Medicare Outpatient Prospective Payment System

Payment Rule Brief — Calendar Year 2018 Final Rule with Comment Period

Overview

The final calendar year (CY) 2018 payment rule for the Medicare Outpatient Prospective Payment System (OPPS) was released on November 1, 2017. The final rule includes annual updates to the Medicare fee-for-service (FFS) outpatient payment rates as well as regulations that implement new policies. The final rule includes policies that will:

- Reinstate the nonenforcement of direct supervision for CAHs and small rural hospitals having 100 or fewer beds;
- Change the rate for nonpass-through drugs purchased by hospitals through the 340B program;
- Change the inpatient only list;
- Payment changes for packaging of low-cost drug administration services;
- Change the laboratory date of service policy;
- Make a payment change for non-excepted services furnished in off-campus provider-based departments;
- Change exceptions to the list of services to be packaged into APCs as opposed to separately paid; and
- Update payment rates and policies for Ambulatory Surgical Centers (ASCs).

A copy of the *Federal Register* and other resources related to the OPPS are available on the Centers for Medicare and Medicaid Services (CMS) website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. Comments related to the payment classifications assigned to HCPCS codes identified in Addenda B, AA, and BB with the comment indicator "NI" are due to CMS by December 31, 2017 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1678-FC".

An online version of the rule is available at https://federalregister.gov/a/2017-23932. Page numbers noted in this summary are from the *Federal Register* (FR) version of the final rule. A brief summary of the major hospital OPPS sections of the final rule is provided below.

OPPS Payment Rate

FR pages 52,396 – 52,398

The tables below show the final CY 2018 conversion factor compared to CY 2017 and the components of the update factor:

	Final CY 2017	Final CY 2018	Percent Change
OPPS Conversion Factor	$75.001	$78.636	+4.85%

Final CY 2018 Update Factor Component	Value
Marketbasket (MB) Update	+2.70%
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.6 percentage points (PPT)
ACA-Mandated Pre-Determined MB Reduction	-0.75 PPT
340B Drug Payment Reduction BN Adjustment	+3.19%
Wage Index BN Adjustment	-0.03%
Pass-through Spending / Outlier BN Adjustment	+0.20%
Cancer Hospital BN Adjustment	+0.08%
Overall Final Rate Update	**+4.85%**

Adjustments to the Outpatient Rate and Payments

- **Wage Indexes *(FR pages 52,398 – 52,402)*:** As in past years, for CY 2018 OPPS payments, CMS will use the federal fiscal year (FFY) 2018 inpatient PPS (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustment.

  CMS states that Social Security Administration (SSA) county codes are no longer being updated. Therefore CMS will transition to the use of the Federal Information Processing Standard (FIPS) county codes for crosswalking to CBSAs. Coinciding with this, the Census Bureau has made the following updates to the FIPS codes:
  - Petersburg Borough, AK (FIPS 02195) created from part of former Petersburg Census Area (FIPS 02195) and part of the Hoonah-Angoon Census Area (FIPS 02105).
  - The name of La Salle Parish, LA (FIPS 22059) is renamed to LaSalle Parish, LA (FIPS 22059).
  - The name of Shannon County, SD (FIPS 46113) is renamed to Oglala Lakota County, SD (FIPS 46102).

  Regarding the new CBSA delineations adopted in FFY 2015, in some very limited circumstances (i.e. urban to rural changes that affect geographic location or Lugar status), the three-year hold-harmless transition has expired. Hospitals affected by this transition had received a wage index based on their prior geographic CBSA.

  CMS has extended the imputed rural floor policy through December 31, 2018 with regards to the OPPS.

  The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2018, CMS will continue to use a labor-related share of 60%.

- **Payment Increase for Rural SCHs and EACHs *(FR pages 52,404 – 52,405)*:** CMS will continue a 7.1% payment increase for rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs). This payment add-on excludes separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

- **Cancer Hospital Payment Adjustment and Budget Neutrality Effect *(FR pages 52,405 – 52,407):*** CMS will continue its policy to provide payment increases to the 11 hospitals identified as exempt cancer hospitals. Previously, CMS did this by providing a payment adjustment such that the cancer hospital's target payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals (and thus the adjustment was budget neutral). However, beginning CY 2018, the 21st Century Cures Act requires that the weighted average PCR for the other OPPS hospitals be reduced by 1.0 percentage point. Therefore, CMS has set the target PCR to 0.88, instead of 0.89, in order to determine the CY 2018 cancer hospital payment adjustment based on the most recent data available. CMS states that this required reduction does not significantly impact the budget neutrality adjustments for this policy.

