Overview
The display copy of the final calendar year (CY) 2019 payment rule for the Medicare Outpatient Prospective Payment System (OPPS) was released on November 2, 2018. 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:

- Change the rate for biosimilars purchased by hospitals through the 340B program;
- Change the inpatient only list;
- Make payment changes for clinic services furnished in excepted off-campus provider-based departments;
- Extend the 340B drug payment adjustment (ASP – 22.5%) to non-excepted PBDs;
- 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-1695-FC.html. Comments related to the interim APC assignments and HCPCS code status indicators are due to CMS by December 3, 2018 and can be submitted electronically at http://www.regulations.gov by using the website’s search feature to search for file code “1695-FC”.

An online version of the rule is available at https://www.federalregister.gov/d/2018-24243. 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 proposed rule is provided below.

Note: Text in italics is extracted from the November 21, 2018 Federal Register.

OPPS Payment Rate
DISPLAY pages 141 – 147
The tables below show the adopted CY 2019 conversion factor compared to CY 2018 and the components of the update factor:

<table>
<thead>
<tr>
<th>Final CY 2019 Update Factor Component</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPS Conversion Factor</td>
<td>Final CY 2018</td>
</tr>
<tr>
<td>Marketbasket (MB) Update</td>
<td>+2.90%</td>
</tr>
<tr>
<td>Affordable Care Act (ACA)-Mandated Productivity MB Reduction</td>
<td>-0.8 percentage points (PPT)</td>
</tr>
<tr>
<td>ACA-Mandated Pre-Determined MB Reduction</td>
<td>-0.75 PPT</td>
</tr>
<tr>
<td>Wage Index BN Adjustment</td>
<td>-0.16%</td>
</tr>
<tr>
<td>Pass-through Spending / Outlier BN Adjustment</td>
<td>-0.10%</td>
</tr>
<tr>
<td>Cancer Hospital BN Adjustment</td>
<td>+0.00%</td>
</tr>
<tr>
<td><strong>Overall Final Rate Update</strong></td>
<td><strong>+1.09%</strong></td>
</tr>
</tbody>
</table>
Adjustments to the Outpatient Rate and Payments

• **Wage Indexes** (*DISPLAY pages 147 – 162*): As in past years, for CY 2019 OPPS payments, CMS will use the federal fiscal year (FFY) 2019 inpatient PPS (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustment.

  CMS is using this rule to inform the public that the Census Bureau has created a CBSA for the following MSA:
  - Twin Falls, Idaho (CBSA 46300), which is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

  CMS will allow the imputed rural floor policy to expire after 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 2019, CMS will continue to use a labor-related share of 60%.

• **Payment Increase for Rural SCHs and EACHs** (*DISPLAY page 166 – 170*): 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. CMS will maintain this for future years until their data supports a change to the adjustment.

• **Cancer Hospital Payment Adjustment and Budget Neutrality Effect** (*DISPLAY pages 170 – 177*): 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).

  In order to determine a budget neutrality factor for the cancer hospital payment adjustment, CMS calculated a final PCR of 0.89 which, after applying the 1.0 percentage point reduction mandated by the 21st Century Cures Act, results in the adopted target PCR of 0.88 for each cancer hospital, which is equivalent to the target PCR for CY 2018. Therefore, CMS has adopted a +0.00% adjustment to the CY 2019 conversion factor to account for this policy.

• **Outlier Payments** (*DISPLAY pages 177 – 184*): To maintain total outlier payments at 1.0% of total OPPS payments, CMS is adopting a CY 2019 outlier fixed-dollar threshold of $4,825. This is an increase compared to the current threshold of $4,150. 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

*DISPLAY pages 44 – 140, 197 – 519, 630 – 658, and 679 – 683*

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.


CMS is not removing any codes from the CY 2019 bypass list.

