HOSPITAL OUTPATIENT PPS/ASC
FINAL RULE FOR CY 2019

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) issued its calendar year (CY) 2019 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) final rule. In addition to standard updates, the rule expands Medicare "site-neutral" payment policies and changes the payment policies for 340B-acquired drugs.

Our Take
CMS’s misguided final rule will have negative consequences for hospitals and patients. This rule, which phases in over two years payment cuts to hospital outpatient clinic visits, is based on unsupported analyses and erroneous policy rationales and will hit patients in rural and vulnerable communities especially hard.

Congress recognized the crucial role of hospital outpatient departments in the communities they serve and, in 2015, specifically protected existing facilities from unwarranted payment reductions. The rule ignores this, as well as the real and crucial differences between hospital outpatient departments and other sites of care. According to a study conducted by KNG Health Consulting, patients who receive care in a hospital outpatient department are more likely to be poorer and have more severe chronic conditions than patients treated in an independent physician office. In addition, hospitals are held to far higher regulatory standards because of the complexity of caring for sicker patients.

The final rule also compounds the losses the Administration has imposed on hospitals serving vulnerable communities by extending the nearly 30 percent cuts in payment for 340B drugs to more sites of care.

These actions clearly exceed the Administration’s legal authority. The AHA, joined by the Association of American Medical Colleges and member hospitals, intends to promptly bring a court challenge to the rule’s site-neutral provisions. The AHA, along with other associations and member hospitals, is already challenging the 340B policy included in the current rule.

What You Can Do
✓ Participate in the AHA’s member-only webinar to discuss the final rule. Click here to register for this 90-minute webinar on Thursday, Nov. 29 at 3:00 p.m. ET.
✓ Share this advisory with your chief financial officer, chief medical officer, pharmacy leaders and other senior management, billing and coding staff, nurse managers, and key physician leaders.
✓ Model the impact of the APC changes on your expected CY 2019 Medicare revenue.

Further Questions
Contact Roslyne Schulman, director of policy, at rschulman@aha.org, for payment policy questions and Caitlin Gillooley, senior associate director, at cgillooley@aha.org, for questions regarding quality.
# Hospital Outpatient PPS/ASC Final Rule for CY 2019

## Table of Contents

Overview ....................................................................................................................................................... 3  
Changes to the CY 2019 OPPS......................................................................................................................... 3  
OPPS Update and Linkage to Hospital Quality Data Reporting................................................................. 3  
Changes to Site-neutral Payment Policy for Off-campus PBDs ................................................................. 3  
Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals ....................................................... 4  
Changes to the Device-Intensive Procedures Policy for 2019 ................................................................. 7  
Wage Index............................................................................................................................................... 8  
Recalibration and Scaling of APC Relative Weights ................................................................................ 8  
Comprehensive APCs ................................................................................................................................. 10  
Changes to the Inpatient-only List ............................................................................................................ 11  
New Technology APC Payment for Low-volume Procedures ................................................................. 11  
Hospital Outpatient Outlier Payments ...................................................................................................... 12  
Transitional Pass-through Payments ....................................................................................................... 12  
Partial Hospitalization Program (PHP) Payment ..................................................................................... 13  
Cancer Hospital Adjustment ...................................................................................................................... 14  
Rural Adjustment for Sole Community Hospitals .................................................................................... 14  
Beneficiary Coinsurance ........................................................................................................................... 14  
Hospital Outpatient Quality Reporting Program .................................................................................. 15  
Changes to the Inpatient Quality Reporting Program (IQR) .................................................................. 17  
Inpatient Quality Reporting Program (IQR) HCAHPS Pain Questions ................................................ 17  
Changes to the CY 2019 ASC Payment System ...................................................................................... 18  
Updates and Changes to ASC Payment Policy .......................................................................................... 18  
Expansion of the Definition of “Surgery” for ASC-covered Surgical Procedures .................................. 18  
Additions to the List of ASC-covered Surgical Procedures ..................................................................... 19  
Payment for Non-opioid Pain Management Therapy ............................................................................... 19  
Changes for ASC Quality Reporting Program (ASCQR) ..................................................................... 19  
Requests for Information (RFIs) .............................................................................................................. 20  
Next Steps.................................................................................................................................................. 21
Overview

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) issued its calendar year (CY) 2019 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) final rule. In addition to standard updates, the rule expands Medicare “site-neutral” payment reductions to outpatient clinic visits in grandfathered (excepted) off-campus provider-based departments (PBDs) and makes changes to the payment policies for drugs, including 340B-acquired drugs. The agency also makes significant changes to payment policy for ASCs in order to encourage the shifting of outpatient surgical services to this setting. Among other changes, CMS also demonstrates its commitment to its Meaningful Measures initiative by removing eight of the 10 measures initially proposed for removal from the Outpatient Quality Reporting (OQR) program. The rule takes effect Jan. 1, 2019.

Changes to the CY 2019 OPPS

OPPS Update and Linkage to Hospital Quality Data Reporting

The CY 2018 OPPS conversion factor is $78.636. To calculate the conversion factor for CY 2019, the agency adjusted the 2018 conversion factor by the “fee schedule increase factor” and made further adjustments for various budget neutrality factors. The fee schedule increase factor equals the hospital inpatient marketbasket of 2.9 percent, reduced by a productivity adjustment of 0.8 percentage points and an additional reduction of 0.75 percentage points, as required by the Affordable Care Act (ACA). Thus, CMS applies a fee schedule increase factor of 1.35 percent for the CY 2019 OPPS final rule. Hospitals that do not meet OQR program requirements are subject to a further reduction of 2.0 percentage points, resulting in a fee schedule increase factor of -0.65 percent. The resulting CY 2019 OPPS conversion factor is $79.490 for hospitals meeting OQR requirements and $77.900 for hospitals not meeting OQR requirements.

These payment adjustments, in addition to other changes in the rule (including CMS’s nonbudget-neutral reduction in payment for hospital outpatient clinic visits in excepted off-campus PBDs) are estimated to result in a net increase in OPPS payment of approximately $440 million in CY 2019, including beneficiary cost-sharing, but excluding estimated changes in enrollment, utilization and case-mix. Taking into account estimated changes in enrollment, utilization and case-mix, CMS estimates that OPPS expenditures for 2019 will be approximately $74.1 billion, an increase of approximately $5.8 billion compared to 2018 OPPS payments.