  CMS will calculate a budget neutrality factor as if the adopted cancer hospital adjustment target PCR was 0.89, not the 0.88 PCR that was finalized in this rule. Therefore, CMS has adopted a +0.08% adjustment to the CY 2018 conversion factor to account for this policy.

- **Outlier Payments *(FR pages 52,407 – 52,408)*:** To maintain total outlier payments at 1.0% of total OPPS payments, CMS is adopting a CY 2018 outlier fixed-dollar threshold of $4,150. This is an increase compared to the current threshold of $3,825. Outlier payments will continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold are met.

Updates to the APC Groups and Weights

FR pages 52,367-52,395, 52,411-52,513

As required by law, CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.

The final payment weights and rates for CY 2018 are available in Addenda A and B of the final rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.

CMS will be removing 35 HCPCS codes from the CY 2018 bypass list. These codes are listed on pages 52,367-52,368.

The table below shows the adopted shift in the number of APCs per category from CY 2017 to CY 2018 (Addendum A):

APC Category	Status Indicator	Final CY 2017	Final CY 2018
Pass-Through Drugs and Biologicals	G	48	50
Pass-Through Devices Categories	H	3	0
OPD Services Paid through a Comprehensive APC	J1	61	61
Observation Services	J2	1	1
Non-Pass-Through Drugs/Biologicals	K	313	312
Partial Hospitalization	P	2	2
Blood and Blood Products	R	36	36
Procedure or Service, No Multiple Reduction	S	77	77
Procedure or Service, Multiple Reduction Applies	T	34	34
Brachytherapy Sources	U	17	18
Clinic or Emergency Department Visit	V	11	11
New Technology	S/T	110	112
Total		**713**	**714**

New Comprehensive APCs ***(FR pages 52,374 – 52,386)*****:** Comprehensive Ambulatory Payment Classifications APCs (C-APCs) provide all-inclusive payments for certain procedures. A C-APC covers payment for all Part B services that are related to the primary procedure (including items currently paid under separate fee schedules). The C-APC encompasses diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; coded and un-coded services and supplies used during the service; outpatient department services delivered by therapists as part of the comprehensive service; durable medical equipment as well as the supplies to support that equipment; and any other components reported by HCPCS codes that are provided during the comprehensive service. The costs of blood and blood products <u>are included</u> in the C-APCs.

The C-APCs do <u>not</u> include payments for services that are not covered by Medicare Part B or are not payable under OPPS such as: certain mammography and ambulance services; brachytherapy sources; pass-through drugs and devices; and charges for self-administered drugs (SADs).

For CY 2018, CMS did not create any new C-APCs or make any extensive changes to the already established methodology used for C-APCs. There is a total number of 62 C-APCs.

CMS will delete composite APC 8001 (LDR Prostate Brachytherapy Composite) and assign HCPCS code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) to status indicator "J1" and C-APC 5375 (Level 5 Urology and Related Services) instead.

For C-APC 5627 (Level 7 Radiation Therapy): Stereotactic Radio Surgery (SRS), CMS will continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. Additionally, the data collection period for SRS claims with modifier "CP" is set to conclude on December 31, 2017. Accordingly, for CY 2018, CMS will delete and discontinue the required use of this modifier.

- **Composite APCs** ***(FR pages 52,386 – 52,390):*** Composite APCs are another type of packaging to provide a single APC payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are seven composite APCs for:
    - Low-Dose Rate (LDR) Prostate Brachytherapy (APC 8001) **[deleted for CY 2018]**;
    - Mental Health Services (APC 8010); and
    - Multiple Imaging Services (APCs 8004, 8005, 8006, 8007 and 8008).

CMS adopted its proposal that when aggregate payment for specified mental health services provided by a hospital to a single beneficiary on single date of service exceed the maximum per diem payment rate for partial hospitalization services, those services will instead be paid through composite APC 8010 for CY 2018. In addition, the payment rate for composite APC 8010 will be set to that established for APC 5863, which is the maximum partial hospitalization per diem payment rate for a hospital.

For CY 2018, CMS will otherwise continue its current composite APC payment policies. Table 6 on pages 52,388 – 52,390 displays the HCPCS codes that would be subject to the multiple imaging procedure composite APC policy and their respective families.

- **Packaged Services** ***(FR pages 52,390 – 52,395)*****:** CMS is continuing its efforts to create more complete APC payment bundles over time to package more ancillary services when they occur on a claim with another service, and only pay for them separately when performed alone.

