# Medicare Hospital Outpatient Prospective Payment System

## PROPOSED RULE FOR CALENDAR YEAR 2018

August 9, 2017

# OPPS Proposed Rule for CY 2018

## QUICK FACTS

### WHO?

Centers for Medicare and Medicaid (CMS)

### WHAT?

Hospital outpatient prospective payment system (OPPS), ambulatory surgical center (ASC) payment system, and quality reporting programs proposed rule for the calendar year (CY) 2018

CMS-1678-P
82 Fed. Reg. 33,558 (Jul. 20, 2017)

### WHERE?

- Nationwide

### WHEN?

- Published in Federal Register on July 20, 2017
- Comments due September 11, 2017

33558 **Federal Register** / Vol. 82, No. 138 / Thursday, July 20, 2017 / Proposed Rules

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 416 and 419**

**[CMS–1678–P]**

**RIN 0938–AT03**

**Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2018 to implement changes arising from our continuing experience with these systems and certain provisions under the 21st Century Cures Act (Pub. L. 114–255). In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. In addition, this proposed rule would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

**DATES:** *Comment period:* To be assured consideration, comments on this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on September 11, 2017.

**ADDRESSES:** In commenting, please refer to file code CMS–1678–P when commenting on the issues in this proposed rule. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the "submit a comment" tab.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1678–P, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments via express or overnight mail to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1678–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** (We note that public comments must be submitted through one of the four channels outlined in the **ADDRESSES** section above. Comments may not be submitted via email.)

Advisory Panel on Hospital Outpatient Payment (HOP Panel), contact the HOP Panel mailbox at *APCPanel@cms.hhs.gov*.

Ambulatory Surgical Center (ASC) Payment System, contact Elisabeth Daniel at 410–786–0237 or via email *Elisabeth.Daniel1@cms.hhs.gov*.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Administration, Validation, and Reconsideration Issues, contact Anita Bhatia at 410–786–7236 or via email *Anita.Bhatia@cms.hhs.gov*.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures, contact Vinitha Meyyur at 410–786–8819 or via email *Vinitha.Meyyur@cms.hhs.gov*.

Blood and Blood Products, contact Josh McFeeters at 410–786–9732 or via email *Joshua.McFeeters@cms.hhs.gov*.

Cancer Hospital Payments, contact Scott Talaga at 410–786–4142 or via email *Scott.Talaga@cms.hhs.gov*.

Care Management Services, contact Scott Talaga at 410–786–4142 or via email *Scott.Talaga@cms.hhs.gov*.

CPT Codes, contact Marjorie Baldo at 410–786–4617 or via email *Marjorie.Baldo@cms.hhs.gov*.

CMS Web Posting of the OPPS and ASC Payment Files, contact Chuck Braver at 410–786–6719 or via email *Chuck.Braver@cms.hhs.gov*.

Composite APCs (Low Dose Brachytherapy and Multiple Imaging), contact Twi Jackson at 410–786–1159 or via email *Twi.Jackson@cms.hhs.gov*.

Comprehensive APCs (C–APCs), contact Lela Strong at 410–786–3213 or via email *Lela.Strong@cms.hhs.gov*.

Hospital Outpatient Quality Reporting (OQR) Program Administration, Validation, and Reconsideration Issues, contact Anita Bhatia at 410–786–7236 or via email *Anita.Bhatia@cms.hhs.gov*.

Hospital Outpatient Quality Reporting (OQR) Program Measures, contact Vinitha Meyyur at 410–786–8819 or via email *Vinitha.Meyyur@cms.hhs.gov*.

Hospital Outpatient Visits (Emergency Department Visits and Critical Care Visits), contact Twi Jackson at 410–786–1159 or via email *Twi.Jackson@cms.hhs.gov*.

Inpatient Only (IPO) Procedures List, contact Lela Strong at 410–786–3213 or via email *Lela.Strong@cms.hhs.gov*.

New Technology Intraocular Lenses (NTIOLs), contact Scott Talaga at 410–786–4142 or via email *Scott.Talaga@cms.hhs.gov*.

No Cost/Full Credit and Partial Credit Devices, contact Twi Jackson at 410–786–1159 or via email *Twi.Jackson@cms.hhs.gov*.

OPPS Brachytherapy, contact Scott Talaga at 410–786–4142 or via email *Scott.Talaga@cms.hhs.gov*.

OPPS Data (APC Weights, Conversion Factor, Copayments, Cost-to-Charge Ratios (CCRs), Data Claims, Geometric Mean Calculation, Outlier Payments, and Wage Index), contact Erick Chuang

# OPPS Proposed Rule for CY 2018

## Highlights

- 1.75% projected update for 2018
  - market basket increase of 2.9%
  - minus 0.4% productivity adjustment
  - minus 0.75% adjustment required by the Affordable Care Act (ACA)
- 2% payment reduction for hospitals that fail to report quality data
- Total Medicare payments to OPPS providers proposed to increase by approximately $5.7 billion to approximately $70 billion
- Addenda available 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.

