

OVERVIEW OF THE MEDICARE OPPS AND ASC FINAL RULE CY 2018

SUMMARY OF CALCULATION ELEMENTS

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Rule to take effect January 1, 2018

OPPS UPDATE

OPPS fee schedule increasing payments by 1.35 percent

- Hospital IPPS market basket percentage increase of **2.7 percent**
- Minus the MFP adjustment of **0.6 percentage point**
- Minus a **0.75 percentage point** adjustment required by the ACA

Continuation of 2.0 percentage point reduction in payments for hospitals failing to meet outpatient quality reporting requirements

- An increase of \$5.8 billion compared to CY 2017 OPPS payments

Estimated 17.2 percent increase in CY 2018 payments to CMHCs from CY 2017 payments

- Only paid for partial hospitalization services under the OPPS

OPPS UPDATE

Rural Adjustment

- Continuing 7.1 percent adjustment to the OPPS payments to certain rural sole community hospitals (SCHs) including essential access community hospitals (EACHs)
 - Applies to all services paid under the OPPS (some exclusions apply)
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Cancer Hospital Payment Adjustment

- Continuing to provide additional payments to cancer hospitals so that payment-to-cost ratio (PCR) after additional payments equals weighted average PCR for other OPPS hospitals
- Target PCR of 0.88 used to determine CY 2018 cancer hospital payment adjustment
 - Reduction of weighted average PCR by 1.0 percentage point beginning CY 2018 required by the 21st Century Cures Act

OPPS UPDATE

Device-Intensive Procedures

- Device-intensive status is assigned to all procedures requiring device implantation and have an individual HCPCS code-level device offset of greater than 40%, regardless of APC assignment
 - Calculating device offset amount at HCPCS code level rather than at APC level better represents procedures device cost

Chronic Care Management (CCM)

- Minor changes applied to CCM furnished to hospital outpatients
- Changes for CY 2018:
 - 5 behavioral health HCPCS codes are being replaced by CPT codes to reduce burden on reporting providers (stronger alignment between CMS requirements and CPT guidance for new and existing codes)

OPPS UPDATE

Revisions to the Laboratory Date of Service Policy

- The components of a lab service may take place on different dates: physician orders lab, specimen collection, lab receives specimen, specimen is tested, and results are produced
 - Former DOS policy permits hospital to bill Medicare for lab tests that they did not perform and required that the lab that *did* perform the service seek payment from the hospital that billed for it
- As of CY 2018:
 - DOS for chemotherapy sensitivity tests is the date the test was performed as long as specific conditions are met
 - Current lab DOS policy has been revised for tests granted **ADLT** status by CMS and **molecular pathology** tests that are excluded from OPPS packaging policy so that the **labs performing the tests may bill and be paid directly by Medicare for these tests**
 - Exception to DOS rule for ADLTs only: DOS is the date the laboratory test was performed

OPPS UPDATE

Packaging Policies

- Aligning the packaging logic for all of the conditional packaging status indicators so that packaging would occur at claim level (instead of based on the date of service)
 - Removal of the exception for certain drug administration services
 - Conditionally package payment for low-cost drug administration services

Payment Modifier for X-Ray Films

- Payment reduction for X-rays taken using film that would otherwise be made under the OPPS
 - Amended to allow for a phased roll-out of the payment reduction
 - 7% reduction in CY 2018-2022
 - 10% reduction in CY 2023 and beyond
- New modifier established to be used with the applicable HCPCS code to make reduction

OPPS UPDATE

Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Departments of a Provider

- Section 603 of the Bipartisan Budget Act of 2015
 - Requires that certain items and services furnished in certain off-campus PBDs shall not be covered OPD services for purposes for OPPS payment
 - Will instead be paid under the applicable payment system beginning January 1, 2017
- Excepted off-campus PBDs will continue to be paid under the OPPS for services rendered
 - No proposal to limit clinical service line expansion for CY 2018

ASC PAYMENT UPDATE

Increasing payment rates by 1.2 percent for ASCs that meet the quality reporting requirements under the ASCQR Program

CPI-U update of 1.7%

Minus

MFP adjustment of 0.5%

Range of impact in total payments by specialty groups for CY 2018 compared to CY 2017 between 1-5%, depending on the service (with some exceptions).