  CMS will remove the exception for certain drug administration services and conditionally package payment for low-cost drug administration services, except for Medicare Part B vaccine administration services. Specifically, for CY 2018 CMS will conditionally package payment for HCPCS codes in Levels 1 and 2 Drug Administration services (APCs 5691 and 5692), except for add-on codes and preventive services, when these services are performed with another service. A list of HCPCS codes that will be conditionally packaged are shown in Table 8 on pages 52,393 – 52,394.

- **Payment for Medical Devices with Pass-Through Status** ***(FR pages 52,460 – 52,473)*****:** The current HCPCS codes for devices on the pass-through payment list are:

  - C1822 – Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system;
  - C2613 – Lung biopsy plug with delivery system; and
  - C2623 – Catheter, transluminal angioplasty, drug-coated, non-laser.

  For CY 2018, CMS will be removing all three of these HCPCS codes from the list of medical devices currently provided pass-through payment status. As a result, the costs of these devices will be packaged into the costs related to the procedures with which they are reported. CMS did not approve any new device pass-through payment applications for CY 2018.

- **Device-Intensive Procedures** ***(FR pages 52,473 – 52,475)*****:** Beginning in CY 2017, CMS defined device-intensive APCs as those procedures which require the implantation of a device, and are assigned an individual HCPCS code-level device offset of more than 40%, regardless of APC assignment

  Additionally, for new HCPCS codes describing device implantation procedures that do not yet have associated claims data, CMS applies a device offset of 41% until claims data are available to establish an offset for the procedure.

  As finalized in the CY 2017 final rule, CMS applies the CY 2016 device coding requirements to newly defined device-intensive procedures. In addition, any device code would satisfy this edit when it is reported on a claim with a device-intensive procedure.

  CMS did not make any changes to this policy for CY 2018.

- **Payment Adjustment for No Cost/Full Credit and Partial Credit Devices** ***(FR pages 52,475 – 52,476)*****:** For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital received a credit from the manufacturer. The offset can be 100% of the device amount when a hospital attains the device at no cost or receives a full credit from the manufacturer; or 50% when a hospital receives partial credit of 50% or more.

  CMS determines the procedures to which this policy applies using three criteria:
  - All procedures must involve implantable devices that would be reported if device insertion procedures were performed;
  - The required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (even if temporarily); and

- The procedure must be device-intensive (defined as devices exceeding 40% of the procedure's average cost).

CMS did not make any changes to this policy for CY 2018.

- **Payment Policy for Low-Volume Device-Intensive Procedures (*FR pages 52,476 – 52,477*):** In the CY 2017 final rule CMS adopted a policy where, for any device-intensive procedure assigned to a clinical APC with fewer than 100 total claims for all procedures in the APC, the payment rate for that procedure will be calculated using the median cost. For CY 2018 the only procedure to which this policy would apply continues to be CPT code 0308T (insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis), which is currently assigned to APC 5495.

- **Payment for Drugs, Biologicals and Radiopharmaceuticals *(FR pages 52,477 - 52,485)*:** CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold.

  For CY 2018, CMS is adopting a packaging threshold of $120. Drugs, biologicals and radiopharmaceuticals that are above the $120 threshold are paid separately using individual APCs; the baseline payment rate for CY 2018 is the average sales price (ASP) + 6%.

  As adopted in the CY 2017 final rule, CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved in CY 2017 and subsequent years in order to grant a pass-through period as close to a full three years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

  Finally, CMS will allow the pass-through status to expire on December 31, 2017 for 19 drugs and biologicals, listed in Table 69 on page 52,480; and is granting pass-through status in CY 2018 to 50 others, shown in Table 70 on pages 52,481 – 52,482.

- **High Cost/Low Cost Threshold for Packaged Skin Substitutes *(FR pages 52,485 – 52,488)*:** CMS divides skin substitutes into a high cost group and a low cost group in terms of packaging. CMS assigns skin substitutes with a geometric mean unit cost (MUC) or a products per day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the high cost group.

  CMS will continue to assign those skin substitutes that did not exceed the thresholds but were assigned to the high cost group in CY 2017 to the high cost group in CY 2018 as well. CMS will also assign those with pass-through payment status to the high cost category, however there are no skin substitutes with pass-through payment for CY 2018.

  The list of packaged skin substitutes, and their group assignments, may be found in Table 72 on page 52,488.

- **Payment for Drugs Purchased under the 340B Drug Discount Program *(FR pages 52,493 – 52,511)*:** The 340B Drug Pricing Program, administered by the Health Resources & Services Administration (HRSA), allows participating hospitals and other health care providers to purchase certain "covered outpatient drugs" at discounted prices from drug manufacturers.

