per day cost threshold for the high cost group.

For CY 2019, CMS proposes continuing payment in the high-cost group for those in the high-cost group in 2018. Additionally, CMS requests feedback on potential payment methodologies to promote payment stability for skin substitutes.

Drugs, Biologicals and Radiopharmaceuticals. Drugs and biologicals that do not have pass-through status are paid in one of two ways – packaged into the APC for the associated service or assigned to their own APC for separate payment. The determination for coverage is based on the packaging threshold. In CY 2019, CMS proposes increasing the packaging threshold for drugs, biologicals and radiopharmaceuticals to $125. Drugs, biologicals and radiopharmaceuticals with an estimated cost per day of less than $125 are packaged, while those with a cost greater than $125 receive separate payment, unless they are packaged under other bundling policies.

Non-Opioid Pain Management Treatments. The President's Commission on Combating Drug Addiction and the Opioid Crisis recommended CMS review policies where non-opioid treatments for pain are packaged and not paid separately. Based on this recommendation and stakeholder feedback, CMS examined policies in OPPS and concluded that packaging policies do not discourage utilization of non-opioid treatment alternatives; however, decreased utilization was found in the ASC setting. CMS proposes separate payment for pain management drugs that function as surgical supplies in ASCs for CY 2019. Additionally, CMS is 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 warrant separate payment.

Inpatient-Only List

The inpatient-only (IPO) list is a group of payer-identified procedures that are typically provided only in an inpatient setting and therefore, would not be paid as an outpatient hospital service. Medicare reviews and updates the IPO list as part of its annual rate update. In its review, Medicare uses specified criteria to determine whether or not any procedures should be removed from the list and assigned to an APC group for outpatient hospital payment. In CY 2019, there are 1,745 CPT/HCPCS proposed for the IPO list.

For CY 2019, CMS proposes removing two procedures from the IPO list and add one procedure. Table 5 shows the procedure codes proposed to be removed from and added to the IPO list for CY 2019.

Table 5

CY 19 Proposed Inpatient Only List Changes						
HCPCS	Short Descriptor	Final CY 18 Status Ind	Proposed CY 19			
			Status Ind	APC	Relative Weight	Payment Rate
Proposed additions						
C9606	Perc revascularization single vessel during AMI		C			
Proposed removals						
01402	Anesth knee arthroplasty	C	N			
31241	Nasal/sinus endoscopy, surgical; w/ligation of sphenopalatine artery	C	J1	5153	17.2414	$1,371.48

Notes:

1. *Federal Register* 83:147 (July 31, 2018), pp. 37136–37137.
2. Centers for Medicare and Medicaid Services, Hospital Outpatient Regulations and Notices Items Webpage, 2018 OPPS Addenda, 2018 Addendum A.10.26.17 and 2018 Addendum B.10.27.17.
3. Centers for Medicare and Medicaid Services, Hospital Outpatient Regulations and Notices Items, Details for title CMS 1695-P Webpage, 2019 NPRM OPPS Addenda: 2019 NPRM Addendum A.06.28.18 and 2019 NPRM Addendum B.06.28.18.
4. Status indicators: C = Inpatient procedures; J1 = Hospital Part B services paid through a comprehensive APC; N = Items and services packaged into APC rates.

Device-Intensive Procedures

Categorization as a device-intensive procedure occurs when the cost of the device exceeds more than half of the total procedure payment. Examples of common device-intensive procedures include cervical and lumbar spinal fusions, joint reconstruction and cochlear implants.

In CY 2019, CMS proposes two changes related to device-intensive procedures. First, procedures that involve surgically inserted or implanted, single-use devices that meet the device offset threshold will qualify as device-intensive procedures, regardless of whether the device remains in the patient's body after the conclusion of the procedure. Second, CMS proposes lowering the device offset percentage threshold from 40 percent to 30 percent to allow a greater number of procedures to qualify as device-intensive. Device-intensive status is assigned to procedures with a device offset greater than 30 percent due to the device costs exceeding 30 percent of the individual device HCPCS code.

CMS is also proposing to lower the default device offset from 41 percent to 31 percent for new HCPCS codes describing procedures requiring the implantation of a medical device that do not yet have associated claims data.

CMS proposes no changes to the device edit policy for CY 2019.

