Advisory Board | Financial Leadership Council

Medicare Outpatient Payment Update

Examining CMS CY 2018 Final Hospital Outpatient and Ambulatory Surgical Center Rule

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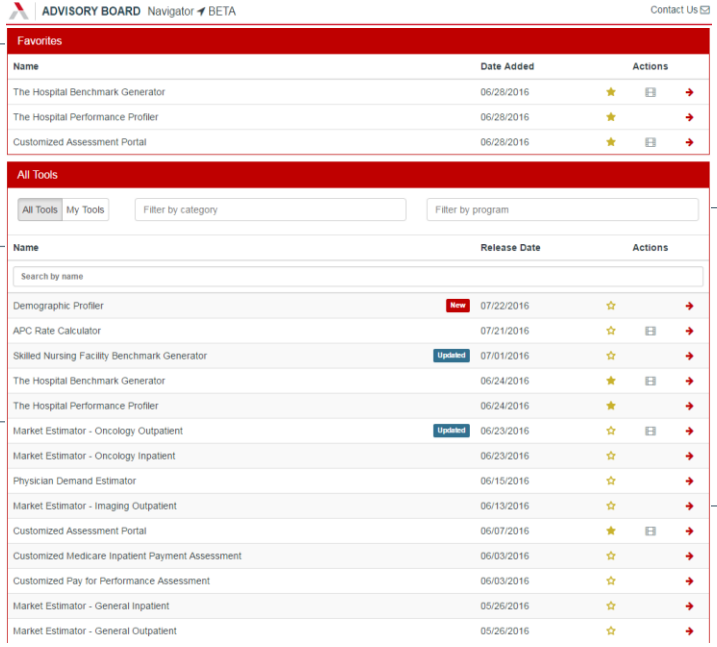

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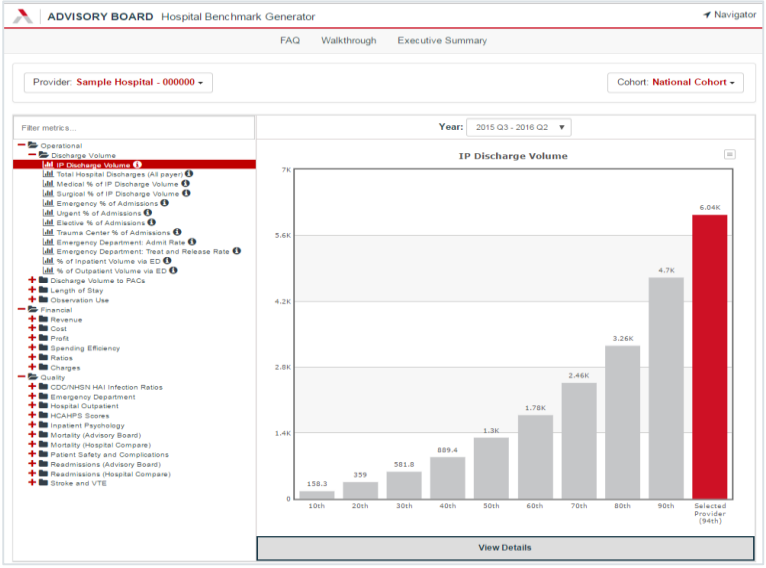

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Upcoming and On-Demand Webconferences Available

Advisory Board Payment Policy Presentations
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Medicare Inpatient Payment Update: Final Rule FY 2018

Presented: August 24, 2017

Learn about changes to inpatient payment, quality reporting, and the pay-for-performance programs in FY 2018.

2017-2018 Inpatient Quality Reporting and Meaningful Use Modifications

Presented: August 31, 2017

Join us as we review the details of the Meaningful Use (MU) and Inpatient Quality Reporting (IQR) Program-related changes finalized in the 2018 Inpatient Prospective Payment System rule.

2018 MACRA Final Rule Detailed Analysis

Upcoming: December 12, 2017

Decode changes to the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) requirements and get advice on program management, reporting alignment, and how to leverage health IT to achieve success.

Road Map

1 Key Provisions of the CY 2018 Hospital Outpatient Final Rule

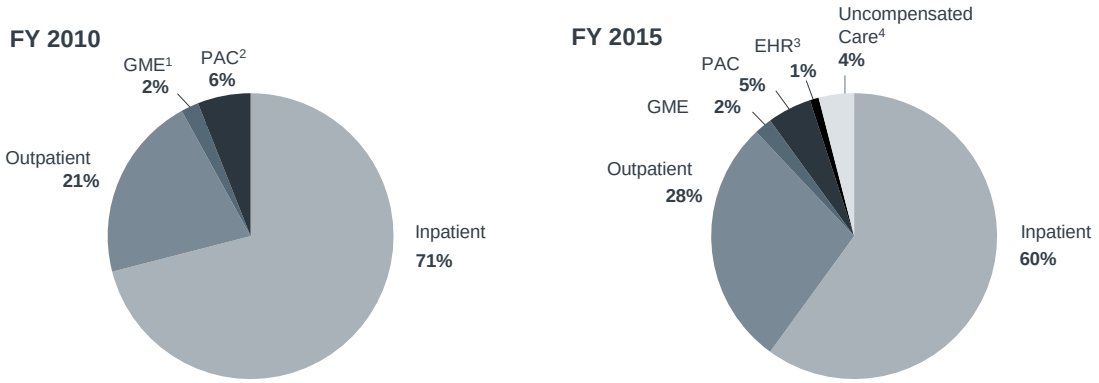
2 Key Provisions of the CY 2018 Ambulatory Surgical Surgery Center Final Rule

3 Related Tools and Analytics; Q&A

Outpatient Spending Continues to Rise

Distribution of Hospital Revenue by Source, FY 2010 vs. FY 2015

MedPAC analysis using hospital cost report data



Key Forces Driving Outpatient Shift

- Technological innovation allowing for safe, efficient care in the outpatient setting
- Increased focus on medical appropriateness; denials mitigation
- Payers encouraging care in most appropriate low-cost setting create emphasis on investment by health care systems to capture business

1) Graduate medical education.
2) Post-acute care.
3) Electronic health record (EHR payments did not exist in 2010).
4) Uncompensated care revenue was included in Inpatient revenue prior to 2014.

