July 14, 2017

Re: CMS Proposes Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Changes for 2018, and Releases a Request for Information (CMS-1678-P)

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (CMS-1678-P).

In addition, CMS is proposing policies that would support care delivery; reduce burdens for providers, especially in rural areas; lower beneficiary out of pocket drug costs for several drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare. Most of these proposals are more provider centric, not technology centric, in nature and are not addressed in the following sections of this memorandum.

CMS will accept comments on the proposed rule until September 11, 2017, and will respond to comments in a final rule on or about November 1, 2017.

The following summary is extracted from the CMS fact sheet, accessed at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13.html

Access to the online version of the federal register can be located at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-14883.pdf

Additional data files can be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-P.html
OPPS Proposed Payment Policy Changes

Proposed OPPS Payment Update

CMS proposes to update OPPS rates by 1.75 percent for 2018. The change is based on the projected hospital market basket increase of 2.9 percent minus both a 0.4 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes proposed under the OPPS (except for the 340B drug payment proposal), including estimated spending for pass-through payments, CMS estimates an overall impact of 2.0 percent payment increase for hospitals paid under the OPPS in CY 2018.

Payment for Drugs and Biologicals ("Drugs") Purchased with a 340B Program Discount

In the CY 2009 OPPS/ASC final rule with comment period, CMS solicited comments on whether CMS should implement a payment methodology for participating 340B hospitals and whether there should be exceptions for certain classes of drugs under this methodology. To address recent trends of increasing drug prices, for which some of the cost burden falls to Medicare beneficiaries, for CY 2018, CMS is proposing to pay separately payable, non pass-through drugs (other than vaccines) purchased at a discount through the 340B drug pricing program at the average sales price (ASP) minus 22.5 percent rather than ASP plus 6 percent. ASP minus 22.5 percent was the Medicare Payment Advisory Commission’s (MedPAC’s) estimate of the average minimum discount eligible hospitals received for drugs acquired under the 340B program. Applicable drugs not purchased under the 340B drug program would continue to receive ASP plus 6 percent payment. CMS seeks comment on implementing this proposal in a manner that will bring down out-of-pocket drug costs for Medicare patients and allows providers to best meet their patients’ needs.

Supervision of Hospital Outpatient Therapeutic Services

In the CY 2009 and CY 2010 OPPS/ASC proposed rule and final rule with comment period, CMS clarified that direct physician supervision is generally required for hospital outpatient therapeutic services that are furnished in hospitals, critical access hospitals (CAHs), and in provider-based departments of hospitals. For several years, there has been a moratorium on the enforcement of the direct supervision requirement for CAHs and small rural hospitals, with the latest moratorium on enforcement expiring on December 31, 2016. In this proposed rule, CMS is proposing to reinstate the non-enforcement of direct supervision enforcement instructions for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019.
Proposed Packaging of Low-Cost Drug Administration Services

A tenet of a prospective payment system is to package payment of all integral, ancillary, supportive, dependent, or adjunctive services into payment for primary services. In CY 2014, CMS proposed but did not finalize, to package all add-on procedures, including drug administration add-on services. In CY 2015, CMS conditionally packaged payment for ancillary services when those ancillary services are assigned to an ambulatory payment classification group with a geometric mean cost of $100 or less, but excluded drug administration services. To continue CMS’ work on bundles of payment under the OPPS and encourage hospital efficiencies, CMS is proposing to conditionally package payment for low-cost drug administration services. CMS is also soliciting comment on payment methodologies for drug administration add-on services.

Comment Solicitation on Packaging

CMS is broadly soliciting comments on existing packaging policies under the OPPS, including those related to drugs that function as a supply in a diagnostic test, diagnostic procedure, or surgical procedure. In addition, CMS is interested in stakeholder feedback on common clinical scenarios involving separately payable items and services for which payment would be most appropriately packaged under the OPPS. We are soliciting public comments from a broad cross-section of stakeholders, including beneficiaries, patient advocates, hospital providers, clinicians, manufacturers, and other interested parties.

Inpatient Only List

The Medicare inpatient-only (IPO) list includes procedures that are only paid under the Hospital Inpatient Prospective Payment System. Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. For CY 2018, CMS is proposing to remove total knee arthroplasty from the IPO list. The CY 2018 OPPS/ASC proposed rule also seeks comment regarding whether partial and total hip arthroplasty should also be removed from the IPO list.

Proposed High Cost/Low Cost Threshold for Packaged Skin Substitutes

Under the OPPS, payment for skin substitutes – products used to aid in wound healing – is packaged into the payment for the associated primary procedure. These products are assigned to either a “high cost group” or a “low cost group” depending on how costly they are relative to certain cost thresholds. Consistent with current policy, CMS is proposing to assign 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 for CY 2018, CMS is proposing that a skin substitute product that does not exceed either the CY 2018 MUC or PDC threshold for CY 2018, but was assigned to the high cost group for CY 2017, will be assigned to the high cost group for
CY 2018. The goal of the proposal 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.

Potential Revisions to the Laboratory Date of Service Policy

For a clinical diagnostic laboratory test, the date of service (DOS) is often the date the specimen was collected, unless certain conditions are met. For example, if the physician orders the test at least 14 days after a patient’s discharge from the hospital and certain other requirements are met, the DOS is the date the test is performed (instead of the date the specimen was collected). Under the current DOS policy, if the test is ordered less than 14 days after the date of the patient’s discharge from the hospital, the hospital must bill Medicare for the test and then pay the laboratory that performed the test, if the laboratory provided the test under arrangement.

CMS has received feedback from stakeholders that the DOS policy creates unintentional operational burden for hospitals and the laboratories that perform molecular pathology tests and certain advanced diagnostic laboratory tests (ADLTs). Therefore, CMS is considering potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for molecular pathology tests and ADLTs which are excluded from the OPPS packaging policy and ordered less than 14 days following the date of the patient’s discharge from the hospital. We are seeking information from stakeholders on whether these tests, by their nature, are appropriately separable from the hospital stay that preceded the test and therefore, should have a DOS that is the date of performance rather than the date of collection.

Partial Hospitalization Program (PHP) Rate Setting

The CY 2018 OPPS/ASC proposed rule updates Medicare payment rates for PHP services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). The PHPs are structured intensive outpatient programs consisting of a group of mental health services paid on a per diem basis under the OPPS, based on PHP per diem costs.

The CY 2018 OPPS/ASC proposed rule maintains the methodology established in CY 2017. In CY 2017, CMS implemented a unified rate structure with a single PHP payment rate for each provider type for days with 3 or more services per day.
ASC Proposed Payment Policy Provisions

ASC Payment Update

ASC payments are annually updated by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a multi-factor productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is projected to be 2.3 percent. The MFP adjustment is projected to be 0.4 percent, resulting in a proposed MFP-adjusted CPI-U update factor of 1.9 percent.

Comment Solicitation on ASC Payment Reform

Currently, ASC payment rates are tied to data derived from the OPPS. Given concerns about the difference between OPPS payments relative to ASC payments (56 percent in 2017), CMS is soliciting comments on ways to improve payment accuracy to ASCs and seeking comments on the collection of ASC cost data.

ASC Covered Procedures List

For CY 2018, CMS is proposing to add three procedures to the ASC covered procedures list (CPL). In addition, CMS is soliciting comment on whether total knee arthroplasty, partial hip arthroplasty, and total hip arthroplasty meet the criteria to be added to the ASC-CPL. CMS is also soliciting comments from stakeholders on whether there are codes outside of the AMA-CPT surgical code range that, nonetheless, should be considered to be a surgical procedure.