CMS identified seven device pass-through applications under consideration. 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. The devices for which an application was received include:

- AquaBeam System
- BioBag® (Larval Debridement Therapy in a Contained Dressing)
- BlastX™ Antimicrobial Wound Gel
- EpiCord®
- remedē® System Transvenous Neurostimulator
- Restrata® Wound Matrix
- SpaceOAR® System

Hospital Outpatient Visits and Critical Care Services

Since implementation, CMS has struggled with how to report and appropriately reimburse facility resources for hospital clinic, emergency department and critical care services within an OPPS payment approach. CMS could not develop a single national standard to cover the wide range of providers and their services, leading selection of the appropriate CPT code to be based upon internal guidelines at each hospital that reflected the intent of the CPT code descriptors.

Generally, these services are billed and paid using CPT/HCPCS evaluation and management (E/M) codes and G-codes, depending on the service. Emergency department and clinic visits may be paid separately or as a composite APC. Under certain circumstances, CMS pays a combined rate for critical care E/M codes and packages payment for ancillaries when they are billed on the same date of service.[2]

For CY 2019, CMS proposes no changes to payment policies for clinic and emergency department hospital outpatient visit or critical care services. (Please refer to the Off-Campus Provider-Based Departments section for related proposals.)

Partial Hospitalization Program (PHP)

Partial hospitalization programs (PHPs) are generally defined by Medicare as an alternative to inpatient psychiatric care for individuals with an acute mental illness. These services provide intensive and structured outpatient mental health and substance abuse services, consisting of individual, group, family therapy, medication management and other services, and offering less than 24-hour daily care.

Medicare pays a per diem for PHP services when provided by a hospital to outpatients or by a community mental health center (CMHC). The PHP APC per diem payment rates are the national unadjusted payment rates. These rates are calculated based on the APC per diem costs (geometric mean per diem) using the most recent claims and cost data for each provider type for PHP service days providing three or more services.

For CY 2019, CMS is proposing no changes to its partial hospitalization program policies. The proposed rule maintains the ratesetting methodology established in CY 2016, modified in CY 2017 and continued in CY 2018, which identifies PHP services with two APCs. The CY 2019 proposed payment rates are $216.55 for hospital-based PHP services and $117.35 for CMHCs.

In the CY 2017 final rule, CMS restated recent concerns that some beneficiaries may not be receiving the full benefit of the required minimum 20 hours per week of therapeutic care.[3] CMS proposes to continue monitoring the issue in CY 2019. Analysis of CY 2017 claims shows that both PHPs and CMHCs have remained steady in maintaining appropriately low utilization of three service days compared to CY 2015 and CY 2016. No changes to the requirements are proposed at this time.

Table 6 shows a comparison between the final CY 2018 and the proposed CY 2019 APC payment rates for partial hospitalization program services.

Table 6

Partial Hospitalization Program APCs Comparison						
APC	Group Title	SI	Final CY 18		Proposed CY 19	
			Relative Weight	Payment Rate	Relative Weight	Payment Rate
5853	Partial Hospitalization (3 or more services) for CMHCs	P	1.8224	$143.31	1.4752	$117.35
5863	Partial Hospitalization (3 or more services) for hospital-based PHPs	P	2.6480	$208.23	2.7223	$216.55

Notes:

1. Centers for Medicare and Medicaid Services, Hospital Outpatient Regulations and Notices Items Webpage, 2018 Correction Notice NFRM OPPS Addenda, CY 2018 NFRM Addendum A.11.29.17.
2. Centers for Medicare and Medicaid Services, Hospital Outpatient Regulations and Notices Items Webpage, Addendum A.-Proposed OPPS APCs for CY 2019, 2019 NPRM Addendum A.06.28.18.

Off-Campus Provider-Based Departments (PBDs)

Section 603 of the 2015 Bipartisan Budget Act outlined requirements that exclude off-campus provider-based departments (PBDs) created after November 2, 2015, from OPPS payment. Specifically, any "applicable items and services" furnished in the off-campus PBD will not be considered covered outpatient department services for purposes of OPPS.

