OPPS and Physician Proposed Rules Top Issues

July 14, 2017

On July 13, 2017, the Centers for Medicare and Medicaid Services (CMS) released two proposed rules – the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule, and the Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule. Both contain various policies and payment updates as well as once again requests for information on flexibilities and efficiencies within the programs.

This memo highlights the top issues within each proposed rule with page numbers to the language within the proposal. The deadline for comments to both proposals is September 11, 2017.

Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Changes for 2018

The proposed rule includes updates to the 2018 rates and quality provisions, and proposes other policy changes. To read the CMS fact sheet, click here. To read the proposed rule, click here.

- **Decrease in prices for payment for drugs and biologicals ("drugs") purchased with a 340B Program Discount** - CMS is proposing to reimburse hospitals for Part B drugs at a rate of average sales price minus 22.5 percent, which is what MedPAC estimates to be the minimum 340B discount received by hospitals. The current reimbursement rate for Part B drugs to 340B hospitals is average sales price plus 6 percent. The proposal does not apply to vaccines and CMS is soliciting comment on whether certain types of drugs such as blood-clotting factors should also be excluded. This is based on a MedPAC recommendation in a report on the program from May 2015, click here. *Summary begins on page 298 of the proposed rule, and the proposed language begins on page 615.*

- **Direct supervision of hospital outpatient therapeutic services** - 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. *Summary begins on page 369 of the proposed rule, and the proposed language begins on page 633.*

- **Removal of total knee arthroplasty from Inpatient Only List** - CMS is proposing to remove total knee arthroplasty from the IPO list. *Summary begins on page 344 and 420 of the proposed rule. Pages 348 and 640 show the updated tables.*

- **Solicitation on possible removal of partial and total hip arthroplasty from Inpatient Only 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. *Solicitation summary begins on page 349of the proposed rule.*

- **Potential revisions to the Laboratory Date of Service policy to allow laboratories to bill Medicare directly** - CMS is considering potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for molecular pathology tests and diagnostic laboratory tests 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. *Summary begins on page 374.*

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018

This proposed rule includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018. To read the CMS fact sheet, click here. To read the proposed rule, click here.

- **Reduce PFS rates for off-campus departments from 50 percent to 25 percent** - The proposal would change the PFS payment rates for non-excepted items and services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate. For off-campus sites that were not mid-build by November 2, 2015, CMS pays half of hospital rates, and CMS proposes to pay only 25 percent of hospitals rates next year. *Summary begins on page 111 of the proposed rule.*

- **New codes for Medicare telehealth services -** For CY 2018, CMS is proposing to add several codes to the list of telehealth services, including:
  - HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
  - CPT code 90785 (Interactive Complexity);
  - CPT codes 96160 and 96161 (Health Risk Assessment);
  - HCPCS code G0506 (Care Planning for Chronic Care Management); and
  - CPT codes 90839 and 90840 (Psychotherapy for Crisis).

  Additionally, CMS is proposing to eliminate the required reporting of the telehealth modifier for professional claims.
  Summary begins on page 80 of the proposed rule.

- **Adopting certain codes for care management services -** CMS is proposing to adopt Current Procedural Terminology (CPT) codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. Also CMS is seeking public comment on ways they might further reduce burden on reporting practitioners for chronic care management and similar services. *Summary begins on page 385 of the proposed rule.*

- **New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs) -** CMS proposes for RHCs and FQHCs to receive payment for regular and complex chronic care management services, general behavioral health integration services, and psychiatric collaborative care model services using two new billing codes created exclusively for RHC and FQHC payment. This payment would be in addition to the payment for an RHC or FQHC visit. *Summary begins on page 380 of the proposed rule.*

- **Modification to Medicare Shared Savings Program rules** - CMS is proposing several modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. The proposals include the following:
  - Revisions to the assignment methodology to reflect the requirement under the 21st Century Cures Act that beginning on or after January 1, 2019, HHS will determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of services furnished by rural health clinics (RHCs) or federally qualified health centers (FQHCs);
  - The addition of three new chronic care management codes (CCM) and behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology; and
  - Reduction of burden for stakeholders submitting an initial Shared Savings Program application and the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver.

  Summary on Medicare Shared Savings proposals begin on page 463 of the proposed rule.