Source: MedPAC March 2017 Report to Congress, p. 80, available at http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf; CMS; Advisory Board analysis.

Key Provisions Finalized for HOPD Payment in CY18

340B Payment Cut, TKA Outpatient Shift Dominate Headlines

Highlights of Today's Presentation

Hospital Outpatient Payment Update

Moderate HOPD rate update bolstered by 340B savings

- Hospital outpatient payment rates increase by 1.35%.[1] Comprises +2.7% market basket, -0.6% MFP,[2] -0.75% ACA cut
- Hospital outpatient payments estimated to increase by 1.4%/$5.8B overall in CY 2018, compared to CY 2017

Payment for Non-Drug Items and Services in CY 2018

The updates from CMS above do not account for a 3.2% increase in payment rates for non-drug items and services under the HOPPS (redistributed dollars from the 340B rate cut).

CMS Slashes 340B Payments

CMS to reimburse 340B covered entities closer to acquisition cost

- CMS reduces 340B covered entities discounted drug payments to average sales price (ASP) minus 22.5% in CY 2018, down from current reimbursement of ASP+6%.
- 340B payment rate decrease *does not apply to*: critical access, children's, rural sole community PPS-exempt cancer hospitals; non-excepted outpatient providers billing under site-neutral MPFS[3]
- CMS to begin collecting data on use of drugs purchased with 340B discounts using "JG," "TB" modifiers

TKA Leaves Inpatient Only List starting January 2018

Medicare sets the stage for outpatient shift

- Removal of total knee arthroplasty (TKA) from inpatient only (IPO) list allows Medicare to reimburse TKA in HOPD setting starting in CY 2018
- RAC[4] patient status audits for TKA suspended for CY 2018 and CY 2019
- CMS suggests future removal of total, partial hip replacement (THA, PHA) from IPO list
- CMS suggests future addition of TKA, THA, PHA to ASC covered procedures list

Other Provisions of Note

CMS further reduces payments for nonexcepted HOPDs

Nonexcepted HOPDs Reimbursed Under the MPFS

- These providers will be reimbursed at 40% of HOPPS rate for most services in CY18 (currently reimbursed at 50% of HOPPS rate)

Hospital Outpatient Quality Reporting (OQR) Program

- 6 OQR metrics will be removed in CY 2020
- Mandatory data collection for Outpatient and Ambulatory Surgery CAHPS patient experience measures delayed indefinitely (data collection originally scheduled to begin January 1, 2018)

1) Excludes 2% sequestration reduction.
2) Multi-factor productivity adjustment.
3) Medicare Physician Fee Schedule.
4) Medicare Recovery Audit Contractors.

Source: CMS CY 2018 HOPPS and ASC Final Rule, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html; Advisory Board analysis.

CMS Finalizes Moderate Rate Increase for HOPDs

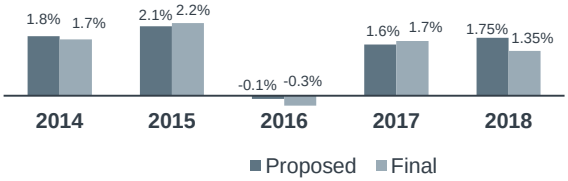
Published Update Does Not Reflect 3.2% Increase from 340B Savings

CY 2018 Hospital Outpatient Payment Rate Update Scenarios

Scenario	Market Basket Update	Multi-factor Productivity Adjustment	ACA Mandated Adjustment	Final Rate Update	OQR[1] Reporting Penalty	Effective Update
Meets OQR[1] Reporting Requirements	2.9%	-0.4%	-0.75%	1.75%	No Penalty	**1.35%**
Fails OQR Reporting Requirements	2.9%	-0.4%	-0.75%	1.75%	-2.0%	**-0.65%**

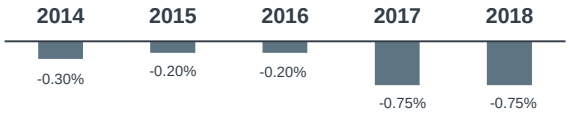
Proposed and Finalized HOPPS Rate Updates

CY 2010 – CY 2018



ACA Market Basket Cuts Depress Rates

CY 2010 – CY 2018



1) Hospital Outpatient Quality Reporting Program

Source: CMS; Advisory Board analysis.

Anatomy of an Outpatient Payment

Conversion Factor the Key Element Impacted By Standard Rate Update

National-Level Factor

Conversion Factor

Standard factor modified by rate update (including market basket rate, MFP,[1] ACA adjustments).

Proposed conversion factor for CY 2018 is **$78.636**.

Geographic Adjustment

40%	60%
Non-labor	Area wages (wage index)

X

APC-Specific Factor

APC[2] Relative Weight

Budget-neutral weighting that reflects overall relative costliness of service.[3]

Hospital Outpatient APCs:

Group hospital outpatient services by resource-intensiveness

=

APC Payment Rate

Base payment rate.

Facility-Specific Factors

Additional facility-specific rates and adjustments may apply:

- Composite payments for multiple services
- Transitional/hold harmless payments for SCH, rural, cancer hospitals
- Pass-through payments for designated devices
- Outlier payments for exceptionally high-cost patients
- Pass-through payments for designated drugs and biologicals

1) Multifactor productivity adjustment.
2) Ambulatory payment classification.
3) APC relative weight based on the geometric mean of costs in each APC as of CY 2013 (previously based on the median cost).

