WHAT SHOULD BE ON YOUR MEDICARE RADAR

August 17, 2017

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Overview

- Key Provisions in the OPPS Proposed Rule
- Post-Acute Care PPS Updates
- IMPACT Act Implementation Updates
  - MedPAC Recommendations
- Status of Episode Based Payment Models
- Site Neutral Payment Provisions for Off Campus Provider-Based HOPD
Key Provisions
CY 2018 OPPS Proposed Rule

- Released on July 13
- Comments due on September 11
- Submit comments to [www.regulations.gov](http://www.regulations.gov)
Proposed Rate Adjustments

<table>
<thead>
<tr>
<th>CY 2017 Final Outpatient Conversion Factor</th>
<th>$75.001</th>
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<tbody>
<tr>
<td>Proposed CY 2018 Adjustments:</td>
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<tr>
<td>Marketbasket Update</td>
<td>+2.9%</td>
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<tr>
<td>ACA-Mandated Productivity Reduction</td>
<td>-0.4 ppts</td>
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<tr>
<td>ACA-Mandated Predetermined Reduction</td>
<td>-0.75 ppts</td>
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<tr>
<td>Other Proposed Adjustments:</td>
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<tr>
<td>Wage Index budget neutrality (BN) adj.</td>
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<tr>
<td>Cancer hospital payment BN adj.</td>
<td>1.0003</td>
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<tr>
<td>Pass-through spending adjustment</td>
<td>1.0022</td>
</tr>
<tr>
<td>Outlier BN adjustment</td>
<td>0.9996</td>
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<tr>
<td>Other BN adjustments</td>
<td>1.0002</td>
</tr>
<tr>
<td>CY 2018 Proposed Outpatient Conversion Factor</td>
<td>$76.483</td>
</tr>
</tbody>
</table>

340B Drug Discount Program

CMS' Proposal:

- Beginning in CY 2018, reduce payment for separately payable, non-pass through OPPS drugs purchased under the 340B program by 28.5%
  - Current payment for Part B drugs: ASP + 6%
  - Proposed 340B hospitals: ASP - 22.5%
    - Excludes drugs on pass-through status; and
    - Vaccines
- Establish a modifier to identify drugs not acquired under 340B
- 340B payment reduction will done in a budget neutral manner
340B Drug Discount Program

CMS seeks additional input on:

- Redistribution of the savings
- Phase-in the proposed payment rate over 2-3 years
- Different payment rate to account for average minimum discount of OPPS drugs purchased under the 340B
- Report acquisition costs and charges for each drug on the Medicare claim
- Exceptions due to access of care issues (cancer, rural SCHs)
- Exclude certain drugs (i.e. blood clotting factors)

340B Advocacy/Comments

- Strongly Oppose Proposal
- Does not address real issue of rising drug prices
- Cuts reimbursement to safety net hospitals
Inpatient Only List

CMS’ Proposal:
- For CY 2018, removal of two CPT codes from the IP only list:
  - Removal of Total Knee Arthroplasty (CPT 27447) from the IP only list and assign to C-APC 5115 (Level 5 Musculoskeletal Procedures)
    - If adopted RACs would be prohibited from performing patient status reviews for TKA procedures performed in an inpatient setting for a period of 2 years
  - Laparoscopy, surgical prostatectomy (CPT 55866);
- These codes will be packaged with the associated procedure and assigned SI “JI”
- Seeks input on removing Total or Partial Hip Arthroplasty in future years

Direct Supervision Requirements

CMS’ Proposal:
- Reinstate the non-enforcement of direct supervision instructions for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds for CY 2018 and 2019
  - These hospitals are still subject to COPs
## Changes to Packaging of Items and Services

**CMS’ Proposal:**
- Conditionally package payment for low-drug administration in APC 5691 (Level 1 Drug Administration) and APC 5692 (Level 2 Drug Administration) when performed with another service.
- Preventive services are still excluded from the packaging policy
  - Therefore, Medicare Part B vaccine administration services will continue to be paid separately

