Major Changes to Outpatient Hospital, Ambulatory Surgery Center, and Physician Medicare Payment Policy for 2019

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Agenda

- **CMS 2019 Hospital Outpatient Prospective Payment System (OPPS) / Ambulatory Surgical Center (ASC) Final Rule**
  - Site Neutrality Policy Changes
  - Changes to 340B Program
  - Incentivizing Care in Non-Hospital Settings
  - Quality Reporting Program Updates
- **CMS 2019 Physician Fee Schedule (PFS) Final Rule**
  - Evaluation & Management (E&M) Policy Changes for Office/Clinic Visits
  - Practice Expense (PE) RVU Updates
  - Quality Payment Program (QPP) Updates
  - Technology-based Services

CMS 2019 Final Rule
Policy & Payment Changes

Hospital Outpatient Prospective Payment System (OPPS)
and
Ambulatory Surgery Center (ASC)

CMS 2019 Final Rule Policy & Payment Changes

Hospital Outpatient Prospective Payment System (OPPS)

CMS finalizes 2019 OPPS annual payment increases of +1.35%
for approximately 3,900 acute care hospitals paid under OPPS system

2019 Hospital Market Basket	+2.9%
Multifactor Productivity (MFP) Adjustment (ACA-mandated)	-0.8%
Additional Adjustments Required by the ACA	-0.75%
Final 2019 OPPS Payment Update	**+1.35%**
Final 2019 OPPS Conversion Factor	**$79.490**

Each year, OPPS payment rates are updated based on changes to the hospital market basket and other mandated regulatory adjustments.

CMS 2019 Final Rule Policy & Payment Changes

Ambulatory Surgery Center (ASC)

CMS finalizes 2019 ASC annual payment increases of 2.1%
for approximately 5,300 Free-standing Ambulatory Surgery Centers paid under the ASC system

2019 Hospital Market Basket	+2.9%
Multifactor Productivity (MFP) Adjustment (ACA-mandated)	-0.8%
Final 2019 ASC Payment Update	**+2.1%**
Final 2019 ASC Conversion Factor	**$46.551**

NEW FOR 2019-2023:
CMS's shift from annual CPI updates to hospital market basket updates for calculating ASC payment rates.

- *Designed to:*
  - *stabilize the differential between ASC and OPPS rates;*
  - *promote procedure migration from hospitals to ASCs; and*
  - *increase beneficiary access to care*
- *CMS will reassessed for CY 2024 to determine if these changes increase ASC procedure volumes, improve patient access to care and lowers costs.*

CMS 2019 Final Rule Policy & Payment Changes

Site Neutrality (OPPS)

CMS continues its move towards greater payment neutrality between sites of service to reduce Medicare spending and patient cost-sharing.

- CMS will phase in a reduction in payments for hospital outpatient clinic visits provided in an "Off-Campus Provider-Based Department (PBD)". This change affects all off-campus PBDs, including those originally grandfathered (excepted) from cuts.
  - **Grandfathered (excepted) off-campus PBDs**:
    - Two-year phase-in beginning in 2019 for grandfathered off-campus PBDs
      - 2019 = 70% of OPPS payment rate
      - 2020 and beyond = 40% of OPPS payment rate
  - **Non-grandfathered (non-excepted) off-campus PBDs**
    - 2019 and beyond = 40% of OPPS payment rate
- The hospital outpatient clinic visit (G0463) is the most commonly billed service under the OPPS.
- CMS estimates savings to be $380M, in 2019.

HCPCS Code	Short Descriptor	2018 OPPS Payment Rate	2019 OPPS Payment Rate	2019 OPPS Payment Rate *(Excepted PBDs)*	2019 OPPS Payment Rate *(Non-Excepted PBDs)*
G0463	Hospital outpat clinic visit	$114	$116	$81	$46

CMS 2019 Final Rule Policy & Payment Changes

Site Neutrality (ASC)

CMS continues its move towards greater payment neutrality between sites of service to reduce Medicare spending and patient cost-sharing.

- CMS updates their surgery definition to include "surgery-like procedures" and expands its "*ASC List of Covered Procedures*" by adding an additional 17 procedures.