CMS estimates that the fee schedule increase factor and all other policies in the proposed rule will result in the following per-case changes in payment:

<table>
<thead>
<tr>
<th>All Hospitals</th>
<th>0.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban Hospitals</td>
<td>0.7%</td>
</tr>
<tr>
<td>Large Urban</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other Urban</td>
<td>0.6%</td>
</tr>
<tr>
<td>Rural</td>
<td>0.5%</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------</td>
</tr>
<tr>
<td>Sole Community</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other Rural</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

**Changes to Site-neutral Payment Policy for Off-campus PBDs**

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) requires that, with the exception of dedicated emergency department (ED) services, services furnished in off-campus PBDs that began billing under the OPPS on or after Nov. 2, 2015, or that cannot meet the 21st Century Cures "mid-build" exception, will no longer be paid under the OPPS, but under another applicable Part B payment system. In the CY 2019 physician fee schedule (PFS) final rule, the agency continues to set the PFS as the applicable payment system for most of these non-grandfathered (non-excepted) services and also continues to set payment for most non-excepted services at the “PFS-equivalent” rate of 40 percent of the OPPS rate.

**Site-neutral Reduction in Payment for Hospital Outpatient Clinic Visits in Excepted Off-campus PBDs.** Citing “unnecessary” increases in the volume of clinic visits in hospital PBDs allegedly due to payment differentials driving the site-of-service decision, CMS finalized its policy to pay for visits furnished in grandfathered (excepted) off-campus PBDs at the same rate they are paid in non-grandfathered (non-excepted) off-campus PBDs. Specifically, CMS will pay for clinic visit (i.e., evaluation and management) services in excepted PBDs at the “PFS-equivalent” payment rate of 40 percent of the OPPS payment amount. The agency will, however, phase in the application of this policy over two years. That is, in CY 2019, 50 percent of the reduction will be applied, meaning that for this year, excepted off-campus PBDs will be paid 70 percent of the OPPS rate for clinic visit services (Healthcare Common Procedure Coding System (HCPCS) code G0463). In CY 2020 and subsequent years, these excepted off-campus PBDs will be paid 40 percent of the OPPS rate for these services. This payment cut will not apply to on-campus clinic visits. CMS indicates that during the phase in, it will monitor the impact of this policy on access and quality of care for beneficiaries. The agency also will consider for future rulemaking the comments it received on expanding the “unnecessary increase in volume” policy to additional items and services paid under the OPPS.

The agency will implement the clinic visit policy in a non-budget neutral manner, which means that it is estimated to cut hospital payments under the OPPS by $380 million in CY 2019.

**Expansion of Clinical Families of Services at Excepted Off-campus PBDs.** Under current policy, an excepted off-campus PBD may expand the type of services it furnishes and will receive the full OPPS rate for such services. However, in the proposed rule, CMS set forth a policy that, if an excepted off-campus PBD began to furnish a new service from a clinical family for which it did not previously furnish and bill for during a baseline period (generally from Nov. 1, 2014 through Nov. 1, 2015), the new service would no longer be a covered outpatient department service. Instead, it would be a non-excepted service and paid under the PFS at 40 percent of the OPPS amount.
In the CY 2019 final rule, CMS did not finalize this policy, which would have penalized hospitals’ off-campus PBDs that expand the types of critical services they offer to their communities – preventing them from caring for the changing needs of their patients. The agency cites stakeholder concerns about the operational complexity and administrative burden that the policy would impose on hospitals in its decision. While the agency did not finalize this proposal for CY 2019, it indicates that it will continue to monitor the expansion of services in excepted off-campus PBDs and may propose to adopt a limitation in future rulemaking.

Applying the 340B Drug Payment Policy to Non-excepted Off-campus PBDs. In CY 2018, CMS finalized an OPPS policy to reduce payment for separately payable drugs and biologicals (other than drugs on pass-through payment status and vaccines) acquired under the 340B program from average sales price (ASP) plus 6 percent to ASP minus 22.5 percent. However, because services furnished in non-excepted off-campus PBDs are no longer considered to be covered outpatient department services, 340B-acquired drugs furnished in these settings were not subject to this policy and so continued to be paid at ASP plus 6 percent in 2018.

For CY 2019, CMS finalized its proposal to pay for separately payable Part B drugs and biologicals (other than vaccines and drugs with pass-through payment status) acquired under the 340B program at a rate of ASP minus 22.5 percent when they are furnished by non-excepted off-campus PBDs. To effectuate this expansion of the 340B payment reduction, beginning Jan. 1, 2019, non-excepted off-campus PBDs of a hospital paid under the PFS are required to report modifier “JG” on the same claim line as the drug or biological HCPCS code to identify a 340B-acquired drug or biological. This payment change is not budget neutral and is estimated to result in a cut of $48.5 million in CY 2019.

This policy will not apply to rural sole community hospitals, children’s hospitals or PPS-exempt cancer hospitals. These hospitals will be required to report informational modifier “TB” for 340B-acquired drugs and biologicals, and will continue to be paid ASP plus 6 percent. Because this is an OPPS policy, the payment reduction also will not apply to critical access hospitals.

Collecting Data on Services Furnished in Off-campus EDs. In the final rule, CMS again shares the concerns raised by the Medicare Payment Advisory Commission (MedPAC) and others that the growth in the number of off-campus provider-based EDs may be a result of the higher Medicare payment rates for services furnished in these settings compared to similar services in physician offices or urgent care centers. Further, the agency speculates that Section 603’s exemption of services furnished in provider-based EDs also may be driving this growth.

