Medicare Outpatient Prospective Payment System (OPPS) Proposed Rule for Calendar Year 2018 Impact Analysis

The proposed calendar year (CY) 2018 payment rule for the Medicare Outpatient Prospective Payment System (OPPS) was published in the July 20, 2017 Federal Register (FR). The proposed rule includes annual updates to the Medicare fee-for-service (FFS) outpatient payment rates as well as proposed regulations that implement new policies, among other regular updates and policy changes. Comments related to this proposed rule with comment period are due to CMS by September 11, 2017 and can be submitted electronically at http://www.regulations.gov by using the website’s search feature to search for file code “1678-P”.

The proposed rule also includes policies that would:

- Reinstate the nonenforcement of direct supervision for CAHs and small rural hospitals having 100 or fewer beds;
- Change the rate for nonpass-through drugs purchased by hospitals through the 340B program;
- Change the inpatient only list;
- Payment changes for packaging of low-cost drug administration services;
- Change the Laboratory date of service policy;
- Make a payment change for non-excepted services furnished in off-campus provider-based departments;
- Change exceptions to the list of services to be packaged into APCs as opposed to separately paid; and
- Update payment rates and policies for Ambulatory Surgical Centers (ASCs).

A brief summary of the major hospital OPPS sections of the proposed rule is provided below.

**OPPS Payment Rate**

*Federal Register pages 33563 – 33566, 33588 - 33590*

The tables below show the proposed CY 2018 conversion factor compared to CY 2017 and the components of the update factor:

<table>
<thead>
<tr>
<th>Proposed CY 2018 Update Factor Component</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPS Conversion Factor</td>
<td>Final CY 2017: $75.001  Proposed CY 2018: $76.483  Percent Change: +1.98%</td>
</tr>
<tr>
<td>Marketbasket (MB) Update</td>
<td>+2.9%</td>
</tr>
<tr>
<td>Affordable Care Act (ACA)-Mandated Productivity MB Reduction</td>
<td>-0.4 percentage points (PPT)</td>
</tr>
<tr>
<td>ACA-Mandated Pre-Determined MB Reduction</td>
<td>-0.75 PPT</td>
</tr>
<tr>
<td>Wage Index BN Adjustment</td>
<td>-0.01%</td>
</tr>
<tr>
<td>Pass-through Spending BN Adjustment</td>
<td>+0.22%</td>
</tr>
<tr>
<td>Outlier BN Adjustment</td>
<td>-0.04%</td>
</tr>
<tr>
<td>Cancer Hospital BN Adjustment</td>
<td>+0.03%</td>
</tr>
<tr>
<td>Other BN Adjustments</td>
<td>+0.02%</td>
</tr>
<tr>
<td>Overall Proposed Rate Update</td>
<td>+1.98%</td>
</tr>
</tbody>
</table>
Adjustments to the Outpatient Rate and Payments

- **Wage Indexes** ([Federal Register pages 33590 – 33592]): As in past years, for CY 2018 OPPS payments, CMS is proposing to use the federal fiscal year (FFY) 2018 inpatient PPS (IPPS) wage indexes, including all reclassifications, add-ons, rural floors, and budget neutrality adjustment.

  CMS states that Social Security Administration (SSA) county codes are no longer being updated. And, as mentioned in the IPPS FFY 2018 proposed rule, CMS proposes for FFY 2018 to transition to the use of the Federal Information Processing Standard (FIPS) county codes for crosswalking to CBSAs. Coinciding with this, the Census Bureau has made the following updates to the FIPS codes:
  - Petersburg Borough, AK (FIPS 02195) created from part of former Petersburg Census Area (FIPS 02195) and part of the Hoonah-Angoon Census Area (FIPS 02105).
  - The name of La Salle Parish, LA (FIPS 22059) is renamed to LaSalle Parish, LA (FIPS 22059).
  - The name of Shannon County, SD (FIPS 46113) is renamed to Oglala Lakota County, SD (FIPS 46102).

Regarding the new CBSA delineations adopted in FFY 2015, in some very limited circumstances (i.e. urban to rural changes that affect geographic location or Lugar status), the three-year hold-harmless transition has expired. Hospitals affected by this transition had received a wage index based on their prior geographic CBSA.