## Payment Changes for Computed Radiography

**CMS’ Proposal:**
- Reduce OPPS payment for X-rays taken using computed radiography (including the X-ray component of a packaged service) by 7% for CY’s 2018-2022. By 2023 the reduction would be increased to 10%.
  - Establish a new modifier to report X-rays taken using computed radiography
Other OPSS Proposed Changes

- **Rural SCH Adjustment**: Continue to apply a 7.1% payment adjustment for rural SCHs.
- **Cancer Hospital Payment Adjustment**: Continue to provide additional payments to cancer hospitals
  - 21st Century Cures Act mandates a reduction of 1.0 ppt
- **Outlier Threshold**: Increase the outlier fixed-loss threshold from $3,825 in CY 2017 to $4,325 in CY 2018
  - Designate approx. 0.0027% of the outlier threshold for CMHCs
- **Site-of-Service Price Transparency**: 21st Century Cures Act mandates price transparency beginning in 2018
  - For items & services made to a hospital outpatient dept or ASC
  - CMS will make this information available to the public via a searchable website
  - *Federal Register* page 33648

Proposed OQR Measures for CY 2020 Program

CMS’ Proposal:

- Removal of Two Measures
  - OP–21: Median Time to Pain Management for Long Bone Fracture; and
  - OP–26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
- Delay the Implementation of CAHPS
Proposed OQR Measures for CY 2021 Program

CMS' Proposal:

- Removal of Four Measures
  - OP–1: Median Time to Fibrinolysis;
  - OP–4: Aspirin at Arrival;
  - OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional; and
  - OP–25: Safe Surgery Checklist

Text 703-340-9850
## Post-Acute Care PPS Updates

### Final rules for IRF, SNF, LTCH and IPF

### Home Health Proposed Rule

### SNF Refinement Proposed Rule

## Post-Acute Final Rule Updates

<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rate Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IPF Rate Notice</strong></td>
<td>CMS estimates IPF payments to increase by 0.99 percent or $45 million in FY 2018. CMS finalizes a market basket update of 1.25 percent. Additionally, estimated payments to IPFs are reduced by 0.26 percentage point due to updating the outlier fixed-dollar loss threshold amount.</td>
<td>CMS is not finalizing its proposal to add Medication Continuation Following Inpatient Psychiatric Discharge (NQF #3205), to the IPF QRP.</td>
<td>Update Notice Released August 2, 2017 <a href="https://www.cms.gov/New.sroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02-2.html">https://www.cms.gov/New.sroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02-2.html</a></td>
<td></td>
</tr>
<tr>
<td><strong>LTCH Final Rule</strong></td>
<td>CMS estimates +2.4% increase MACRA authorized 1% MB update</td>
<td>3rd year of site neutral (SN) payment method; paid full SN rate in FFY 2018 (2yr transition blend over) Finalized 1 year delay full application of 25% PMT threshold until Oct. 2018. Made modifications to short stay outlier policy.</td>
<td>Update Vent Measures and removes Potentially Preventable Readmissions measure from QRP</td>
<td>No longer subject to a suspension on the increase of # of beds if they meet criteria. Removes MA and SN cases from ALOS calculation.</td>
</tr>
</tbody>
</table>
### Post-Acute Final Rule Updates (cont.)

<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rate Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notables</th>
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</thead>
<tbody>
<tr>
<td><strong>IRF Final Rule</strong></td>
<td>CMS estimates 0.9% increase or $75 million MACRA limits update to 1%</td>
<td>Loss of Rural adjustment (Final year of 3 year transition)</td>
<td>Finalized changes to the FFY 2020 QRP including removing an all-cause unplanned readmission measure, and replacing a % of residents w/ pressure ulcers that are new or worsened with a modified version: &quot;Changes in skin integrity PAC: pressure ulcer/infarct.&quot;</td>
<td>Eliminates the 25% penalty for late IRF patient assessment instrument submissions; Finalizes refinements to the codes used to assess a facility’s compliance with 80% Rule.</td>
</tr>
</tbody>
</table>

| **SNF Final Rule** | CMS estimates 1.0% increase or $370 million MACRA limits update to 1% | Revising and Rebasing of SNF MB to 2014 base year. | VBPs beg FFY 2019 providing incentive payments to SNFs w/ > levels of performance and penalties of up to 2% w/ performance on readmissions; Finalizes changes to the FFY 2020 QRP including a revised measure that address pressure ulcer changes while adding 4 function outcome measures. | Additional rulemaking is soliciting comments on revisions to SNF methodology: replacing CMI classification model, RUG-IV, to RCS-1. Comments due 8/25 |

