

2018 Medicare Hospital Outpatient Prospective Payment System Final Rule Released

On November 1, 2017 the Centers for Medicare and Medicaid Services (CMS) published the CY 2018 Proposed Rule which includes payment rates and policy changes to the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. These policy changes and payment rates are effective as of January 1, 2018.

In general, the rule provides for a 1.35% update in hospital outpatient payment rates in 2018. The payments made under OPPS cover facility resources including equipment, supplies, and hospital staff, but do not include services of physicians or non-physician practitioners paid separately under the Medicare Physician Fee Schedule. Services under OPPS, which are clinically similar and require similar resources are classified into payment groups called Ambulatory Payment Classifications (APCs) and a payment rate is established for each APC. The APC payment rates are adjusted for geographic cost differences, and payment rates and policies are updated annually through rulemaking.

Highlights of the final rule of interest to Epilepsy Centers

APC Payment Rates for Epilepsy Center Services – Attached to this summary are charts showing the changes in APC payment rates for 2018 for epilepsy center services. In general the APC payment rates for services are increasing.

Site Neutral Payments – Off-Campus/Provider-Based Departments (PBD) – In 2017, CMS implemented the requirement that that services furnished in off-campus provider-based hospital outpatient departments that began billing under the OPPS on or after Nov. 2, 2015 would no longer be paid under the OPPS, but under the physician fee schedule at 50% of the OPPS rate. The rule created several exceptions to the new payment rate, which include items and services provided in:

- A dedicated emergency department
- An off-campus PBD that was billing for services prior to November 2, 2015 that has not been relocated or changed ownership
- A PBD that is considered “on campus” or within 250 yards of the hospital or remote location of the hospital

In the 2018 final rule, CMS did not implement its proposal to reduce payment to PBD’s under the physician fee schedule so that they are equal to 25% of the OPPS rate, but instead set the rate at 40% of the OPPS rate.

Laboratory Date of Service – CMS finalized its proposal to allow laboratories to bill Medicare directly for molecular pathology tests and advanced diagnostic lab tests (ADLTs). The rule provides an exception to the general laboratory date of service rule (14-day rule) if the specimen

was collected during a hospital outpatient encounter, the test is performed once the patient was discharged, and the results do not guide treatment provided during the outpatient encounter.

340B Drug Pricing – CMS finalized its proposal to reduce payments for separately payable drugs and biologicals (other than vaccines and pass-through drugs, but including clotting factors and radiopharmaceuticals) acquired under the 340B program from the current payment rate of average sales price (ASP) plus 6% to ASP minus 22.5%. CMS exempted rural sole community hospitals, children’s hospitals and PPS-exempt cancer hospitals participating in the 340B program from the payment reduction in 2018. CMS plans to create modifiers for 340B drug billing; one for hospitals subject to the payment reduction and one for hospitals that are not subject to the payment reduction. CMS is implementing the proposal in a budget neutral manner by redistributing the projected decrease in drug payments of \$1.6 billion to non-drug items and services paid for under OPPS.

It should be noted that the three major hospital associations - the American Hospital Association, the Association of American Medical Colleges, and America’s Essential Hospitals – have filed a lawsuit to stop CMS from implementing this provision. Also, bi-partisan legislation has been introduced in the House of Representatives to prevent implementation.