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Our Presentation:

Outpatient Prospective Payment System CY 2018 Final Rule

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Advisor Live

Outpatient Prospective Payment System and CY 2018 Final Rules

November 13, 2017

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Agenda

- Outpatient Prospective Payment System (OPPS)
  - Payment
  - 340B Program
  - Packaged Items and Services
  - Inpatient Only Procedures
  - Outpatient Quality Reporting
  - ASC Quality Reporting
  - ASC Payment Updates

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Outpatient Prospective Payment System (OPPS)

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OPPS Final Rule: Summary

- OPPS Final Rule published in the November 13, 2017 *Federal Register*.
- Market basket of 2.70%; update of 1.35%; average payment increase of ≈1.4% for hospitals reporting quality data
- Reduces payment for Part B Drugs acquired under the 340B program by 28.5%.
- Conditionally packages payment for low-cost drug administration services, except for Medicare Part B vaccine administration services.
- Removes total knee arthroplasty (TKA) from the inpatient only list in CY 2018.
- Removes 6 measures for CY 2018 reporting/2020 payment.
- Delays Outpatient and Ambulatory Surgery CAHPS.

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- 2018 Hospital Update and Estimated Change in Expenditures:
  - Update:

Market basket	2.70%
Multifactor Productivity	-0.60 percentage points
ACA Factor	-0.75 percentage points
Total	**1.35%**

  - Change in Expenditures:

Update	1.35%
Pass-Through Adjustment	+0.20 percent
Outliers ('17→'18, 1.11% to 1%)	-0.11 percent
Total	**≈1.4 percent**

- Average payment increase may be higher or lower for an individual hospital:
  - Final rule estimates a decrease of 0.9 percent for major teaching hospitals and an increase of 1.7 percent for minor teaching hospitals.
  - Changes from the average are accounted for by the differential impact of APC recalibration and wage index.

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OPPS Final Rule: CF and Change in Spending

- **Conversion Factor (CF):**
  - 2017 CF = $75.001
  - Pass-Through x 1.0020
  - Wage Index x 0.9997
  - Cancer Hospital x 1.0008
  - 340B Adjustment x 1.0319
  - 2018 CF = $78.636
- **Quality Data:**
  - Reporting Hospital CF = $78.636
  - Non-reporting Hospital CF = $77.064
- **CMS estimates:**
  - Total expenditure increase due only to the changes to OPPS finalized in this final rule with comment period, will be approximately $690 million.
  - Including changes in enrollment, utilization, case-mix, CMS says spending will ↑ $5.8 billion.

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OPPS Final Rule: Wage Index

- Wage Index – Generally, prior policies continued without change in 2018.
  - Adopts the proposed fiscal year IPPS post-classified wage index as the OPPS calendar year wage index for adjusting the OPPS standard payment amounts for labor market differences.
  - Retains OPPS labor-related share of 60%.
  - Continues Frontier State wage index floor of 1.00.
  - Continues to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration wage adjustment if in a “Section 505” out-migration county.
  - Imputed Floor: extends the imputed floor for an additional year through FY 2018. CMS will continue to assess the effects of this policy and whether to continue or discontinue the imputed floor for the long term.

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OPPS Final Rule: Special Case Hospitals

- Rural Adjustment
  - Continues a budget neutral 7.1% payment increase for rural Sole Community Hospital (including Essential Access Community Hospital) services, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.
- Cancer Hospitals
  - Continues to provide additional payments to 11 cancer hospitals sufficient to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals–less 1.0 percentage point per the 21st Century Cures Act. (CMS makes an aggregate payment at cost report settlement rather than a claims-based adjustment).
  - **1.0008 OPPS budget neutrality conversion factor adjustment** for the cancer hospital adjustment.
  - **Final rule target PCR of 0.88** will be used (including the 1.0% reduction for the 21st Century Cures Act) to determine the CY 2018 cancer hospital payment adjustment to be paid at cost report settlement, using the latest available cost data.