### Updates to Patient Assessment Tools proposed for April or Oct. 1, 2018

**Proposed IRF-PAI (Oct. 1, 2018)**


**Proposed CARE Tool (LTCH) (April 1, 2018)**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Proposed-LTCH-CARE-Data-Set-Version-4-00-Change-Table-Effective-April-.pdf


**Proposed MDS (Oct. 1, 2018) (SNF)**


Home Health Proposed Rule

- MACRA limits the update to 1%
- CMS proposes refinements to the case-mix adjustment methodology, including a change in the unit of payment from 60-day episodes of care to 30-day episodes for periods of care beginning on or after Jan. 1, 2019.
- The proposed rule also includes proposals for the home health value-based purchasing model and Quality Reporting Program.
- Comments are due September 25
IMPACT Act Implementation
MedPAC Recommendations

IMPACT Act Goals

- Passed by Congress on Bipartisan basis - October 2014
- Improve Medicare beneficiary outcomes
- Facilitate comparable data and quality across PAC settings
- Support provider access to longitudinal information to facilitate coordinated care
- Develop payment models based on patient characteristics
IMPACT Act – A 3-Part Series

- RTI and Abt: Standardized Quality Measurement
- RAND and Abt: Standardized Patient Assessment Data
- MedPAC and CMS: Unified PAC PPS

IMPACT Act Implementation

"Before I write my name on the board, I'll need to know how you're planning to use that data."
Timetable for a PAC PPS Considered in the IMPACT Act of 2014

- MedPAC report June 2016
  - Recommend features of a PAC PPS and estimate impacts
- Collection of uniform patient assessment information beginning October 2018 will inform subsequent reports
- Subsequent reports due:
  - Secretary’s report using 2 years’ patient assessment data (2022)
  - MedPAC report on a prototype design (2023)
- Unlikely that a PAC PPS would be proposed before 2024 for implementation sometime after that
- The IMPACT Act does not require implementation of a PAC PPS

MedPAC’s Key Conclusions and Design Features of a PAC PPS in June 2016 Report

Conclusions:
- PAC PPS was feasible and could be implemented sooner than outlined in IMPACT Act
- Include functional assessment data into the risk adjustment when these data become available
- Begin to align regulatory requirements

Design Features:
- Common unit of service and risk adjustment method
- Adjust payments for home health episodes
- Include short-stay and high-cost outlier policies

March 2017 Recommendation

- Congress should direct the Secretary to implement a prospective payment system for post-acute care beginning in **2021 with a 3-year transition; lower aggregate payments by 5%**, absent prior reduction to the level of payments; **concurrently, begin to align setting-specific regulatory requirements**, and periodically revise and rebase payments as needed, to keep payments aligned with the cost of care.
- Unanimous Yes Vote, discussion forthcoming in June 2017 report.
- Future work: Regulatory alignment.


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Stakeholder Response

- Prior to vote, AHA letter expressing concern regarding accelerated timeline.
  - Noted that the prototype relies too much on empirical evidence (regression analysis).
  - Hugely complex as compared to other PPS.
  - Took CMS 3 years to complete SNF rebasing, timeline is not achievable.
- Final recommendation reflects some of the AHA criticisms, e.g., COP changes and other regulatory changes to set the stage.