# OPPS Proposed Rule for CY 2018

## What is proposed to stay the same…

# Policies that are Proposed to Remain the Same

## What is proposed to stay the same. . .

- Payment at Average Sales Price (ASP)+6% for drugs, biologicals, and radiopharmaceuticals with pass-through status
- Payment at ASP+6% for separately payable drugs, biologicals, and therapeutic radiopharmaceuticals without pass-through status *if not purchased under the 340B drug discount program*
- Payment for blood and blood products using the blood-specific cost-to-charge ratio (CCR) methodology
- An additional payment of $10 for radioisotopes derived from non-highly enriched uranium (non-HEU) sources
- Estimation of outlier payments to be 1% of aggregate total OPPS payments

# Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals

## What is proposed to stay the same. . .

- Drugs with pass-through status paid at ASP+6%, as required by statute
  - Pass-through status continues for 38 drugs
  - Pass-through status expires for 19 drugs
- Separately payable drugs, biologicals, therapeutic radiopharmaceuticals, and clotting factors not purchased under the 340B drug discount program also paid at ASP+6%
  - CMS proposes to continue to pay the "statutory default" amount as drug acquisition cost data are not available
  - Statutory default sets reimbursement at rate for drugs administered in the physician office setting
- CMS is proposing to continue to pay for biosimilar biological products based on the payment allowance of the product as determined under Social Security Act § 1847A
  - (100% of the biosimilar's ASP) + (6% of the reference product's ASP) when the product has pass-through status
- Blood clotting factors continue to be paid at ASP+6% plus an updated furnishing fee

# Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals

## Drugs with continuing pass-through status

- Pass-through status would continue for 38 drugs

| CY 2018 HCPCS CODE | CY 2018 LONG DESCRIPTOR |
|---|---|
| A9515 | Choline C 11, diagnostic, per study dose |
| A9587 | Gallium ga-68, dotatate, diagnostic, 0.1 millicurie |
| A9588 | Fluciclovine f-18, diagnostic, 1 millicurie |
| C9140 | Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U. |
| C9460 | Injection, cangrelor, 1 mg |
| C9482 | Injection, sotalol hydrochloride, 1 mg |
| C9483 | Injection, atezolizumab, 10 mg |
| C9484 | Injection, eteplirsen, 10 mg |
| C9485 | Injection, olaratumab, 10 mg |
| C9486 | Injection, granisetron extended release, 0.1 mg |
| Q9989 | Ustekinumab, for Intravenous Injection, 1 mg |
| C9488 | Injection, conivaptan hydrochloride, 1 mg |
| C9489 | Injection, nusinersen, 0.1 mg |
| C9490 | Injection, bezlotoxumab, 10 mg |
| J0570 | Buprenorphine implant, 74.2 mg |
| J1942 | Injection, aripiprazole lauroxil, 1 mg |
| J2182 | Injection, mepolizumab, 1 mg |
| J2786 | Injection, reslizumab, 1 mg |
| J2840 | Injection, sebelipase alfa, 1 mg |
| J7179 | Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco |

| CY 2018 HCPCS CODE | CY 2018LONG DESCRIPTOR |
|---|---|
| J7202 | Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u. |
| J7207 | Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U. |
| J7209 | Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per i.u. |
| J7322 | Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg |
| J7328 | Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg |
| J7342 | Instillation, ciprofloxacin otic suspension, 6 mg |
| J7503 | Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg |
| J9034 | Injection, bendamustine hcl (Bendeka), 1 mg |
| J9145 | Injection, daratumumab, 10 mg |
| J9176 | Injection, elotuzumab, 1 mg |
| J9205 | Injection, irinotecan liposome, 1 mg |
| J9295 | Injection, necitumumab, 1 mg |
| J9325 | Injection, talimogene laherparepvec, 1 million plaque forming units (PFU) |
| J9352 | Injection, trabectedin, 0.1 mg |
| Q5101 | Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram |
| Q5102 | Injection, Infliximab, Biosimilar, 10 mg |
| Q9982 | Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries |
| Q9983 | Florbetaben F18, diagnostic, per study does, up to 8.1 millicuries |

HCPCS = Healthcare Common Procedure Coding System

# Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals

## Drugs with expiring pass-through status

- Pass-through status will expire for 19 drugs

| CY 2018 HCPCS CODE | CY 2018 LONG DESCRIPTOR | CY 2018 STATUS INDICATOR | CY 2018 APC |
|---|---|---|---|
| **A9586** | Florbetapir fl 8, diagnostic, per study dos, up to 10 millicuries | N | |
| **C9447** | Injection, phenylephrine and ketorolac, 4 ml vial | N | |
| **J0596** | Injection, c-1 esterase inhibitor (human), Ruconest, 10 units | K | 9445 |
| **J0695** | Injection, ceftolozane 50 mg and tazobactam 25 mg | K | 9452 |
| **J0875** | Injection, dalbavancin, 5 mg | K | 1823 |
| **J1833** | Injection, isavuconazonium sulfate, 1 mg | K | 9456 |
| **J2407** | Injection, oritavancin, 10 mg | K | 1660 |
| **J2502** | Injection, pasireotide long acting, 1 mg | K | 9454 |
| **J2547** | Injection, peramivir, 1 mg | K | 9451 |
| **J2860** | Injection, siltuximab, 10 mg | K | 9455 |
| **J3090** | Injection, tedizolid phosphate, 1 mg | K | 1662 |
| **J7313** | Injection, fluocinolone acetonide intravitreal implant, 0.01 mg | K | 9450 |
| **J8655** | Netupitant (300 mg) and palonosetron (0.5 mg0 | K | 9448 |
| **J9032** | Injection, belinostat, 10 mg | K | 1658 |
| **J9039** | Injection, blinatumomab, 1 mcg | K | 9449 |
| **J9271** | Injection, pembrolizumab, 1 mg | K | 1490 |
| **J9299** | Injection, nivolumab, 1 mg | K | 9453 |
| **Q4172** | PuraPly, and PuraPly Antimicrobial, any type, per square centimeter | N | |
| **Q9950** | Injection, sulfur hexafluoride lipid microsphere, per ml | N | |