The table below shows the adopted shift in the number of APCs per category from CY 2018 to CY 2019 (Addendum A):

<table>
<thead>
<tr>
<th>APC Category</th>
<th>Status Indicator</th>
<th>Final CY 2018</th>
<th>Final CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass-Through Drugs and Biologicals</td>
<td>G</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Pass-Through Device Categories</td>
<td>H</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>OPD Services Paid through a Comprehensive APC</td>
<td>J1</td>
<td>61</td>
<td>63</td>
</tr>
</tbody>
</table>
Calculation and Use of Cost-to-Charge Ratios (CCRs) *(DISPLAY pages 47 – 55)*: CMS is extending the transition policy by one year and will continue to remove claims from providers that use a “square footage” cost allocation method in order to calculate CCRs used to estimate costs for the CT and MRI APCs identified below:

- APC 5521: Level 1 Imaging without Contrast;
- APC 5522: Level 2 Imaging without Contrast;
- APC 5523: Level 3 Imaging without Contrast;
- APC 5524: Level 4 Imaging without Contrast;
- APC 5571: Level 1 Imaging with Contrast;
- APC 5572: Level 2 Imaging with Contrast;
- APC 5573: Level 3 Imaging with Contrast;
- APC 8005: CT and CTA without Contrast Composite;
- APC 8006: CT and CTA with Contrast Composite;
- APC 8007: MRI and MRA without Contrast Composite; and
- APC 8008: MRI and MRA with Contrast Composite.

New Comprehensive APCs *(DISPLAY pages 58 – 61, 72 – 99)*: 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 are included in the C-APCs.

The C-APCs do not 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 2019, CMS is creating three new C-APCs, bringing to total number to 65 C-APCs:

- APC 5163: Level 3 ENT Procedures;
- APC 5183: Level 3 Vascular Procedures; and
- APC 5184: Level 4 Vascular Procedures.

CMS will also no longer make separate payments for blood and blood products when they appear on the same claim as those services assigned to a C-APC. Finally, in order to ensure that there is sufficient claims data for services assigned to New Technology APCs, CMS will exclude payment for any procedure that is assigned to a New Technology APC from being packaged when included on a claim with a “J1” service assigned to a C-APC.

• **Composite APCs** *(DISPLAY pages 99–111)*: 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 six composite APCs for:
  - Mental Health Services (APC 8010); and
  - Multiple Imaging Services (APCs 8004, 8005, 8006, 8007 and 8008).
For CY 2019, when the aggregate payment for specified mental health services provided by a hospital to a single beneficiary on a single date of service exceed the maximum per diem payment rate for partial hospitalization services, those services will continue to instead be paid through composite APC 8010. In addition, the payment rate for composite APC 8010 will continue to be set to that established for APC 5863, which is the maximum partial hospitalization per diem payment rate for a hospital.

For CY 2019, CMS is otherwise continuing its current composite APC payment policies. Table 8, on pages 107 – 111, displays the HCPCS codes that would be subject to the multiple imaging procedure composite APC policy and their respective families; as well as each family’s geometric mean cost.

- **Payment Policy for Low-Volume New Technology APCs** ([DISPLAY pages 224 – 249]): For CY 2019, in order to promote transparency and stability in payment rates for low volume procedures, CMS will establish a different payment methodology for services assigned to New Technology APCs with fewer than 100 claims. This new methodology may use up to 4 years of claims data to establish a payment rate (based on either the geometric mean, median, or arithmetic mean) for each service both for inclusion in the New Technology APC and for assigning the service to a regular APC at the conclusion of payment for the service through a New Technology APC.

- **Packaged Services** ([DISPLAY pages 111 – 136]): 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 to only pay for them separately when performed alone.

For CY 2019, in order to address the decreased utilization of non-opioid pain management drugs, and to encourage their use rather than that of prescription opioids, CMS will unpackage, and pay separately at ASP+6%, the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting.