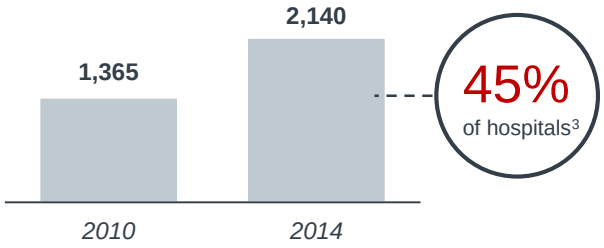
Source: Outpatient Hospital Services Payment System, MedPAC Payment Basics, 2015; Hospital Outpatient Payment System: Payment System Series, Centers for Medicare and Medicaid Services, 2016; Advisory Board analysis.

Recapping the Program

340B Program Overview

- Created in 1992, the 340B Drug Pricing Program requires drug manufacturers to provide separately payable Part B drugs to eligible health care organizations at reduced prices
- The 340B program's intent is to "stretch scarce federal resources as far as possible to provide more care to more patients"[1]
- In 2010, the Patient Protection and Affordable Care Act (PPACA) expanded the group of 340B eligible providers
- In past years, drugs acquired under 340B have been reimbursed at ASP+6%[2]

Number of Participating Hospitals



Health Care Providers that may be 340B Eligible:

- Disproportionate share hospitals (DSHs)[4]
- Children's hospitals and cancer hospitals exempt from the Medicare prospective payment system
- Sole community hospitals
- Rural referral centers
- Critical access hospitals (CAHs)
- Non-hospital covered entities[5]

1) MEDPAC using language from HRSA in May 2015 report.
2) Average sales price plus 6%.
3) MEDPAC estimate from May 2015 report. Note that estimates by other organizations may differ.
4) Hospitals that have a DSH adjustment percentage > 11.75% and meet other criteria.
5) Includes federally qualified health centers (FQHCs), FQHC "look-alikes", state-operated AIDS drug assistance programs, the Ryan White CARE Act Part A, Part B and Part C programs, tuberculosis, black lung, family planning and sexually transmitted disease clinics, hemophilia treatment centers, public housing primary care clinics, homeless clinics, Urban Indian clinics, and Native Hawaiian health centers.

Source: Medicare Payment Advisory Commission. Report to the Congress: Overview of the 340B Drug Pricing Program. *May 2015.* Available at: http://www.medpac.gov/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?sfvrsn=0; Health Care Advisory Board interviews and analysis.

Many Organizations Calling for Reform

Broad Concerns About 340B Incentivizing Higher Drug Utilization

Key Recommendations from Government and Advisory Agencies

Government Accountability Office (GAO)

"Congress should consider **eliminating the incentive** to prescribe more drugs or more expensive drugs than necessary to treat Medicare Part B beneficiaries at 340B hospitals"

Medicare Payment Advisory Commission

"**Reduce Medicare payment rates** for 340B hospitals' separately payable 340B drugs by 10% of the average sales price… the Commission recommends that the program **savings… be redirected to the uncompensated care pool.**"

Office of Inspector General (OIG)

"…It is also necessary that any payment methodology specifically for 340B-purchased drugs addresses issues in **identifying these drugs on Part B claims**."

Congress Conducting Investigation, Discussion of 340B

- House Committee on Energy & Commerce has conducted two 340B hearings in 2017
- Hearings have examined HRSA's oversight of 340B program, as well as covered entities' 340B utilization
- Legislators from both parties praised 340B as vital to health care safety net, but hearings have raised concerns about program:
  - Little transparency around ceiling prices
  - Lack of data on how covered entities use savings realized through 340B
  - Closer scrutiny of 340B's application and penalties for misuse of the program are needed

Source: Medicare Payment Advisory Commission. March 2016 Report to the Congress, *March 2016*; Government Accountability Office. "Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals GAO-15-442," June 2015; Office of Inspector General. "Part B Payment for 340B Purchased Drugs OEI-12-14-00030," November 2015; Advisory Board analysis.

Who is Impacted?

Majority of Covered Entities Should Expect Rate Cut to Apply

Hospital Covered Entities Excluded from Alternative Drug Payment Methodology, and Reason for Exclusion

Covered Entity Type	Reimbursed Under Different Mechanism	Exempted from CY 2018 Rate Cut by CMS
Children's Hospital		✓
PPS-Exempt Cancer Hospital		✓
Rural Sole Community Hospital (SCH)		✓
Critical Access Hospital (CAH)[1]	✓	
Nonexcepted HOPD[2]	✓	

Recommended Checks

1. Contact your CMS Regional Office to learn specifics regarding applicability of 340B cut at your facility.

2. Visit the HRSA[3] 340B database: https://340bopais.hrsa.gov/

Note that HRSA is currently recertifying all covered entities, so information in this database may be subject to change in the short term.

1) Critical access hospitals, which are reimbursed under 340B for "reasonable cost," not "average sales price", will not be impacted by the rate cut.
2) HOPDs that are reimbursed via the MPFS at 'site-neutral' rates under Section 603 of the Bipartisan Budget Act are not subject to the 340B rate cut because they are not paid through the HOPPS.
3) Health Resources and Services Administration, a division of the Department of Health and Human Services.

Source: CMS, "Hospital Outpatient Prospective Payment System," November 2017; Health Care Advisory Board interviews and analysis.