In response to these concerns, CMS will be collecting data to assess the extent to which OPPS services are shifting to off-campus provider-based EDs. Therefore, effective Jan. 1, 2019, it will create a new HCPCS modifier (ER—Items and services furnished by a provider-based off-campus ED) that will be reported with every claim line for outpatient hospital services furnished in an off-campus ED. CMS will accomplish this in its January OPPS transmittal, which typically comes out in December.
Payment Changes for Drugs, Biologicals and Radiopharmaceuticals

Packaging Policy for “Threshold-packaged” and “Policy-packaged” Drugs, Biologicals and Radiopharmaceuticals. The payment rates for drugs, biologicals and radiopharmaceuticals without pass-through status are based on third quarter of CY 2018 ASP data. Updates to the ASP-based rates will be published quarterly and posted on CMS’s website through CY 2019.

CMS pays for drugs, biologicals and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment or separate payment (individual APCs). For CY 2019, CMS increased the packaging threshold for “threshold-packaged” drugs, including nonimplantable biologicals and therapeutic radiopharmaceuticals, to $125 per day, $5 more than in CY 2018. Therefore, drugs costing less than $125 will have their cost packaged in the procedure with which they are billed, such as an outpatient clinic visit. Drugs costing more than $125 will be paid separately through their own APC.

There are exceptions to this threshold-based packaging policy for certain “policy-packaged” drugs, biologicals and radiopharmaceuticals. Consistent with current CMS packaging policy, the agency will continue to package the costs of all anesthesia drugs; intraoperative items and services; drugs, biologicals and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (including contrast agents, diagnostic radiopharmaceuticals and stress agents); and drugs and biologicals that function as supplies when used in a surgical procedure (e.g., skin substitutes), regardless of whether they meet the $125 per day threshold. The packaged or separately payable status of each of these drugs or biologicals is listed in Addendum B to the final rule.

Payment for Drugs and Biologicals without Pass-through Status that are not Packaged.

Separately Payable Drugs and Biologicals. For CY 2019 (with the exception of 340B-acquired drugs and biologicals), CMS will continue its current policy and pay for separately payable drugs and biologicals at the “statutory default rate” of ASP plus 6 percent. CMS notes that this payment requires no further adjustment and represents the combined acquisition and pharmacy overhead payment for drugs and biologicals.

Reduction in Payment for New Drugs Before ASP Data Are Available. Consistent with a similar policy in the CY 2019 PFS final rule, CMS will reduce payment or new nonpass-through Part B drugs and biologicals (that are not acquired under the 340B program) to wholesale acquisition cost (WAC) plus 3 percent, rather than WAC plus 6 percent. This rate only applies during the period of time when ASP data for the new drug are unavailable. This is consistent with recommendations included in the fiscal year (FY) 2019 President’s Budget Proposal and MedPAC’s June 2017 Report to Congress. CMS notes this payment reduction will not apply to single source drugs that are required under law to be paid at 106 percent of the lesser of ASP or WAC. The AHA opposes this payment reduction because it unfairly shifts the burden for the high list prices imposed by drug manufacturers onto hospitals and physicians.
Separately Payable 340B-acquired Drugs. For CY 2019, CMS will continue to pay for separately payable nonpass-through drugs and biologicals acquired under the 340B program at the rate of ASP minus 22.5 percent. The agency clarifies that the 340B payment adjustment also applies to drugs that are priced using either WAC or average wholesale price (AWP). That is, the 340B payment adjustment for WAC-priced drugs continues to be WAC minus 22.5 percent\(^1\).

Change in Payment Policy for Separately Payable 340B-acquired Biosimilar Products. In CY 2018, CMS finalized a policy in which biosimilars without pass-through payment status that were acquired under the 340B program would be paid the ASP (of the biosimilar) minus 22.5 percent (of the reference product’s ASP). However, in the proposed rule the agency noted stakeholder concern that the policy may unfairly lower the OPPS payment for separately payable biosimilars because the payment reduction is based on the reference product’s ASP, which is generally priced higher than the biosimilar, thus resulting in a more significant reduction in payment than warranted.

Therefore, for CY 2019, CMS will pay for nonpass-through biosimilars acquired under the 340B program at ASP minus 22.5 percent of the biosimilar’s own ASP instead of the biosimilar’s ASP minus 22.5 percent of the reference product’s ASP. The AHA supports this final policy.

High-cost/Low-cost Threshold for Packaged Skin Substitutes. Consistent with current policy, CMS will assign skin substitutes with a geometric mean unit cost (MUC) or a per-day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the “high-cost” group. In addition, for CY 2019, in an effort to limit year-to-year fluctuations in payment, CMS again will allow a skin substitute product that does not exceed the CY 2019 MUC or PDC threshold for CY 2019, but was assigned to the high-cost group for CY 2018, to be assigned to the high-cost group for CY 2019. Table 41 of the final rule shows the final 2019 assignment of each skin substitute to either the high- or low-cost category. In addition, CMS notes that it will continue to study issues related to changing the methodology for paying for skin substitute products for the CY 2020 OPPS rulemaking.

Changes to the Device-intensive Procedures Policy for 2019
Currently, CMS assigns device-intensive status to all procedures that require the implantation of a device that remains in the patient’s body after the procedure and that have an individual HCPCS code-level device offset of greater than 40 percent. All such device-intensive procedures are subject to the device edit and to the no cost/full credit and partial credit device policies.

In response to comments, and as part of an effort to better capture costs for procedures with significant device costs, for 2019 CMS modifies the criteria for device-intensive procedures to allow procedures that involve single-use devices, regardless of whether or not they remain in the body after the conclusion of the procedure, to qualify as device-intensive procedures. In addition, to allow a greater number of procedures to qualify as devices-intensive, CMS lowers the device offset percentage threshold from

\(^1\) Or 69.46 percent of AWP, as applicable
40 to 30 percent. The agency believes this will help ensure these procedures receive more appropriate payment in the ASC setting. CMS also states this change will help to ensure more procedures containing relatively high-cost devices are subject to device edits, which leads to more correct coding and greater accuracy in the claims data. The full list of final CY 2019 device-intensive procedures is included in Addendum P to the final rule.

Specifically, CMS device-intensive procedures will be subject to the following criteria:
- All procedures must involve implantable devices assigned a Current Procedural Terminology (CPT) or a HCPCS code;
- The required devices (including single-use devices) must be surgically inserted or implanted; and
- The device-offset amount must be significant, which is defined as exceeding 30 percent of the procedure’s mean cost.