The imputed rural floor policy is set to expire on December 31, 2017. CMS is not proposing an additional extension to this policy. As a result, the imputed rural floor would no longer be considered a factor in the national budget neutrality adjustment.

The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2018, CMS is proposing to continue to use a labor-related share of 60%.

- **Payment Increase for Rural SCHs and EACHs** ([Federal Register page 33566, 33594 - 33595]): CMS is proposing to continue a 7.1% payment increase for rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs). This payment add-on excludes separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

- **Cancer Hospital Payment Adjustment and Budget Neutrality Effect** ([Federal Register pages 33566, 33595 - 33595]): CMS is proposing to continue its policy to provide payment increases to the 11 hospitals identified as exempt cancer hospitals. Previously, CMS did this by providing a payment adjustment such that the cancer hospital’s payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals (and thus the adjustment was budget neutral). However, beginning CY 2018, the 21st Century Cures Act requires the weighted average PCR for the other OPPS hospitals be reduced by 1.0 percentage point. Therefore, CMS is proposing to set the target PCR to 0.89, instead of 0.90, in order to determine the CY 2018 cancer hospital payment adjustment based on using the most recent data available. CMS states that this required reduction does not significantly impact the budget neutrality adjustments for this policy.

CMS is proposing to calculate a budget neutrality factor as if the proposed cancer hospital adjustment target PCR was 0.90, not the 0.89 PCR that was proposed in this rule. Therefore, CMS is proposing a +0.03% adjustment to the CY 2018 conversion factor to account for this policy.

- **Outlier Payments** ([Federal Register pages 33596 - 33598]): To maintain total outlier payments at 1.0% of total OPPS payments, CMS is proposing a CY 2018 outlier fixed-dollar threshold of $4,325. This is an increase compared to the current threshold of $3,825. Outlier payments will continue to be paid at 50% of the amount by which the hospital’s cost exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold are met.
Updates to the APC Groups and Weights

As required by law, CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.

The proposed payment weights and rates for CY 2018 are available in Addenda A and B of the proposed rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.

CMS is proposing to remove 29 HCPCS codes from the CY 2018 bypass list. These codes are listed on Federal Register page 33569.

The table below shows the proposed shift in the number of APCs per category from CY 2017 to CY 2018 (Addendum A):

<table>
<thead>
<tr>
<th>APC Category</th>
<th>Status Indicator</th>
<th>Final CY 2017</th>
<th>Proposed CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass-Through Drugs and Biologicals</td>
<td>G</td>
<td>48</td>
<td>38</td>
</tr>
<tr>
<td>Pass-Through Devices Categories</td>
<td>H</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>OPD Services Paid through a Comprehensive APC</td>
<td>J1</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>Observation Services</td>
<td>J2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-Pass-Through Drugs/Biologicals</td>
<td>K</td>
<td>313</td>
<td>306</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>P</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>R</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Procedure or Service, No Multiple Reduction</td>
<td>S</td>
<td>77</td>
<td>78</td>
</tr>
<tr>
<td>Procedure or Service, Multiple Reduction Applies</td>
<td>T</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Brachytherapy Sources</td>
<td>U</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Clinic or Emergency Department Visit</td>
<td>V</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>New Technology</td>
<td>S/T</td>
<td>110</td>
<td>112</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>713</strong></td>
<td><strong>696</strong></td>
</tr>
</tbody>
</table>

New Comprehensive APCs (Federal Register pages 33573 - 33580): Comprehensive Ambulatory Payment Classifications (C-APCs) provide all-inclusive payments for certain procedures. A C-APC covers payment for all Part B services that are related to the primary procedure (including items currently paid under separate fee schedules). The C-APC encompasses diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; coded and un-coded services and supplies used during the service; outpatient department services delivered by therapists as part of the comprehensive service; durable medical equipment as well as the supplies to support that equipment; and any other components reported by HCPCS codes that are provided during the comprehensive service. The costs of blood and blood products are included in the C-APCs.