# OPPS Proposed Rule for CY 2018

## What is proposed to change…

# Proposed Policy Changes for 2018

## "What is proposed to change…"

- Reduce payment for separately payable, non-pass through drugs purchased under the 340B drug discount program
- Increase drug packaging threshold from $110 to $120
- Revise thresholds for high/low cost status for skin substitute products
- Modify/expand packaging policies
  - Drug Administration Services
  - Laboratory Date of Service Proposal
  - New Technology Ambulatory Payment Classifications (APCs) & Comprehensive APCs (C-APCs)
- Payment rates for radiation oncology services
- Payment for off-campus provider-based departments (PBDs)
- Update Hospital Outpatient Quality Reporting (OQR) Program measures

# Payment for 340B Drugs

## "What is proposed to change…"

- CMS proposes to reduce reimbursement for separately-payable drugs without pass-through status that are purchased under the 340B drug discount program to ASP-22.5% instead of ASP+6%
- CMS proposes to exclude from this proposal drugs with pass-through status and vaccines (that already are excluded from the definition of 340B covered outpatient drugs)
- To operationalize this proposal, CMS proposes to adopt a modifier, effective January 1, 2018, for hospitals to report when submitting claims for separately payable drugs "*not acquired* under the 340B program"
  - CMS would assume that the remaining OPPS drugs were purchased through the 340B program
- CMS seeks comment on how to apply the savings achieved as well as whether the proposal should be phased-in and whether certain exceptions should be granted

# Proposed Payment for Non Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

## "What is proposed to change…"

- Packaging threshold proposed to increase from $110 to $120 per day
- "Policy packaged" regardless of cost:

# Revised Thresholds for High/Low Cost Status for Skin Substitutes

## "What is proposed to change…"

- In 2014, CMS began unconditionally packaging skin substitutes into their associated surgical procedures under the policy that they function as supplies when used in a surgical procedure
- For 2018, CMS proposes to determine high/low cost status for each skin substitute product based on a weighted average mean unit cost (MUC) threshold of $\$47$ per $cm^2$ (currently \$33) and a per day cost (PDC) threshold of \$755 (currently \$719)
- Based on stakeholder concern, CMS proposes to continue to assign products that are in the high cost group in 2017 to the high cost group in 2018, regardless of whether they exceed the CY 2018 MUC or PDC threshold
- Where ASP is not available, CMS proposes that Wholesale Acquisition Cost (WAC)+6% would be used instead
- New skin substitutes without pricing data automatically will be assigned to the low cost category

# Revised Thresholds for High/Low Cost Status for Skin Substitutes

## "What is proposed to change…"

- Based on CMS's 2018 proposal, the following products are proposed to be assigned to the high cost group because they were assigned to the high cost group in CY 2017

| CY 2018 HCPCS Code | CY 2018 Short Descriptor |
|---|---|
| **Q4103** | Oasis Burn Matrix |
| **Q4110** | Primatrix |
| **Q4122** | Dermacell |
| **Q4127** | Talymed |
| **Q4147** | Architect ecm, 1 cm |
| **Q4158** | MariGen 1 Square cm |
| **Q4161** | Bio-Connekt per square cm |

# Modify/Expand Packaging Policies

## "What is proposed to change…"

### Packaging of Level 1 and Level 2 Drug Administration Services

- CMS currently excludes packaging of low-cost drug administration services with a geometric mean cost of less than or equal to $100 from the ancillary services packaging policy
- CMS proposes to package Level 1 drug administration (APC 5691) and Level 2 drug administration (APC 5692) services when they are performed with another separately payable service
- The agency proposes to pay for them separately when they are performed alone
- CMS believes that conditional packaging of drug administration services would promote equitable payment between physician offices and hospital outpatient departments
- The agency proposes to continue to pay vaccine administration services separately, because preventive services are excluded from the packaging policy
- CMS seeks comment on whether it should package all drug administration add-on codes and whether it should consider an encounter-based payment approach for drug administration services