CPT Code	Short Descriptor	2019 ASC Payment Indicator
93451	Right heart cath	G2
93452	Left hrt cath w/ventrclgrphy	G2
93453	R&l hrt cath w/ventriclgrphy	G2
93454	Coronary artery angio s&i	G2
93455	Coronary art/grft angio s&i	G2
93456	R hrt coronary artery angio	G2
93457	R hrt art/grft angio	G2
93458	L hrt artery/ventricle angio	G2
93459	L hrt art/grft angio	G2
93460	R&l hrt art/ventricle angio	G2
93461	R&l hrt art/ventricle angio	G2
93462	L hrt cath trnsptl puncture	N1
93566	Inject r ventr/atrial angio	N1
93567	Inject suprvlv aortography	N1
93568	Inject pulm art hrt cath	N1
93571	Heart flow reserve measure	N1
93572	Heart flow reserve measure	N1

Source: CMS 2019 OPPS/ASC Final Rule; Table 60.

CMS 2019 Final Rule Policy & Payment Changes

340B Drug Payment Policy (OPPS)

CMS expands its 340B drug payment policy to include non-excepted off-campus Provider-Based Departments (PBDs)

- CMS finalized its policy to extend the 340B drug program policy to non-excepted PBDs in 2019.
- CMS will pay average sales price (ASP) minus 22.5% for drugs acquired under the 340B program and administered in non-excepted off-campus PBDs.
  - For new drugs and biological products where ASP data is not yet available, Medicare will pay at wholesale acquisition cost (WAC) plus 3%, instead of WAC plus 6%.

CMS 2019 Final Rule Policy & Payment Changes

Device-Intensive Policy *(ASC)*

CMS modifies its criteria for defining procedures identified as "device-intensive"

In 2019, CMS finalized its policy to modify the criteria for defining "device-intensive" procedures, thereby increasing the number of procedures that qualify as "device-intensive".

- **NEW FOR 2019**: Allows procedures involving single-use devices, whether or not the devices remain in the body after the conclusion of the procedure or not, to qualify as "device-intensive".
- **NEW FOR 2019** : Reduction in the device-offset percentage from 40% to 30%.
  - Results in 150 additional procedures qualifying as "device-intensive".

HCPCS	Short Descriptor	SI	APC	Final CY 2019 APC Payment Rate	Device Offset Percentage	Device Offset Amount
11970	Replace tissue expander	J1	5114	$5,699.59	31.70%	$1,806.77
19105	Cryosurg ablate fa each	J1	5091	$2,816.01	46.71%	$1,315.36
19296	Place po breast cath for rad	J1	5093	$7,448.83	47.16%	$3,512.87
19342	Delayed breast prosthesis	J1	5093	$7,448.83	31.41%	$2,339.68
19357	Breast reconstruction	J1	5094	$12,127.14	30.89%	$3,746.07
20690	Apply bone fixation device	J1	5114	$5,699.59	32.23%	$1,836.98

Source: CMS 2019 OPPS/ASC Final Rule; OPPS Addendum P.

CMS 2019 Final Rule Policy & Payment Changes
Quality Reporting Programs (OPPS/ASC)

CMS continues its commitment to Meaningful Measures Initiatives

- *CMSs Meaningful Measures Initiative aims to reduce costs and minimize program burden/complexity*
- Measures were removed if:
  - They do not align with current clinical guidelines or practice;
  - Performance or improvement on a measure is not strongly linked to better patient outcomes;
  - They are "topped out", meaning that the overwhelming majority of providers are performing highly on them; or
  - Their costs are greater than benefits in reporting.
- **Hospital Outpatient Quality Reporting Program;**
  - **8 measures removed** *(1 in CY 2020; 7 in CY 2021)*
- **ASC Quality Reporting Program**
  - **2 measures removed** *(1 in CY 2020; 1 in CY 2021)*

CMS 2019 Final Rule
Policy & Payment Changes

Physician Fee Schedule (PFS)

CMS 2019 Final Rule Policy & Payment Changes

Physician Fee Schedule (PFS)

CMS finalizes 2019 PFS annual payment increases of +0.25%
for approximately 919,000 clinicians paid under PFS system

2019 PFS Conversion Factor Calculation

2018 PFS Conversion Factor	$35.9996
Statutory Update Factor	+0.25%
2019 RVU Budget Neutrality Adjustment	-0.14%
Final 2019 PFS Conversion Factor	**$36.0391**

2019 Anesthesia Conversion Factor Calculation

2018 Anesthesia Conversion Factor	$22.1887
Statutory Update Factor	+0.25%
2019 RVU Budget Neutrality Adjustment	-0.14%
2019 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	+0.27%
Final 2019 Anesthesia Conversion Factor	**$22.2730**

Source: CMS 2019 PFS Final Rule, Tables 92 and 93

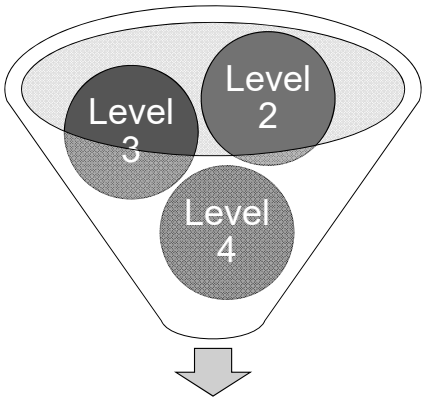
CMS 2019 Final Rule Policy & Payment Changes

Evaluation & Management (E&M) Codes (PFS)

CMS delays implementation of E&M payment policy changes until 2021.