**Wage Index**

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. CMS has historically adopted the final FY inpatient prospective payment system (IPPS) wage index as the CY wage index for adjusting OPPS payments. Thus, the wage index that applies to a particular hospital under IPPS also applies to that hospital under the OPPS. The agency finalizes its continuation of this policy, using the final FY 2019 IPPS wage indices for calculating CY 2019 OPPS payments. (See AHA’s IPPS Final Rule Regulatory Advisory for more information about the wage index for FY 2019). For hospitals paid under the OPPS but not the IPPS, CMS finalizes its longstanding policy for CY 2019 to assign the wage index that would be applicable if the hospital were paid under the IPPS, based on its geographic location and any applicable wage index adjustments. As in prior years, 60 percent of the APC payment is adjusted by the wage index. In addition, consistent with the FY 2019 IPPS final rule, CMS finalizes its proposal not to extend the imputed rural floor policy under OPPS.

**Recalibration and Scaling of APC Relative Weights**

CMS recalibrates the relative APC weights using hospital claims for services furnished during CY 2017. As in previous years, the agency standardizes all of the relative payment weights to the APC 5012 (Level 2 Examinations and Related Services) because that is the APC to which HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient) is assigned. G0463 is the most frequently billed OPPS services. That is, CMS calculates an "unscaled" – i.e., not adjusted for budget neutrality – relative payment weight by comparing the geometric mean cost of each APC to the geometric mean cost of the APC 5012.

Although CMS finalized a CY 2019 policy to phase in reduced payment for clinic visits furnished in excepted off-campus PBDs, CMS continues to use visits in these settings in determining the relative weight scalar. The agency notes that the PFS-equivalent adjuster is applied to the clinic visit payment, not the relative weight, and that CMS’s policy is not budget neutral while changes to the weights are budget neutral.
To comply with budget neutrality requirements, CMS compares the estimated unscaled relative payment weights in CY 2019 to the estimated total relative payment weights in CY 2018 using the service volume in the CY 2017 claims data. Based on this comparison, the CY 2019 unscaled APC payment weights are adjusted by a weight scalar of 1.4574. The effect of the adjustment is to increase the unscaled relative weights by about 45.74 percent in order to ensure that the CY 2019 relative payment weights are budget neutral.

Calculation and Use of Cost-to-charge Ratios. To convert billed charges on the outpatient claims to estimated costs, CMS multiplies the charges by a hospital-specific cost-to-charge ratio (CCR) associated with each revenue code and cost center. To calculate CCRs for 2019, CMS will employ the same basic approach used for APC rate construction for 2007 and each subsequent year. CMS applies the relevant hospital-specific CCR to the hospital’s charges at the most detailed level possible based on a revenue code-to-cost center crosswalk containing a hierarchy of CCRs for each revenue code. CCRs are calculated for the standard and nonstandard cost centers accepted by the electronic cost report database at its most detailed level. Generally, the most detailed level will be the hospital-specific departmental level.

In the 2014 OPPS/ASC final rule, CMS created distinct CCRs for implantable devices, magnetic resonance imaging (MRIs), computerized tomography (CT) scans and cardiac catheterization. However, in response to public comment, CMS removed claims from providers that use a cost allocation method of “square feet” to calculate CCRs because of concerns about the lack of accuracy of this cost allocation method. CMS indicated that it would provide hospitals with four years to transition to a more accurate cost allocation method and would use cost data from all providers, regardless of the cost allocation statistic employed, beginning in 2018. It subsequently extended this delay for one year, through 2018.

Table 1 of the final rule shows the relative effect on imaging APC payments of removing cost data for providers that report CT and MRI standard cost centers using “square feet.” Table 2 provides statistical values based on the CT and MRI standard cost center CCRs using the different cost allocation methods.

### Table 1. Percentage Change in Estimated Cost for CT and MRI APCs when Excluding Claims from Providers Using “Square Feet” as the Cost Allocation

<table>
<thead>
<tr>
<th>APC</th>
<th>APC Descriptor</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5521</td>
<td>Level 1 Imaging without Contrast</td>
<td>-4.0%</td>
</tr>
<tr>
<td>5522</td>
<td>Level 2 Imaging without Contrast</td>
<td>5.6%</td>
</tr>
<tr>
<td>5523</td>
<td>Level 3 Imaging without Contrast</td>
<td>4.2%</td>
</tr>
<tr>
<td>5524</td>
<td>Level 4 Imaging without Contrast</td>
<td>5.3%</td>
</tr>
<tr>
<td>5571</td>
<td>Level 1 Imaging with Contrast</td>
<td>7.8%</td>
</tr>
<tr>
<td>5572</td>
<td>Level 2 Imaging with Contrast</td>
<td>8.3%</td>
</tr>
<tr>
<td>5573</td>
<td>Level 3 Imaging with Contrast</td>
<td>2.8%</td>
</tr>
<tr>
<td>8005</td>
<td>CT and CTA without Contrast Composite</td>
<td>14.1%</td>
</tr>
<tr>
<td>8006</td>
<td>CT and CTA with Contrast Composite</td>
<td>11.5%</td>
</tr>
<tr>
<td>8007</td>
<td>MRI and MRA without Contrast Composite</td>
<td>6.5%</td>
</tr>
<tr>
<td>8008</td>
<td>MRI and MRA with Contrast Composite</td>
<td>6.8%</td>
</tr>
</tbody>
</table>
CMS indicates that since it adopted its policy in 2014 of excluding providers that use the square foot cost allocation method, the number of valid MRI CCRs has increased by 17.5 percent to 2,177 providers, and the number of valid CT CCRs has increased by 15.1 percent to 2,251 providers. As shown in Table 1, eliminating these hospitals from the OPPS rate setting methodology increases the payment for all but one of the imaging APCs because hospitals that use the square foot allocation have lower CCRs for their imaging cost centers.

In the final rule, CMS acknowledges that CT and MRI CCRs may have a significant impact on the PFS, because the technical component payment for many imaging services is capped at the OPPS payment amount. Therefore, CMS says it will continue to monitor OPPS imaging payments in the future and consider the potential impacts of payment changes to other payment systems.