# Proposed OPPS Drug Administration Rates for CY 2018

## Facts

**97%** For CY 2018, approximately 97% of drug administration rates are proposed to increase

**2.44% to 5.77%** The range of payment increases among codes with increasing rates

**-2.44%** The payment decrease among codes with decreasing rates

| HCPCS Code | Short Descriptor | 2018 Payment Rate | 2017 Payment Rate | Change 2018-2017 |
|---|---|---|---|---|
| 90471 | Immunization admin | 56.24 | 53.17 | 5.77% |
| 90473 | Immune admin oral/nasal | 56.24 | 53.17 | 5.77% |
| 96360 | Hydration iv infusion init | 184.16 | 179.77 | 2.44% |
| 96361 | Hydrate iv infusion add-on | 35.73 | 34.78 | 2.73% |
| 96365 | Ther/proph/diag iv inf init | 184.16 | 179.77 | 2.44% |
| 96366 | Ther/proph/diag iv inf addon | 35.73 | 34.78 | 2.73% |
| 96367 | Tx/proph/dg addl seq iv inf | 56.24 | 53.17 | 5.77% |
| 96369 | Sc ther infusion up to 1 hr | 184.16 | 179.77 | 2.44% |
| 96370 | Sc ther infusion addl hr | 35.73 | 34.78 | 2.73% |
| 96371 | Sc ther infusion reset pump | 56.24 | 53.17 | 5.77% |
| 96372 | Ther/proph/diag inj sc/im | 56.24 | 53.17 | 5.77% |
| 96373 | Ther/proph/diag inj ia | 184.16 | 179.77 | 2.44% |
| 96374 | Ther/proph/diag inj iv push | 184.16 | 179.77 | 2.44% |
| 96375 | Tx/pro/dx inj new drug addon | 35.73 | 34.78 | 2.73% |
| 96379 | Ther/prop/diag inj/inf proc | 35.73 | 34.78 | 2.73% |
| 96401 | Chemo anti-neopl sq/im | 56.24 | 53.17 | 5.77% |
| 96402 | Chemo hormon antineopl sq/im | 56.24 | 53.17 | 5.77% |
| 96405 | Chemo intralesional up to 7 | 56.24 | 53.17 | 5.77% |
| 96406 | Chemo intralesional over 7 | 184.16 | 179.77 | 2.44% |
| 96409 | Chemo iv push sngl drug | 184.16 | 179.77 | 2.44% |
| 96411 | Chemo iv push addl drug | 56.24 | 53.17 | 5.77% |
| 96413 | Chemo iv infusion 1 hr | 286.62 | 279.45 | 2.57% |
| 96415 | Chemo iv infusion addl hr | 56.24 | 53.17 | 5.77% |
| 96416 | Chemo prolong infuse w/pump | 286.62 | 279.45 | 2.57% |
| 96417 | Chemo iv infus each addl seq | 56.24 | 53.17 | 5.77% |
| 96420 | Chemo ia push tecnique | 286.62 | 279.45 | 2.57% |
| 96422 | Chemo ia infusion up to 1 hr | 184.16 | 179.77 | 2.44% |
| 96423 | Chemo ia infuse each addl hr | 35.73 | 34.78 | 2.73% |
| 96425 | Chemotherapy infusion method | 286.62 | 279.45 | 2.57% |
| 96440 | Chemotherapy intracavitary | 286.62 | 279.45 | 2.57% |
| 96446 | Chemotx admn prtl cavity | 286.62 | 279.45 | 2.57% |
| 96450 | Chemotherapy into cns | 286.62 | 279.45 | 2.57% |
| 96521 | Refill/maint portable pump | 184.16 | 179.77 | 2.44% |
| 96522 | Refill/maint pump/resvr syst | 184.16 | 179.77 | 2.44% |
| 96523 | Irrig drug delivery device | 53.22 | 54.55 | -2.44% |
| 96542 | Chemotherapy injection | 184.16 | 179.77 | 2.44% |
| 96549 | Chemotherapy unspecified | 35.73 | 34.78 | 2.73% |

# Modify/Expand Packaging Policies

## "What is proposed to change…"

### Current policy

- The current Medicare laboratory date of service (DOS) policy is used to determine when a hospital may bill Medicare for a clinical diagnostic laboratory test (CDLT) and when the laboratory performing the test may bill Medicare directly
- When the DOS falls during an inpatient or outpatient stay, payment for the laboratory test usually is bundled with the hospital service and is not separately payable if it is ordered within 14 days of discharge.

### Laboratory Date of Service Proposal

- CMS is considering potential modifications to the DOS policy that would allow laboratories to bill Medicare directly for molecular pathology tests and advanced diagnostic laboratory tests (ADLTs)
- CMS is soliciting public comment on whether these tests may be separated from the hospital stay that preceded the test and therefore should have a DOS that is the date of performance rather than the date of collection
- CMS also is considering an alternative option under which the contemplated DOS rule exception would apply only to ADLTs and not to molecular pathology tests

# Modify/Expand Packaging Policies

## “What is proposed to change…”

### Revision of new technology APCs

- CMS proposes to narrow the cost bands of New Technology APCs 1901 ($100,001-$115,000) through 1906 ($130,001-$145,000) from $19,999 cost bands to $14,999 cost bands
- CMS also proposes to add one additional pair of New Technology APCs
- The new pair will have a payment level, ranging from $145,001-$160,000, with one set subject to the multiple procedure payment reduction (status indicator T) and the other set not subject to the multiple procedure payment reduction (status indicator S)

# Modify/Expand Packaging Policies

## "What is proposed to change…"

### C-APCs

- CMS does not propose any new C-APCs for 2018
- CMS proposes minor changes to the C-APC payment methodology, including:
  - Establishing a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed
  - Deleting the "CP" modifier (currently used to identify adjunctive services reported on separate claims) and discontinuing its required use for stereotactic radiosurgery (SRS), C-APC 5627 (Level 7 Radiation Therapy), codes 77371 and 77372
  - Proposing to create a new HCPCS C-code to describe blue light cystoscopy (HCPCS code C97XX (Adjunctive blue light cystoscopy with fluorescent imaging agent (List separately in addition to code for primary procedure)) and to allow for a complexity adjustment to APC 5374 (Level 4 Urology and Related Services) when a white light followed by blue light cystoscopy procedure is performed