PAYMENT FOR PARTIAL HOSPITALIZATION

CMS has established a per diem payment methodology for PHP APCs

- Based on geometric mean per diem costs

Update for CY 2018:

- Continue use of CMHC APC 5853 and hospital-based PHP APC 5863 (Partial Hospitalization (3 or more services per day))
 - Calculation of costs based on CY 2016 claims only

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

CY 2018

- Notice of participation deadline will not be extended

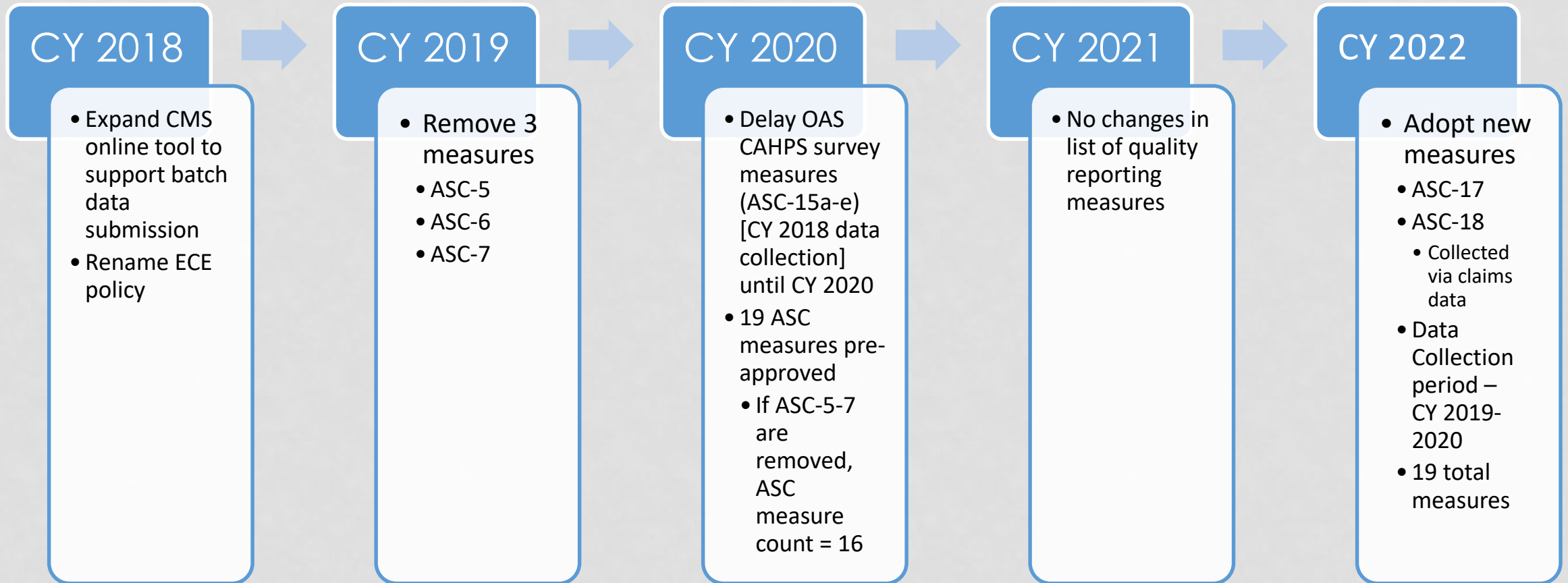
CY 2019

- Finalizing a total of seven measures
 - Two claims-based measures
 - Five OAS CAHPS Survey-based measures were delayed until CY 2020
- CY 2018 reporting period

CY 2020

- CY 2018: removal of 6 measures:
 - OP-1
 - OP-4
 - OP-21
 - OP-26
 - OP-20
 - OP-25
- Total measure count: 27

AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM



MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS

Under Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018

- Eliminates the **Clinical Decision Support (CDS)** and **Computerized Provider Order Entry (CPOE)** objectives and measures
- **Lowers the reporting thresholds** for a subset of the remaining objectives and measures
- Revised requirements focus on **reducing hospital administrative burden**
- For 2018, the reporting period is a **full calendar year** for all EHR Incentive Program participants

WAGE INDEXES

- Update of wage indexes based on FY 2018 IPPS final rule wage indexes
 - Approximate increase of <1%-5% for urban hospitals
 - No change for rural hospitals
- Wage indexes include the continued implementation of the OMB labor market area delineations

OPPS:

- Conversion Factor:
 - \$78.636
 - OPD fee schedule increase of 1.35%
 - Budget neutrality adjustment of 0.9997
 - Cancer hospital payment adjustment of 1.0008
 - 340B Program adjustment of 1.0319
 - Pass-through and outlier payment adjustment of 0.2%

ASC:

- Conversion Factor:
 - \$45.575 (ASC meets quality reporting requirements)
 - Budget neutrality adjustment of 1.0007
 - MFP-adjusted CPI-U of 1.2%
 - \$44.663 (ASC does not meet quality requirements)
 - Budget neutrality adjustment of 1.0007
 - MPI-adjusted CPI-U of -0.8%

OPD FEE SCHEDULE INCREASE FACTOR

OPD fee schedule increase factor of 1.35 percent to conversion factor for CY 2018 will mitigate the impacts of other budget neutrality adjustments



**Urban hospitals:
1.3 percent**



**Rural hospitals:
2.7 percent**

C-APCs

Apply frequency and cost criteria thresholds to determine combination of primary care codes that qualify for complexity adjustment