In CY 2017, CMS implemented acceptable exceptions to the policy for payment by OPPS and established policies for payment for nonexcepted items and services provided by nonexcepted off-campus PBDs. Nonexcepted services are paid using the Medicare Physician Fee Schedule (MPFS)[4] rather than OPPS. Outpatient services provided in the emergency department (both emergency and non-emergency services) are exempt from the regulation and therefore continue to be paid under OPPS. CMS uses two modifiers under this policy to monitor billing patterns and utilization: modifier PO (Excepted service provided at PBD) and modifier PN (Nonexcepted services provided at PBD), which capture the frequency and types of services performed in an off-campus PBD.

For CY 2019, CMS is soliciting comments for a method to control increases in the volume of outpatient services in a non-budget neutral manner. CMS indicated concerns with "the shift in services from the physician's office to the hospital outpatient department, thus unnecessarily increasing hospital outpatient department volume and Medicare program and beneficiary expenditures." CMS cites MedPAC's March 2017 Report to Congress, which attributes this shift, in part, "to hospitals purchasing freestanding physician practices and converting the billing from the Physician Fee Schedule to higher paying hospital outpatient department (HOPD) visits."[5]

Site-neutral clinic visit payment. CMS is proposing to apply site-neutral payments for clinic visits in all off-campus PBDs. Currently, nonexcepted off-campus PBDs already receive a reduced site-specific Medicare Physician Fee Schedule (MPFS) rate for clinic visits (identified by HCPCS code G0463 Hospital outpatient clinic visit and APC 5012). For CY 2019, CMS is proposing to extend the same payment level when the services are provided at an excepted off-campus PBD.

This proposal would reduce the OPPS payment rate for the clinic visit by the MPFS relativity adjuster of 40 percent, to an amount of $46 and a beneficiary copay of $9. Hospitals would continue to use modifiers PO and PN that identify excepted and nonexcepted services provided at off-campus PBDs. CMS estimates $760 million in savings to the Medicare program, inclusive of $150 million in beneficiary's reduced copayments under the proposed reduction.

340B-acquired drugs pricing. CMS is proposing to identify the MPFS as the "applicable payment system" for 340B-acquired drugs and biologicals and accordingly, pay under the MPFS instead of ASP minus 22.5 percent. This payment method would apply to any off-campus PBD, regardless of whether it is excepted or nonexcepted.

Emergency departments. CMS proposes adopting MedPAC's recommendation[6] and implement a new informational HCPCS modifier – ER- Items and services furnished by a provider-based off-campus emergency department. Providers would report the modifier with every claim line for outpatient hospital services provided in an off-campus PBD. The modifier will allow CMS to collect data on these services for further analysis of the upward trend in emergency department visits at PBDs. Critical access hospitals (CAHs) would not be required to report this modifier.

Expanding services at PBDs. CMS is soliciting public comment for alternate methodologies to limit the expansion of excepted services in excepted off-campus PBDs for CY 2019. The agency is also proposing that if an excepted off-campus PBD furnishes services from a clinical family of services from which they did not furnish an item or service during the baseline period (November 1, 2014, through November 1, 2015), these items and services would not be covered as outpatient, but rather from the MPFS. CMS is also proposing to revise the definition of "excepted items and services" in accordance with this proposal.

340B Drug Pricing Program

The 340B Drug Pricing Program allows eligible hospitals, primarily safety net hospitals[7] and other providers to purchase certain outpatient prescription drugs at discounted prices from drug manufacturers participating in the Medicaid Drug Rebate Program. The intent of the 340B discount is to allow providers to maximize federal resources and provide more care to more patients. At present, Medicare pays the same rate for separately payable drugs to 340B hospitals and to non-340B hospitals, regardless of the discount price.

In CY 2018, CMS implemented a reduction in payment for separately payable drugs acquired under the 340B discount. This pricing policy is intended to address concerns with payments exceeding drug acquisition costs raised in previous government reports.[8]

For CY 2019, CMS proposes continuing the policies implemented in CY 2018, with a change to the calculation of payment for 340B-acquired biosimilars to ASP minus 22.5 percent when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Further, excepted off-campus PBDs and nonexcepted PBDs will be paid the same payment rates with the same discounts.

Table 7 summarizes the main provisions of the 340B payment policy and the proposed changes.