The C-APCs do not include payments for services that are not covered by Medicare Part B or are not payable under OPPS such as: certain mammography and ambulance services; brachytherapy sources; pass-through drugs and devices; and charges for self-administered drugs (SADs).
For CY 2018, CMS is not proposing to create any new C-APCs or any extensive changes to the already established methodology used for C-APCs. There is a total number of 62 C-APCs.

CMS is proposing that for C-APC 5627 (Level 7 Radiation Therapy): Stereotactic Radio Surgery (SRS), they will continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. Additionally, the data collection period for SRS claims with modifier “CP” is set to conclude on December 31, 2017. Accordingly, for CY 2018, CMS is proposing to delete and discontinue the required use of this modifier.

- **Composite APCs (Federal Register pages 33580 – 33584):** Composite APCs are another type of packaging to provide a single APC payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are seven composite APCs for:
  - Low-Dose Rate (LDR) Prostate Brachytherapy (APC 8001);
  - Mental Health Services (APC 8010); and
  - Multiple Imaging Services (APCs 8004, 8005, 8006, 8007 and 8008).

CMS is proposing to delete composite APC 8001 (LDR Prostate Brachytherapy Composite) and assign HCPCS code 55875 (transperineal placement of needles or catheters into prostate for interstitial radionuclide application, with or without cystoscopy) to status indicator “J1” and C-APC 5375 (Level 5 Urology and Related Services) instead. A code edit for claims with brachytherapy services, effective January 1, 2018, will require the brachytherapy application HCPCS code 77778 (Interstitial radiation source application; complex) be added on the claim with the brachytherapy insertion procedure (HCPCS code 55875).

For CY 2018, CMS is proposing to continue its current composite APC payment policies. Table 6 on pages 33582 - 33584 of the Federal Register shows the proposed HCPCS codes that would be subject to the multiple imaging procedure composite APC policy and their respective families.

- **Packaged Services (Federal Register 33583 –33588):** CMS is continuing its efforts to create more complete APC payment bundles over time to package more ancillary services when they occur on a claim with another service, and only pay for them separately when performed alone.

CMS is proposing to remove the exception for certain drug administration services and conditionally package payment for low-cost drug administration services, except for Medicare Part B vaccine administration services. Specifically, CMS is proposing for CY 2018 to conditionally package payment for HCAHPS codes in Levels 1 and 2 Drug Administration services (APCs 5691 and 5692), except for add-on codes and preventive services, when these services are performed with another service. A list of HCPCS codes that will be conditionally packaged are displayed in Table 7 (pages 33585-33586) of the Federal Register. CMS is soliciting feedback on whether Levels 3 and 4 Drug Administration services (APC 5693 and 5694) may be appropriate for packaging.

Separately, CMS is also soliciting comment on a payment methodology for conditionally or unconditionally packaging drug administration add-on services that ensures patient access.

- **Payment for Medical Devices with Pass-Through Status (Federal Register pages 33610 – 33618):** The current HCPCS codes for devices on the pass-through payment list are:
  - C1822 – Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system;
  - C2613 – Lung biopsy plug with delivery system; and
  - C2623 – Catheter, transluminal angioplasty, drug-coated, non-laser.
CMS is proposing that, beginning in CY 2018, all three of these HCPCS codes be removed from the list of medical devices currently provided pass-through payment status. As a result, the costs of these devices would be packaged into the costs related to the procedures with which they are reported.

- **Device-Intensive Procedures** *(Federal Register pages 33618 - 33619)*: Beginning in CY 2017, CMS defined device-intensive APCs as those procedures which require the implantation of a device, and are assigned an individual HCPCS code-level device offset of more than 40%, regardless of APC assignment.

  Additionally, for new HCPCS codes describing device implantation procedures that do not yet have associated claims data, CMS applies a device offset of 41% until claims data are available to establish an offset for the procedure.

  As finalized in the CY 2017 final rule, CMS applies the CY 2016 device coding requirements to newly defined device-intensive procedures. In addition, any device code would satisfy this edit when it is reported on a claim with a device-intensive procedure.

  CMS is not proposing any changes to this policy for CY 2018.

