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Seven Highlights From the 2018 OPPS, ASC, PFS and Quality Reporting Program Proposed Rules

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The Centers for Medicare and Medicaid Services (CMS) has released its annual proposed rules updating the Hospital Outpatient Prospective Payment System (OPPS), Ambulatory Surgical Center Payment System (ASC), Physician Fee Schedule (PFS) and Quality Reporting Programs, among others.[1] Below are seven major takeaways from these proposed rules that health systems and providers should keep in mind.

1. Non-excepted hospital off-campus provider-based departments will receive 50 percent less in 2018 than in 2017

The 2015 Bipartisan Budget Act (the "Act") declared that beginning January 1, 2017, hospital off-campus provider-based departments (HOPDs) that were not established at the time of the Act (November 2, 2015) would no longer be paid at OPPS rates. Since then, the 2017 interim final rule[2] further scaled the PFS rate for non-excepted HOPD services by 50 percent in an effort to strike an appropriate balance between underestimating the resources involved in providing non-excepted HOPD services as compared to the services provided in other settings paid under PFS. In the proposed PFS rule, CMS has not yet received data on claims from 2017 but has proposed to reduce non-excepted HOPD services another 50 percent, resulting in these locations receiving payment at 25 percent of the OPPS payment rate. CMS came up with this reduction by evaluating the codes most commonly billed at HOPD settings (clinic visit – HCPCS G0463) as compared to the weighted average of facility and nonfacility outpatient visits paid under PFS (CPT 99201-99205 and CPT 99211-99215). CMS states that it will revise the adjusted payment when more data is available, if necessary, but its ultimate goal is "to ensure that hospitals are not paid more than others would be paid through the PFS nonfacility rate." Please also refer to our previous publications on this subject: "21st Century Cures Act Grants Additional Grandfathered Status to Some Off-Campus Hospital Outpatient Departments" and "CMS Issues Guidance on Billing to Newly Excepted Off-Campus Hospital Outpatient Departments."

2. Hospitals are projected to receive approximately 2.0 percent more in outpatient procedure payments in 2018 than in 2017

CMS is projecting that OPPS providers will receive approximately $5.7 billion more in 2018 than they

are estimated to receive in 2017. This increase is driven primarily by a complex calculus of changes to the OPPS fee schedule. CMS proposes to increase the OPPS payment rates by 1.75 percent through a 2.9 percent market basket update, a 0.4 percent reduction based on a multifactor productivity adjustment, which may be further adjusted if estimates that are more recent are made available before publication, and a 0.75 percent reduction based on provisions in the Affordable Care Act. All told, the changes proposed by CMS in the proposed rule result in a projected 2.0 percent increase in payments to hospitals for OPPS-paid services.

3. Non-pass-through drugs purchased through the 340B program will be discounted by 22.5 percent

CMS proposes to reduce costs to Medicare beneficiaries by applying an average discount of 22.5 percent of the average sales price for non-pass-through separately payable drugs purchased by hospitals participating in the 340B program. CMS used the 2015 MedPAC report to Congress[3] as its primary reasoning to apply this discount, believing that it will result in payments that better reflect drug acquisition costs while preserving the confidential nature of discounts applied to a specific drug. Notably, vaccines and drugs on pass-through status paid through Medicare Part D Drug Average Sales Price methodology would be excepted from this proposed reduction. CMS is seeking comments on whether this average discount is appropriate or whether drug-specific reductions should be required. With a drug-specific reduction, 340B hospitals would be required to report their acquisition costs, including discounts, which could be difficult to reconcile with the statutory requirement to keep ceiling prices confidential.

4. Two procedures are proposed for elimination from the inpatient-only list

When CMS considers removing procedures from the inpatient-only list, it looks at five questions:

- Are most outpatient departments equipped to provide the services?
- Can the simplest procedure described by the HCPCS/CPT code proposed for elimination be performed by most outpatient departments?
- Is the procedure related to previously removed codes?
- Are many hospitals performing the procedure in outpatient settings?
- Can the procedure be performed safely in an ambulatory surgery center, is the procedure on the ambulatory surgery center list of approved procedures, or is the procedure proposed for inclusion on that list?

Looking at these questions, CMS is proposing to eliminate two CPT codes from the inpatient-only list. First, CPT 27447 (total knee arthroplasty) has been considered for many years, with the majority of commenters in favor of its removal. CMS believes the procedure passes criteria A, B and D but cautions providers to create evidence-based patient selection criteria to identify appropriate candidates for outpatient procedure performance. Next, CPT 55866 (surgical laparoscopic prostatectomy) is also proposed. CMS did not offer much analysis, simply stating that the procedure meets criteria A and B.

Along with these two procedures, CMS is also asking for comments on whether to remove CPT 27125 (partial hip arthroplasty) and CPT 27130 (total hip arthroplasty) from the inpatient-only list. CMS cites recent innovations with minimally invasive techniques, improved perioperative anesthesia, alternative post-operative pain management, and expedited rehabilitation protocols as evidence that some patients may be good candidates for an outpatient, minimally invasive procedure.

5. Three new telehealth procedures are proposed for payment under PFS

When CMS considers paying for telehealth services under the PFS, several criteria must be met:

- The procedure must be furnished via an interactive telecommunications system.
- The procedure must be furnished by a physician or an authorized practitioner.
- The procedure must be furnished to an eligible telehealth individual.
- The recipient must be in a telehealth originating site.

In addition, the services must either be similar to a professional consultation, office visit or office psychiatric service currently on the telehealth list, or provide a demonstrable clinical benefit.[4] If these criteria are met, the originating site receives a facility fee and the distant site practitioner receives a separate fee.