Table 7

340B Drug Payment Policy	
Provision	Description
Payment level	• ASP minus 22.5% for drugs purchased under the 340B discount • ASP plus 6% will continue for drugs not purchased under the 340B discount
Applicable drugs	• Separately payable drugs under OPPS (status indicator K)
Excluded drugs	• Drugs with transitional pass-through payment status (status indicator G) and • Vaccines (status indicator F, L or M)
Included providers	• 340B participating hospitals paid under OPPS, except for OPPS-excluded hospitals • (e.g., CAHs or paid under the Maryland waiver)
Excluded providers	• Rural sole community hospitals (SHCs), • Children's hospitals and • PPS-exempt cancer hospitals
Provider-based departments (PBDs)	• Excepted off-campus PBDs and nonexcepted PBDs to be paid the same payment rates with the same discounts
Modifier JG	• Triggers the payment adjustment • Reported by included 340B hospitals for drugs acquired under the 340B discount program
Modifier TB	• Informational modifier for tracking and purposes, does not trigger the cutback policy • Reported by excluded 340B hospitals for drugs acquired under the 340B discount program
Dual eligibles	"State Medicaid programs should be aware of modifier "JG" to help further prevent inappropriate billing of manufacturer rebates."

Notes:

1. *Federal Register* 82:247 (December 27, 2017), p. 61188.
2. *Federal Register* 82:239 (December 14, 2017), pp. 59355–59371, 59482–59485.
3. *Federal Register* 83:147 (July 31, 2018), p. 37145.

Hospital Outpatient Quality Reporting (OQR) Program

The Hospital Outpatient Quality Reporting (OQR) Program is a pay-for-reporting program and is the source of outpatient quality reporting for CMS Hospital Compare website. It provides useful quality information to empower patient choice of providers. For required measures, non-reporting hospitals are penalized with a payment reduction of 2 percent to their annual payment update.

For CY 2019, the proposed rule removes several quality measures from the Hospital OQR Program; no new measures are being proposed. The first changes consider factors for removing quality measures. The wording for Factor 7 is proposed to be changed from, "Collection or reporting of a measure leads to negative unintended consequences such as patient harm," to "... other than patient harm," because measures causing patient harm will be removed immediately and outside of rulemaking. A new measure removal factor, Factor 8, is proposed, "The costs associated with a measure outweigh the benefit of its continued use in the program."

The CY 2019 proposed rule proposes removing 10 measures from the Hospital OQR Program, as shown in Table 8.

No action is being taken regarding use of social risk factors in quality measurement, although this was considered in the CY 2018 final rule. CMS continues to examine options to reduce health disparities among patient groups, "by increasing the transparency of disparities as shown by quality measures."

In the CY 2018 final rule, CMS delayed implementation of Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures beginning with the CY 2020 payment determination (CY 2018 data submission). No changes to this policy are proposed in the CY 2019 proposed rule.

Table 8

Proposed OPPS Quality Measures to be Removed		
	Reason for Removal	Effective Date of Removal
OP-27 Influenza vaccination coverage among healthcare personnel	Costs outweigh the benefit of its continued use	CY 2020 (as proposed)
OP-5 Median time to ECG	Costs outweigh the benefit of its continued use	CY 2021 (as proposed)
OP-9 Mammography follow-up rates	Measure does not align with current clinical guidelines or practice	CY 2021 (as proposed)
OP-11 Thorax Computed Tomography (CT)—Use of contrast material	Measure topped out	CY 2021 (as proposed)
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	Improvement does not result in better patient outcomes	CY 2021 (as proposed)
OP-14 Simultaneous use of brain computed tomography (CT) and sinus CT	Measure topped out	CY 2021 (as proposed)
OP-17 Tracking clinical results between visits	Improvement does not result in better patient outcomes	CY 2021 (as proposed)
OP-29 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	Costs outweigh the benefit of its continued use	CY 2021 (as proposed)
OP–30: Endoscopy/Polyp Surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—avoidance of inappropriate use	Costs outweigh the benefit of its continued use	CY 2021 (as proposed)
OP-31 Cataracts—Improvement in patient's visual function within 90 days following cataract surgery	Costs outweigh the benefit of its continued use	CY 2021 (as proposed)

Notes:
1. *Federal Register* 83:147 (July 31, 2018), p. 37090.