- **Payment Adjustment for No Cost/Full Credit and Partial Credit Devices** *(Federal Register pages 33619 - 33620)*: For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital received a credit from the manufacturer. The offset can be 100% of the device amount when a hospital attains the device at no cost or receives a full credit from the manufacturer; or 50% when a hospital receives partial credit of 50% or more.

  For CY 2018, CMS is proposing to continue to reduce OPPS payment, for device-intensive procedures, by the full or partial credit that a provider receives for a replaced device. CMS is also proposing to continue to determine the procedures to which this policy would apply using three criteria:

  - All procedures must involve implantable devices that would be reported if device insertion procedures were performed;
  - The required devices must be surgically inserted or implanted devices that remain in the patient’s body after the conclusion of the procedure (even if temporarily); and
  - The procedure must be device-intensive (defined as devices exceeding 40% of the procedure’s average cost).

- **Payment Policy for Low-Volume Device-Intensive Procedures** *(Federal Register pages 33620 - 33621)*: In the CY 2017 final rule CMS adopted a policy in which for any device-intensive procedure assigned to a clinical APC with fewer than 100 total claims for all procedures in the APC, the payment rate for that procedure will be calculated using the median cost. For CY 2018, CMS is proposing to continue with this policy. For CY 2018 the only procedure to which this policy would apply continues to be CPT code 0308T (insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis), which is currently assigned to APC 5495.

- **Payment for Drugs, Biologicals and Radiopharmaceuticals** *(Federal Register pages 33621 - 33626)*: CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold.

  For CY 2018, CMS is proposing a packaging threshold of $120. Drugs, biologicals and radiopharmaceuticals that are above the $120 threshold are paid separately using individual APCs; the proposed payment rate for CY 2017 is the average sales price (ASP) + 6%.
As finalized in the CY 2017 final rule, CMS is allowing for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved in CY 2017 and subsequent years in order to grant a pass-through period as close to a full three years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

Finally, CMS is proposing the pass-through status to expire on December 31, 2017 for 19 drugs and biologicals, listed in Table 21 on page 33622 of the Federal Register; and is proposing pass-through status in CY 2018 for 38 others, shown in Table 22 on page 33623 of the Federal Register.

• **High Cost/Low Cost Threshold for Packaged Skin Substitutes** *(Federal Register pages 33626 - 33628)*: Previously, CMS had finalized a policy in which skin substitutes are divided into a high cost group and a low cost group in terms of packaging. CMS is proposing to assign skin substitutes with a geometric mean unit cost (MUC) or a products per day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the high cost group for CY 2018, as for CY 2017. CMS is also proposing to assign those that did not exceed the thresholds but were assigned to the high cost group for CY 2017 to the high cost group in CY 2018 as well. Lastly, CMS is also proposing to assign skin substitutes with pass-through payment status to the high cost category, however there are no skin substitutes that are proposed to have pass-through payment for CY 2018.

• **Payment for Drugs Purchased under the 340B Drug Discount Program** *(Federal Register pages 33631 - 33635)*: The 340B program allows participating hospitals and other health care providers to purchase certain “covered outpatient drugs” at discounted prices from drug manufacturers. Due to the correlation between drug spending increases and hospital participation in the 340B program, as well as CMS’ belief that the current payment methodology may lead to unnecessary utilization and potential overutilization of separately payable drugs, CMS is proposing to change their current Medicare Part B drug payment methodology for 340B hospitals.

Specifically, CMS is proposing to apply a discount of 22.5 percent of the ASP, rather than the current rate of ASP + 6% for nonpass-through separately payable drugs purchased under the 340B program. CMS believes that 22.5 percent below the ASP reflects the average minimum discount that 340B hospitals receive for drugs acquired under the 340B program.

As CMS is proposing to implement this payment reduction in a budget neutral manner, CMS is soliciting comment on whether all, or part, of the savings generated should be applied to increase payments for specific services paid under OPPS, or under part B generally, in CY 2018, rather than simply increasing the conversion factor.

