CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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CY 2019 OPPS and ASC Rule Encourages More Choices and Lower Costs for Seniors

On November 2, CMS released a final rule that strengthens the Medicare program by providing seniors more choices and lower cost options in making the best decisions on their care. The policies adopted in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period will help lay the foundation for a patient-driven healthcare system.
"President Trump is committed to strengthening Medicare and lowering costs for patients. Today's rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care," said CMS Administrator Seema Verma. "The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options."
To increase the sustainability of the Medicare program and improve the quality of care for patients, CMS is finalizing its proposed method to control unnecessary volume increases for certain clinical visits by utilizing site-neutral payments for these visits. This change will be phased in over two years. Clinic visits are the most common service billed under the OPPS. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting. This policy would result in lower copayments for beneficiaries and savings for the Medicare program in an estimated amount of $380 million for 2019. For example, for a clinic visit furnished in an excepted off-campus provider-based department (PBD), average beneficiary cost sharing is currently $23. Under this final rule, that cost sharing would be reduced to $16 (based on a two year phase-in), saving beneficiaries an average of $7 each time they visit an off-campus department in CY 2019.

Additionally, CMS is giving patients more options on where to obtain care by increasing the services that can be furnished in ASCs. These changes are intended to help improve access and convenience and ensure that CMS policies are not favoring any particular provider type. For 2019, CMS is finalizing policies that will:

- Expand the number of surgical procedures payable at ASCs to include additional procedures that can safely be performed in that setting
- Ensure ASC payment for procedures involving certain high-cost devices generally parallels the payment amount provided to hospital outpatient departments for these devices
- Help ensure that ASCs remain competitive by addressing the differential between how ASC payment rates and hospital outpatient department payment rates are updated for inflation

As part of the agency's "Patients Over Paperwork" Initiative—a cross-cutting process that evaluates and streamlines regulations with the goal of reducing burden—CMS is finalizing proposals to remove measures from the Hospital Outpatient Quality Reporting Program and from the Ambulatory Surgery Center Quality Reporting Program. These removals are aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. This action will decrease burden for providers by approximately $27 million over the next two years.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments that were acquired through the 340B program—a program that allows certain hospitals to buy outpatient drugs at lower cost. Due to CMS' policy change, Medicare beneficiaries are now benefitting from the discounts that 340B hospitals enjoy when they receive 340B-

acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding on this policy by extending the 340B payment change to additional off-campus provider-based hospital outpatient departments that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis, to comply with the requirements of the SUPPORT for Patients and Communities Act (P.L. 115-271), and to avoid any potential unintended consequences that would encourage overprescribing of opioids, CMS is removing questions regarding pain communication from the hospital patient experience survey. Additionally, CMS is adopting a policy to encourage increased use of non-opioid drugs following a surgical procedure in the ASC setting.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended that CMS review its payment policies for certain drugs that function as a supply, specifically non-opioid pain management treatments. Payment for drugs that function as a supply in surgical procedures or diagnostic tests is packaged under the OPPS and ASC payment systems. However, in response to this recommendation as well as stakeholder comments and peer-reviewed evidence, for 2019, CMS is finalizing the proposal to pay separately at average sales price plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

For More Information:

- Final Rule
- Fact Sheet

Read the full text of this excerpted CMS Press Release (issued November 2)