CMS Requests for Information

CMS asks for feedback and comment in each of its proposed rules. This applies to almost every section and policy change. Some of the key areas that CMS has requested comment on in the CY 2019 OPPS proposed rule are:

- **Price transparency.** CMS requests information, consistent with other rules released this year, on how to best inform beneficiaries about charges and payment in a consumer-friendly manner. The intent is to provide them with the necessary information about their liability and allow comparison pricing across settings.
- **Interoperability.** CMS is soliciting ideas on improving interoperability or the sharing of healthcare data electronically between providers. The objective is to achieve better transitions of care for patients moving between hospitals and community providers.
- **Competitive Acquisition Program (CAP)-like Model.** CMS requests specific feedback on the design of a potential alternative payment model, similar to the previous CAP model for certain drugs (in effect from July 2005–December 2008). This potential model would test private-sector vendor-administered payment arrangements for certain separately payable Part B drugs and biologicals, including high cost therapies.

CMS also solicits comment related to some of the proposed changes. Examples include outcome measures to be considered for the Hospital OQR Program; ideas on ways to prevent opioid use disorders and improve access to treatment; and potential methodologies that would limit the expansion of excepted services in excepted off-campus PBDs.

Resources

The CY 2019 Outpatient Prospective Payment System (OPPS) proposed rule, addenda and related tables home page may be accessed here.

The CMS factsheet of the CY 2019 Outpatient Prospective Payment System (OPPS) proposed rule may be accessed here.

Appendix A

Proposed CY 19 Comprehensive APCs (C-APCs)			
C-APC	APC Group Title	Clinical Family	HCPCS Codes
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	EBIDX	98
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	EBIDX	105
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	24
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	13
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS	5
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	BREAS	1
5112	Level 2 Musculoskeletal Procedures	ORTHO	130
5113	Level 3 Musculoskeletal Procedures	ORTHO	439
5114	Level 4 Musculoskeletal Procedures	ORTHO	289
5115	Level 5 Musculoskeletal Procedures	ORTHO	67
5116	Level 6 Musculoskeletal Procedures	ORTHO	16
5153	Level 3 Airway Endoscopy	AENDO	20
5154	Level 4 Airway Endoscopy	AENDO	25
5155	Level 5 Airway Endoscopy	AENDO	27
5163*	Level 3 ENT Procedures	ENTXX	45
5164	Level 4 ENT Procedures	ENTXX	129
5165	Level 5 ENT Procedures	ENTXX	232
5166	Cochlear Implant Procedure	COCHL	1
5183*	Level 3 Vascular Procedures	VASCX	53
5184*	Level 4 Vascular Procedures	VASCX	48
5191	Level 1 Endovascular Procedures	VASCX	15
5192	Level 2 Endovascular Procedures	VASCX	20
5193	Level 3 Endovascular Procedures	VASCX	27
5194	Level 4 Endovascular Procedures	VASCX	16
5200	Implantation Wireless PA Pressure Monitor	WPMXX	2
5211	Level 1 Electrophysiologic Procedures	EPHYS	5
5212	Level 2 Electrophysiologic Procedures	EPHYS	8
5213	Level 3 Electrophysiologic Procedures	EPHYS	3
5222	Level 2 Pacemaker and Similar Procedures	AICDP	16
5223	Level 3 Pacemaker and Similar Procedures	AICDP	9
5224	Level 4 Pacemaker and Similar Procedures	AICDP	4
5231	Level 1 ICD and Similar Procedures	AICDP	7
5232	Level 2 ICD and Similar Procedures	AICDP	4
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	1
5302	Level 2 Upper GI Procedures	GIXXX	61
5303	Level 3 Upper GI Procedures	GIXXX	18