Sweeping Cut Sets Up Winners and Losers Scenario

New Rate is ASP -22.5%; Savings to be Redistributed Across Hospitals

1 Cut Drug Reimbursement[1] to Most[2] Hospital Covered Entities

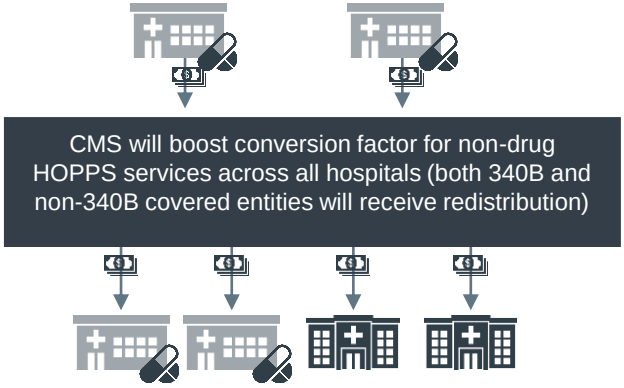
CY 2017 Rate
Average Sales Price
+ 6%

→

CY 2018 Rate
Average Sales Price
- 22.5%

$1.6B Total estimated CY 2018 cut in drug reimbursement for covered entities

2 Redistribute $1.6B in Savings as Higher Payments for Non-Drug Services



3 CMS Starts to Track Use of Drugs Purchased With 340B Discounts

All Part B drugs acquired with 340B discounts must be flagged on claims with one of two new modifiers:

- 'JG' for covered entities impacted by rate cut
- 'TB' for covered entities not impacted by rate cut[2]

1) Rate cut excludes vaccines and pass-through drugs.
2) Children's hospitals, PPS-exempt cancer hospitals, rural sole community hospitals, critical access hospitals, and nonexcepted HOPDs reimbursed under the MPFS will not be subject to the ASP minus 22.5% 340B drug payment rate in CY 2018.

Source: CMS; Advisory Board analysis.

Net Projected Impact of 340B Varies by Hospital Type

For-Profit Hospitals See Significant Payment Bump

Impact of 340B Alternative Drug Payment Methodology on CY18 Hospital Payments[1]

Teaching Status

Non-teaching	+1.3%
Minor Teaching	+0.1%
Major Teaching	-2.4%

Ownership Type

For-profit	+2.7%
Not-for-Profit	-0.3%
Government	-1.6%

Urban vs. Rural

Rural SCH[2]	+2.6%
Other Rural	0.0%
Large Urban	-0.2%
Other Urban	-0.3%

DSH Patient Percent[3]

0%	+3.2%
0.16 – 0.23	+2.6%
>0.35	-2.2%

1) Impacts stated by CMS in Table 88 of the CY 2018 HOPPS Final Rule.
2) Rural Sole Community Hospitals, a class of hospital not subject to the 340B alternative payment methodology.
3) Disproportionate Share Hospital Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days). Higher DSH patient percent indicates that hospital serves larger proportion of low-income patients.

Source: CMS CY 2018 HOPPS Final Rule, Table 88, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html; Advisory Board analysis

Watch for Further Developments

Additional News Likely as 340B Investigations Continue in 2018

Potential for additional scrutiny aimed at 340B as HRSA, Congress, and White House continue public discussions and commentary.

Modifiers to track drugs purchased with 340B discounts will allow greater insight into drug utilization patterns under the program; could guide further modification of 340B payment methodology.

CMS has been clear that the alternative drug payment model for 340B only applies to the CY 2018 payment year. CMS is interested in altering this methodology for future years, including the drug reimbursement rate and the redistribution of 340B savings.

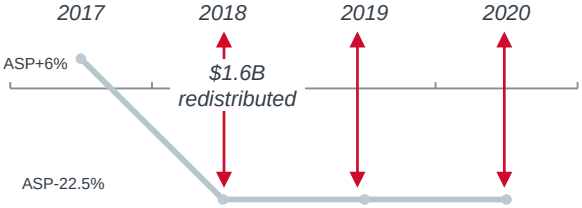
Source: CMS, Advisory Board analysis

CMS Opaque About 340B Related Reimbursement

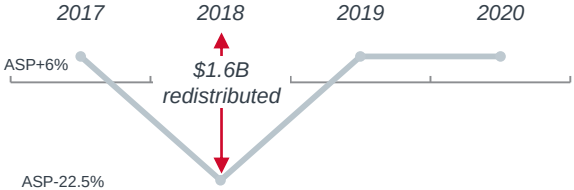
Payment Mechanics, Redistribution Approach Unclear Beyond 2018

Speculating on Potential Approaches to Payment Reduction

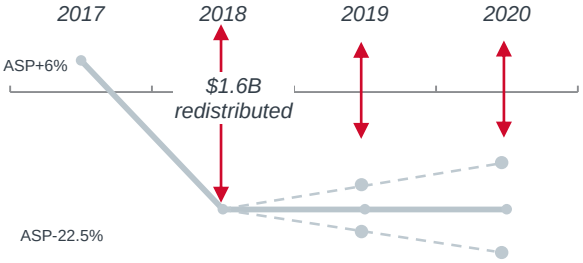
1 Reimbursement Cut Remains; Magnitude Remains Stable



2 Reimbursement Cut Applied for Only One Year



3 Reimbursement Cut Remains; Magnitude Shifts Over Time



Source: CMS, Advisory Board analysis.

TKA Moving Off IPO List Effective January 1, 2018

Finalized Changes for TKA

1. **Covered in HOPD Effective CY 2018, With Lower Reimbursement**

$10,122.22	HOPD reimbursement APC 5115
$12,384.78	Inpatient reimbursement MS-DRG 470[1]

2. **Two-Year RAC Prohibition Will Postpone 2 Midnight-Based Denials**

CMS is easing the outpatient TKA transition by prohibiting RAC patient status review for any inpatient TKA procedures for CY 2018 and CY 2019.

However, TKA cases may still be audited for other reasons (e.g., to determine medical necessity).

CMS Doesn't Anticipate Rapid TKA Outpatient Migration

"We **do not expect a significant volume** of TKA cases currently being performed in the hospital inpatient setting **to shift** to the hospital outpatient setting… as providers' knowledge and experience in the delivery of hospital outpatient TKA treatment develops, there may be a greater migration of cases to the hospital outpatient setting."

CY 2018 Final HOPPS Rule

1) Lower extremity joint replacement without major complications and comorbidities.

