Executive Summary: Proposed 2018 OPPS/ASC Rule

Key Financial and Operational Impacts from the Proposed 2018 OPPS Rule:

The 2018 Outpatient Prospective Payment System (OPPS) proposed rule was made available on July 13, 2017. A detailed summary of the rule will be available here shortly.

1) **Conversion Factor**: In calendar year (CY) 2018, CMS is proposing a conversion factor of $76.483. This is an increase from $75.001 in CY 2017. Hospitals failing to meet the Outpatient Quality Reporting (OQR) Program requirements will see a reduced CY 2018 conversion factor of $74.953.

2) **Outlier Threshold:** CMS proposes to increase the outpatient fixed loss outlier threshold for CY 2018 to $4,325 (compared to $3,825 in CY 2017). This is expected to reduce outpatient outlier payments by .04% in CY 2018.

3) **Overall Impact**: CMS estimates that, compared to CY 2017, OPPS payments in CY 2018 will increase by approximately $897 million. This estimate excludes its estimated changes in enrollment, utilization, and case-mix.

   CMS estimates the proposed policies will result in a 1.9% overall increase in OPPS payments to providers. Below is a breakdown of how the proposed rule will impact specific types of hospitals or markets.

	Projected 2018 Impact
All Facilities*	1.9%
All Hospitals	2.0%
Urban Hospitals	2.0%
Rural Hospitals	2.0%
Major Teaching	1.7%
Minor Teaching	2.0%
Non-Teaching	2.1%
Ownership	
Voluntary	1.9%
Proprietary	2.3%
Government	1.9%

*Excludes hospitals permanently held harmless and CMHCs

4) **Payment for Part B Drugs Acquired Under the 340B Program**: Beginning in CY 2018, CMS is proposing to reduce payment for Part B Drugs acquired under the 340B program from average sales price (ASP)+6% to ASP-22.5%. To maintain budget neutrality, CMS will increase all other non-drug OPPS payments by 1.4%. CMS also proposes that 340B hospitals append a modifier to any Part B drugs billed that were not acquired through the 340B program.

5) **Non-Exempt Provider Based Clinics**: In the Physician Fee Schedule proposed 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 25% of the service in question.

6) **Inpatient Only List - Total Knee Arthroplasty**: CMS proposes to remove total knee arthroplasty (TKA) from the inpatient only list in CY 2018, allowing these procedures to be performed in hospital outpatient departments. CMS states that if the proposal is finalized, it will prohibit Recovery Audit Contractors from conducting patient status reviews for two years on TKA procedures performed in the in-patient setting. In the proposed rule, CMS asks whether it should remove total hip arthroplasty (THA) from the inpatient only list. The rule does not add TKA to the ambulatory surgical center (ASC) covered procedure list, though it solicits comments on whether TKA and THA meet the criteria to be included as an ASC covered procedure.

   CMS also proposes to remove CPT code 55866 (laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) from the inpatient only list for CY 2018.

7) **Proposed Packaging of Low-cost Drug Administration Services**: CMS proposes to conditionally package payment for low-cost drug administration services, except for Medicare Part B vaccine administration services. The proposed rule also solicits comments on existing packaging policies under the OPPS, including those related to drugs that function as a supply in a diagnostic test or procedure, or in a surgical procedure.

8) **Direct Supervision of Hospital Outpatient Therapeutic Services**: CMS proposes reinstating the non-enforcement of direct supervision requirements for outpatient therapeutic services or critical access hospitals (CAHs) and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019. The enforcement moratorium is designed to give effected hospitals more time to comply with the requirements.

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

   For the 2020 payment determination:

   i. OP-21: Median Time to Pain Management for Long Bone Fracture (removed)
   ii. OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures (removed)
   iii. OP-37-a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey measures (delayed)

   For the 2021 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-25: Safe Surgery Checklist Use (removed)

10) **ASC Conversion Factor**: CMS increases the CY 2018 ASC conversion factor to $45.876 for ASCs meeting the quality reporting requirements from the CY 2017 conversion factor of $45.003. The proposed CY 2018 conversion factor for ASCs not meeting quality reporting requirements is $44.976.

11) **ASC Impact**: CMS estimates that the changes in the proposed rule will increase payments to ASCs in CY 2018 by approximately $67 million compared to CY 2017. Including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix, Medicare ASC payments for CY 2018 would be approximately $4.68 billion, an increase of approximately $155 million compared to estimated CY 2017.