Commissioner Comments

- Mr. Thomas: *I think this can work. We just can’t change the payment model, though. We have to change the regulatory issues to allow people to move…*

- Dr. Samitt: *I just wonder if there are other areas of similar thinking where we’re not seeing the right care in the right place at the right cost … Pre-acute, urgent care, etc.…*

- Mr. Thomas: *I hope there would be flexibility to create models or pilots between now and 2021 because this is a massive change for the industry … We can’t underestimate the major impact it is going to have.*

- All: *Enthusiastic YES — Great Work Staff.*
IMPACT Act Parallel Tracks

Quality Measure Development

Interoperability

Patient Assessment Data

IMPACT Act: Measures

<table>
<thead>
<tr>
<th>Quality Measure Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
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<tbody>
<tr>
<td>Functional Status</td>
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<td>Skin Integrity</td>
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<td>Medication Reconciliation</td>
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<td>Incidence Major Falls</td>
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<td>Transfer of Health Information</td>
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<td>Resource Use &amp; Other Measures Domain</td>
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<td>IRF</td>
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<td>Medicare Spending Per Beneficiary</td>
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<td>Discharge to Community</td>
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<tr>
<td>Potentially Preventable Hospital Readmissions</td>
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<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>
Domains for Patient Assessment Data (Admission and Discharge)

- Function (e.g., self care and mobility)
- Cognitive function (e.g., express & understand ideas; mental status, such as depression and dementia)
- Special services, treatments & interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
- Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
- Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
Current Assessment Tools

4 Different Settings, 4 Different Assessment Tools

- Skilled Nursing Facilities (SNF) → Minimum Data Set (MDS)
- Home Health Agencies (HHA) → Outcome and Assessment Information Set (OASIS)
- Inpatient Rehabilitation Facilities (IRF) → IRF Patient Assessment Instrument (IRF-PAI)
- Long Term Care Hospitals (LTCH) → LTCH CARE Data Set (LCDS)

Overlapping domains and purposes, but specific items measuring common domains differ across settings.

GOAL: Uniform Data Collection
Standardized Patient Assessment
Data Process

Track 1
“Cross section Feasibility”
Collected every data element under the sun, convened a TEP and put it out for comment for 2 weeks and release 250 page report summary of comments

Alpha 1 Testing
8 Facilities in CT, 24 cognitive interviews
What works and what does not work?
Narrow/expand the set of data elements
Report to be released in May

Alpha 2 Testing
Narrow the set of questions and test on 16 facilities, 3 markets
Summary Report to be released in Fall 2017

Beta Testing
Field Testing in 220 organizations in 14 markets based on comments and feedback from Alpha 2 Testing
Sign-up deadline Sept. 1

CMS FY 2018 Rulemaking, April 2017, Seeking Comment from Track 1 documents

LTCH  IRF  SNF  HHA
April–June 2017  April–June 2018  April–June 2019

Beta Design

• National sample will include:
  • 210 PAC facilities from 14 geographic/metropolitan areas
  • 28 IRFs, 28 LTCHs, 84 SNFs, and 70 HHAs
  • An average of 2 IRFs, 2 LTCHs, 6 SNFs, and 5 HHAs per PAC market

• Providers will be randomly selected to participate
• Patients/residents will be enrolled upon admission
• Design will include admission and discharge assessments
• Subset of patients/residents will be double-assessed by research and facility staff (as in Alpha test) to evaluate reliability
Beta Test Market Areas

14 geographic/metropolitan areas for Beta include:

- Boston, MA
- Harrisburg, PA
- Philadelphia, PA
- Fort Lauderdale, FL
- Durham, NC
- Chicago, IL
- Nashville, TN
- Kansas City, MO
- St. Louis, MO
- Dallas, TX
- Houston, TX
- Phoenix, AZ
- Los Angeles, CA
- San Diego, CA

Beta Recruitment Timeframe

- Mailings to be sent to providers to participate this spring
- Recruitment continues in these markets
- Recruitment target of 210 facilities must be obtained by Sept. 1, 2017
- Field period runs from Oct. 2017 – May 2018
- Debrief activities will be ongoing but summarized in early Summer 2018
Updates to Patient Assessment Tools proposed for April or Oct. 1, 2018

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Proposed MDS (Oct. 1, 2018)

Final Rule Updates

<table>
<thead>
<tr>
<th>Not Finalized</th>
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<tr>
<td>Cognitive function and mental status</td>
<td>Functional status</td>
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<tr>
<td>Special services, treatments and interventions</td>
<td>Medical conditions and comorbidities</td>
</tr>
<tr>
<td>Impairments</td>
<td></td>
</tr>
</tbody>
</table>

