Issue Brief

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KEY POINTS

- Outpatient PPS payments are estimated to increase by 2 percent.
- 340B drug and biological payments proposed to be changed from average sales price plus 6 percent to ASP minus 22.5 percent. Drugs not purchased under 340B would continue to be paid at ASP plus 6 percent.
- ASC payment update proposed to be 1.9 percent.

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CMS Releases Proposed Updates to the CY 2018 Hospital OPPS and ASC Program

The Centers for Medicare and Medicaid Services has issued a proposed rule to update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments and ambulatory surgical centers beginning January 1, 2018.

A copy of the 664-page document is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-14883.pdf. Publication in the Federal Register is scheduled for July 20. The above link will change upon publication. The proposal provides a comment period ending on September 11.

COMMENT

Once again, the document has a well written executive summary, but there is much material that the executive summary simply does not provide or provide in sufficient detail. One must read the rule to understand the magnitude of changes being proposed.

CMS has also provided a well written fact sheet. The fact sheet is at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13.html.

As usual, the addenda are only available on CMS' website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html, and at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html.

Again, CMS still does not help the reader easily locate pertinent sections. The proposal's table of contents extends some 19 pages. It is very difficult to locate cited material. When will CMS provide much needed reference points, like inserting page numbers. Otherwise, searching for an item is in essence looking for a needle in a haystack.

The Office of Management and Budget says it received this rule from CMS on April 12. Why has it taken three months to clear OMB?

Pay careful attention to this item: 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 minus 22.5 percent rather than ASP plus 6 percent. 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. This item appears to have serious financial implications.

I. OPPS PROPOSED PAYMENT POLICY CHANGES

A. Proposed OPPS Payment Update

CMS proposes to update the OPPS rates by 1.75 percent. This is the same increase CMS has proposed for the hospital inpatient PPS. The change is based on a projected hospital market basket

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increase of 2.9 percent minus both a 0.4 percentage point adjustment for the multi-factor productivity requirement and a 0.75 percentage point adjustment required by the Affordable Care Act.

CMS estimates that the total increase in Federal government expenditures under the OPPS for CY 2018, compared to CY 2017 due to the changes in this proposed rule, will be approximately $897 million

CMS proposes to continue to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements, by applying a proposed reporting factor of 0.980 to the OPPS payments and copayments for all applicable services.

The proposed national unadjusted payment rate for most APCs are contained in Addendum A and for most HCPCS codes to which separate payment under the OPPS has been assigned in Addendum B.

B. Proposed Conversion Factor

CMS is proposing to use a conversion factor of $76.483 in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs; that is, the proposed OPD fee schedule increase factor of 1.75 percent for CY 2018, a required proposed wage index budget neutrality adjustment of approximately 0.9999, a proposed cancer hospital payment adjustment of 1.0003, and a proposed adjustment of 0.22 percentage point of projected OPPS spending for the difference in the pass-through spending and outlier payments.

C. Proposed Wage Index Changes

The OPPS labor-related share remains at 60 percent of the national OPPS payment.

CMS is proposing to use the proposed FY 2018 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2018. Therefore, any adjustments to the FY 2018 IPPS post-reclassified wage index would be reflected in the final CY 2018 OPPS wage index.

For CY 2018, CMS is proposing to continue its policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003). CMS is including the out-migration adjustment information in Addendum L

For IPPS wage index purposes, for hospitals that were located in urban Core Based Statistical Areas in FY 2014 but were designated as rural under revised OMB labor market area delineations, CMS generally assigned them the urban wage index value of the CBSA in which they were physically located for FY 2014 for a period of three fiscal years. To be consistent, CMS applied the same policy to hospitals paid under the OPPS so that such hospitals will maintain the wage index of the CBSA in which they were physically located for FY 2014 for three calendar years (until December 31, 2017). Because this three-year transition will end in CY 2017, it will no longer be applied in CY 2018.

For Community Mental Health Centers, CMS also is proposing to continue to

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calculate the wage index by using the post-reclassification IPPS wage index based on the CBSA where the CMHC is located.