Beginning in CY 2021, CMS will:

- ***Pay a single rate*** for E&M office and outpatient visits levels 2 through 4 for established and new patients
- ***Implement add-on codes that describe additional resources inherent in visits*** for primary care and for particular kinds of non procedural, specialized medical care
- ***Adopt "extended visit" add-on codes*** to account for the additional resources required when providers need to spend extended time with a patient



CMS NEW E&M Payment Policy
(eff. CY 2021)

CMS 2019 Final Rule Policy & Payment Changes

Practice Expense: Supply and Equipment Pricing Update (PFS)

CMS finalizes updates to "direct expense" inputs for Practice Expense (PE) RVUs

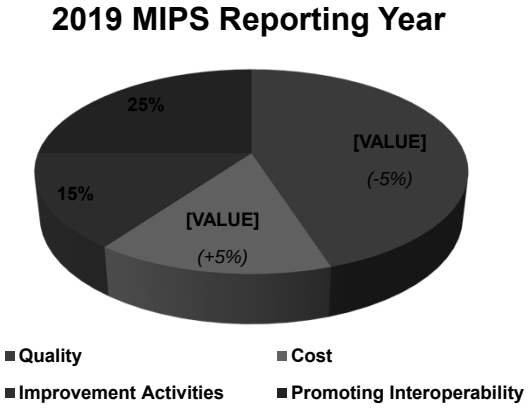
- Practice Expense RVUs represent approximately 45% of total RVUs for physician services.
- Inputs to the PE RVUs are comprised of Direct and Indirect Expenses
  - ***Direct expenses*** include clinical labor, medical supplies, and medical equipment
    - Using a contractor, CMS updated supply and equipment prices (which had not been updated since 2004-2005)
  - *Indirect expenses* include administrative labor, office expense, and all other expenses
- CMS will phase in changes to the Direct Expense inputs for PE RVUs over a 4-year period beginning CY 2019.

CMS 2019 Final Rule Policy & Payment Changes

Quality Payment Program (QPP) (PFS)

CMS outlines changes to MIPS reporting requirements and continues its commitment to reduce overall program burden

- Removal of certain quality measures to focus on those with greater impact on health outcomes and less of a reporting burden
- Requirement for clinicians and practices to adopt 2015 edition Certified EHR Technology for Promoting Interoperability reporting
- CMS increases the weight of the MIPS "cost" category and lowers the weight of the "quality" category by 5%, respectively



CMS 2019 Final Rule Policy & Payment Changes

New Codes for Technology-Based Services (PFS)

CMS finalizes policies to expand coverage of telehealth and virtual care

- **NEW for 2019:** CMS is finalizing policies to pay separately for several new codes including:
  - newly defined physicians' services furnished using communication technology;
  - chronic care remote physiologic monitoring
  - Inter-professional internet consultations

Category	HCPCS Code	Short Descriptor	2019 PFS Payment Rate *(Facility based)*	2019 PFS Payment Rate *(Non-Facility based)*
Newly defined services furnished using communication technology	G2010	*Remot image submit by pt*	$9	$13
	G2012	*Brief check in by md/qhp*	$13	$15
New chronic care remote physiologic monitoring services	99453	Rem mntr physiol param setup	n/a	$19
	99454	Rem mntr physiol param dev	n/a	$64
	99457	Rem physiol mntr 20 min mo	$32	$52
	99451	Ntrprof ph1/ntrnet/ehr 5/>	$37	$37
	99452	Ntrprof ph1/ntrnet/ehr rfrl	$37	$37
New Inter-professional internet consultation services	99446	Ntrprof ph1/ntrnet/ehr 5-10	$18	n/a
	99447	Ntrprof ph1/ntrnet/ehr 11-20	$36	n/a
	99448	Ntrprof ph1/ntrnet/her 21-30	$55	n/a
	99449	Ntrprof ph1/ntrnet/ehr 31/>	$73	n/a

Thank you!