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OPPS Final Rule: Outliers

- Outliers – No Methodological Changes for 2018:
  - The OPPS makes outlier payments on a service-by-service basis when the cost of a service exceeds the outlier threshold.
  - The final rule continues to set aside **1.0 percent** of the estimated aggregate total payments under the OPPS for outlier payments
  - To qualify for outlier payments in 2018, a service or procedure cost must exceed **1.75 times** the APC payment amount *and* also exceed the APC payment rate plus a **$4,150 fixed-dollar threshold** (compared to $3,825 in 2017).
  - Payment equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both thresholds are met.
  - Allocates **0.02% of the 1% outlier pool to Community Mental Health Centers** for partial hospitalization program outlier payments.
  - The inflation adjustment factors for cost-to-charge ratios and charges are the same as were used for the FY 2018 IPPS final rule.

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OPPS Final Rule: CMS' 340B Proposal

- Effective January 1, 2018, Medicare payments for all separately-payable Part B drugs purchased under the 340B program dispensed to hospital outpatients will be the average sales price (ASP) minus 22.5 percent.
- CMS will continue to pay for drugs that were not purchased with a 340B discount at ASP+6 percent.
- Policy does not include:
  - "Pass Through" drugs
  - Vaccines

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OPPS Final Rule: Implications of 340B Proposal

- CMS estimates that the payment reduction will result in $1.6 billion in savings in Medicare payment for Part B outpatient hospital drugs.
- Being implemented budget neutral by increasing payment for all other services paid under OPPS
- CMS estimates the redistribution in payments would result in an increase in other payments under OPPS by approximately 3.2 percent
- To accurately identify 340B acquired drugs for payment adjustment a modifier will be required beginning January 1, 2018 for all 340B hospitals
  - “JG” modifier will indicate a drug was purchased through the 340B program triggering the payment adjustment
  - Providers who are excepted (rural SCHs, Children’s Hospitals and Cancer Hospitals) should report the “TB” informational modifier that **does not** trigger a payment adjustment

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OPPS Final Rule: Packaged Items & Services

- CY 2015 OPPS final rule began conditionally packaging services assigned to APCs with a geometric mean cost of $100 or less prior to packaging. Drug administration was not included.

- CMS is finalizing its proposal to conditionally package payment for low-cost drug administration services in an effort to continue to work toward bundling payments under the outpatient PPS and encouraging hospital efficiencies.

- Because preventive services are excluded from packaging policies, Medicare Part B vaccine administration services will continue to be paid separately.

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OPPS Final Rule: Packaged Skin Substitutes

- Payment for skin substitutes is packaged into the payment for the associated primary procedure and based on whether they are assigned to either a “high cost group” or a “low cost group.”
- For CY 2018, CMS finalized its proposal to continue assigning skin substitutes with a geometric mean unit cost (MUC) or a per day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the high cost group.
- In addition, Skin substitutes not exceeding either the CY 2018 MUC or PDC threshold for CY 2018 but were assigned to the high cost group in CY 2017 will be assigned to the high cost group for CY 2018.
- CMS’ goal is to maintain similar levels of payment for skin substitute products for CY 2018 while CMS analyzes the current skin substitute payment methodology to determine whether refinements to the existing methodologies may be warranted.

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OPPS Final Rule: Inpatient Only List

- CMS will to continue to use the same methodology to decide whether to remove a procedure from the inpatient-only list.

- **Total Knee Arthroplasty**: will remove total knee arthroplasty (TKA) from the inpatient only list in CY 2018, allowing these procedures to be performed in hospital outpatient departments.
    - Recovery Audit Contractors are prohibited from conducting patient status reviews for two years on TKA procedures performed in the inpatient setting.
    - Notes that removing TKA from inpatient only list allows Medicare to pay when performed outpatient but does not require TKA to be performed outpatient if not appropriate for the patient.