Source: CMS; Advisory Board analysis.

Estimating the Magnitude of TKA Outpatient Shift

97% Average percentage of Medicare TKA cases per organization that are assigned to MS-DRG 470 (lower joint replacement without major complications and comorbidities)[1]

410,503 Medicare TKA cases recorded in CMS's MEDPAR inpatient claims data for FY 2016[1]

48% Average percentage of Medicare TKA cases per organization that are potentially eligible to be performed in outpatient setting, per exclusion criteria listed at right[1]

Analytical Assumptions: Outpatient TKA Exclusion Criteria Used in Our Analysis
(Ref: Kort et al. with modifications for ICD-10)

- Reviewed joint replacement cases that include ICD-10 primary procedure codes for TKA (0SRD0J9, 0SRC0J9, 0SRC0JA, 0SRD0JA) but are assigned to MS-DRG 469 (indicating patient has major complications and comorbidities)
- Patient is ≥80 years old
- Patient was recorded as having one or more of the following ICD-10 dx codes: history of falling, cognitive impairment, BMI >30, ESRD, respiratory failure, heart failure, kidney failure, liver failure, diabetes

Want to learn more about TKA case shift risk for individual hospitals across the country? Download Advisory Board's TKA Outpatient Shift Modeler Reference file.

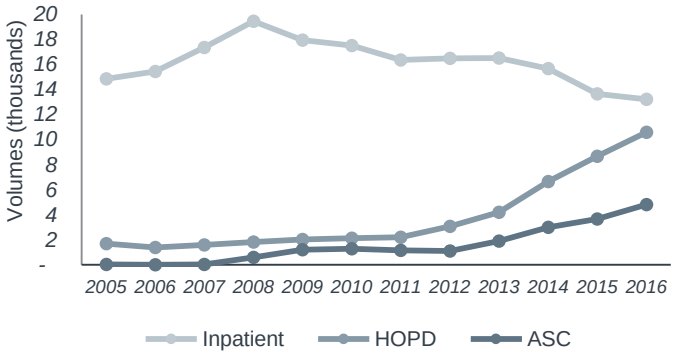
1) Analysis of MEDPAR inpatient Medicare FFS claims from FY 2016 per six-digit Medicare CCN. Analysis reviewed cases assigned MS-DRG 469 or 470 with a TKA primary procedure code for distinct Medicare CCN. Cases with MS-DRG 470 were considered eligible to shift outpatient if the patient did not fulfil any of the exclusion criteria listed above. Please note that this is a generous analysis of eligibility, as other patient criteria not present in claims data (e.g., preference for no hospital stay; post-operative presence of a caregiver in patient's home) also impact whether a case should be performed outpatient.

Source: Kort et al, Patient selection criteria for outpatient joint arthroplasty, Knee Surgery Sports Traumatology Arthroscopy, April 2016; CMS; Advisory Board analysis.

What OP Shift Might Look Like: Lessons from PKA

Partial Knee Arthroplasty Shifted Gradually After Removal from IPO List

Volumes of PKA[1] Covered by Medicare, 2005-2016[2]



PKA Begins to Move Outpatient

794%

Increase in outpatient Medicare PKA cases, 2005-2016

-11%

Decline in inpatient Medicare PKA cases, 2005-2016

54%

Proportion of all Medicare PKA cases performed outpatient, 2016

Drivers Contributing to PKA Outpatient Shift

- Minimally invasive technology; advanced surgical techniques make outpatient procedures possible
- Cost reduction; care management efforts encourage procedure shift to lower-cost outpatient settings

1) Partial knee arthroplasty. Defined by CPT/HCPCS code 27446.
2) Volumes are total allowable Medicare physician claims from inpatient, hospital outpatient, and ASC settings, CY 2005 – 2016.

Source: CMS Physician/ Supplier Procedure Summary Master File CY 2005-2016, CMS, Advisory Board analysis.

TKA Outpatient Shift: Additional Considerations

Payment Rate Reduction

18% Difference in reimbursement between the inpatient and outpatient setting[1]

Clinical Documentation

Necessary to demonstrate:

- Medical appropriateness of TKA
- Appropriateness of post-operative admission following OP procedure
- Appropriateness of IP procedure

Competitive Landscape

Providers will need to strengthen physician relationships and employ consumer engagement strategies to capture outpatient TKA volumes

CJR/BPCI Interactive Effects

Significant shift of TKAs to the outpatient setting would effectively reduce eligible volumes for these bundled payment programs, unless CMS adjusts current program methodology

1) $9,912.69 outpatient rate for CY 2018, $12,380.76 national inpatient rate for FY 2018.

Source: CMS; Advisory Board analysis.

Logical Next Steps for Hip, Knee Arthroplasty: ASCs

CMS Gathers Feedback on Covering THA, PHA, TKA in OP Sites

	Arthroplasty Procedure	Medicare Volumes of HCPCS Code[1] *(CY 2016)*	Medicare Covers in These Sites: *(CY 2018)*	CMS Considering Expanding Coverage to:
	Total Hip (HCPCS 27130)	240,884	• Inpatient	• Hospital outpatient • ASC
	Partial Hip (HCPCS 27125)	12,742	• Inpatient	• Hospital outpatient • ASC
	Total Knee (HCPCS 27447)	467,019	• Inpatient • Hospital outpatient	• ASC

1) Volume of allowed incidences of HCPCS code from Medicare's Provider/Supplier Physician Summary File, a 100% sample of Medicare FFS Part B claims.

Source: CMS; Advisory Board analysis.