- Code combinations qualifying for complexity adjustment will no longer create a 2 times rule violation (as established in CY 2017)

No additional C-APCs being added under existing APC payment policy

- 62 C-APCs established during CY 2017 will continue for CY 2018

COMPOSITE APCs

Mental Health Composite APC:

- When aggregate payment for specified mental health services exceeds max per diem payment rate for partial hospitalization services on a given day, services to be paid through composite APC 8010 (Mental Health Services)
 - Set rate for C-APC 8010 as equal to C-APC 5863 rate – the max partial hospitalization per diem payment rate for a hospital

Multiple Imaging Composite APCs:

- Continue the use of the 5 established composite APCs
- Payment rates based on proposed geometric mean costs

CHANGES TO PACKAGED ITEMS AND SERVICES

- Packaging of level 1 and 2 drug administration services:
 - Due to low geometric mean costs, when these services are performed with another separately payable service, they should be packaged.
 - HCPCS codes describing drug administration services in APC 5691 and APC 5692 (except for add-on codes and preventive services) would be eligible when performed with another service
- No proposal to create a composite APC for pathology services or other services such as x-ray, respiratory care, cardiology, or allergy testing
 - Composite APCs are becoming less necessary as the move is made to larger bundles (in the form of C-APCs)

HOSPITAL OUTLIER PAYMENTS

OPPS provides hospitals with a payment for cases that may result in significant financial loss to hospital due to high-cost, complex procedures

CMS will continue policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS

OPPS fixed-dollar threshold is \$4,325 for CY 2018

APC GROUP POLICY

Finalizing without modification the APC assignments and status indicators of new HCPCS codes that were implemented on April 1, 2017 and July 1, 2017

Adopting the proposed APC and/or status indicator assignments for:	<ul style="list-style-type: none">• April 1, 2017:<ul style="list-style-type: none">• Level II HCPCS codes J1428, J9285, J1627, J3358, and C9488• July 1, 2017:<ul style="list-style-type: none">• 10 Category III CPT Codes• 13 Level II HCPCS Codes – C and Q-codes have been replaced with J-codes
Excepted from the 2 times rule:	<ul style="list-style-type: none">• 6 of the 12 proposed APCs from the 2 times rule (5112, 5521, 5691, 5731, 5771, and 5823)• 5 additional APCs (5522, 5524, 5571, 5721, and 5732)

APC GROUP POLICY

There are currently 51 levels of New Technology APCs.

In CY 2017, APCs 1901-1906 were created.

- For CY 2018, cost band increments will be narrowed from \$19,999 to \$14,999 cost bands

Established 2 new groups of New Technology APCs (1907 and 1908)

- New Technology Level 52 (\$145,001-\$160,000)
 - Allows for an appropriate payment of retinal prosthesis implantation procedures

OPPS PAYMENTS FOR DEVICES

Currently three device categories eligible for transitional pass-through payment

- HCPCS codes C2623, C2613, and C1822
 - Applying policy to expire device categories at end of CY when at least 2 years of pass-through payments have been made
- Beginning CY 2018, HCPCS codes C2623, C2613, and C1822 will be packaged with the procedure payment

5 new device pass-through payment applications were received for CY 2018, but none was approved

OPPS PAYMENT CHANGES TO DRUG, BIOLOGICALS, AND RADIOPHARMACEUTICALS

For CY 2018, the pass-through status of 19 drugs and biologicals will expire December 31, 2017

50 drugs continue to have pass-through payment status at the rate of average sales price (ASP) + 6%

For CY 2018, CMS has set a \$120 drug packaging threshold payment for drugs

CHANGES TO THE 340B PROGRAM

- The 340B Program allows participating hospitals to purchase covered outpatient drugs at a discount from drug manufacturers.
- Reduction in payment to hospitals for drugs purchased through the 340B program
 - CY 2018 payment rate: average sales price (ASP) – 22.5%
 - Payment decrease of 28.5% compared to CY 2017
 - Excludes vaccines, sole community hospitals in rural areas, children's hospitals, PPS-exempt cancer hospitals, and critical access hospitals
- \$1.6 billion decrease in drug payments to be redistributed to other non-drug items and services within the OPSS

CHANGES TO INPATIENT ONLY LIST

Codes Removed from the IPO

- **27447** (Total Knee Arthroplasty) – CY 2018 OPPS APC: 5115
- **43282** – CY 2018 OPPS APC: 5362
- **43772** – CY 2018 OPPS APC: 5303
- **43773** – CY 2018 OPPS APC: 5361
- **43774** – CY 2018 OPPS APC: 5303
- **55866** – CY 2018 OPPS APC: 5362

Codes Added to the IPO

- **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

NEW HEALTH ANALYTICS

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