# Proposed OPPS Radiation Oncology Rates for CY 2018

## Facts

**74%** — For CY 2018, approximately 74% of radiation oncology rates are proposed to increase

**1.30% to 32.8%** — The range of payment increases among codes with increasing rates

**-1.0% to -6.0%** — The range of payment decrease among codes with decreasing rates

| HCPCS Code | Short Descriptor | 2018 Payment Rate | 2017 Payment Rate | Change 2018-2017y |
|---|---|---|---|---|
| 76873 | Echograp trans r pros study | 149.67 | 112.73 | 32.8% |
| 77280 | Set radiation therapy field | 122.37 | 117.59 | 4.1% |
| 77285 | Set radiation therapy field | 315.51 | 311.57 | 1.3% |
| 77290 | Set radiation therapy field | 315.51 | 311.57 | 1.3% |
| 77295 | 3-d radiotherapy plan | 1158.79 | 1066.24 | 8.7% |
| 77300 | Radiation therapy dose plan | 122.37 | 117.59 | 4.1% |
| 77301 | Radiotherapy dose plan imrt | 1158.79 | 1066.24 | 8.7% |
| 77321 | Special teletx port plan | 315.51 | 311.57 | 1.3% |
| 77331 | Special radiation dosimetry | 122.37 | 117.59 | 4.1% |
| 77332 | Radiation treatment aid(s) | 122.37 | 117.59 | 4.1% |
| 77333 | Radiation treatment aid(s) | 122.37 | 117.59 | 4.1% |
| 77334 | Radiation treatment aid(s) | 315.51 | 311.57 | 1.3% |
| 77336 | Radiation physics consult | 122.37 | 117.59 | 4.1% |
| 77338 | Design mlc device for imrt | 315.51 | 311.57 | 1.3% |
| 77370 | Radiation physics consult | 122.37 | 117.59 | 4.1% |
| 77371 | Srs multisource | 7335.22 | 7455.99 | -1.6% |
| 77372 | Srs linear based | 7335.22 | 7455.99 | -1.6% |
| 77373 | Sbrt delivery | 1635.59 | 1651.29 | -1.0% |
| 77401 | Radiation treatment delivery | 124.45 | 114.35 | 8.8% |
| 77470 | Special radiation treatment | 511.67 | 494.63 | 3.4% |
| 77520 | Proton trmt simple w/o comp | 511.67 | 494.63 | 3.4% |
| 77522 | Proton trmt simple w/comp | 941.77 | 994.12 | -5.3% |
| 77523 | Proton trmt intermediate | 941.77 | 994.12 | -5.3% |
| 77525 | Proton treatment complex | 941.77 | 994.12 | -5.3% |
| 77750 | Infuse radioactive materials | 213.83 | 204.51 | 4.6% |
| 77761 | Apply intrcav radiat simple | 511.67 | 494.63 | 3.4% |
| 77762 | Apply intrcav radiat interm | 511.67 | 494.63 | 3.4% |
| 77763 | Apply intrcav radiat compl | 694.43 | 738.63 | -6.0% |
| 77778 | Apply interstit radiat compl | 694.43 | 738.63 | -6.0% |
| 77789 | Apply surf ldr radionuclide | 124.45 | 114.35 | 8.8% |
| 77799 | Radium/radioisotope therapy | 124.45 | 114.35 | 8.8% |
| 76873 | Echograp trans r pros study | 149.67 | 112.73 | 32.8% |
| 77280 | Set radiation therapy field | 122.37 | 117.59 | 4.1% |
| 77285 | Set radiation therapy field | 315.51 | 311.57 | 1.3% |
| 77290 | Set radiation therapy field | 315.51 | 311.57 | 1.3% |
| 77295 | 3-d radiotherapy plan | 1158.79 | 1066.24 | 8.7% |
| 77300 | Radiation therapy dose plan | 122.37 | 117.59 | 4.1% |

# Payment for Certain Off-Campus Provider-Based Departments

## "What is proposed to change…"

- Section 603 of the Bipartisan Budget Act (BBA) of 2015 requires payment for items and services furnished by certain off-campus hospital outpatient departments to be made under a payment system other than the OPPS, effective 1/1/17
- The affected ("nonexcepted") departments are those that began billing for services payable under the OPPS after 11/2/15, unless they qualify for an exception for mid-build or cancer hospitals under the 21st Century Cures Act
- In the CY 2017 OPPS final rule, CMS finalized that it will pay for certain items and services furnished in nonexcepted off-campus PBDs through the PFS rather than the OPPS, and it established new PFS rates equal to 50% of OPPS rates
- For CY 2018, CMS does not propose to make any changes "to limit clinical service line expansion or volume increases" at excepted off-campus PBDs

# Payment for Certain Off-Campus Provider-Based Departments

## CY 2018 Proposals in the Physician Fee Schedule Proposed Rule

- For CY 2018, CMS proposes to reduce the payment rates by half, from 50% to 25% of the OPPS rates, but requests comment and suggests 40% as a middle-ground alternative
  - This proposed rate is based on a comparison of payment rates for clinic and office visits under both payment systems, although CMS previously recognized that these rates are not entirely comparable due to OPPS packaging policies that do not apply in the physician office setting
- CMS is concerned that paying 50% of the OPPS rate might result in payments for items and services in PBDs that are greater than would otherwise be paid under the PFS in the non-facility setting
- CMS does not address whether the payment reduction for drugs acquired under the 340B Program or the modifier for drugs not acquired under that program would apply to these departments

# Examples of Proposed 2018 Payment Rates

| Code | Description | Physician Office (non-facility setting) | Excepted Hospital Outpatient Department | Nonexcepted Hospital Outpatient Department |
|---|---|---|---|---|
| 96413 | Chemo iv infusion 1 hr | $143.60 | $286.62 | $71.65 |
| 96372 | Ther/proph/diag inj sc/im | $20.87 | $56.24 | $14.06 |
| G0463/ 99201-99215 | Hospital outpatient clinic visit for assessment and management of a patient/ E/M visits for new or established patients | $21.95 - $210.18 | $109.58 | $27.40 |
| 74177 | Ct abd & pelv w/contrast | $221.34 (TC) | $339.14 | $84.79 |