More Than Just Total Knee Arthroplasty

CMS Finalizes Several Other Notable Changes to IPO List

	Px Type	HCPCS Code	CY 2016 Medicare Inpatient Volumes	New APC Assignment[1]
Removed from IPO List	**Joint Replacement**	**27447**: Total knee arthroplasty (TKA)	467,019	C-APC 5115 Level 5 MSK Procedures
	Laparoscopy	**55866:** Surgical prostatectomy	20,087	C-APC 5362 Level 2 Laparoscopy & Related Services
		43282: Paraesophageal hernia repair[2]	6,321	
		43773: Replace adjustable gastric restrictive device[2]	22	C-APC 5361 Level 1 Laparoscopy & Related Services
		43772: Remove adjustable gastric restrictive device[2]	98	C-APC 5303 Level 3 Upper GI Procedures
		43774: Remove adjustable gastric restrictive device and subcomponents[2]	2,130	
Added to IPO List	**Percutaneous transluminal revascularization**	**92941**: PTCR during acute myocardial infarction[2]	43,629	NA

1) Procedures leaving the inpatient only list are eligible for reimbursement in the outpatient setting. Clinically appropriate procedures are still performed and reimbursed in the inpatient setting. For the full inpatient only list, see CY 2018 HOPPS Final Rule Addendum E.
2) Addition/ removal of procedure not discussed in Proposed Rule but finalized in Final Rule.

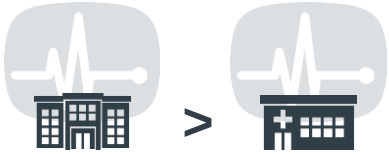
Source: CMS; Advisory Board analysis.

Site Payment Differential Draws National Attention

MedPAC Notices Significant Payment Differential for Certain Services

140%

Percent more that Medicare paid for a level II echocardiogram when performed in HOPD[1] rather than physician's office, 2012



Patients Confused, Angry About Facility Fees

Reader responses to February 2015 *New York Times* article, "When Hospitals Buy Doctor's Offices, Patient Fees Soar":

"When [my doctor] called me after the procedure and told me I had to pay a facility fee […] I said: '**You mean I have to pay separately for the building?!**'"

Robert, Cincinnati

"Isn't there a regulation or two against this sort of thing? Doctors and hospitals have found too many ways to squeeze money out of patients and insurance companies."

Henry, New York

1) Hospital outpatient department.

Source: "Report to Congress: Medicare Payment Policy," *Medicare Payment Advisory Council*, 14 Mar. 2014; Sanger-Katz, M, "When Hospitals Buy Doctor's Offices, Patient Fees Soar," *The New York Times*, 6 Feb. 2015; Advisory Board analysis.

Current Approach Toward Site-Neutral Payments

CMS Has Not Provided List of Provider-Based Departments Affected

Who is impacted?

Select off-campus[1] hospital outpatient departments that were not furnishing services billable under the HOPPS prior to November 2, 2015.[2]

How will the affected outpatient departments be paid?

Affected provider-based departments are no longer permitted to bill under the HOPPS. Instead, affected providers bill the CMS-1500 institutional claim with new modifier 'PN' and are reimbursed through a site-specific MPFS[3] technical component payment.

When did it begin?

January 1, 2017 for all affected provider-based departments.

What is the impact?

Individual sites: Payments for non-excepted services reimbursed at 50% of HOPPS rates ("PFS[3] relativity adjustor" of 50%).

Nationally: Site-neutral payments anticipated to reduce total Medicare Part B payments by $50 million in CY 2017.

1) 'Off-campus' defined as >250 yards from main hospital building.
2) Facilities that were mid-build on November 2, 2015 are counted as new facilities, and are subject to site-neutral payments.
3) Medicare Physician Fee Schedule.

Source: CMS; Advisory Board analysis.

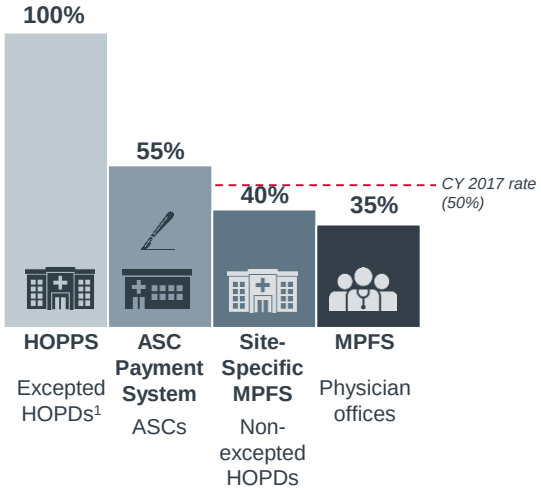
Sizable Rate Cuts for a Subset of HOPDs

CMS Reduces Payments from 50% to 40% of HOPPS rate

Assessing the HOPPS vs. MPFS Payment Differential to Set Non-Excepted HOPD Rates

- **For CY 2017**, CMS analyzed payment differential between MPFS and HOPPS for 22 highest-volume off-campus hospital outpatient HCPCS codes using **9 months of claims** from CY 2016:
  - CMS found MPFS reimbursement was lower: weighted average MPFS rate = 45% of HOPPS rate
  - CMS set CY 2017 MPFS rate for non-excepted HOPDs at **50% of HOPPS rate**
- **For CY 2018**, CMS analyzed payment differential between MPFS and HOPPS for 22 highest-volume off-campus hospital outpatient HCPCS codes using **full year of claims** from CY 2016:
  - CMS found MPFS reimbursement was lower: weighted average MPFS rate = 35% of HOPPS rate
  - CMS set CY 2018 MPFS rate for non-excepted HOPDs at **40% of the HOPPS rate** (reducing CY 2017 rate by 20%)

Relative Outpatient Payment Rates in CY 2018[1]



1) HOPPS and MPFS relativity determined by CMS, using 22 highest-volume off-campus HOPD HCPCS codes.

Source: CMS; Advisory Board analysis.

CMS Seeking Greater Cost Efficiency

Clear Commitment to Steerage Towards Low-Cost Care Settings

Site Neutral Payments Here to Stay

- "We believe that, by removing the financial incentive for hospitals to purchase freestanding facilities, we allow market forces to determine the appropriate number and distribution of hospital PBDs and physician offices."