CMS also notes that while it has encouraged hospitals to use more precise cost reporting methods, it has not seen a substantial decline in the number of hospitals that use the square feet cost allocation method. However, it acknowledges that although there are costs and challenges with transitioning to a different accounting method for CT and MRI costs, the agency continues to believe that adopting CT and MRI cost center CCRs improves the accuracy of the cost estimation process for the OPPS relative weights. **Therefore, CMS will extend its policy of not using providers that use the square foot cost allocation methodology in calculating the OPPS relative weights for one additional year through 2019.** The AHA supports the extension of this transitional policy and has encouraged the agency to continue to educate providers about the benefits of switching to a more accurate cost allocation method.

### Comprehensive APCs

There are currently 62 C-APCs that package together an expanded number of related items and services contained on the same claim into a single payment for a comprehensive primary service under the OPPS.

**Additional C-APCs for 2019.** CMS adds three C-APCs under the existing C-APC payment policy beginning in CY 2019: C-APC 5163 (Level 3 ENT Procedures); C-APC 5183 (Level 3 Vascular Procedures); and C-APC 5184 (Level 4 Vascular Procedures). Table 7 of the final rule includes a list of all of the C-APCs for 2019. This increases the total number of C-APCs to 65.
Exclusion of Procedures Assigned to New Technology APCs from C-APC Packaging. CMS finalizes its proposal to exclude procedures assigned to new technology APCs (APCs 1491 through 1599 and APCs 1901 through 1908) from being packaged into C-APCs because of a concern that packaging payment reduces the number of claims for the new technology that are available for APC pricing. The rule indicates that packaging in this circumstance is contrary to the objective of the New Technology APC payment policy, which is to gather sufficient claims data to enable CMS to assign the service to an appropriate clinical APC. The AHA supported this policy change in its comments to CMS.

Changes to the Inpatient-only List
The inpatient-only list specifies those procedures and services for which the hospital will be paid only when the procedures are provided in the inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged.

For CY 2019, CMS removes four services from the inpatient-only list:

- CPT code 31241 (Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery). Assigned to C-APC 5153 (Level 3 Airway Endoscopy) with a status indicator of “J1.”

- CPT code 01402 (Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty). Packaged with the associated procedure and assigned status indicator “N” (Items and Services Packaged into APC Rates).

- CPT 0266T (Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed). Assigned to APC 5463 (Level 3 Neurostimulator and Related Procedures) with a status indicator of “J1”).

- CPT code 00670 (Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures). Packaged with the associated procedure and assigned status indicator “N.”

In addition, CMS adds one service to the inpatient-only list: HCPCS code C9606 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel).

New Technology APC Payment for Low-volume Procedures
Currently, there are 52 levels of New Technology APC groups with two parallel status indicators. One set with a status indicator of “S” (Significant procedure, not discounted when multiple) and the other set with a status indicator of “T” (Significant procedure,
The New Technology APC levels range from the cost band assigned to APC 1491 (New Technology – Level 1A ($0 - $10)) through the highest cost band assigned to APC 1908 (New Technology – Level 52 ($145,001 - $160,000)). Payment for each APC is made at the mid-point of the APC’s assigned cost band. The payment rates for these New Technology APCs are included in Addendum A to the final rule.

One of CMS’s objectives in establishing New Technology APCs is to generate sufficient claims data for a new procedure for assignment to an appropriate clinical APC. CMS considers procedures with fewer than 100 claims annually as low-volume procedures and is concerned that the payment data for these procedures may not have a normal statistical distribution, which could affect the quality of its standard cost methodology used to assign services to an APC.

**Therefore, CMS finalizes a policy to establish a different payment methodology for these low-volume services using its equitable adjustment authority.**

Specifically, CMS will use up to four years of claims data to establish a payment rate for each applicable low-volume service both for assigning a service to a New Technology APC and for assigning a service to a regular APC at the conclusion of its payment through a New Technology APC. The agency will calculate the cost of furnishing the applicable service using the geometric mean, the median, and the arithmetic mean and include the results of each statistical methodology in annual rulemaking. Based on stakeholder comments, CMS will assign the service to the appropriate New Technology APC.

**Hospital Outpatient Outlier Payments**

Outlier payments are added to the APC amount to mitigate hospital losses when treating high-cost cases. CMS again proposes to establish separate thresholds for community mental health centers (CMHCs) and hospitals. For CY 2019, CMS sets the projected target for outlier payments at 1 percent of total OPPS payments. The agency allocates 0.01 percent of outlier payments to CMHCs for Partial Hospitalization Program services.

The rule continues to include both a fixed-dollar and a percentage outlier threshold. But, in CY 2019, CMS increases the fixed-dollar threshold for outliers to $4,825, which is $675 more than in CY 2018, to ensure that outlier spending does not exceed the outlier target.

Thus, to be eligible for an outlier payment in CY 2019, the cost of a hospital outpatient service would have to exceed 1.75 times the APC payment amount (the percentage threshold), and at least $4,825 more than the APC payment amount. When the cost of a hospital outpatient service exceeds these applicable thresholds, Medicare will make an outlier payment that is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

**Transitional Pass-through Payments**

Congress created temporary additional, or “transitional pass-through payments,” for certain innovative medical devices, drugs and biologicals to ensure that Medicare
beneficiaries have access to new technologies in outpatient care. For CY 2019, CMS projects that pass-through payments will be 0.14 percent of total OPPS payments, or $100.8 million. This includes $10 million in pass-through payments for devices and $90.8 million for drugs and biologicals. These payments are implemented in a budget-neutral manner.

Partial Hospitalization Program (PHP) Payment

Payment for PHP Services in 2019. For CY 2019, CMS will continue to apply its established policies and methodology to calculate the PHP APC per diem payment rates for CMHCs and hospital-based PHP providers based on geometric mean per diem costs using the CY 2017 claims and cost data for each provider type. Specifically, the agency will continue to use hospital-based PHP APC 5863 (Partial Hospitalization (3 or More Services Per Day)) and CMHC APC 5853 (Partial Hospitalization (3 or More Services Per Day)) to pay for all PHP services. The resulting PHP geometric mean per diem costs and payment rates for CY 2019 are in the table below.