CMS also intends to establish a modifier to be effective January 1, 2018, for hospitals to report with separately payable drugs that were not acquired under the 340B program. Such changes would allow the Medicare program and Medicare beneficiaries to share in some of the savings of hospitals participating in the program.

CMS is also soliciting comments on whether they should adopt a different payment rate to account for the average minimum discount of OPPS drugs purchased under the 340B drug discount program. Also, CMS is seeking comment on whether the proposal to pay ASP minus 22.5 percent for 340B purchased drugs should be phased in over time (potentially 2 or 3 years).

**Other OPPS Policies**

• **Partial Hospitalization Program (PHP) Services** *(Federal Register pages 33637 -33653)*: The PHP is an intensive outpatient psychiatric program to provide outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding Community Mental Health Center (CMHC). PHP providers are paid on a per diem basis with payment rates calculated using CMHC- or hospital-specific data.
The table below compares the final CY 2017 and proposed CY 2018 PHP payment rates:

<table>
<thead>
<tr>
<th>APC Code</th>
<th>Description</th>
<th>Final Payment Rate 2017</th>
<th>Proposed Payment Rate 2018</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5853</td>
<td>Partial Hospitalization (3+ services) for CMHCs</td>
<td>$121.48</td>
<td>$123.84</td>
<td>1.9%</td>
</tr>
<tr>
<td>5863</td>
<td>Partial Hospitalization (3+ services) for Hospital-based PHPs</td>
<td>$207.27</td>
<td>$205.36</td>
<td>-0.9%</td>
</tr>
</tbody>
</table>

For CMHCs, CMS is proposing to continue to make outlier payments for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year.

- **Updates to the Inpatient-Only List** ([Federal Register pages 33653 - 33645](#)): The inpatient list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. For CY 2018, CMS is proposing to remove the following services from the inpatient-only list:
  - CPT code 27447 — Total knee arthroplasty (TKA).
  - CPT code 55866 — Laparoscopy, surgical prostatectomy, retropubic radical, including nerve paring, includes robotic assistance, when performed.

  In addition, CMS is seeking public comment on whether partial and total hip arthroplasty should also be removed from the inpatient only list and added to the ASC Covered Surgical Procedures List.

- **Payment for Off-Campus Outpatient Departments** ([Federal Register pages 33645 - 33648](#)): In the CY 2018 Proposed Physician Fee Schedule rule (Display pages 120-124), CMS proposes to pay hospitals at 25%, rather than the current 50%, of the OPPS rate for non-excepted services furnished in off-campus provider-based departments of a hospital that began billing under the OPPS on or after Nov. 2, 2015.

  The 21st Century Cures Act requires that “off-campus outpatient department of a provider” excludes certain cancer hospitals. The act also requires that for services furnished on or after January 1, 2018, a target PCR that is 1 percentage point less than the target PCR that would otherwise apply must be used. In addition to the 1 point reduction, an additional percentage point reduction to the target PCR may be considered that takes into account payment rates for applicable items and services, other than for services furnished by certain cancer hospitals.

- **Enforcement Instruction for the Supervision of Outpatient Therapeutic Services in Critical Access Hospitals (CAHs) and Certain Small Rural Hospitals** ([Federal Register pages 33649 -33649](#)): Currently, CMS requires direct supervision for hospital outpatient therapeutic services covered by Medicare that are furnished in hospitals as well as in provider-based departments of hospitals, including CAHs. Up until December 31, 2016, due to the difficulty of meeting this standard, CMS created an interim nonenforcement (“enforcement instruction”) for CAHs and small rural hospitals with 100 or fewer beds that allowed Medicare administrative contractors not to evaluate or enforce the supervision requirements.

  CMS is proposing to reinstate the moratorium on enforcement of direct supervision for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019. This will provide CAHs and small rural hospitals more time to comply with the supervision requirements; and also give providers time to submit specific services to be evaluated by the Advisory Panel on Hospital Outpatient payment to determine changes in supervision level. These hospitals will continue to be subject to conditions of participation for hospitals and other Medicare rules regarding supervision.

