



CMS Finalizes 2019 Physician & Outpatient Fee Schedules

In the course of twenty-four hours, the *Centers for Medicare & Medicaid Services* (CMS) finalized the calendar year (CY) 2019 Medicare Physician Fee Schedule (MPFS), the Hospital Outpatient Prospective Payment System (OPPS), and the Ambulatory Surgical Center (ASC) Payment System.

The finalized rules generally remained unchanged from their proposed versions, with a couple of exceptions. Each finalized rule is reviewed briefly below.

MPFS Final Rule Provisions

On November 1, 2018, CMS finalized the 2019 MPFS rule, which includes a number of changes to the payment system, and one noteworthy proposal that was not implemented.

CMS finalized the 2019 MPFS conversion factor at \$36.04 (no change from the proposed rule), which it noted was a “*slight increase above the 2018 [M]PFS conversion factor of \$35.99.*”¹

In its July 12, 2018 proposed rule, CMS sought comments on consolidating the current structure of *evaluation and management* (E/M) office visits, from five levels to two levels.² In its final rule, CMS delayed this significant change until CY 2021, while, in the interim, implementing a number of smaller changes to the documentation guidelines for E/M office visits. Part of CMS’s reason for the delay was the strong negative reactions from industry stakeholders. As CMS admitted, “*Commenters largely objected to our proposal to eliminate payment differences for office/outpatient E/M visit levels 2 through 5 based on the level of visit complexity.*”³ Notably, CMS also did not finalize components of the E/M proposal that would have: “(1) *reduced payment when E/M office/outpatient visits are furnished on the same day as procedures, (2) established separate coding and payment for podiatric E/M visits, or (3) standardized the allocation of practice expense RVUs for the codes that describe these services.*”⁴

Regarding the updates to the *Merit-based Incentive Payment System* (MIPS), one of the ways in which providers can participate in the *Quality Payment Program* (QPP) established by the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), CMS adjusted the weight of the categories upon which clinicians are scored. Specifically, CMS increased the weight of the MIPS *cost* category to 15% (previously

10%), while lowering the *quality* category weight to 45% (previously 50%).⁵

OPPS Final Rule Provisions

On November 2, 2018, CMS finalized the 2019 OPPS rule, which includes a number of notable changes to the payment system.

CMS finalized the OPPS payment rates by 1.35%, a slight increase from the proposed update of 1.25%,⁶ which was based upon the 2% hospital market basket increase, minus a 0.8 percentage point multifactor productivity (MFP) adjustment, and a statutorily-required 0.75 percentage point adjustment.⁷

One notable provision is the new requirement that payments for clinic visits conducted at off-campus HOPDs (i.e., those allowed to bill under OPPS) be made at the reduced rate applied to non-excepted off-campus HOPDs. CMS asserts that this will “*control unnecessary increases in the volume of covered [HOPD] services by applying [an MPFS] equivalent payment rate for the clinic visit service when provided at an off-campus [HOPD]...*” as well as reduce copayments for Medicare beneficiaries.⁸

As noted in the August issue of *Health Capital Topics*,⁹ there is currently a difference between *excepted* off-campus HOPD and *non-excepted* off-campus HOPD receivable payments for furnished 340B-acquired drugs, with services in non-excepted off-campus HOPDs garnering providers a higher payment for these drugs.¹⁰ The 340B Program allows participating hospitals and providers to purchase certain covered outpatient drugs from the manufacturer at discounted prices.¹¹ However, in 2017, CMS finalized a payment policy, for excepted HOPDs, to cover outpatient drugs and biologicals at a rate of the drug’s average sales price (ASP) *minus* 22.5%, rather than that under the previous payment system, i.e., ASP *plus* 4.3%, resulting in both large cuts to the 340B Program and significantly higher drug expenditures for hospitals participating in the program.¹² Consequently, CMS finalized its proposal to extend the 2017 340B Drug Payment Policy (i.e., ASP *minus* 22.5%) to non-excepted off-campus HOPDs, to eliminate the incentive for hospitals to move 340B-acquired drug services to non-excepted off-campus HOPDs solely to receive the higher payment amounts for these drugs.