<table>
<thead>
<tr>
<th>CY 2019 APC</th>
<th>Group Title</th>
<th>Final PHP APC Geometric Mean Per Diem Costs</th>
<th>Final Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC 5853</td>
<td>Partial Hospitalization (three or more services per day) for CMHCs</td>
<td>$121.62</td>
<td>$120.58</td>
</tr>
<tr>
<td>APC 5863</td>
<td>Partial Hospitalization (three or more services per day) for hospital-based PHPs</td>
<td>$222.76</td>
<td>$220.86</td>
</tr>
</tbody>
</table>

Changes to the Revenue-Code-to-Cost Center Crosswalk. CMS added a new cost center for “Partial Hospitalization Program,” on line 93.99 of Worksheet A for hospital-based PHPs for cost reporting periods ending on or after Sept. 30, 2017. The cost center includes all costs associated with providing PHP services and excludes costs for non-PHP outpatient mental health services.

The Revenue-Code-to-Cost Center crosswalk identifies primary, secondary (if any), and tertiary (if any) cost centers associated with each PHP revenue code which are used for the CCRs in rate setting. CMS must update the crosswalk for hospital-based PHP cost estimation to correctly match hospital-based PHP revenue code charges with the PHP cost center CCR for future rate setting.

Therefore, for CY 2019 and subsequent years, hospital-based PHPs will be required to follow a new Revenue-Code-to-Cost-Center crosswalk that only applies to hospital-based PHPs. Specifically, this new PHP-only crosswalk is comprised of the existing PHP allowable revenue codes, with each mapped to the new PHP cost center (Line 93.99) as the primary cost center source for the CCR. The agency designates as the new secondary cost center the cost center that is currently listed as the existing primary cost center, and designates as the new tertiary cost center the cost center that is listed as the existing secondary cost center. In addition, CMS makes one exception to this policy for the mapping for revenue code 0904, which is the
only PHP-allowable revenue code in the existing crosswalk with a tertiary cost center source for the CCR. This exception is described fully in the final rule. The current and PHP-only Revenue-Code-to-Cost-Center Crosswalks are displayed in Table 44 in the final rule.

PHP Service Utilization. CMS has previously expressed concern about the low frequency of individual therapy in PHP services. CMS believes that appropriate treatment for PHP patients includes individual therapy. Table 45 of the final rule shows the provision of individual therapy by provider type and claims year from 2015 through 2017. However, its analysis of 2017 claims data (the first year of data that reflect the change to the single-tier PHP APCs) shows that both hospital-based PHPs and CMHCs have decreased the provision of individual therapy.

In addition, because of its single-tier payment policy, CMS remains concerned that PHP providers may provide only three services per day when payment is heavily weighted to providing four or more services. Table 46 in the final rule shows the percentage of PHP days by the number of services provided per day. Based on its review of 2017 claims, CMS believes that PHPs have maintained an appropriately low utilization of three service days as compared to the two preceding years, but the agency will continue to monitor utilization of days with only three PHP services.

Cancer Hospital Adjustment
For CY 2019, CMS continues to provide additional OPPS payments to each of the 11 “exempt” cancer hospitals so that each cancer hospital’s payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. However, a result of a provision in the 21st Century Cures Act requires this weighted average PCR be reduced by 1.0 percentage point. Based on the data and the required 1.0 percentage point reduction, a target PCR of 0.88 will be used to determine the CY 2019 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.88 for each cancer hospital. Table 10 in the final rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals.

Rural Adjustment for Sole Community Hospitals
CMS will continue to increase payments to rural sole community hospitals, including essential access community hospitals, by 7.1 percent for all services paid under the OPPS, with the exception of drugs, biologicals, services paid under the pass-through policy, and items paid at charges reduced to costs. The adjustment is budget neutral to the OPPS and applied before calculating outliers and coinsurance.

Beneficiary Coinsurance
Medicare law provides that the minimum coinsurance is 20 percent of the OPPS payment amount. The statute also limits a beneficiary’s actual cost-sharing amount for a service to the inpatient hospital deductible for the applicable year, which is $1,364 in 2019. CMS estimates that, in aggregate, the percentage of beneficiary liability for OPPS payments in 2019 will be 18.5 percent, the same percentage estimated for 2018.
**Hospital Outpatient Quality Reporting Program**

The Tax Relief and Health Care Act of 2006 required CMS to establish a program under which hospitals must report data on the quality of outpatient care to receive the full annual update to the OPPS payment rate. Hospitals failing to report the data incur a reduction in their annual payment update factor of 2.0 percentage points.

While CMS proposed to remove a total of 10 measures from the OQR program, the agency only finalized the removal of eight of those measures. One measure will be removed starting with the CY 2020 payment year, which is based on 2018 provider performance, and seven will be removed starting with the CY 2021 payment year, which is based upon 2019 provider performance. In addition, the final rule clarifies certain OQR program logistics.

**Updates to Measure Removal Factors.** As part of CMS’s Meaningful Measures initiative (which applies to all CMS quality reporting programs), the agency is reviewing measures currently in use to determine how quality reporting programs can be developed in the least burdensome manner possible. In the CY 2013 OPPS/ASC final rule, CMS finalized a set of seven factors to determine whether a measure should be removed from the OQR on a case-by-case basis; if a measure meets one or more of these removal factors, CMS would consider permanently removing the measure from the OQR. CMS notes that it might choose to retain a measure that meets removal criteria if the measure addresses significant gaps in care or if removing the measure might result in decreases in quality.

In this rule, CMS finalizes the list of measure removal factors the agency will use. These factors, which are the same for each Medicare quality reporting program, are:

- Factor 1: Measure performance among providers is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made (measure is “topped out”).
- Factor 2: Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3: The measure does not align with current clinical guidelines or practice.
- Factor 4: A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5: A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6: A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7: Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
- Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.