- **Payment for Medical Devices with Pass-Through Status** ([DISPLAY pages 338 – 399]): There are currently no device categories eligible for pass-through payment. As of the final rule, CMS has approved one new device pass-through payment application for CY 2019: remedé® System Transvenous Neurostimulator.

- **Device-Intensive Procedures** ([DISPLAY pages 399 – 425]): 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.

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

For CY 2019, CMS will allow procedures that involve surgically inserted/implanted, single-use devices that meet the device offset percentage threshold to qualify as device-intensive procedures regardless of if the device remains in the patient’s body post-procedure. CMS is also lowering the device offset percentage threshold from 40% to 30% (resulting in a 31% device offset for new HCPCS device codes) to allow more procedures to qualify as device-intensive.

In addition, to align the device-intensive policy with the criteria used for device pass-through status, to satisfy the device-intensive criteria, for CY 2019 and subsequent years, a device-intensive procedure must involve a device that:

- “Has received FDA marketing authorization, has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA... or meets another appropriate FDA exemption from premarket review;
- Is an integral part of the service furnished;
- Is used for one patient only;
- Comes in contact with human tissue;
- Is surgically implanted or inserted (either permanently or temporarily); and
- Is not any of the following:
  - Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets... ; or
Finally, CMS is adopting its proposal that “for CY 2019 and subsequent years, in limited instances where a new HCPCS code does not have a predecessor code as defined by CPT, but describes a procedure that was previously described by an existing code... [CMS will] use clinical discretion to identify HCPCS codes that are clinically related or similar to the new HCPCS code but are not officially recognized as a predecessor code by CPT, and to use the claims data of the clinically related or similar code(s) for purposes of determining whether or not to apply the default device offset to the new HCPCS code.”

• **Payment Adjustment for No Cost/Full Credit and Partial Credit Devices (DISPLAY pages 419 – 422):** 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:

  o All procedures must involve implantable devices that would be reported if device insertion procedures were performed;
  o 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
  o The procedure must be device-intensive (defined as devices exceeding 30% of the procedure’s average cost).

For CY 2019, CMS will apply the no cost/full credit and partial credit device policies to all procedures that qualify as device-intensive.

• **Payment Policy for Low-Volume Device-Intensive Procedures (DISPLAY pages 422 – 425):** 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 2019 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 (DISPLAY pages 425 – 463 and 477 – 490):** 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. CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved since CY 2017 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.

For CY 2019, CMS is adopting a packaging threshold of $125. Drugs, biologicals and radiopharmaceuticals that are above the $125 threshold are paid separately using individual APCs; the baseline payment rate for CY 2019 is the average sales price (ASP) + 6%.

For separately payable drugs and biological products that do not have pass-through status and are not acquired under the 340B program, CMS is also reducing wholesale acquisition cost (WAC)-based drug payments from WAC+6% to WAC+3% for CY 2019 and future years, which was also proposed by MedPAC in their June 2017 Report to Congress.

For CY 2019, CMS will pay for therapeutic radiopharmaceuticals with pass-through payments status, based on ASP+6%. If ASP data are not available, payment will instead be based on WAC+3%; or 95% of AWP if WAC data are also not available.

Finally, CMS will allow the pass-through status to expire on December 31, 2018 for 23 drugs and biologicals, listed in Table 37 on pages 433-434; and to continue/establish pass-through status in CY 2019 to 65 others, shown in Table 38 on pages 438 – 443 and Table 39 on page 450.

• **High Cost/Low Cost Threshold for Packaged Skin Substitutes (DISPLAY pages 463 – 477):** 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 2018 to the high cost group in CY 2019 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 2019.

The list of packaged skin substitutes, and their group assignments, may be found in Table 41 on pages 474 –
477.

- **Payment for Drugs Purchased under the 340B Drug Discount Program** *(DISPLAY pages 490 – 494, 504 – 511, and 630 –
658):* 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.