- Look to alternative methods for data collection
- CMS concluded it is burdensome
- Will make new proposals no later than FY 2020
Implications for Hospitals

- If providing PAC services; more information being collected than ever before
- Will require additional IT infrastructure, personnel, and ongoing training
- Data collection will continue to evolve over time
- Time of enormous change
- PAC providers will need time to develop efficiencies and patient workflows, leading to potential upstream impacts on patient transitions to PAC
- May see changes in care transition patterns with PAC providers as they begin to understand implications going forward
What’s Happening in EPMs

- 2-year extension, possibility of 2.0 (MACRA)
- “Education cycle” (staff change, evolving understanding, changing rules)
- Hospitals only
- Mandated nature driving change in BPCI
- EPM rule added remaining hip/femur fractures
- **NEW RULE ISSUED August 15!**

- Physician practices only
- Risk stratification critical
- Mandatory – **NEW RULE ISSUED AUG 15 CANCELLED**
- Hospitals only
- Complex Target methodology
Year 1 Reconciliation — Struggles

- Reconciliation began in April, Deadline to appeal was in June
- Change in standardization methodology
- First of two reconciliations
- Implications for true-up in 2018

Claims Lag: True-ups

- Targets are fixed prior to performance period
- Claims continue to accrue for episodes

This is why you need to reserve!

<table>
<thead>
<tr>
<th>DRG</th>
<th>Performance Period Episode Count</th>
<th>Performance Period Episode Target $</th>
<th>Total Performance Target $ (a*b)</th>
<th>Total Actual Performance $ (c)</th>
<th>Reconciliation Amount $ ((a*b) - c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>470 w/o Fracture</td>
<td>100</td>
<td>$24,000</td>
<td>$2,400,000</td>
<td>$2,222,000</td>
<td>$178,000</td>
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<tr>
<td>470 w/o Fracture</td>
<td>10</td>
<td>$40,000</td>
<td>$400,000</td>
<td>$555,500</td>
<td>($155,500)</td>
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<tr>
<td>Hospital A Total</td>
<td>110</td>
<td>$2,800,000</td>
<td>$2,777,500</td>
<td>$22,500</td>
<td></td>
</tr>
</tbody>
</table>

Spend increase of 1%

Savings cut in half!
Common Strategies

- Pre-op optimization and expectation-setting
- Longer inpatient LOS
- Increase discharge to home
- Developing post-acute networks
- Strategic use of current PAC staff — IRF and SNF following the patient into the community
- Gainsharing
  - *Success REQUIRES Physician champions...*

Real-Time Management vs. Strategy Review

- Downside risk has started
- Real-time management
  - Identify at scheduling
  - Coordinate with discharge planners
  - Monitor patient progress through 90 days
- Strategy Review
  - What was my strategy?
  - Did I follow it?
  - Did it have the expected impact?
First, CMS Delayed EPMs

- CMS issued Final Rules on May 20, 2017 to further delay the start date for the Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model to Jan. 1, 2018
- This also delayed the effective date for certain changes to the Comprehensive Joint Replacement (CJR) Model to align CJR with the EPMs to Jan. 1, 2018; CJR provisions in the original EPM final rule are also effective as of May 20, 2017
- CHA comments at www.calhospital.org/cha-news-article/cha-submits-comments-delay-cardiac-epms-cjr-model-expansion

August 15 New Rule Released

- Cancels AMI and CABG EPM as well as the Cardiac Rehab Incentive Payment Model
  - Effective Immediately
- Prospectively make participation voluntary for all eligible hospitals in 33, of the current 67 MSAs currently part of the CJR program. Further allows a subset of rural and low volume hospitals the option to be excluded or to participate voluntarily
  - Effective January 1, 2018
- Comments Due October 16
Site Neutral Payment Updates
PFS Proposed Rule
21st Century Cures Act

- Enacted into law on Dec. 13, 2016
- Sections 16001 and 16002 amend section 1833(t)(21) of the Social Security Act (the Act) and provide additional criteria by which off-campus departments of a provider can be excepted from application of Section 603
  - Section 16001: Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers
  - Section 16002: Treatment of cancer hospitals in off-campus outpatient department of a provider policy
- CMS released guidance titled, “Note Regarding Implementation of Sections 16001 and 16002 of the 21st Century Cures Act”
Sec. 603 Off-Campus HOPD PBD Site-Neutral Policy

2017 Final Rule

• **Service expansion**: Allows *grandfathered* HOPDs to expand service offerings and still maintain OPPS-level payments for all services.