ASC Payment System Final Rule Provisions

The OPSS final rule also included provisions related to ASCs. Significantly, CMS finalized their proposal to change the index upon which it updates ASC payment rates, with the goal that it “will help to promote ‘site-neutrality’ between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.”¹³ Historically, these rates were annually updated by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). However, starting 2019, CMS will update the ASC payment rates using the hospital market basket (through at least CY 2023), which it has historically used for updating HOPD payments.¹⁴ For CY 2019, this results in an update to a payment rate update of 2.1%, based

upon the 2.9% hospital market basket increase, minus the 0.8 percentage point MFP adjustment.¹⁵

Regarding the ASC Quality Reporting program, CMS had proposed removing eight measures from the program. Ultimately however, only two were removed:

- (1) ASC-8: *Influenza Vaccination Coverage Among Healthcare Personnel* (beginning CY 2020); and,
- (2) ASC-10: *Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use* (beginning CY 2021).¹⁶

Forthcoming issues of *Health Capital Topics* will feature coverage of these payment systems, and their impact on the U.S. healthcare industry generally, as well as on the valuation of healthcare enterprises, assets, and services.

1 “Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019” Centers for Medicare & Medicaid Services, November 1, 2018, <https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year> (Accessed 11/2/18).

2 “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program: Proposed rule” Federal Register Vol. 83, No. 145 (July 27, 2018), p. 35837.

3 CMS, November 1, 2018.

4 *Ibid.*

5 “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act” Centers for Medicare & Medicaid Services, CMS-1693-F, CMS-1693-IFC, CMS-5522-F3, and CMS-1701-F.

6 “Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model: Proposed Rule” Federal Register Vol. 83, No. 147 (July 31, 2018), p. 37049.

7 “CMS finalizes Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment

System changes for 2019 (CMS-1695-FC)” Centers for Medicare & Medicaid Services, November 2, 2018, <https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center> (Accessed 11/2/18).

8 *Ibid.*

9 “CMS’s Continued Payment System Overhaul: OPSS Proposed Rule” Health Capital Topics, Vol. 11, Issue 8 (August 2018), https://www.healthcapital.com/hcc/newsletter/08_18/HTML/OPSS/convert_final_opss_8.21.18.php (Accessed 11/2/18).

10 “CMS Targets Off-Campus Provider-Base Departments in 2019 OPSS Proposed Rule” Polsinelli, July 2018, <https://sites-polsinelli.vutrevx.com/33/977/july-2018/upd0718eri.asp?sid=16fc9a05-9e5f-48f3-832d-6605cbc599aa> (Accessed 7/31/18).

11 “CMS Releases Proposed Updates to the CY 2019 Hospital Outpatient and ASC Prospective Payment Systems” Federal Issue Brief, Missouri Hospital Association, July 26, 2018, https://www.mhanet.com/mhaimages/Issue%20Briefs/Issue%20Brief_Proposed%202019%20OPSS.pdf, p. 2 (Accessed 8/1/18).

12 “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs” Federal Register Vol. 82, No. 138 (June 20, 2017), p. 33564; “Medicare’s Hospital Outpatient Prospective Payment System Proposed Rule: Big Changes For 2019” By Billy Wynne, Health Affairs, July 27, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180727.105372/full/> (Accessed 8/1/18). Payment was previously determined by ASP plus 6%, but the 2013 budget sequester, effective through 2025, reduced payments providers receive by 1.6%, resulting in a net payment equivalent to ASP plus 4.3%: “Chapter 2: Medicare Part B drug payment policy issues” MedPAC, June 2017, http://www.medpac.gov/docs/default-source/reports/jun17_ch2.pdf?sfvrsn=0, p. 67, n. 4 (Accessed 8/02/18).

13 CMS, November 2, 2018.

14 *Ibid.*

15 *Ibid.*

16 CMS, CMS-1695-FC.



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