- CY 2018 HOPPS Final Rule

Interest in ASCs as a Lower-Cost Setting

- "[We] share the commenters' concern that the disparity in payments between the OPPS and ASC payment systems may affect migration from the HOPD setting to the less costly ASC setting…

  We believe it would be appropriate to remove payment disincentives to facilitate this choice."

- CY 2018 HOPPS Final Rule

Source: CMS; Advisory Board analysis.

Conditional Packaging and C-APC Recap

Category	Conditional Packaging Policy (Ancillary Services)	Comprehensive APCs (C-APCs)
What is the purpose of the policy?	Packaging payments for low-cost ancillary services when appearing on the same claim as a primary service[1]	Packaging all payments for services adjunctive or supportive to most costly (mainly device dependent) procedures
Which procedures or services are "triggers"?	Pre-identified HCPCS codes for ancillary procedures and services	2,329 pre-identified HCPCS codes covered by 62 C-APCs.[2]
Coding Indicator	Eligible ancillary service HCPCS codes Tagged with status indicator Q1, Q2, or Q4	Primary procedure HCPCS codes to receive status indicator "J1" or "J2"[3]
Higher payment for complex combinations of services?	No additional payments	Yes, if CMS predetermines that combination of procedures is costly/complex
Summary of Payment Approach	1. If primary service is performed, ancillary services packaged (effectively ignored for payment) 2. If no primary service performed, ancillary services reimbursed separately (not packaged); Services receive status indicator "S", not "Q"	1. If no complexity adjustment: single payment based on C-APC of primary procedure 2. With complexity adjustment: If procedure combination is costly, promote to clinically similar, higher C-APC for greater single payment

1) Psychiatric-related, counseling-related, and low-cost drug administration services exempt from packaging in 2017.
2) For a complete list of procedures covered by the conditional packaging and Comprehensive APC policies, please download the addenda to the CY 2018 HOPPS Final Rule.
3) J1' HCPCS: primary services that trigger a comprehensive payment bundle. 'J2' HCPCS: services that, when provided in combination with one another, trigger a comprehensive payment bundle.

Source: CMS; Advisory Board analysis.

CMS Makes Lab Reimbursement, Packaging Changes

Drug Packaging

Expansion of Packaging, Including to Drug Administration Services, in CY 2018

- Increase drug packaging threshold from $110 (CY 2017 threshold) to $120 in CY 2018.
- Package Level I and Level II Drug Administration HCPCS codes (those in APCs 5691 and 5692) when these codes appear on claims with another separately payable service.[1]

Possible Packaging of Drug Administration Add-on Codes in Future Years

CMS asked for public feedback about whether it should proposed packaging payment for drug add-on codes in future years.

Comments were largely in opposition. One commenter suggested that CMS develop a drug administration C-APC as an alternate payment mechanism.

Lab Payment Policy: Revision of Date of Service Policy for Certain Tests

Starting CY 2018, ADLTs[2] and molecular pathology tests ordered within 14 days of a hospital outpatient facility discharge are billable by lab, not hospital, if test meets certain criteria.[3]

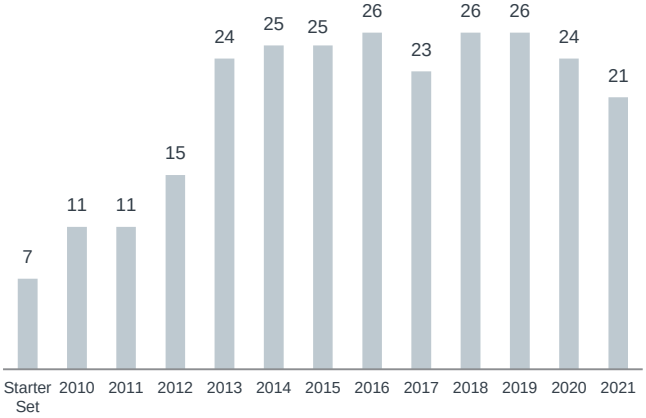
1) Vaccine administration excepted from packaging.
2) Advanced diagnostic lab test, a clinical diagnostic laboratory test covered under Medicare Part B performed by a single laboratory.
3) Test must fulfill the following requirements: a) test was performed following the hospital outpatient's discharge from HOPD; b) specimen was collected from hospital outpatient during HOPD encounter; c) it was medically appropriate to have collected the sample during the hospital outpatient encounter; d) results of the test do not guide treatment provided during HOPD encounter; e) test was reasonable and medically necessary.

Source: CMS; Advisory Board analysis.

Whittling Down List of HOPD Quality Measures

CMS Seeks to Reduce Reporting Burden for Providers

OQR[1] Payment Determination Measures, By Calendar Year (Finalized)



Continuing Pay-for-Reporting

2.0% CMS continuing the 2.0% rate cut for facilities that fail to report quality data

Summary of Changes to OQR

Measures to be Removed in CY 2020:

- ***OP-21*** Medium time to pain management for long bone fracture
- ***OP-26*** Outpatient volume data on certain surgical procedures
- ***OP-1*** Medium time to fibrinolysis
- ***OP-4*** Aspirin on arrival
- ***OP-20*** Door-to-door diagnostic evaluation by qualified medical professional
- ***OP-25*** Safe surgery checklist

Measures Delayed (until further notice):

- ***OP-37(a-e)*** Patient Experience measures
  a. About Facilities and Staff
  b. Communication About Procedure
  c. Preparation for Discharge and Recovery
  d. Overall Rating of Facility
  e. Recommendation of Facility

1) Hospital Outpatient Quality Reporting (OQR) Program; excludes voluntary measures

Source: CMS; Advisory Board analysis.