Using these criteria, CMA is proposing to add three codes to the approved telehealth procedures list. First, HCPCS G0296 (lung cancer screening using low dose CT scan) is considered sufficiently similar to existing office visits. Next, CPT 90839 and 90840 (psychotherapy for crisis for 60 minutes; psychotherapy for crisis for each additional 30 minutes) is considered sufficiently similar to existing psychiatric services; however, for these codes the distant site practitioner must be able to mobilize resources at the originating site to defuse the crisis and restore safety.

CMS is also seeking comments on whether to include four additional codes: CPT 90785 (interactive complexity), CPT 96160 (administration of patient-focused health risk assessment), CPT 96161 (administration of caregiver-focused health risk assessment) and HCPCS G0506 (comprehensive assessment and care planning for patients requiring chronic care management services). Each of these codes would only be considered telehealth services when billed as an add-on code to codes already on the telehealth list.

Finally, CMS is also proposing to eliminate the need to add the GT modifier on telehealth claims from distant providers because these claims must use a Place of Service code. Institutional claims will continue to use the GT modifier.

6. Seven quality measures are under consideration for the hospital outpatient Quality Reporting Program

Measure Number	Description	Proposed Action	Reason
OP-21	Median time to pain management for long bone fracture	Eliminate	CMS is concerned that its inclusion creates pressure for hospital staff to prescribe opioids unnecessarily.
OP-26	Volume data on selected outpatient surgical procedures	Eliminate	CMS believes there is a lack of evidence that merely measuring a number of procedures does not demonstrate quality improvement.
OP-1	Median time to	Eliminate	CMS believes OP-2 is a

	fibrinolysis		better quality measure because it measures whether fibrinolysis was performed within 30 minutes of arrival in the emergency department. OP-1 does not demonstrate whether the 30-minute threshold was met.
OP-4	Administration of aspirin upon presentation of chest pain	Eliminate	CMS believes performance has become so universal that measurement is no longer meaningful.
OP-20	Door to diagnostic evaluation by qualified medical personnel	Eliminate	CMS believes this measure provides limited evidence linked to improved patient outcomes. The measure fails to account for inaccuracy in time stamps and institutional variations and confounding factors.
OP-25	Safe surgery checklist use	Eliminate	CMS believes that the use of checklists has become so universal that meaningful distinctions in measuring improvements can no longer be made.
OP-37a-e	Outpatient and ambulatory surgery consumer assessment of health care providers and systems	Delay in adopting	CMS proposes to delay including this measure until more operational and implementation data is available and survey measures are appropriate to capture patient responses in a reliable, non-burdensome way.

In addition to these changes, CMS is soliciting comments on future measure topics and future adoption of the electronic version of OP-2.

7. Seven quality measures are under consideration for the ASC Quality Reporting Program

Measure Number	Description	Proposed Action	Reason
ASC-5	Prophylactic IV antibiotic timing	Eliminate	CMS believes that intravenous antibiotic use given timely to prevent surgical site infections has become so universal that meaningful distinctions in measuring improvements can no longer be made.
ASC-6	Using safe surgery checklists	Eliminate	CMS believes that the use of checklists has become so universal that meaningful distinctions in measuring improvements can no longer be made.
ASC-7	Facility capacity and surgery procedure volume	Eliminate	CMS believes that other more specific measurement rubrics have been adopted to measure the improvement this measure was intended to capture.
ASC-15a-e	Outpatient and ambulatory surgery consumer assessment of health care providers and systems	Delay in adopting	CMS proposes to delay including this measure until more operational and implementation data is available and survey measures are appropriate to capture patient responses in a reliable, non-burdensome way.
ASC-16	Toxic Anterior Segment Syndrome after anterior segment eye surgery	Add	CMS believes the measure is appropriate for the measurement of quality care furnished by ophthalmologists performing in ambulatory surgery centers and the

			condition measured is preventable through appropriate care and sterilization techniques.
ASC-17	Seven-day unplanned hospital visits after orthopedic ambulatory surgery center procedure	Add	CMS believes measuring and reporting seven-day unplanned hospital visits after orthopedic procedures performed in ambulatory surgery centers will incentivize providers to improve care and care transitions.
ASC-18	Seven-day unplanned hospital visits after urology ambulatory surgery center procedures	Add	CMS believes measuring and reporting seven-day unplanned hospital visits after urology procedures performed in ambulatory surgery centers will incentivize providers to improve care and care transitions.

In addition to these proposed changes, CMS is soliciting comments on potential inclusion of the Ambulatory Breast Procedure Surgical Site Infection Outcome measure as developed by the Centers for Disease Control and Prevention.

Comments are due by September 11, 2017. Please contact the authors or any other Drinker Biddle health care attorney if you have any questions about the proposed rules or if you would like assistance preparing comments.

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[1]82 Fed. Reg. 33558 (July 20, 2017); 82 Fed. Reg. 33950 (July 21, 2017).

[2] 81 Fed. Reg. 79562, 79722 (Nov. 14, 2016).

[3] Medicare Payment Advisory Commission, Report to the Congress, Medicare and the Health Care Delivery System (2015).

[4] These benefits include (i) diagnosing a condition in a patient population without access to in-person diagnostic care; (ii) treating a patient population without access to in-person treatment options; (iii) reduced rate of complications; (iv) decreased rate of additional diagnostic or therapeutic interventions; (v) decreased number of future hospitalizations or physician visits; (vi) more rapid resolution of the issue; (vii) decreased pain, bleeding, or other symptom; or (viii) reduced recovery rate.

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