D. Rural Adjustment

CMS is proposing to continue the 7.1 percent adjustment to the OPPS payments to certain rural sole community hospitals, including essential access community hospitals. This adjustment applies to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

E. Proposed Statewide Average Default CCRs

CMS is proposing to update the default ratios for CY 2018 using the most recent cost report data. The proposed statewide values are presented in the proposed rule's Table 10.

F. Proposed Payment Adjustment for Certain Cancer Hospitals for CY 2018

Section 16002(b) of the 21st Century Cures Act requires that a payment adjustment for certain cancer hospitals (11 hospitals), for services furnished on or after January 1, 2018, the target payment-to-cost ratio adjustment be reduced by 1.0 percentage point less than what would otherwise apply.

The table below indicates the proposed estimated percentage increase in OPPS payments to each cancer hospital for CY 2018 due to the proposed cancer hospital payment adjustment policy.

Proposed Estimated CY 2018 Hospital-Specific Payment Adjustment for Cancer Hospitals to Be Provided at Cost Report Settlement

Provider Number	Hospital Name	Proposed Estimated Percentage Increase in OPPS Payments for CY 2018 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	32.9%
050660	USC Norris Cancer Hospital	11.5%
100079	Sylvester Comprehensive Cancer Center	24.3%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.1%
220162	Dana-Farber Cancer Institute	45.8%
330154	Memorial Sloan-Kettering Cancer Center	47.1%
330354	Roswell Park Cancer Institute	21.4%
360242	James Cancer Hospital & Solove Research Institute	28.9%
390196	Fox Chase Cancer Center	8.8%
450076	M.D. Anderson Cancer Center	76.9%
500138	Seattle Cancer Care Alliance	53.9%

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G. Proposed Hospital Outpatient Outlier Payments

CMS is proposing to continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. CMS is proposing that a portion of that 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPPS payments) would be allocated to CMHCs for the Partial Hospital Program outlier payments.

CMS estimates that a fixed-dollar threshold of $4,325, combined with the proposed multiplier threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. For CMHCs, CMS proposes a CMHC's cost for partial hospitalization services, paid under APC 5853, exceeds 3.40 times the payment rate for APC 5853, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 5853 payment rate.

II. PROPOSED OPPS AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

A. Proposed OPPS Treatment of New CPT and Level II HCPCS Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the hospital OPPS. Specifically, CMS recognizes the following codes on OPPS claims:

- Category I CPT codes, which describe surgical procedures and medical services;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures; and
- Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes.

The proposal identifies:

- The proposed treatment of 5 new HCPCS codes that were effective April 1, 2017 and for which CMS is soliciting public comments. See the rule's Table 13.
- The proposed treatment of 23 new HCPCS codes that were effective July 1, 2017 and for which CMS is soliciting public comments. See the rule's Table 14.
- The proposed process for New Level II HCPCS Codes that will be effective October 1, 2017 and January 1, 2018. CMS will solicit comments on new Level II HCPCS codes that are effective October 1, 2017 and January 1, 2018 in the CY 2018 OPPS/ASC final rule. These codes will be released to the public through the October and January OPPS quarterly update CRs and via the CMS HCPCS website (for Level II HCPCS codes).
- The proposed treatment of new and revised CY 2018 Category I and III CPT Codes that will be effective January 1, 2018. For the CY 2018 OPPS update, CMS received the CY 2018 CPT codes from AMA in time for inclusion in this CY 2018 OPPS/ASC proposed rule.
- The proposed Care Management Coding changes effective January 1, 2018 (APCs 5821 and 5822). CMS is proposing to adopt CPT replacement codes for CY 2018 for 5 of the care management services finalized last year and is seeking public comment on ways CMS might further reduce burden on reporting providers, including through stronger alignment between CMS requirements and CPT guidance for existing and potential new codes. The rule's Table 15 lists the five codes.

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B. Proposed OPPS Changes – Variations Within APCs

The following table lists the proposed APCs that CMS will exempt from the 2 times rule for CY 2018.