• **Dedicated EDs**: Allowed OPPS-level payments for emergency and non-emergency services for DEDs. No restriction on proportion of services that must be emergent.

2018 Proposed Rule

• **Service expansion**: No Change — but CMS will continue to monitor claims data for changes in billing patterns and utilization

• **Dedicated EDs**: No Change

2017 Final Rule

• **Definition of campus**: Maintains existing regulatory definition.

• **Relocation/rebuild**: Precludes *grandfathered* sites from relocating/rebuilding with only a *limited exception* for natural disasters.

• **Change in ownership**: HOPDs can maintain *grandfathered* status if main provider is transferred and the provider agreement is accepted by the new owner.

2018 Proposed Rule

• **Definition of campus**: No Change.

• **Relocation/Rebuild**: No Change.

• **Change in ownership**: No Change.
CMS Guidance on Exceptions Requests

- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Subregulatory-Guidance-Section-603-Bipartisan-Budget-Act-Relocation.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Subregulatory-Guidance-Section-603-Bipartisan-Budget-Act-Relocation.pdf)

- CMS Region IX has granted seismic relocation requests for provider-based hospital outpatient departments in California

- CHA is unaware of any hospital that has requested or been granted an exception for any other circumstance as described in the final rule

Sec. 603 Off-Campus HOPD PBD Site-Neutral Policy

**2017 Final Rule**
- **Payment:** Allows non-excepted HOPDs to bill Medicare and be paid directly for services at about 50% of OPPS level

**2018 Proposed Rule**
- **Payment:** Reduces payment for non-excepted HOPDs to bill Medicare and be paid directly for services at 25% of the OPPS level. ([Medicare PFS Proposed Rule](Medicare PFS Proposed Rule))
CMS’ Relativity Adjustment Factor

- Applicable to “non-excepted” off-campus providers
  - Modifier PO (identifies off-campus providers)
    - Effective CY 2016
  - Modifier PN (identifies non-excepted off-campus providers)
    - Effective CY 2017
- CMS’ Relativity Adjustment Calculation:
  - OPPS 2017 Final Rule:
    - Analyzed Top 25 utilized codes
    - Considered PFS as well as ASC Reimbursement Levels
    - Estimated PFS pays 45% of OPPS, but proposed a 50% relativity factor to split the difference between ASC
  - PFS 2018 Proposed Rule:
    - Analyzed a single HCPCS code (G0463)
    - Did not incorporate ASC Reimbursement Levels
    - Estimated a 25% relativity factor based on a single code

Talking Points:
- CMS’ 2017 Approach takes into account a larger sample of off-campus utilization services/codes
- CMS’ 2018 Approach oversimplifies bundle of off-campus services to a single HCPCS (G0463)
- Both approaches do not capture site-by-site variation in service mix.
- As a result, CMS should delay the adjustment until better data is made available (i.e. 2017 PN Modifier).

Physician Fee Schedule Reimbursement Percentage (PFS Payment/OPPS Payment)

<table>
<thead>
<tr>
<th>Code</th>
<th>2017 Approach</th>
<th>2018 Approach</th>
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<tbody>
<tr>
<td>93005</td>
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<td>96413</td>
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</tbody>
</table>

Hospital outpatient clinic visit for assessment and management of a patient
Sec. 603 Advocacy/Comments

- Oppose the 25% PFS Relativity Adjuster

- Continue to push CMS to allow hospitals to expand services at excepted sites PBD sites and still maintain an OPPS payment

- Continue to address restrictions on relocation and rebuilding of excepted, “grandfathered,” sites

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