- **Changes for Payment for X-Rays Taken Using Computed Radiography Technology** ([Federal Register pages 33649 - 33650](#)): Required by the Consolidated Appropriations Act of 2016 and effective for services furnished CY 2017 and subsequent years, the payment under the OPPS for imaging services that are X-rays taken using film will be reduced by 20 percent with modifier “FX”. CMS is proposing a phased-in reduction of payments for imaging
services that are taken using computed radiography technology. Payments for such services furnished during CYs 2018 through 2022 would be reduced by 7 percent, and by 10 percent in CY 2023 or subsequent years. CMS is establishing a new modifier “XX” that would be reported on claims to identify those HCPCS codes that describe X-rays taken using computed radiography technology beginning January 1, 2018.

- **Revisions to the Laboratory Date of Service Policy** (*Federal Register* pages 33650 - 33653): Date of service (DOS) is a required field on all Medicare claims for laboratory services. The requirements for DOS are used to determine whether a hospital bills Medicare for a clinical diagnostic laboratory test or whether the laboratory performing the test bills Medicare directly.

  Under the current rules, if a test was ordered more than 14 days after a patients discharge date, the DOS is the date the test was performed, and the laboratory would bill Medicare directly for the test and the laboratory would be paid directly by Medicare. If the test is ordered less than 14 days after a patients discharge date, the DOS is the date the specimen was collected from the patient and the hospital (not the laboratory) would bill Medicare for the test and then the hospital would pay the laboratory.

  CMS is considering potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for certain laboratory tests excluded from the OPPS packaging policy, and ordered less than two weeks following the date of the patients discharge. CMS is seeking public comment on these suggestions.

**Updates to the Hospital Outpatient Quality Reporting (OQR) Program**

*Federal Register* pages 33671-33685

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 percentage point reduction to the OPPS marketbasket update for the applicable year.

A table that lists the 26 measures CMS is currently collecting for the CY 2019 and subsequent payment determinations is available in the final CY 2017 *FR* (pages 79754-79755).

The CY 2018 OPPS proposed rule proposes to remove six measures from the Hospital Outpatient Quality Reporting Program. (*Federal Register* pages 33673-33675)

- The two measures proposed to be removed in CY 2020 are:
  - OP-21: Median Time to Pain Management for Long Bone Fracture and
  - OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures.

- The four measures proposed to be removed in CY 2021 are:
  - OP-1: Median Time to Fibrinolysis,
  - OP-4: Aspirin at Arrival,
  - OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional, and

A table listing the 31 measures proposed to be collected for CY 2020 payment determinations is available on *Federal Register* page 33677 of the CY 2018 proposed rule; a table listing the 27 measures proposed to be collected for CY 2021 and subsequent years is available on *Federal Register* pages 33677 - 33678 of the CY 2018 proposed rule.

Additionally, CMS proposes to delay the mandatory implementation of the OP-37a-e Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) measures beginning with the CY 2020 payment determination (2018 data collection) until further action in future rulemaking since they lack important operational and implementation data regarding the collection and reliability of the data. (*Federal Register* pages 33675-33676)
As CMS continues to move towards outcomes measures and away from the use of clinical process measures across its Medicare quality reporting programs, CMS seeks comments on any outcome measures that would be useful to add to the Hospital OQR Program as well as any clinical process measures that should be eliminated.

As CMS reviews numerous reports, they are seeking comment on whether social risk factors should be considered in the Hospital OQR Program, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. (Federal Register pages 33671-33672)

CMS clarified the procedures for validation of chart-abstracted measures and noted that 50 outlier hospitals, based on poor measure scoring, will be targeted for validation. CMS proposed formalizing chart-abstracted measure validation educational review procedures and updates to include a correction process. Additional proposals include changes to the Notice of Participation deadline and alignment of the naming of the Extraordinary Circumstances Exceptions policy with other quality reporting programs. (Federal Register pages 33682-33684)

Request for Information on CMS Flexibilities and Efficiencies
Federal Register pages 33703 - 33704

CMS is issuing a Request for Information on how Medicare can contribute to making the healthcare delivery system less bureaucratic and complex, and how they can reduce burden to clinicians, providers, and patients in a way that increases the quality of care and decreases costs.