Proposed APC Exceptions to the 2 Times Rule for CY 2018	
Proposed CY 2018 APC	**Proposed CY 2018 APC title**
5112	Level 2 Musculoskeletal Procedures
5161	Level 1 ENT Procedures
5311	Level 1 Lower GI Procedures
5461	Level 1 Neurostimulator and Related Procedures
5521	Level 1 Imaging without Contrast
5573	Level 3 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5691	Level 1 Drug Administration
5731	Level 1 Minor Procedures
5735	Level 5 Minor Procedures
5771	Cardiac Rehabilitation
5823	Level 3 Health and Behavior Services

C. Proposed New Technology APCs

For CY 2017, there are 51 New Technology APC levels, ranging from the lowest cost band assigned to APC 1491 (New Technology - Level 1A ($0-$10)) through the highest cost band assigned to APC 1906 (New Technology - Level 51 ($140,001-$160,000)).

CMS is proposing to narrow the increments for New Technology APCs 1901 – 1906 from $19,999 cost bands to $14,999 cost bands.

CMS is proposing to add New Technology APCs 1907 and 1908 (New Technology Level 52 ($145,001-$160,000), which would allow for an appropriate payment of retinal prosthesis implantation procedures.

The table below includes the complete list of the proposed modified and additional New Technology APC groups for CY 2018.

Proposed CY 2018 Additional New Technology APC Groups			
Proposed CY 2018 APC	**Proposed CY 2018 APC Title**	**Proposed CY 2018 SI**	**Updated or New APC**
1901	New Technology - Level 49 ($100,001-$115,000)	S	Updated
1902	New Technology - Level 49 ($100,001-$115,000)	T	Updated
1903	New Technology - Level 50 ($115,001-130,000)	S	Updated
1904	New Technology - Level 50 ($115,001-$130,000)	T	Updated
1905	New Technology - Level 51 ($130,001-$145,000)	S	Updated
1906	New Technology - Level 51 ($130,001-$145,000)	T	Updated
1907	New Technology - Level 52 ($145,001-$160,000)	S	New
1908	New Technology - Level 52 ($145,001-$160,000)	T	New

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continued

The proposed payment rates for New Technology APCs 1901 through 1908 can be found in Addendum A

Currently, there are four CPT/HCPCS codes that describe magnetic resonance image guided high intensity focused ultrasound (MRgFUS) procedures, three of which CMS is proposing to continue to assign to standard APCs and one of which CMS is proposing to continue to assign to a New Technology APC. Refer to the rule's Table 14.

III. PROPOSED OPPS PAYMENT FOR DEVICES

The pass-through payment status of the device categories for HCPCS codes C2623, C2613, and C1822 will end on December 31, 2017. CMS is proposing, beginning in CY 2018, to package the costs of these devices into the costs related to the procedure with which each device is reported in the hospital claims data.

CMS received five applications for Device Pass-Through Payment for CY 2018 by the March 1, 2017 deadline. None have been approved. The five are:

- (1) Architect® Px
- (2) Dermavest and Plurivest Human Placental Connective Tissue Matrix (HPCTM)
- (3) FloGraft®/FloGraft Neogenesis®
- (4) Kerecis™ Omega3 Wound (Skin Substitute)
- (5) X-WRAP®

IV. PROPOSED OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

a. Proposed Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2017

CMS is proposing that the pass-through payment status of 19 drugs and biologicals will expire on December 31, 2017, as listed in the rule' Table 21. All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than three years by December 31, 2017. These drugs and biologicals were approved for pass-through payment status on or before January 1, 2016.

The proposed packaged or separately payable status of each of these drugs or biologicals is listed in Addendum B.

b. Proposed Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Payment Status in CY 2018

CMS is proposing to continue pass-through payment status in CY 2018 for 38 drugs and biologicals. None of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than three years by December 31, 2017. These drugs and biologicals are listed in the rule's Table 22.

The APCs and HCPCS codes for these drugs are assigned status indicator "G" in Addenda A and B.

c. Proposed Provisions for Reducing Transitional Pass-Through Payments for Policy-Packaged Drugs, Biologicals, and Radiopharmaceuticals to Offset Costs Packaged into APC Groups

CMS is proposing to continue to apply the same policy packaged offset policy to payment for pass-through diagnostic radiopharmaceuticals, pass-through contrast agents, pass-through stress agents, and pass-through skin substitutes. The proposed APCs to which a payment offset may be applicable are identified in the rule's Table 23.

