
Health Law Daily Wrap Up

Click to open document in a browser

By Sheila Lynch-Afryl, J.D., M.A.

Reimbursement to outpatient departments in 2018 will increase $5.8 billion compared to 2017, according to an advance release of the hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) PPS Final rule for calendar year 2018. However, CMS will drastically reduce reimbursement for drugs under the 340B Program, much to the ire of providers and associations, which have already threatened to sue. The Final rule will be published in the Federal Register November 13, 2017.

340B Program. In calendar year (CY) 2018, CMS will change its reimbursement for separately payable drugs and biologics (other than pass-through drugs and vaccines) acquired through the 340B Program from average sales price (ASP) plus 6 percent to ASP minus 22.5 percent. Rural sole community hospitals, PPS-exempt cancer hospitals, and children’s hospitals will be exempt from this policy for CY 2018. This change, said CMS, addresses recent trends of increasing drug prices and will save beneficiaries about $320 million on copayments in 2018. CMS will offset the projected $1.6 billion decrease in drug payments by redistributing this amount for non-drug items and services across the OPPS.

The 340B Program (see 42 U.S.C. §256b, as expanded by Secs. 2501, 7101, and 7102 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), has been controversial, as critics have accused hospitals of abusing the program (see Participants in drug delivery system testify to impacts on patient prescription drug costs, October 18, 2017). However, the American Hospital Association, the Association of American Medical Colleges, and America’s Essential Hospitals criticized the cut to 340B spending as contrary to Congressional intent and a threat to safety net hospitals (see, e.g., Testimonies focus on benefits of 340B Drug Program, October 12, 2017).

Further, said the AHA, the policy “does nothing to address the stated goal of reducing the cost of pharmaceuticals” and could cause increases in beneficiaries’ out-of-pocket costs for non-drug Part B benefits. America’s Essential Hospitals predicted that, “given their fragile financial position, essential hospitals will not weather this policy’s 27 percent cut to Part B drug payments without scaling back services or jobs.” The three associations plan legal action to stop CMS from cutting 340B spending.

OPPS update. For CY 2018, CMS increased the payment rates under the OPPS by an increase factor of 1.35 percent, which is based on the hospital inpatient market basket percentage increase of 2.7 percent, minus the multifactor productivity adjustment of 0.6 percentage point, and minus a 0.75 percentage point adjustment required by Sec. 3401(i) of the ACA.

Direct supervision requirement.42 C.F.R. Sec. 410.27(a)(1) requires therapeutic outpatient services to be furnished under the direct supervision of a physician or nonphysician practitioner. Sec. 16004 of the 21st Century Cures Act (P.L. 114-255) delayed enforcement through 2016 of this requirement for therapeutic hospital services provided by critical access hospitals and small rural hospitals with fewer than 100 beds. The CY 2018 OPPS Final rule continues the nonenforcement of the direct supervision requirement for hospital outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019.

Inpatient only list. Services that typically would be paid in an inpatient setting will not be paid by Medicare under the OPPS (see 42 C.F.R. Sec. 419.22(n)). These are services that require inpatient care because of (1) the invasive nature of the procedure; (2) the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged; or (3) the underlying physical condition of the patient.
Effective for CY 2018, CMS will remove total knee arthroplasty (TKA) and five other procedures from the inpatient only list and will add one procedure to the list. CMS is also prohibiting recovery audit contractors from reviewing TKA procedures for "patient status" for two years to give providers time to gain experience with the procedure in the outpatient setting.

**Packaging.** CMS will conditionally package low-cost drug administration services assigned to Ambulatory Payment Classifications (APCs) 5691 and 5692 effective January 1, 2018. In addition, CMS assigned 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. For CY 2018, a skin substitute product that was assigned to the high cost group for CY 2017, but does not exceed either the CY 2018 MUC or PDC threshold for CY 2018, will be assigned to the high cost group for CY 2018.

**OQR program.** CMS removed six measures from the Outpatient Quality Reporting (OQR) program beginning with the CY 2020 payment determination (CY 2018 reporting). CMS stated that the removal of these measures results in a burden reduction of 457,490 hours and a saving of $16.7 million in CY 2020 for hospitals. CMS also delayed the mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey under the Hospital OQR Program beginning with the CY 2018 data collection.

**Laboratory tests.** A new exception to the laboratory date of service policy will generally permit laboratories to bill Medicare directly for advanced diagnostic laboratory tests and molecular pathology tests excluded from OPPS packaging policy if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department.

**ASCs.** For CY 2018, payments to ASCs will increase 1.2 percent, or $4.62 billion, based on a projected consumer price index of 1.7 percent minus a multifactor productivity adjustment required by the ACA of 0.5 percentage point. For CY 2018, CMS added three procedures to the ASC covered procedures list. In addition, CMS removed three measures from ASC Quality Reporting program for the CY 2019 payment determination and later and added two measures of hospital events following specified surgical procedures for the CY 2022 payment determinations and later (see Approximate 2 percent increase in OPPS, ASC payments proposed for 2018; cuts to 340B drug discount pay, July 20, 2017).