Keep Your Eye on the Regulatory Side

BY LEAH RALPH

All eyes are on Congress in recent months with Affordable Care Act repeal and tax reform, but the real action—and consequential reimbursement decisions for ACCC cancer programs—is happening on the regulatory side. The Centers for Medicare & Medicaid Services (CMS) has been busy, recently finalizing 2018 payment policies in the Hospital Outpatient Prospective Payment System (OPPS) and Physician Fee Schedule. Here's what you need to know.

The most notable, and controversial, provision in the 2018 rule is the substantial cuts to Part B drug reimbursement for 340B hospitals. Starting Jan. 1, 2018, 340B entities will be paid average sales price (ASP) minus 22.5 percent, instead of ASP + 6 percent, for separately payable drugs that were acquired under the 340B Program, excluding drugs on pass-through status and vaccines. Most 340B entities are included in this reduction; however, for 2018 there are exemptions for rural sole community hospitals, Prospective Payment System-exempt cancer hospitals, and children's hospitals. In the final rule, CMS indicated that it will revisit these exemptions in 2019. Drugs not purchased under the 340B Drug Pricing Program will continue to be paid at ASP + 6 percent.

In addition to reimbursement, this policy will pose some operational challenges, because CMS now requires the use of a modifier to identify whether a drug was purchased under the 340B Drug Pricing Program. One modifier, "JG," is required for hospitals that are subject to the payment reduction on drugs that are acquired under the 340B program, which will trigger the reduced reimbursement rate, and another informational modifier, "TB," is required for hospitals that are exempt from the payment reduction but still acquire drugs under the 340B Program.

CMS also continues to put forward policies that move OPPS toward bundled payments. In 2015, the agency conditionally packaged payment for ancillary services assigned to an Ambulatory Payment Classification group with a geographic mean cost of $100 or less but excluded low-cost drug administration services. This year CMS is finalizing its policy to conditionally package payment for low-cost drug administration services.

In 2018, CMS also extends nonenforcement of direct supervision requirements for outpatient therapeutic services for critical access hospitals and rural hospitals with 100 or fewer beds in 2018 and 2019. Additionally, the agency is making changes to the date-of-service policy (i.e., the "14-day rule") so that, in general, labs can bill Medicare directly for advanced diagnostic laboratory tests and molecular pathology tests.

Under the Physician Fee Schedule, CMS is finalizing a reduction to payment rates for services provided at nonexcepted off-campus hospital outpatient provider-based departments (i.e., off-campus facilities that began billing under OPPS after Nov. 2, 2015). Payment rates for services provided at these facilities will be reduced from 50 percent of the OPPS rate to 40 percent of the OPPS rate in 2018. The agency states that this payment decrease is meant to "level the playing field" between hospitals and physician practices by promoting "greater payment alignment." The agency indicated that they will revisit this rate in 2019 and will continue to pursue policies to achieve site neutral payments between privately owned physician offices and hospitals. ACCC also expressed strong opposition to CMS's proposal to further reduce these rates.

In a reversal of agency policy, CMS also finalized a policy that each biosimilar product will receive its own unique reimbursement code. This is a departure from a policy in the 2017 OPPS final rule requiring that biosimilar products that rely on a common reference product be grouped into the same payment calculation for determining a single ASP payment limit.

CMS is also significantly expanding telehealth services in 2018, adding numerous codes to the telehealth services list, including new codes for visits to determine low-dose computed tomography eligibility, interactive complexity, health risk assessments, care planning for chronic care management, and psychotherapy for crisis. To reduce the administrative burden for providers, CMS also finalizes a proposal that will not require reporting a telehealth modifier on future telehealth claims.

Additionally, CMS finalizes that practitioners will be required to begin reporting consultation of appropriate use criteria beginning in 2020.

Big changes to Medicare reimbursement are coming in 2018. Make sure to check out ACCC resources to help you and your program understand what these changes will mean for your cancer program and patients.

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