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OPPS Final Rule: Inpatient Only List Continued…

Five other procedures will also be removed and one procedure added to the IPO list in response to public comment.

2018 CPT Code	CY2018 Long Descriptor	Status
27447	Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)	Removed
43282	Laparoscopy, surgical, repair of paraesophageal hernia with implantation of mesh	Removed
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Removed
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Removed
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Removed
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Removed
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	Added

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OPPS Final Rule: Other Finalized Policies

- CMS will reinstate the non-enforcement of **direct supervision requirements for outpatient therapeutic services or critical access hospitals (CAHs) and small rural hospitals** having 100 or fewer beds for CYs 2018 and 2019. The enforcement moratorium is designed to give affected hospitals more time to comply with the requirements.
- An additional exception to the **current laboratory DOS regulations** is being added that **will permit laboratories to bill Medicare directly for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests excluded from the outpatient PPS packaging policy** if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department.
- Enforces phased in **reduction in payments for x-rays taken using CRT** as required by statute during CYs 2018 through 2022 by 7 percent, and for services furnished during CY 2023 or a subsequent year by 10 percent. A **new modifier** will be reported on claims to identify those HCPCS codes that describe X-rays taken using CRT beginning January 1, 2018.

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PFS: Outpatient Provider-Based Departments - Background

- Section 603 of the Bipartisan Budget Act of 2015, enacted on November 2, 2015, imposed new payment rules for certain off-campus outpatient provider-based departments (PBDs).
- Beginning January 1, 2017, non-excepted items and services furnished by non-excepted off-campus PBDs will no longer be paid under the OPPS; they will be paid under another Medicare Part B payment system not specified by the law.
- The law does not apply to on-campus PBDs (main provider).
- The law provides exceptions for:
  - PBDs within 250 yards of a remote location (straight line measurement from any point of the inpatient hospital at the remote location).
  - PBDs billing prior to November 2, 2015.
  - Services furnished in a dedicated emergency department (ED). CMS clarified in rulemaking that exception will apply all services in a dedicated ED, not just ED visits.

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PFS: Outpatient Provider-Based Departments

- CY 2017 OPPS interim Final Rule
  - CMS issued Interim Final Rule with Comment (IFC) to make payment to hospitals at a special Medicare Physician Fee Schedule (MPFS) rate for the non-excepted off-campus PBDs at 50% of OPPS rates for 2017, the PFS Relativity Adjuster
  - Billed on an institutional claim with new claim line modifier “PN”
  - OPPS payment policies (e.g. C-APCs, OPPS packaging) will apply
  - Partial Hospitalization will be paid at CMHC rate.
  - Services paid under other fee schedules (MPFS, Clinical Laboratory Fee Schedule and Ambulance Fee Schedule) will continue to be paid the same as currently without a reduction.
  - OPPS geographic adjustor (wage index) and OPPS supervision rules will apply
- CY 2018 MPFS Final Rule
  - Adjust the PFS Relativity Adjuster to 40% of the OPPS rates
  - CMS estimates that this change will result in total Medicare Part B savings of $12 million.

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Hospital Outpatient Quality Reporting Program

Data Collection Summary

Measure Category	CY 2017	CY 2018	CY 2019
Chart-Abstracted	10 9 Required 1 Voluntary	6 5 Required 1 Voluntary Removed 4	6 5 Required 1 Voluntary
Claims-Based	7	9	9
NHSN	1	1	1
Web-Based	8	6 Remove 2	6
CAHPS		5 Delay	5 Delay
TOTALS	26	22	22

*CY refers to data collection not payment year. Collection in 2018 applies to payments in 2020,

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OQR: Changes

- Remove 6 measures for CY 2018 reporting/2020 payment
  - OP-21: Median Time to Pain Management for Long Bone Fracture
  - OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
  - OP-1: Median Time to Fibrinolysis
  - OP-4: Aspirin at Arrival
  - OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
  - OP-25: Safe Surgery Checklist
- Delay OAS CAHPS
- Public Display
  - Will not include OP-18c Median Time from ED Arrival to ED Departure for Discharged ED strata for psychiatric/mental health patients on Hospital Compare but data will be available in downloadable database
- Proposed Rule sought comments on future measure topics
  - OP-2: Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival as an eCQM
  - Accounting for Social Risk Factors