Appendix A

Proposed CY 19 Comprehensive APCs (C-APCs)			
C-APC	APC Group Title	Clinical Family	HCPCS Codes
5313	Level 3 Lower GI Procedures	GIXXX	56
5331	Complex GI Procedures	GIXXX	14
5341	Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	51
5361	Level 1 Laparoscopy and Related Services	LAPXX	101
5362	Level 2 Laparoscopy and Related Services	LAPXX	38
5373	Level 3 Urology and Related Services	UROXX	96
5374	Level 4 Urology and Related Services	UROXX	60
5375	Level 5 Urology and Related Services	UROXX	82
5376	Level 6 Urology and Related Services	UROXX	10
5377	Level 7 Urology and Related Services	UROXX	11
5414	Level 4 Gynecologic Procedures	GYNXX	76
5415	Level 5 Gynecologic Procedures	GYNXX	29
5416	Level 6 Gynecologic Procedures	GYNXX	11
5431	Level 1 Nerve Procedures	NERVE	48
5432	Level 2 Nerve Procedures	NERVE	42
5462	Level 2 Neurostimulator and Related Procedures	NSTIM	12
5463	Level 3 Neurostimulator and Related Procedures	NSTIM	12
5464	Level 4 Neurostimulator and Related Procedures	NSTIM	4
5471	Implantation of Drug Infusion Device	PUMPS	3
5491	Level 1 Intraocular Procedures	INEYE	58
5492	Level 2 Intraocular Procedures	INEYE	38
5493	Level 3 Intraocular Procedures	INEYE	2
5494	Level 4 Intraocular Procedures	INEYE	1
5495†	Level 5 Intraocular Procedures	INEYE	0
5503	Level 3 Extraocular, Repair and Plastic Eye Procedures	EXEYE	75
5504	Level 4 Extraocular, Repair and Plastic Eye Procedures	EXEYE	46
5627	Level 7 Radiation Therapy	RADTX	4
5881	Ancillary Outpatient Services When Patient Dies	N/A	0
8011	Comprehensive Observation Services	N/A	0
Total			**2,964**

Notes:

1. *Federal Register* 83:147 (July 31, 2018), pp. 37062–37063.
2. HCPCS counts are based on our analysis of the 2019 NPRM Addendum B.06.28.18 and the 2019 NPRM Addendum J 7.12.18, available online on the CMS website.
3. (*) Proposed new C-APCs. Other proposed changes: 8 HCPCS codes to be removed and 168 additional HCPCS codes to be linked to C-APCs.
4. (†) CMS proposes deleting C-APC 5495.

Notes

1. This estimate reflects: 1.25 percent for the fee schedule increase factor, minus 1.2 percent for the proposed off-campus provider-based department visits policy, minus 0.13 percent for the proposed change in the pass-through payment estimate between CYs 2018 and 2019, plus a proposed increase of 0.02 percent for the difference in estimated outlier payments between CYs 2018 and 2019. *Federal Register* 83:147 July 31, 2018), p. 37228.
2. Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 4 Part B Hospital, §160 Clinic and Emergency Visits and 160.1 Critical Care Services (Rev. 3795, 06-16-17)
3. In its analysis of CYs 2015–2016, CMS found that approximately half of Medicare PHP beneficiaries "received 20 hours or more in 50 percent or more of non-transitional weeks" (not admission or discharge weeks). CMS also indicated concerns with the low frequency of individual therapy provided to beneficiaries and will continue to monitor utilization in this area. *Federal Register* 82:239 (December 14, 2017), pp. 59378–59381.
4. CMS currently pays for these services under the MPFS based on a percentage of the OPPS payment rate. For CY 2018, CMS finalized their decision to reduce the payment rate from 50 percent to 25 percent of the OPPS rate. Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018, Final Rule," *Federal Register* 82:219 (November 15, 2017), pp. 53019–53024
5. U.S. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2017), pp. 69–70
6. U.S. Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2017), pp. 245–246
7. Eligible hospitals generally include hospitals with a Medicare disproportionate share hospital (DSH) percentage above 11.75 percent, critical access hospitals, children's hospitals and freestanding cancer hospitals with a DSH adjustment greater than 11.75 percent, as well as sole community hospitals and rural referral centers with a DSH adjustment percentage of 8.0 percent or higher. Some hospitals must meet other established criteria.
8. Referenced reports are from MedPAC, the Office of Inspector General, the Government Accountability Office and the Health Resources and Services Administration (2015–2016). In its discussion of the 340B payment reduction and review of these studies, CMS reiterated that it is "timely to reexamine the appropriateness" of its current payment policy. Specific reported concerns include the growth of 340B providers, unnecessary utilization and potential overutilization of separately payable drugs, payment that exceeds drug acquisition costs and cost-sharing burden on beneficiaries. *Federal Register* 82:138 (July 20, 2017), pp. 33632–33635. *Federal Register* 82:217 (November 13, 2017), pp. 52494–52495

Contact Us

For additional information, please contact us:
govhealthcare@conduent.com

www.conduent.com/medicaid

CONDUENT