# Hospital OQR Program Measures Updated

## "What is proposed to change…"

- CMS proposes no new measures for the Hospital OQR Program
- CMS proposes to remove a total of six measures and, beginning with the CY 2020 payment determination, and to delay implementation of five measures for CY2020:

| Measure | Proposed Action |
| --- | --- |
| OP-21: Median Time to Pain Management for Long Bone Fracture | Remove as of CY2020 |
| OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures | |
| OP-1: Median Time to Fibrinolysis | Remove as of CY2021 |
| OP-4: Aspirin at Arrival | |
| OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional | |
| OP-25: Safe Surgery Checklist | |
| OP-37a-e: The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Based Measures | Delay implementation in CY2020 |

# Medicare Physician Fee Schedule

## PROPOSED RULE FOR CY 2018

August 9, 2017

# Medicare Physician Fee Schedule Proposed Rule for CY 2018

## QUICK FACTS

### WHO?

Centers for Medicare and Medicaid (CMS)

### WHAT?

Medicare Physician Fee Schedule (PFS) Proposed Rule for CY 2018

CMS-1676-P
82 Fed. Reg. 33,950 (Jul. 21, 2017)

### WHERE?

- Nationwide

### WHEN?

- Published in Federal Register on July 21, 2017
- Comments due September 11, 2017

33950 Federal Register / Vol. 82, No. 139 / Friday, July 21, 2017 / Proposed Rules

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 405, 410, 414, 424, and 425**

**[CMS–1676–P]**

**RIN 0938–AT02**

**Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This major proposed rule addresses changes to the Medicare physician fee schedule (PFS) and other Medicare Part B payment policies.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 11, 2017. (See the **SUPPLEMENTARY INFORMATION** section of this final rule with comment period for a list of provisions open for comment.)

**ADDRESSES:** In commenting, please refer to file code CMS–1676–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *www.regulations.gov*. Follow the instructions for "submitting a comment."

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1676–P, P.O. Box 8016, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1676–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC— Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD— Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

**FOR FURTHER INFORMATION CONTACT:**

Jamie Hermansen, (410) 786–2064, for issues related to the valuation of anesthesia services and any physician payment issues not identified below.

Lindsey Baldwin, (410) 786–1694, and Emily Yoder, (410) 786–1804, for issues related to telehealth services and primary care.

Roberta Epps, (410) 786–4503, for issues related to PAMA section 218(a) policy and transition from traditional X-ray imaging to digital radiography.

Isadora Gil, (410) 786–4532, for issues related to the valuation of cardiovascular services, bone marrow services, surgical respiratory services, dermatological procedures, and payment rates for nonexcepted items and services furnished by nonexcepted off-campus provider-based departments of a hospital.

Donta Henson, (410) 786–1947, for issues related to ophthalmology services.

Tourette Jackson, (410) 786–4735, for issues related to the valuation of musculoskeletal services, allergy and clinical immunology services, endocrinology services, genital surgical services, nervous system services, INR monitoring services, injections and infusions, and chemotherapy services.

Ann Marshall, (410) 786–3059, for issues related to primary care, chronic care management (CCM), and evaluation and management (E/M) services.

Geri Mondowney, (410) 786–4584, for issues related to malpractice RVUs.

Patrick Sartini, (410) 786–9252, for issues related to the valuation of imaging services and malpractice RVUs.

Michael Soracoe, (410) 786–6312, for issues related to the practice expense methodology, impacts, conversion factor, and valuation of pathology and surgical procedures.

Pamela West, (410) 786–2302, for issues related to therapy services.

Corinne Axelrod, (410) 786–5620, for issues related to rural health clinics or federally qualified health centers.

Felicia Eggleston, (410) 786–9287, for issues related to DME infusion drugs.

Rasheeda Johnson, (410) 786–3434, for issues related to initial data collection and reporting periods for the clinical laboratory fee schedule.

Edmund Kasaitis, (410) 786–0477, for issues related to biosimilars.

JoAnna Baldwin, (410) 786–7205, or Sarah Fulton, (410) 786–2749, for issues related to appropriate use criteria for advanced diagnostic imaging services.

Alesia Hovatter, (410) 786–6861, for issues related to PQRS.

Alexandra Mugge, (410) 786–4457, or Elizabeth Holland, (410) 786–1309, for issues related to the EHR incentive program.

Rabia Khan or Terri Postma, (410) 786–8084 or *ACO@cms.hhs.gov*, for issues related to the Medicare Shared Savings Program.

Kimberly Spalding Bush, (410) 786–3232, or Fiona Larbi, (410) 786–7224, for issues related to Value-based Payment Modifier and Physician Feedback Program.

Wilbert Agbenyikey, (410) 786–4399, for issues related to MACRA patient relationship categories and codes.

Carlye Burd, (410) 786–1972, or Albert Wesley, (410) 786–4204, for issues related to diabetes prevention program.