In CY 2018, due to 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 changed the Medicare Part B drug payment
methodology for 340B hospitals.

Specifically, CMS now (since January 1, 2018) pays 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, if 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.

Rural sole-community hospitals (SCHs), children’s hospitals, and PPS-exempt cancer hospitals are exempt from
the 340B adjustment, and receive drug payments based on ASP + 6%.

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

For CY 2019 and subsequent years, CMS will pay nonpass-through biosimilars acquired under the 340B
Program at ASP minus 22.5% of the biosimilar’s ASP, instead of the biosimilar’s ASP minus 22.5% of the
reference product’s ASP.

CMS clarifies that the 340B payment adjustment also applies to those drugs for which pricing is determined
based on WAC and average wholesale price (AWP). Drugs acquired under WAC pricing will be paid at WAC
minus 22.5%, while those acquired under AWP pricing will be paid at 69.46% of AWP.

In this final rule, CMS finalizing its proposal to extend the ASP – 22.5% payment rate to 340B drugs (excluding
vaccines and drugs on pass-through payment status) provided at non-excepted off-campus provider-based
departments. This policy continues to not apply to rural sole community hospitals, children’s hospitals, or to
PPS-exempt cancer hospitals.

**Other OPPS Policies**

- **Partial Hospitalization Program (PHP) Services** *(DISPLAY pages 521 – 571):* 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 2018 and final CY 2019 PHP payment rates:
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** (DISPLAY pages 571 – 586): The inpatient list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. For CY 2019, CMS will make the following changes to the services included on the inpatient-only list:

- **Remove:**
  - CPT code 31241—Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery [proposed assignment to APC 5153];
  - CPT code 01402—Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty;
  - CPT code 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); and
  - CPT code 00670—Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures).

- **Add:**
  - CPT code C9606—Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, and combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel.

**Collecting Data on Services Furnished in Off-Campus Provider-Based Emergency Departments** (DISPLAY pages 586 – 589): MedPAC’s June 2017 Report to Congress states that there has been significant growth recently in the number of health care facilities located apart from hospitals that are devoted primarily to emergency department services; including both OPPS-eligible off-campus provider-based emergency departments and OPPS-ineligible freestanding emergency departments not affiliated with a hospital. MedPAC is concerned that the payment incentives linked to operating off-campus emergency departments may be the driver of this growth.

In order to track this CMS is, through the subregulatory process, requiring that effective January 1, 2019, a HCPCS modifier “ER” (Items and services furnished by a provider-based off-campus emergency department) be reported with every claim line for outpatient hospital serviced furnished in an off-campus provider-based emergency department. The modifier would be reported on the UB-04 form (CMS Form 1450) for hospital outpatient services. Critical access hospitals would be exempt from reporting this modifier.

**Payment for Off-Campus Outpatient Departments** (DISPLAY pages 589 – 589 & 658 – 679): The Bipartisan Budget Act of 2015 restricted OPPS payments for services provided by certain off-campus outpatient departments (OPDs) of providers on or after January 1, 2017. Covered OPD services provided in these off-campus OPDs prior to November 2, 2015 would continue to be paid under OPPS, while those added after that date would be paid under the Medicare Physician Fee Schedule (MPFS):

- All excepted off-campus provider-based departments (PBDs) may bill for excepted services under the OPPS (using the claim line indicator “PO”). These include those furnished in a dedicated emergency department (ED), in an on-campus PBD, or within 250 yards from a remote location of a hospital facility.
- Excepted off-campus PBDs are allowed to relocate (temporarily or permanently), without loss of excepted status, in the rare event of extraordinary circumstances outside of the hospital’s control, such as natural disasters, seismic building code requirements, or significant public health and safety issues. Relocation requests will be evaluated by the CMS Regional Offices and either approved or denied. Excepted status is also be lost if ownership of the off-campus PBD changes, unless the new owner also acquires the main hospital and adopts the existing Medicare provider agreement.
The MPFS is the “applicable payment system” for the majority of nonexcepted items and services furnished in an off-campus PBD. These services will be paid under the MPFS at these newly established rates (or 40% of the amount paid under OPPS), which will continue to be billed on the institutional claim, and will require the new claim line modifier “PN” which will flag the service as nonexcepted, with some exceptions:

- Items and services assigned status indicator “A” will continue to be reported on an institutional claim and paid under the MPFS, Clinical Laboratory Fee Schedule (CLFS), or the Ambulance Fee Schedule, as appropriate, will not receive reduced payments.
- Drugs and biologicals that are separately payable under the OPPS (status indicators “G” and “K”) will continue to be paid at ASP +6%. Those that are always packaged (status indicator “N”) will be bundled into the MPFS payment, and will not be paid separately.

In CY 2019, in order to control what CMS deems an unnecessary increase in OPPS service volume for a basic clinic visit representing a large share of the services provided at off-campus PBDs, CMS is adopting its proposal to expand the MPFS payment methodology to excepted off-campus PBDs (currently paid under the OPPS rates), for HCPCS code G0463. However, due to comments received, this reduction will be phased in over two years. Excepted off-campus PBDs will instead see payments for HCPCS code G0463 reduced to 70% of OPPS for CY 2019, and then finally reduced to 40% of OPPS for CY 2020 and subsequent years. These excepted PBDs will continue to bill HCPCS code G0463 with modifier “PO”. CMS further states that this payment method would be implemented in a non-budget neutral manner. This change does not apply to on-campus clinic visits, but CMS will consider the possibility of expanding to additional items and services paid under OPPS in future rulemaking.

In addition, due to comments received, CMS is not adopting its proposal that if an excepted off-campus PBD furnishes services from any clinical family of services (Table 32 on page 37,150 of the proposed rule), that it did not provide under OPPS during the baseline period of November 1, 2014 through November 1, 2015, then the items and services from the new clinical families of service would not be covered OPD services and thus be paid under the MPFS. CMS will continue to monitor the expansion of services in excepted off-campus PBDs.

**Updates to the Hospital Outpatient Quality Reporting (OQR) Program**

*DISPLAY pages 831 – 937*

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.

In the CY 2019 OPPS final rule, CMS removing eight measures from the Hospital Outpatient Quality Reporting Program:

The one measure to be removed for CY 2020 payment determinations is:
- OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431);

The seven measures to be removed for CY 2021 payment determinations are:
- OP-5: Median Time to ECG (NQF #0289);
- OP-9: Mammography Follow-up Rates;
- OP-11: Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513);
- OP-12: The Ability for Providers with HIT (Health Information Technology) to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data;
- OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT;
- OP-17: Tracking Clinical Results between Visits; and
- OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (NQF #0659).

A table listing the 26 measures to be collected for CY 2020 payment determinations is available on pages 906 – 907 of the CY 2019 final rule.

A table listing the 19 measures to be collected for CY 2021 payment determinations is available on page 908 of the CY 2019 final rule.
Additionally, CMS is removing submission of the Notice of Participation (NOP) form as a requirement for the Hospital OQR Program beginning with the CY 2020 payment determination, as CMS has concluded that it does not provide any unique information and thus is unnecessarily burdensome for hospitals to complete.

CMS is also changing the reporting period for OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy from one year, to three years, beginning with CY 2020 payment determinations in order to improve the reliability of the measure.

**Additional Inpatient Quality Reporting (IQR) Program Policies**

In order to reduce the potential pressure on hospital staff to prescribe opioids to patients, due to comments received, CMS is updating the HCAHPS Survey by removing the “Communication About Pain” questions effective with October 2019 (instead of January 2022) discharges, for the FFY 2021 (instead of FFY 2024) payment determination and subsequent years.

In addition, CMS will not publicly report data collected from the “Communication About Pain” question.

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