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Final CY 2018 Ambulatory Surgical Center Payment Updates

- Payment increase = 1.2% for ASC reporting quality data, 0.1% for other ASCs
- Consumer price index = 1.7%
- Productivity adjustment = -0.5%
- Net Update = 1.2%
- Wage Index Budget Neutrality = 1.0007
- Conversion factor of $45.575 ($44.663 for ASCs that do not submit quality data).
- Estimated increase in aggregate ASC payments of $130 million over CY 2017.

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ASCQR: Changes

- Remove 3 measures for CY 2017 reporting/2019 payment
  - ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing
  - ASC-6: Safe Surgery Checklist Use
  - ASC-7: ASC Facility Volume Data on Selected Procedures
- Delay OAS CAHPS
- Two new measures for CY 2020 reporting/2022 payment
  - ASC-17: Hospital Visits after Orthopedic ASC Procedures
  - ASC-18: Hospital Visits after Urology ASC Procedures
- Did not finalize additional measure for CY 2019 reporting/2021 payment
  - ASC-16: Toxic Anterior Segment Syndrome (TASS) measure
- Proposed Rule sought comments on future measure topics
  - Ambulatory Breast Procedure Surgical Site Infection outcome measure (NQF #3015)
  - Accounting for social risk factors

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Important Links

OPPS:

Premier Detailed Summary

Final Rule

CMS Press Release

CMS Fact Sheet

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APPENDIX

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OPPS: Overview of the 340B Program

- Congress created the 340B program in 1992 to help uninsured indigent patients gain better access to prescription drugs.
- The program is intended to reduce outpatient drug costs for certain types of health care facilities serving large numbers of uninsured indigent patients.
- The law requires pharmaceutical manufacturers to give statutorily specific discounts for drugs dispensed to outpatients of qualifying entities
- Administered by Health Resources and Services Administration (HRSA)
- Dramatically expanded due to ACA (583 participating hospitals in 2005 to 2,140 in 2014) (Some of the growth since 2010 has been in critical access hospitals that are paid differently than other hospitals for outpatient drugs.)

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340B Program "Covered Entity" Eligibility

- Federal health care grant recipients
- Certain disproportionate share hospitals (DSH), children's hospitals, cancer hospitals, critical access hospitals, sole community hospitals and rural referral centers
- All 340B-eligible hospitals except critical access hospitals must have a Medicare DSH adjustment percentage either greater than 11.75 percent (for DSH hospitals, Children's hospitals and cancer hospitals) or greater than or equal to 8 percent (for rural referral centers and sole community hospitals).

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OPPS: 340B Ceiling Price

- Maximum price a drug manufacturer can charge a covered entity for a drug
- The 340B ceiling price is statutorily defined as the Average Manufacturer Price (AMP) reduced by the rebate percentage, Unit Rebate Amount (URA)
- The URA is the greater of 23.1% of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the best price per unit and adjusted by the Consumer Price Index- Urban (CPI-U) based on launch data and current quarter AMP.

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OQR: OAS CAHPS Measures

- Composite Survey-Based Measures
  - The proportion of "top box" (yes or yes definitely) responses for each question are averaged
  - OP-37a: OAS CAHPS—About Facilities and Staff
  - OP-37b: OAS CAHPS—Communication About Procedure
  - OP-37c: OAS CAHPS—Preparation for Discharge and Recovery
- Global Survey-Based Measures
  - The proportion of "high-value" (9-10 or definitely yes) responses
  - OP-37d: OAS CAHPS—Overall Rating of Facility
  - OP-37e: OAS CAHPS—Recommendation of Facility

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