Road Map

1 Key Provisions of the CY 2018 Hospital Outpatient Final Rule

2 Key Provisions of the CY 2018 Ambulatory Surgical Center Final Rule

3 Related Tools and Analytics; Q&A

ASC Volumes Continue to Grow

Lower Cost Efficient Surgical Care Gives ASCs Market Advantage

Notable ASC Trends

176

Average number of new Medicare-certified ASCs each year, 2010-2015

7.3%

Increase in total Medicare payments to ASCs between 2014-2015

$1.0B

Increase in annual Medicare payments to ASCs from 2008 to 2015

Spotlight on the ASC-HOPD Price Differential

56%

ASCs are reimbursed at 56% of the HOPPS rate per service in CY 2017. The differential between HOPPS and ASC payment is 14% greater than in 2008.[1]

Regulation Watch: H.R.1838, Ambulatory Surgical Center Quality and Access Act of 2017

Introduced to the House of Representatives in March 2017. Resolution aims to shore up ASC payments in three main ways:

1) Require that ASCs and HOPDs receive equivalent payment rate adjustments each year
2) Allow publicly available side-by-side quality reporting of ASCs and HOPDs in the same geographical area
3) Require DHHS to explain reasoning when excluding procedures from ASC Covered Procedures List

1) Stated by CMS in the CY 2018 ASC Final Rule.

Source: MedPAC 2017 Data Book, p. 108, available at http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0; CMS; Advisory Board analysis.

Modest Payment Rate Increase for ASCs in CY18

Update Smaller Than Proposed

Final Payment Updates

- ASC payment rates will increase by 1.2% for CY 2018. Comprises 1.7% Consumer Price Index for urban consumers (CPI-U) and multifactor productivity adjustment of -0.5%
- Final CY 2018 ASC conversion factor: $45.575
- Total ASC payments for CY 2018 will increase by $130M as compared to CY 2017
- CMS sought comments on potential payment reform for ASCs, including whether/how to update the rate factor and whether /how ASCs should submit cost data. Expect more discussion in future Rules

Quality Reporting

- 2% penalty for failure to report quality data continues for CY 2018
- 3 ASCQR measures will be removed for CY 2019 payment determination
- 2 new measures added for CY 2021, focusing on hospital visits after ASC procedures
- As previously finalized, 11 measures mandatory for reporting for CY 2018 payment determination

ASC Covered Procedures

- Adding three procedures to ASC Covered Procedures List for CY 2018: total disc arthroplasty procedures (HCPCS 22856 and 22858) and laparoscopy procedure (HCPCS 58572)
- CMS sought comment on possible inclusion of total knee replacement, total and partial hip replacement on ASC Covered Procedures List in future years. Expect more discussion in future Rules

Source: CMS; Advisory Board analysis.

Possible Payment Changes on the Horizon

CMS Seeks Comment on ASC Cost Data Collection and Billing Changes

1

Payment Rate Factor

Question: Should the ASC payment system continue to be updated by the CPI-U[1], or by an alternative update factor (e.g., hospital market basket)?

Final Rule: "Given the many comments supporting alternative update methodologies, and given our interest in site neutrality and efficiency of care in the ASC setting, we intend to explore this issue further."

2

Reporting Cost Data

Question: Should ASCs be required to report cost data as hospitals are? If so, what data should it be reported and by what method (e.g., cost reports)?

Final Rule: "[ASCs] generally expressed a willingness to complete a [cost reporting] survey so long as it was not administratively burdensome."

3

Institutional vs. Professional Billing

Question: Should ASCs begin to bill using the institutional claim form (UB-04) rather than the professional claim form (CMS-1500) currently used?

Final Rule: Billing on a UB-04 "is not a foreign concept… a transition period would be necessary to allow for successful implementation."

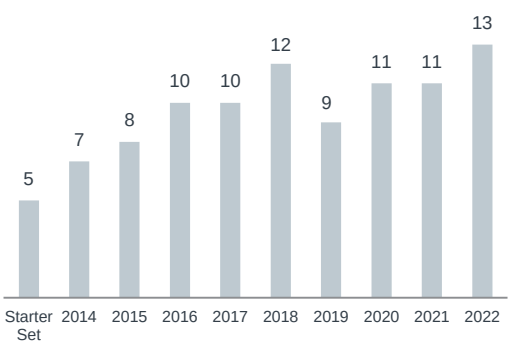
1) Consumer Price Index for Urban Consumers.

Source: CMS; Advisory Board analysis.

Post-ASC Hospital Admissions Come Into Focus

Hospital Visit Measures to Enter ASC Quality Program in CY 2022

ASCQR[1] Payment Determination Measures By Calendar Year



Continuing Pay-for-Reporting

- ASCs with ≤ 240 Medicare claims exempt
- ASC must report quality data for ≥ 50% of relevant claims to avoid 2% penalty

Summary of Changes

Measures to be Removed in CY 2019:

- ***ASC-5*** Prophylactic Intravenous Antibiotic Timing
- ***ASC-6*** Safe Surgery Checklist Use
- ***ASC-7*** Outpatient Volume Data on Select Surgical Procedures

Measures to be Added in 2022:[2]

- ***ASC-17*** Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
- ***ASC-18*** Hospital Visits After Urology Ambulatory Surgical Center Procedures

Measures Delayed (until further notice):

- ***OP-37(a-e)*** Patient Experience measures
  a. About Facilities and Staff
  b. Communication About Procedure
  c. Preparation for Discharge and Recovery
  d. Overall Rating of Facility
  e. Recommendation of Facility

1) Ambulatory Surgical Center Quality Reporting Program.
2) ASC-16, Toxic Anterior Segment Syndrome, was proposed for addition to the CY 2021 ASCQR in the CY 2018 Proposed Rule. CMS did not finalized the measure due to concerns that low TASS volumes would not justify the extra administrative burden of adding the measure.

Source: CMS; Advisory Board analysis.

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