Health Care Alert: CMS Proposes New Reimbursement Cuts for 2019 Medicare OPPS – Comments Due September 24

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On July 31, 2018, the Centers for Medicare and Medicaid Services (CMS) published its proposed changes to the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year 2019.

A primary goal of the proposed rule (available here) is to eliminate financial incentives for providers to furnish services in a certain location when it is not medically necessary to do so. Practically speaking, this "site neutrality" objective generally translates into reimbursement cuts for provider-based outpatient departments and increases for ASCs.

For example, although CMS proposes to update OPPS payment rates by 1.25%, the agency projects that this increase will be largely offset by another noteworthy provision of the proposed rule: the shift of reimbursement for clinic visits at excepted provider-based outpatient departments from the OPPS to the Medicare Physician Fee Schedule (PFS).

By way of background, CMS' 2014 OPPS update required that providers bill all outpatient clinic visits using Healthcare Common Procedure Coding System (HCPCS) code G0463, now the most common service billed under the OPPS. Additionally, section 603 of the Bipartisan Budget Act of 2015 provided that, effective January 1, 2017, providers would no longer be reimbursed for items and services furnished at "non-excepted" outpatient departments under the OPPS, but would instead receive payment under the PFS. Significantly, the PFS is subject to a "relativity adjuster," meaning that payment rates are scaled downward to a percentage designated by CMS. For 2018, the PFS relativity adjuster is 40%.

"Excepted" outpatient departments (who remained eligible for payment under the OPPS) were those that (1) were located within 250 yards of the provider's main buildings or one of its remote locations, or (2) furnished provider-based services prior to November 2, 2015.[1] Under the proposed rule, however, these outpatient departments will also receive payment for HCPCS code G0463 at the PFS rate, reducing

average clinic visit payments from $116 to $46.

Additionally, the proposed rule contemplates that excepted provider-based outpatient departments will receive payment under the OPPS only for services within the "clinical families" of services which it offered and billed under the OPPS prior to November 2, 2015. It further indicates CMS' intent to expand last year's cuts in reimbursement for drugs acquired under the 340B program, reduced from average sales price (ASP) plus 6% to ASP minus 22.5%, to non-excepted provider-based outpatient departments in 2019.

ASC payment rates, by contrast, are proposed to increase by 2%, and CMS has proposed to expand the category of services eligible for Medicare coverage in the ASC setting. Specifically, the proposed rule would include certain Common Procedural Terminology (CPT) codes outside of the "surgical range" (as defined by the American Medical Association) that directly crosswalk or are clinically similar to codes within the range.

Providers and other stakeholders who would like to offer feedback on these proposed changes may submit comments to CMS until **September 24, 2018**. If you have questions or would like more information, please contact Matt Albers, Jolie Havens, Mairi Mull, or your regular Vorys attorney.

[1] *See* 42 C.F.R. § 419.48(b).