  Due a correlation between increases in drug spending and hospital participation in the 340B program, as well as CMS' belief that the current payment methodology may lead to unnecessary utilization and potential overutilization of separately payable drugs, CMS is changing their current Medicare Part B drug payment methodology for 340B hospitals.

  Specifically, CMS will pay a reduced rate of ASP - 22.5%, rather than the current rate of ASP + 6% for nonpass-through separately payable drugs and biosimilar biological products purchased under the 340B program. CMS believes that 22.5 percent below the ASP reflects the average minimum discount that 340B hospitals receive for drugs acquired under the 340B program.

  CMS will implement the estimated $1.6 billion drug payment reduction in a budget neutral manner by increasing the OPPS conversion factor across non-drug rates by 3.19%.

Due to comments received, for CY 2018 CMS will be exempting rural sole-community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals from the 340B adjustment, and will continue to receive payments based on ASP + 6%.

CMS is establishing modifiers "JG" and "TB", effective January 1, 2018, in order to implement this payment adjustment. Modifier "JG" will be used by non-exempt hospitals to report separately payable drugs that were acquired through the 340B program, and thus will be paid the reduced rate. Modifier "TB" will be used by hospitals exempt from the 340B payment adjustment to report separately payable drugs that were acquired through the 340B program.

Other OPPS Policies

- **Partial Hospitalization Program (PHP) Services** ***(FR pages 52,513 – 52,521)*****:** The PHP is an intensive outpatient psychiatric program to provide outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding Community Mental Health Center (CMHC). PHP providers are paid on a per diem basis with payment rates calculated using CMHC- or hospital-specific data.

  The table below compares the final CY 2017 and final CY 2018 PHP payment rates:

	Final Payment Rate 2017	Final Payment Rate 2018	% Change
APC 5853: Partial Hospitalization (3+ services) for CMHCs	$121.48	$143.30	+18.0%
APC 5863: Partial Hospitalization (3+ services) for Hospital-based PHPs	$207.27	$208.21	+0.5%

  For CMHCs, CMS will continue to make outlier payments for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year.

- **Updates to the Inpatient-Only List** ***(FR pages 52,521 – 52,528)*****:** The inpatient list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. For CY 2018, CMS will remove the following services from the inpatient-only list:
  - CPT code 27447— Total knee arthroplasty (TKA) [C-APC 5115 with status indicator "J1"];
  - CPT code 55866 — Laparoscopy, surgical prostatectomy, retropubic radical, including nerve paring, includes robotic assistance, when performed [C-APC 5362 with status indicator "J1"].
  - CPT code 43282 — Laparoscopy, surgical, repair of paraesophageal hernia with implantation of mesh [C-APC 5362 with status indicator "J1"];
  - CPT code 43772 — Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only [assigned to C-APC 5303 with status indicator "J1"];
  - CPT code 43773 — Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only [C-APC 5361 with status indicator "J1"];
  - CPT code 43774 — Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components [C-APC 5303 with status indicator "J1"].

  In addition, the public's comments on whether partial (CPT 27125) and total hip arthroplasty (CPT 27130) should also be removed from the inpatient only list and added to the ASC Covered Surgical Procedures List may be found on pages 52,527 – 52,528. CMS will consider these comments in future rulemaking.

  In addition to those services removed, CMS has added the following existing outpatient service to the inpatient-only list:
  - CPT code 92941 — Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, artherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel.
- **Payment for Off-Campus Outpatient Departments** ***(FR pages 52,528 – 52,529)*****:** The 21st Century Cures Act requires that "off-campus outpatient department of a provider" excludes certain cancer hospitals. The act also requires that for services furnished on or after January 1, 2018, a target PCR that is 1 percentage point less than the target PCR that would otherwise apply must be used. In addition to the 1 point reduction, an additional

percentage point reduction to the target PCR may be considered that takes into account payment rates for applicable items and services, other than for services furnished by certain cancer hospitals.

In the CY 2018 Final Physician Fee Schedule rule (*DISPLAY* pages 173-212), CMS adopted a policy to pay hospitals at 40%, rather than the current 50%, of the OPPS rate for non-excepted services furnished in off-campus provider-based departments of a hospital that began billing under the OPPS on or after Nov. 2, 2015.

- **Enforcement Instruction for the Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Certain Small Rural Hospitals** ***(FR pages 52,530 – 52,531):*** Currently, CMS requires direct supervision for hospital outpatient therapeutic services covered by Medicare that are furnished in hospitals as well as in provider-based departments of hospitals, including CAHs. Up until December 31, 2016, due to the difficulty of meeting this standard, CMS had created an interim nonenforcement ("enforcement instruction") for CAHs and small rural hospitals with 100 or fewer beds that allowed Medicare administrative contractors to not evaluate or enforce the supervision requirements.