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d. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Payment Status

CMS is proposing a packaging threshold for CY 2018 of $120, the same as the current amount.

e. Proposed High Cost/Low Cost Threshold for Packaged Skin Substitutes

CMS is proposing to assign skin substitutes with a mean unit cost or a product's per day cost that does not exceed either the MUC threshold or the PDC threshold to the low cost group, unless the product was assigned to the high cost group in CY 2017, in which case CMS is proposing to assign the product to the high cost group for CY 2018, regardless of whether it exceeds the CY 2018 MUC or PDC threshold.

CMS is proposing to continue to use payment methodologies including ASP+6 percent, WAC+6 percent, or 95 percent of AWP for skin substitute products that have pricing information but do not have claims data to determine if their costs exceed the CY 2018 MUC threshold. Finally, CMS is proposing to continue to assign new skin substitute products without pricing information to the low cost group.

The rule's Table 24 displays the proposed CY 2018 high cost or low cost category assignment for each skin substitute product.

V. PROPOSED ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage," currently not to exceed 2.0 percent of total program payments estimated to be made for all covered services under the OPPS furnished for that year.

CMS estimates that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2018 and those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2018 is approximately $26.2 million. Therefore, CMS estimates that pass-through spending in CY 2018 will not amount to 2.0 percent of total projected OPPS CY 2018 program spending.

VI. PROPOSED OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES

CMS is proposing to continue with and not make any changes to its current clinic and emergency department hospital outpatient visits payment policies.

VII. PROPOSED PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES

A partial hospitalization program is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

CMS is proposing to continue to use CMHC APC 5853 (Partial Hospitalization (Three or More Services Per Day)) and hospital-based PHP APC 5863 (Partial Hospitalization (Three or More Services Per Day)).

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continued

The proposed CY 2018 geometric mean per diem cost for all CMHCs for providing three or more services per day (APC 5853) is $128.81.

The proposed geometric mean per diem cost for hospital-based PHP providers that provide three or more services per service day (hospital-based PHP APC 5863) is $213.60.

VIII PROPOSED PROCEDURES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES

CMS is proposing to remove the procedures described by the following codes from the inpatient only list for CY 2018: CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)) and CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed).

IX. PROPOSED NONRECURRING POLICY CHANGES

Supervision of Hospital Outpatient Therapeutic Services

CMS is proposing to reinstate the non-enforcement of direct supervision enforcement instruction for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019.

Potential Revisions to the Laboratory Date of Service Policy

The date of service is a required data field on all Medicare claims for laboratory services. However, a laboratory service may take place over a period of time—the date the physician orders the laboratory test, the date the specimen is collected from the patient, the date the laboratory accesses the specimen, the date the laboratory performs the test, and the date results are produced may occur on different dates.

The DOS requirements are used to determine whether a hospital bills Medicare for a clinical diagnostic laboratory test or whether the laboratory performing the test bills Medicare directly.

Under the current DOS policy, if a 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. 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. CMS is 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.

X. PROPOSED CY 2018 OPPS PAYMENT STATUS AND COMMENT INDICATORS

Payment status indicators that CMS assigns to HCPCS codes and APCs serve an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the

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OPPS or another payment system and also whether particular OPPS policies apply to the code.

The complete list of the payment status indicators and their definitions that CMS is proposing to apply for CY 2018 is displayed in Addendum D1

XI. PROPOSED UPDATES TO THE AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

a. Proposed Treatment of New and Revised Level II HCPCS Codes

The rule's Table 31 lists 6 new Level II HCPCS codes that were implemented April 1, 2017, along with their proposed payment indicators for CY 2018. The proposed payment rates, where applicable, for these April codes can be found in Addendum BB.

The rule's Table 32 lists seven new Level II HCPCS codes that are effective July 1, 2017.