**SUPPLEMENTARY INFORMATION:**

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F. Implementation of Reduced Payment for Film-Based Imaging Services
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# PFS Proposed Rule for CY 2018

## Overview

- Projects a conversion factor of $35.9903
- Reflects the +0.5% update mandated by the Protecting Access to Medicare Act of 2014 (PAMA) for 2018 and the -0.19% reduction required by law because CMS failed to meet the annual target for reducing relative value units (RVUs) for misvalued codes
- Addenda available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html

# Cumulative Effect on Cancer Care Physicians

- Estimated combined impact on physicians involved in cancer care if all of the proposals in the Proposed Rule are finalized:

| Specialty | Allowed Charges (Millions) | Combined Impact |
|---|---|---|
| Hematology/Oncology | $1,802 | 0% |
| Radiation Oncology and Radiation Therapy Centers | $1,784 | 1% |
| Radiology | $4,863 | -1% |

# Policies that are Proposed to Remain the Same

## What is proposed to stay the same. . .

- No changes to payment at ASP+6% for drugs, biologicals, and radiopharmaceuticals
- No new proposals related to the Multiple Procedure Payment Reduction (MPPR)
- No changes to payment for mammography services that have seen major revisions in recent years
- No major additions or changes to care management and collaborative care codes that have seen major revisions in recent years

# Proposals Related to Cancer Care

## What is proposed to change . . .

- CMS proposes new payment rates for chemotherapy administration (Current Procedural Terminology (CPT®)* 96401, 96402, 96409, 96411) based on AMA Specialty Society RVU Update Committee (RUC)-recommended work RVUs, equipment times, and practice expense (PE) inputs
  - Proposal generally would decrease payment rates with the exception of 96401 (Chemo anti-neopl sq/im)
  - These codes were identified as potentially misvalued in the CY 2016 PFS proposed rule through CMS's high-expenditure screen

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# Proposed PFS Drug Administration Rates for 2018

## Facts

**44%** For CY 2018, approximately 44% of non-facility drug administration rates are proposed to decrease

**50%** For CY 2018, approximately 50% of facility drug administration rates are proposed to decrease

| HCPCS | Description | 2017 Non-Facility | 2017 Facility | Proposed 2018 Non-Facility | Proposed 2018 Facility | Non-Facility Change | Facility Change |
|---|---|---|---|---|---|---|---|
| 96360 | Hydration iv infusion init | $58.50 | NA | $47.51 | NA | -18.79% | NA |
| 96365 | Ther/proph/diag iv inf init | $69.98 | NA | $73.06 | NA | 4.40% | NA |
| 96369 | Sc ther infusion up to 1 hr | $180.52 | NA | $174.91 | NA | -3.11% | NA |
| 96375 | Tx/pro/dx inj new drug addon | $22.61 | NA | $18.36 | NA | -18.82% | NA |
| 96401 | Chemo anti-neopl sq/im | $75.37 | NA | $80.62 | NA | 6.97% | NA |
| 96402 | Chemo hormon antineopl sq/im | $33.02 | NA | $29.15 | NA | -11.71% | NA |
| 96405 | Chemo intralesional up to 7 | $82.90 | $30.86 | $82.78 | $31.31 | -0.15% | 1.45% |
| 96406 | Chemo intralesional over 7 | $121.30 | $47.37 | $121.65 | $48.59 | 0.28% | 2.56% |
| 96409 | Chemo iv push sngl drug | $112.33 | NA | $110.49 | NA | -1.64% | NA |
| 96411 | Chemo iv push addl drug | $63.16 | NA | $59.74 | NA | -5.41% | NA |
| 96413 | Chemo iv infusion 1 hr | $139.61 | NA | $143.60 | NA | 2.86% | NA |
| 96415 | Chemo iv infusion addl hr | $28.71 | NA | $30.95 | NA | 7.80% | NA |
| 96416 | Chemo prolong infuse w/pump | $141.04 | NA | $146.12 | NA | 3.60% | NA |
| 96417 | Chemo iv infus each addl seq | $66.04 | NA | $69.10 | NA | 4.64% | NA |
| 96420 | Chemo ia push tecnique | $107.67 | NA | $106.53 | NA | -1.05% | NA |
| 96422 | Chemo ia infusion up to 1 hr | $187.34 | NA | $175.27 | NA | -6.44% | NA |
| 96423 | Chemo ia infuse each addl hr | $76.08 | NA | $84.58 | NA | 11.16% | NA |
| 96425 | Chemotherapy infusion method | $185.54 | NA | $185.35 | NA | -0.10% | NA |
| 96440 | Chemotherapy intracavitary | $789.91 | $128.84 | $793.95 | $126.33 | 0.51% | -1.95% |
| 96446 | Chemotx admn prtl cavity | $205.64 | $29.43 | $209.10 | $28.79 | 1.68% | -2.16% |
| 96450 | Chemotherapy into cns | $184.11 | $82.54 | $186.43 | $82.42 | 1.26% | -0.15% |
| 96523 | Irrig drug delivery device | $25.12 | NA | $28.07 | NA | 11.74% | NA |
| 96542 | Chemotherapy injection | $125.97 | $43.07 | $134.96 | $43.19 | 7.14% | 0.28% |

# Proposals Related to Cancer Care

- CMS proposes to update the payment rates for radiation therapy planning (CPT codes 77261-77263) to reflect RUC-recommended RVUs
  - CMS is concerned that the RUC proposals don't appear to reflect decreased service times associated with these codes
  - CMS seeks comment on whether it should adopt the RUC recommendation or alternative payment rates
- CMS proposes separate payment for superficial radiation treatment planning and management through a new HCPCS code and to adopt the RUC-recommended RVUs with some revisions, including certain inputs related to radiation physics consultation

