Executive Summary: Final 2018 OPPS/ASC Rule

Key Financial and Operational Impacts from the 2018 Outpatient Prospective Payment System (OPPS) Final Rule:

The 2018 OPPS final rule was released on November 1, 2017. A detailed summary of the rule will be available on HFMA's Regulatory Resources page shortly.

1) **Conversion Factor**: In CY18, CMS finalizes a conversion factor of $78.636. This is an increase from $75.001 in CY17. Hospitals failing to meet the Outpatient Quality Reporting Program (OQR) requirements will see a reduced CY18 conversion factor of $77.064.

2) **Outlier Threshold:** CMS increases the outpatient fixed loss outlier threshold for CY18 to $4,150 (compared to $3,825 in CY17). This is expected to reduce outpatient outlier payments by .11% in CY18.

3) **Overall Impact**: CMS estimates that, compared to CY17, OPPS payments in CY18 will increase by approximately $690 million. This estimate excludes its estimated changes in enrollment, utilization, and case-mix.

   CMS estimates the final policies will result in a 1.4% overall increase in OPPS payments to providers. Below is a breakdown of how the final rule will impact specific types of hospitals or markets:

	Projected 2018 Impact
All Facilities*	1.4%
All Hospitals	1.5%
Urban Hospitals	1.3%
Rural Hospitals	2.7%
Major Teaching	-.9%
Minor Teaching	1.7%
Non-Teaching	2.9%
Ownership	
Voluntary	1.3%
Proprietary	4.5%
Government	0.0%

*Excludes hospitals permanently held harmless and CMHCs

4) **Payment for Separately Payable Part B Drugs Acquired Under the 340B Program**: Beginning in CY18, CMS reduces payment for separately payable1 (status K) Part B Drugs acquired under the 340B program from ASP+6% to ASP-22.5%. Rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals are exempted from the program. To maintain budget neutrality, CMS will increase all other non-drug OPPS payments by 3.2%.

1 This policy does not apply to vaccines or drugs on pass through status.

Effective January 1, 2018, 340B hospitals must append modifier "JG" to any Part B separately billable drugs acquired through the 340B program for non-exempted hospitals. Rural SCHs, children's hospitals, and PPS-exempt cancer hospitals are required to report an informational modifier "TB" to identify separately payable drugs purchased under the 340B program for tracking and monitoring purposes. CMS states that it may revisit the 340B policy in the future, including the types of hospitals that are exempt from the payment reduction.

CMS will not adjust payment for 340B-acquired drugs in nonexcepted off-campus provider-based departments in CY18 but may consider adopting such a policy in CY19.

5) **Non-Exempt Provider Based Clinics**: In the physician fee schedule final rule, CMS reduces payments to non-exempt provider based clinics (new clinics that were not in process by November 2, 2015) from 50% of the OPPS payment for the service in question to 40% of the service in question.

6) **Inpatient Only List - Total Knee Arthroplasty**: CMS removes total knee arthroplasty (TKA – CPT Code 27447) from the inpatient only list in CY18, allowing these procedures to be performed in hospital outpatient departments. CMS will prohibit Recovery Audit Contractors from conducting patient status reviews for two years on TKA procedures performed in the in-patient setting.

   Additionally, CMS removes the following codes from the inpatient only (IPO) List:
   - 43282: Laparoscopy, surgical, repair of paraesophageal hernia with implantation of mesh
   - 43772: Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
   - 43773: Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
   - 43774: Laparoscopy, surgical, gastric restrictive procedure; removal of gastric restrictive device and subcutaneous port components
   - 55866: Level 2 Laparoscopy & Related Services

   Finally, in the final rule, CMS adds code 929412 to the IPO list for CY18.

7) **Packaging of Low-cost Drug Administration Services**: CMS finalizes its proposal to conditionally package payment for low-cost drug administration services assigned to ambulatory payment classification (APC) 5691 and 5692. Medicare Part B vaccine administration services are excluded from this policy as a preventative service. Table 8 in the final rule provides the list of Healthcare Common Procedure Coding System codes that are packaged into these APCs.

8) **Direct Supervision of Hospital Outpatient Therapeutic Services**: CMS reinstates the non-enforcement of direct supervision requirements for outpatient therapeutic services or Critical access hospitals and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019.

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2 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, artherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

9) **Outpatient Quality Reporting Program**: CMS makes the following changes to the OQR:

   For the 2020 payment determination:

   i. OP-1: Median Time to Fibrinolysis (removed)
   ii. OP-4: Aspirin at Arrival (removed)
   iii. OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional (removed)
   iv. OP-21: Median Time to Pain Management for Long Bone Fracture (removed)
   v. OP-25: Safe Surgery Checklist Use (removed)
   vi. OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures (removed)
   vii. OP-37-a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey measures (delayed)

10) **ASC Conversion Factor**: CMS increases the CY18 ambulatory surgical center (ASC) conversion factor to $45.575 for ASCs meeting the quality reporting requirements from the CY17 conversion factor of $45.003. The final CY18 conversion factor for ASCs not meeting quality reporting requirements is $44.663.

11) **ASC Impact**: Including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix, Medicare ASC payments for CY18 would be approximately $4.62 billion. This is an increase of approximately $130 million compared to estimated CY17.