Through the July 2017 quarterly update CR, CMS also implemented ASC payment for one new Category III CPT code (0474T) as an ASC covered surgical procedure, effective July 1, 2017. This code is listed in the rule's Table 33, along with its proposed payment indicator. The proposed payment rate for this new Category III CPT code can be found in Addendum AA.

b. Proposed Update to the List of ASC Covered Surgical Procedures and Covered Ancillary Services

CMS has identified two covered surgical procedures, CPT code 37241 (Vascular embolize/occlude venous) and CPT code 67227 (Destruction extensive retinopathy), that CMS believes meet the criteria for designation as office-based. CMS is proposing to permanently designate these items as office-based for CY 2018.

c. Proposed Changes to List of ASC Covered Surgical Procedures Designated as Device-Intensive for CY 2018

CMS is proposing to update the ASC list of covered surgical procedures that are eligible for payment according to the agency's device-intensive procedure payment methodology, reflecting the proposed individual HCPCS code device offset percentages based on CY 2016 OPPS claims and cost report data available for the proposed rule.

d. Proposed Additions to the List of ASC Covered Surgical Procedures

CMS is proposing to include three new procedures on the list of ASC covered surgical procedures for CY 2018.

Proposed Additions to The List of ASC Covered Surgical Procedures for CY 2018		
CY 2018 CPT Code	CY 2018 Long Descriptor	Proposed CY 2018 ASC Payment Indicator
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	J8
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	N1
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g	G2

e. Calculation of the Proposed ASC Conversion Factor and the Proposed ASC Payment Rates

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.

The ASCQR Program affected payment rates beginning in CY 2014 and, under this program, there is a 2.0 percentage point reduction to the CPI-U for ASCs that fail to meet the ASCQR Program requirements. CMS is proposing to reduce the CPI-U update of 2.3 percent by 2.0 percentage points for ASCs that do not meet the quality reporting requirements and then apply the 0.4 percentage point MFP adjustment. Therefore, CMS is proposing to apply a -0.1 percent MFP-adjusted CPI-U update factor to the CY 2017 ASC conversion factor for ASCs not meeting the quality reporting requirements.

For CY 2018, CMS proposing to adjust the CY 2017 ASC conversion factor ($45.003) by the proposed wage index budget neutrality factor of 1.0004 in addition to the MFP-adjusted CPI-U update factor of 1.9 percent, which results in a proposed CY 2018 ASC conversion factor of $45.876 for ASCs meeting the quality reporting requirements.

For ASCs not meeting the quality reporting requirements, CMS is proposing to adjust the CY 2017 ASC conversion factor ($45.003) by the proposed wage index budget neutrality factor of 1.0004 in addition to the quality reporting/MFP-adjusted CPI-U update factor of -0.1 percent, which results in a proposed CY 2018 ASC conversion factor of $44.976.

CMS is soliciting comments on the ASC payment system update factor and are interested in data from ASCs that would help determine whether the ASC payment system should continue to be updated by the CPI-U, or by an alternative update

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factor, such as the hospital market basket, the Medicare economic index, a blend of update factors or other mechanism.

Addenda AA and BB display the proposed updated ASC payment rates for CY 2018.

XII. REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

CMS is proposing to remove a total of six measures. Beginning with the CY 2020 payment determination, CMS is proposing to remove: (1) OP-21: Median Time to Pain Management for Long Bone Fracture; and (2) OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures.

In addition, beginning with the CY 2021 payment determination, CMS is proposing to remove: (1) OP-1: Median Time to Fibrinolysis; (2) OP-4: Aspirin at Arrival; (3) OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional; and (4) OP-25: Safe Surgery Checklist.

By removing these six measures, CMS' intent is to alleviate the maintenance costs and administrative burden to hospitals associated with retaining them.

Additionally, CMS is proposing to delay the mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) under the Hospital OQR Program for CY 2018 data collection. However, hospitals that would like to continue to administer the survey under the voluntary national implementation, may do so in CY 2018.

The tables below outline the Hospital OQR Program measure set CMS is proposing for the CY 2020 and CY 2021 payment determination and subsequent years, respectively. Both of these charts reflect the measure set as if CMS' proposals to remove measures and to delay reporting of OP-37a-e beginning with CY 2018 reporting and for subsequent years are finalized as proposed.