  CMS will reinstate the moratorium on enforcement of direct supervision for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019. This will provide CAHs and small rural hospitals more time to comply with the supervision requirements; and also give providers time to submit specific services to be evaluated by the Advisory Panel on Hospital Outpatient payment to determine changes in supervision level. These hospitals will continue to be subject to conditions of participation for hospitals and other Medicare rules regarding supervision.

- **Changes for Payment for X-Rays Taken Using Computed Radiography Technology** ***(FR pages 52,531 – 52,533)*****:** As required by the Consolidated Appropriations Act of 2016 and effective for services furnished CY 2017 and subsequent years, the payment under the OPPS for imaging services that are X-rays taken using film will be reduced by 20 percent with modifier "FX".

  CMS will phase-in a payment reduction for imaging services that are taken using computed radiography technology. Payments for such services furnished during CYs 2018 through 2022 would be reduced by 7 percent, and by 10 percent in CY 2023 or subsequent years. CMS is establishing a new modifier "FY" that would be reported on claims to identify those HCPCS codes that describe X-rays taken using computed radiography technology beginning January 1, 2018.

- **Revisions to the Laboratory Date of Service Policy** ***(FR pages 52,533 – 52,540):*** Date of service (DOS) is a required field on all Medicare claims for laboratory services. The requirements for DOS are used to determine whether a hospital bills Medicare for a clinical diagnostic laboratory test or whether the laboratory performing the test bills Medicare directly.

  Under the current rules, if a test was ordered more than 14 days after a patients discharge date, the DOS is the date the test was performed, and the laboratory would bill Medicare directly for the test and the laboratory would be paid directly by Medicare. If the is ordered less than 14 days after a patients discharge date, the DOS is the date the specimen was collected from the patient and the hospital (not the laboratory) would bill Medicare for the test and then the hospital would pay the laboratory.

  CMS sought public comment on potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for certain laboratory tests excluded from the OPPS packaging policy, and ordered less than two weeks following the date of the patients discharge. CMS' responses to the comments received may be found on pages 52,534 – 52,540. Additionally, CMS is implementing an additional exception to the current DOS regulations so that the DOS of molecular pathology tests and tests designated by CMS as Criterion (A) advanced diagnostic laboratory tests (ADLTs) is the date that the test was performed only if:
  - The test was performed following the date of a hospital outpatient's discharge from the hospital outpatient department;
  - The specimen was collected from a hospital outpatient during an encounter;
  - It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
  - The results of the test do not guide treatment provided during the hospital outpatient encounter; and
  - The test was reasonable and medically necessary for the treatment of an illness.

Updates to the Hospital Outpatient Quality Reporting (OQR) Program

FR pages 52,564 - 52585

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 percentage point reduction to the OPPS marketbasket update for the applicable year.

A table that lists the 26 measures CMS is currently collecting for the CY 2019 and subsequent payment determinations is available in the final CY 2017 *FR* (pages 79754-79755).

The CY 2018 OPPS final rule removes six measures from the Hospital Outpatient Quality Reporting Program (pages 52,568-52,572):

The six measures to be removed in CY 2020 are:

- OP-1: Median Time to Fibrinolysis *[1-year earlier than proposed]*;
- OP-4: Aspirin at Arrival *[1-year earlier than proposed]*;
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional *[1-year earlier than proposed]*;
- OP-21: Median Time to Pain Management for Long Bone Fracture;
- OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures; and
- OP-25: Safe Surgery Checklist Use *[1-year earlier than proposed]*.

A table listing the 27 measures to be collected for CY 2020 payment determinations is available on *Federal Register* pages 52,574-52,575 of the CY 2018 final rule.

Additionally, CMS will delay the mandatory implementation of the OP-37a-e Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) measures beginning with the CY 2020 payment determination (2018 data collection) until future rulemaking as they lack important operational and implementation data regarding the collection and reliability of the data (pages 52,572-52,573).

As CMS reviews numerous reports, they received comments on whether social risk factors should be considered in the Hospital OQR Program, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors (pages 52,565-52,567).

CMS clarified the procedures for validation of chart-abstracted measures and noted that 50 outlier hospitals, based on poor measure scoring, will be targeted for validation. CMS adopted formalized chart-abstracted measure validation educational review procedures, and updates to include a correction process; in addition to changes to the Notice of Participation deadline, and alignment of the naming of the Extraordinary Circumstances Exceptions policy with other quality reporting programs (pages 52,581-52,583).

####