**Measures Removed.** CMS will remove eight measures from the OQR. These measures and the rationale for their removal can be seen in the table below.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Number</th>
<th>Type</th>
<th>Removal Factor</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccination Coverage among Healthcare Personnel</td>
<td>OP-27</td>
<td>Process</td>
<td>8</td>
<td>OP-27 is only HOPD measure reported through the National Healthcare Safety Network (NHSN), which requires extensive registration/ administration processes; Information largely captured in Inpatient version of same measure; to be removed in CY 2019 (for CY 2020 payment)</td>
</tr>
<tr>
<td>Median Time to ECG</td>
<td>OP-5</td>
<td>Efficiency</td>
<td>8</td>
<td>Little variation in performance; National Quality Forum (NQF) endorsement removed</td>
</tr>
<tr>
<td>Mammography Follow-up Rates</td>
<td>OP-9</td>
<td>Process</td>
<td>3</td>
<td>Not in line with recently updated clinical practices</td>
</tr>
<tr>
<td>Thorax Computed Tomography (CT) Use of Contrast Material</td>
<td>OP-11</td>
<td>Process</td>
<td>1</td>
<td>Statistically indistinguishable difference in performance between the 75th and 90th percentiles</td>
</tr>
<tr>
<td>The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data</td>
<td>OP-12</td>
<td>Process</td>
<td>2</td>
<td>Assesses transmittal of data, but does not directly assess quality or patient outcomes; not NQF-endorsed</td>
</tr>
<tr>
<td>Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT</td>
<td>OP-14</td>
<td>Process</td>
<td>1</td>
<td>Statistically indistinguishable difference in performance between the 75th and 90th percentiles; not NQF-endorsed</td>
</tr>
<tr>
<td>Tracking Clinical Results between Visits</td>
<td>OP-17</td>
<td>Process</td>
<td>2</td>
<td>Assesses transmittal of data, but does not directly assess quality or patient outcomes; NQF endorsement removed</td>
</tr>
<tr>
<td>Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use</td>
<td>OP-30</td>
<td>Process</td>
<td>8</td>
<td>Hospitals also report on other colonoscopy-related measure that is more closely associated with relevant outcomes; same measure is available for gastroenterologists in the Merit-based Incentive Payment System</td>
</tr>
</tbody>
</table>

Measures Retained. Based on feedback from public comments and internal analysis, CMS is not finalizing the proposed removal of two measures; the ASC versions of these measures will be retained in the ASC Quality Reporting (ASCQR) program as well. The measures that will be retained in the OQR and CMS’s rationale for keeping them include:

- **Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (OP-29, ASC-9):** The measure provides valuable information that is not captured in other colonoscopy measures, and data collection burden is not as high as CMS initially believed.
- **Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (OP-31, ASC-11):** While only a small number of facilities consistently report data on this voluntary measure, it is the only measure
addressing cataract surgery in the OQR and ASCQR. In addition, reporting the measure is not burdensome since it is voluntary.

Extension of Reporting Period for Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32, ASC-12). This measure, which is part of both the OQR and the ASCQR, is calculated based on Medicare claims data, and currently uses one calendar year of data. CMS conducted several “dry run” calculations of this measure using various reporting periods, and found that using three years of data yielded the most reliable data. Because of this, CMS will change the reporting period from one year to three beginning with the CY 2020 payment determination. Thus, CY 2020 performance rates will be based on claims data from Jan. 1, 2016 through Dec. 31, 2018. Reporting requirements for facilities will not change.

Frequency of OQR Specifications Manual Release. Currently, CMS releases the OQR Specifications Manual every six months, and addenda as necessary. However, CMS believes it is unnecessary and potentially confusing to release two manuals a year unless there are substantive changes to the program. Therefore, CMS will release an updated manual once every 12 months and addenda as necessary starting CY 2019.

Notice of Participation (NOP) Form. CMS will remove the requirement to submit a NOP form for participation in the OQR beginning with the CY 2018 reporting period/CY 2020 payment determination. CMS believes the form does not provide any unique information and is unnecessarily burdensome for hospitals to complete and submit. Instead, hospitals will indicate participation status in the OQR simply by submitting any OQR Program data through a registered QualityNet account.

Changes to the Inpatient Quality Reporting Program (IQR)

Inpatient Quality Reporting Program (IQR) HCAHPS Pain Questions

In the FY 2018 IPPS final rule, CMS removed previously adopted pain management questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and replaced them with new “Communication about Pain” questions. This was done in response to the nationwide opioid epidemic in an attempt to remove inadvertent incentives to overprescribe opioids to control pain. Rather than asking about whether the patient felt pain, the new questions ask whether hospital personnel talked with the patient about pain. However, stakeholders voiced concerns that these questions could still potentially impose pressure on staff to overprescribe opioids.

The agency initially proposed to remove the questions beginning with January 2022 discharges, as it believed this was the earliest it would be “operationally feasible” to do so. However, the recently passed SUPPORT for Patients and Communities Act (HR 6) prohibits HCAHPS Surveys conducted on or after Jan. 1, 2020 from including questions about communication by hospital staff with an individual about such individual’s pain. In order to comply with this requirement, CMS will remove the questions starting with October 2019 discharges, and will not publicly report data on the questions.
Changes to the CY 2019 ASC Payment System

The final rule includes the annual review and update to the ASC list of covered surgical procedures and covered ancillary procedures, as well as updated payment rates.

Updates and Changes to ASC Payment Policy

ASC Payment Update. For CYs 2019 through 2023, CMS will update the ASC payment system using the hospital marketbasket update rather than the Consumer Price Index for all urban consumers (CPI-U). During this five-year period, CMS will assess whether there is a migration of services from the hospital setting to the ASC setting as a result of the use of a hospital marketbasket update, as well as whether there are any unintended consequences.

In comments to CMS, the AHA had noted that Medicare payment in different settings should reflect the underlying costs and the types of patients served. However, given the absence of any national set of ASC cost data, it is impossible to determine whether using the hospital marketbasket update is appropriate for ASCs. Therefore, AHA had urged CMS not to finalize the use of the hospital market basket to update payments for ASCs, but instead to work expeditiously with ASC stakeholders to develop and implement a minimally burdensome way to collect ASC costs. In the final rule, CMS reports it will assess the feasibility of collaborating with stakeholders to collect ASC cost data in a minimally burdensome manner and could propose a plan to collect such information in the future.