Hospital OQR Program Measure Set Proposed for the CY 2020 Payment Determination	
NQF #	**Measure Name**
0287	OP-1: Median Time to Fibrinolysis†
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0286	OP-4: Aspirin at Arrival†
0289	OP-5: Median Time to ECG†
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-9: Mammography Follow-up Rates
None	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
None	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data

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Hospital OQR Program Measure Set Proposed for the CY 2020 Payment Determination	
NQF #	**Measure Name**
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
None	OP-14: Simultaneous Use of Brain Computed Tomography and Sinus Computed Tomography
0491	OP-17: Tracking Clinical Results between Visits†
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
None	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
None	OP-25: Safe Surgery Checklist Use
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use*
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases
None	OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-37a: OAS CAHPS – About Facilities and Staff***
None	OP-37b: OAS CAHPS – Communication About Procedure***
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery***
None	OP-37d: OAS CAHPS – Overall Rating of Facility***
None	OP-37e: OAS CAHPS – Recommendation of Facility***

† CMS notes that NQF endorsement for this measure was removed.
** CMS notes that measure name was revised to reflect NQF title.*
*** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).*
**** Proposed to delay measure reporting beginning with CY 2018 reporting and for subsequent years.*

Hospital OQR Program Measure Set Proposed for the CY 2021 Payment Determination and Subsequent Years	
NQF #	**Measure Name**
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0289	OP-5: Median Time to ECG†
0514	OP-8: MRI Lumbar Spine for Low Back Pain
None	OP-9: Mammography Follow-up Rates

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continued

Hospital OQR Program Measure Set Proposed for the CY 2021 Payment Determination and Subsequent Years	
NQF #	**Measure Name**
None	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
None	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
None	OP-14: Simultaneous Use of Brain Computed Tomography and Sinus Computed Tomography
0491	OP-17: Tracking Clinical Results between Visits†
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
0499	OP-22: Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use*
1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases
None	OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery
None	OP-37a: OAS CAHPS – About Facilities and Staff***
None	OP-37b: OAS CAHPS – Communication About Procedure***
None	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery***
None	OP-37d: OAS CAHPS – Overall Rating of Facility***
None	OP-37e: OAS CAHPS – Recommendation of Facility***

† CMS notes that NQF endorsement for this measure was removed.
** CMS notes that measure name was revised to reflect NQF title.*
*** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).*
**** Proposed to delay measure reporting beginning with CY 2018 reporting and for subsequent years.*

CMS also provides clarification on the procedures for validation of chart-abstracted measures to note that 50 outlier hospitals, based on poor measure scoring will be targeted for validation. CMS is proposing to formalize chart-abstracted measures validation educational review procedures, updates to include a corrections process, and make corresponding regulatory updates to reflect these proposals. Additional

continued

proposals include changes to the Notice of Participation deadline and alignment of the naming of the Extraordinary Circumstances Exceptions policy with other quality reporting programs and corresponding regulatory updates to the to reflect these proposals.

XIII. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM

CMS is proposing to remove a total of three measures for the CY 2019 payment determination and subsequent years: (1) ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing; (2) ASC-6: Safe Surgery Checklist Use; and (3) ASC-7: ASC Facility Volume Data on Selected Procedures.

CMS is proposing to Delay ASC-15a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures Beginning with the CY 2020 Payment Determination

CMS is proposing to adopt a total of three new measures for the ASCQR Program: one measure collected via a CMS web-based tool for the CY 2021 payment determination and subsequent years (ASC-16: Toxic Anterior Segment Syndrome), and two measures collected via claims for the CY 2022 payment determination and subsequent years (ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures; and ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures).

If the proposals of this proposed rule are finalized, the measure set for the ASCQR Program CY 2021 payment determination and subsequent years would be as listed below. CMS says that the measures being proposed for removal in this proposed rule are not included in this chart.

ASCQR Program Measure Set Previously Finalized and Proposed for the CY 2021 Payment Determination and Subsequent Years

ASC #	NQF #	Measure Name
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/Admission
ASC-8	0431	Influenza Vaccination Coverage among Healthcare Personnel
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome

ASCQR Program Measure Set Previously Finalized and Proposed for the CY 2021 Payment Determination and Subsequent Years		
ASC #	**NQF #**	**Measure Name**
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	OAS CAHPS – About Facilities and Staff**
ASC-15b	None	OAS CAHPS – Communication About Procedure**
ASC-15c	None	OAS CAHPS – Preparation for Discharge and Recovery**
ASC-15d	None	OAS CAHPS – Overall Rating of Facility**
ASC-15e	None	OAS CAHPS – Recommendation of Facility**
ASC-16	None	Toxic Anterior Segment Syndrome***

† CMS notes that NQF endorsement for this measure was removed.
** Measure voluntarily collected effective beginning with the CY 2017 payment determination.*
***Measure proposed for delay in reporting beginning with the CY 2020 payment determination (CY 2018 data collection) and until further action in future rulemaking.*
**** New measure proposed for the CY 2021 payment determination and subsequent years.*

If the proposals of this proposed rule are finalized, the measure set for the ASCQR Program CY 2022 payment determination and subsequent years would be as listed below.

ASCQR Program Measure Set with Previously Finalized and Newly Proposed Measures for the CY 2022 Payment Determination and Subsequent Years		
ASC #	**NQF #**	**Measure Name**
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/Admission
ASC-8	0431	Influenza Vaccination Coverage among Healthcare Personnel
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	None	Normothermia Outcome
ASC-14	None	Unplanned Anterior Vitrectomy
ASC-15a	None	OAS CAHPS – About Facilities and Staff**
ASC-15b	None	OAS CAHPS – Communication About Procedure**
ASC-15c	None	OAS CAHPS – Preparation for Discharge and Recovery**
ASC-15d	None	OAS CAHPS – Overall Rating of Facility**
ASC-15e	None	OAS CAHPS – Recommendation of Facility**
ASC-16	None	Toxic Anterior Segment Syndrome***
ASC-17	None	Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures***
ASC-18	None	Hospital Visits after Urology Ambulatory Surgical Center Procedures****

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continued

† CMS notes that NQF endorsement for this measure was removed.
** Measure voluntarily collected effective beginning with the CY 2017 payment determination as set forth in section XIV.E.3.c. of the CY 2015 OPPS/ASC final rule with comment period.*
***Measure proposed for delay beginning with CY 2018 reporting until further action in future rulemaking.*
**** New measure proposed for the CY 2021 payment determination and subsequent years.*
***** New measure proposed for the CY 2022 payment determination and subsequent years.*

COMMENTS

The quality material — both Outpatient and ASC — comprise more than 100 pages of the proposed rule. Obviously, there is much contained in these pages than reported above. There are many items including details of the measures being proposed for addition and deletion; items being considered for future consideration; and reporting, timing and manner of doing such.

Quality represents both a burden and need to fully understand both the reporting requirements and related financial implications. The length of the material attests to such.

FINAL THOUGHTS

While this proposal is long, it is not nearly as long as last year's proposal. That is helpful. Nonetheless, there still is much history of the program being reported, too much history. If CMS wants to reduce regulatory burden, removing much history would be useful start.

CMS has provided a detailed section on the burdens and costs associated with collecting and reporting quality requirements. The amounts are not inconsequential. One must question the value of the reporting endeavors.

CMS has provided its estimate for providers to review this proposed rule. CMS says "Assuming an average reading speed, we estimate that it would take approximately 6.4 hours for the staff to review half of this proposed rule. For each facility that reviews the rule, the estimated cost is $673 (6.4 hours x $105.16). Therefore, we estimate that the total cost of reviewing this regulation is $1,708,074 ($673 x 2,538 reviewers)."

This simple amount is too low. First, it does not appear to include all reviewers of a provider – quality, clinical and financial personnel all have different objectives to review the rule.

As noted at the beginning of this analysis, CMS is proposing to reduce hospital payments for drugs acquired under the 340B drug program from ASP+6 percent to ASP-22.5 percent. This could greatly impact many hospitals.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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