Using the hospital marketbasket methodology, for CY 2019, CMS increases payment rates under the ASC payment system by 2.1 percent for ASCs that meet the ASC quality reporting requirements. This increase is based on a hospital marketbasket percentage increase of 2.9 percent minus a multifactor productivity (MFP) adjustment required by the ACA of 0.8 percentage point. CMS will continue its policy of reducing the update by 2.0 percentage points for ASCs not meeting the quality reporting requirements, yielding an update of 0.1 percent for such ASCs. The resulting 2019 ASC conversion factor is $46.551 for ASCs reporting quality data, and $45.639 for those that do not.2

Expansion of the Definition of “Surgery” for ASC-covered Surgical Procedures

CMS finalizes its proposal to revise its definition of “surgery” in the ASC payment system to account for certain “surgery-like” procedures that are assigned codes outside the CPT surgical range. Specifically, CMS define these newly-eligible “surgery-like” procedures to be those procedures that are described by Category I CPT codes that are not in the surgical range but that directly crosswalk or are clinically similar to procedures in the Category I CPT surgical range. In addition, these Category I CPT codes need to meet the ASC setting criteria – that they do not pose a significant

2 By comparison, the CY 2019 OPPS conversion factor is $79.490 for hospitals meeting OQR reporting requirements and $77.900 for hospitals that do not meet OQR reporting requirements.
safety risk, are not expected to require an overnight stay when performed in an ASC, and are separately paid under the OPPS.

**Additions to the List of ASC-covered Surgical Procedures**

Using its revised definition of surgery, as discussed above, CMS adds 12 cardiac catheterization procedures (CPT codes 93451-93462) to the list of covered surgical procedures. In addition, based on public comments, it also is adding five procedures performed during cardiac catheterization procedures to the list of ASC-covered surgical procedures (CPT codes 93566, 93567, 93568, 93571, and 93572). In comments to the agency, AHA had urged CMS not to finalize the addition of the diagnostic cardiac catheterization procedures because they may impose a significant safety risk to Medicare beneficiaries when performed in an ASC. However, in the final rule, CMS states that it believes these services can be safely performed in the ASC setting and would not require an overnight stay. The agency notes that although some of these procedures involve blood vessels that could be considered major, it believes these procedures are similar to other procedures currently on the ASC list, and that they may be appropriately performed in an ASC.

**Payment for Non-opioid Pain Management Therapy**

Drugs that function as a supply are currently packaged under the OPPS and the ASC payment system, regardless of the costs of the drugs. CMS examined this policy for 2019 in response to a recommendation from the President's Commission on Combating Drug Addiction and the Opioid Crisis that CMS review and modify rate setting policies that could discourage the use of non-opioid treatments for pain.

As a result, CMS will un-package and pay separately, at ASP plus 6 percent, for non-opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting for 2019. This policy will only currently apply to Exparel – which is the only non-opioid pain management drug that functions as a supply when used in a surgical procedure that is covered under Medicare Part B. However, the agency declined to pay separately for these drugs in hospital outpatient departments, despite recommendations from the AHA and others. CMS notes that it will continue to analyze the issue of access to non-opioid alternatives as they implement section 6082 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, enacted on Oct. 24, 2018.

**Changes for ASC Quality Reporting Program**

The ACA required CMS to establish a program under which ASCs must report data on the quality of care delivered in order to receive the full annual update to the ASC payment rate. ASCs failing to report the data will incur a reduction in their annual payment update factor of 2.0 percentage points.

CMS will adopt the same measure removal factors for the ASCQR as are used in other quality reporting programs, including the OQR. CMS will remove two of the eight measures proposed for removal from the ASCQR program, with one measure removed starting with the CY 2020 payment year, which is based on 2018 provider performance, and one removed starting with the CY 2021 payment year, which is based upon 2019 provider performance.
Updates to Measure Removal Factors. Consistent with the agency’s Meaningful Measures initiative (which applies to all CMS quality reporting programs), CMS will use the same factors listed for the OQR.

Removal of Measures. While CMS initially proposed to remove a total of eight measures from the ASCQR program, the agency only finalized the removal of two of those measures. One measure, Influenza Vaccination Coverage among Healthcare Personnel (ASC-8), will be removed starting with the CY 2020 payment year, which is based on 2018 provider performance, and another, Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use (ASC-10), will be removed starting with the CY 2021 payment year, which is based upon 2019 provider performance.

Based on feedback from public comments and initial internal analysis, CMS is not finalizing six measures originally proposed for removal. The measures that will be retained in the ASCQR and CMS’s rationale for keeping them include:

- Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (ASC-9): Same rationale as for OP-29 above.
- Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (ASC-11): Same rationale as for OP-31 above.
- Patient Burn (ASC-1); Patient Fall (ASC-2); Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (ASC-3); All-Cause Hospital Transfer/Admission (ASC-4): Although these measures are “topped out,” CMS now believes that they still provide valuable information for patients. Since they are not specific to particular procedures, they are widely applicable.

Although measures ASC-1, 2, 3 and 4 will be retained in the ASCQR, the agency acknowledged concerns regarding the accuracy of data reporting for these measures. Thus, CMS will suspend data collection on these measures starting with CY 2019 so the agency can revise the data submission method and conduct analysis to identify other data issues. This means that providers will not have to submit data for measures ASC-1 through 4 until further rulemaking.

Requests for Information (RFIs)

CMS included three RFIs in the proposed rule seeking input on promoting interoperability, price transparency, and a potential CMS innovation center Part B drug model. In the final rule, the agency notes how many comments it received on each and thanks commenters for their input. In addition, on Oct. 25, the agency issued an advanced notice of proposed rulemaking on a potential Part B drug payment model under the Center for Medicare & Medicaid Innovation. See AHA’s Special Bulletin for a summary.
Next Steps

The AHA will host a member-only webinar on Thursday, Nov 29 from 3 p.m. to 4:30 p.m. ET. Please register for this 90-minute event at this link. Related materials and a recording of this webinar will be available on the AHA’s OPPS webpage.

If you have further questions regarding the final rule’s payment provisions, please contact Roslyne Schulman, director of policy, at rschulman@aha.org. Questions regarding the quality provisions should be directed to Caitlin Gillooley, senior associate director, at cgillooley@aha.org.