# Proposals Related to Payment for Drugs

## Payment for Biosimilars

– In the CY 2016 PFS final rule, CMS determined that it would pay for biosimilars based on the ASP of all biosimilar products included in a single HCPCS code, resulting in the same payment rate for all biosimilars that rely on a common reference product

– CMS acknowledges continuing concerns about this policy and requests comment on the effects of this policy on fostering a robust, competitive marketplace for biosimilars, and whether the policy should be revised to account for innate differences in biological products

## DME Infusion Drugs

– The 21st Century Cures Act changed the payment methodology for DME infusion drugs from 95% of 2003 Average Wholesale Price (AWP) to ASP+6% effective 1/1/17

– CMS proposes to update its regulations accordingly

# Payment Changes Related to Transition from X-Ray to Digital Imaging

- The Consolidated Appropriations Act of 2016 reduced payment under the PFS for certain imaging services using older technologies
- CMS began implementation in CY 2017
  - Reduced by 20% payment under the PFS for technical component of imaging services using film X-rays
- CMS now proposes further implementation for CY 2018
  - Would reduce payment for computed radiography X-rays under the PFS by 7% (for CY 2018 to CY 2022) and then by 10% (CY 2023 and thereafter)
- CMS also proposes to add the new equipment PE input for the professional Picture Archiving and Communication System (PACS) used by physicians to interpret digital images, priced at $14,616.93, to 26 additional CPT codes requested by stakeholders

# Potentially Misvalued Codes

- CMS proposes to review as potentially misvalued a limited number of CPT codes
- The proposed codes were not identified through a screen and do not involve oncology services
- Proposed Rule continues PAMA requirement that CMS meet target for net reduction in PFS services through adjustments to misvalued codes
- Target set at 0.5% of PFS expenditures for 2018
- CMS's proposed changes do not meet this target, resulting in a required reduction of -0.19% across all PFS expenditures

# Appropriate Use Criteria for Advanced Diagnostic Imaging

- PAMA directs CMS to establish an appropriate use criteria (AUC) program for advanced diagnostic imaging services (including MRI, CT, PET) provided in physician offices, hospital outpatient departments, and ASCs to be effective 1/1/17
- When the program is fully implemented, professionals who furnish such services (FPs) must report, as a condition of payment for the service, that the professional who ordered the service (OP) consulted AUCs through a qualified clinical decision support mechanism (CDSM)
- In the Proposed Rule, CMS acknowledges that implementation will be delayed until 1/1/19

# AUC for Advanced Diagnostic Imaging

- In the CY 2016 and CY 2017 rulemaking cycles, CMS established a timeline and process for provider-led entities (PLEs) to become qualified to develop, modify, or endorse AUCs and established requirements for the CDSMs
  - CMS has named 17 Qualified PLEs as of June 2017, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/PLE.html
  - CMS has named 7 Qualified CDSMs and 9 CDSMs with Preliminary Qualification as of June 2017 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html
- CMS also codified statutory exceptions to the AUC consultation requirement for:
  - Emergency services when provided to individuals with emergency medical conditions
  - Hospital inpatients
  - OPs who are granted a significant hardship exemption

# AUC for Advanced Diagnostic Imaging

- The Proposed Rule would implement the requirement to consult AUCs and report that consultation as a condition of payment, effective 1/1/19
- FPs would be required to report the following with each claim for an applicable advanced diagnostic imaging service furnished in a physician's office (under the PFS), hospital outpatient department or emergency department (under the OPPS), or ASC (under the ASC Prospective Payment System):
  - which qualified CDSM the OP consulted;
  - whether the service ordered would adhere to the AUCs, would not adhere, or had no applicable AUCs;
  - the National Provider Identifier (NPI) for the OP, if different from the FP

# AUC for Advanced Diagnostic Imaging

- CMS proposes three new HCPCS level 3 G-codes to report AUC consultation and will eventually provide a separate G-code for each qualified CDSM
- CMS proposes a voluntary reporting period to be available before 1/1/19 to allow clinicians to educate themselves and test operations before the consultation requirement takes effect
- In the Quality Payment Program (QPP) Proposed Rule, CMS also proposes to give Merit-Based Incentive Payment System (MIPS) credit to OPs for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning 1/1/18 to incentivize early adoption by motivated eligible physicians
- CMS also proposes a new automatic exemption for OPs who are exempt from the advancing care information category under the MIPS, e.g., if the clinician lacks control over availability of certified EHR technology

# Potential Changes to Evaluation & Management Codes

- CMS seeks comment on changes that it should make to update the existing guidelines for billing evaluation and management (E/M) codes
- CMS suggests it may begin by focusing on the guidelines for the history and physical exam components that CMS believes are the most outdated
- CMS seeks comment on:
  - Removing documentation requirements for the history and physical exam for E/M services at all levels
  - Eliminate the current focus on details of history and physical exam in favor of allowing the medical decision-making guidelines to serve as the key determinant of the E/M visit level

# Request for Information on CMS Flexibilities and Efficiencies

- Both the OPPS and the PFS Proposed Rules include a broad Request for Information (RFI) on changes that CMS could make to the Medicare program to:
  - Reduce unnecessary burdens for providers, physicians, and patients
  - Improve outcomes
  - Improve the quality of care
  - Reduce costs
- Suggestions can be at the regulatory, sub-regulatory, policy, practice, or procedural level
- Examples include payment system redesign, elimination or streamlining of reporting, monitoring, and documentation requirements, operational flexibility, and data sharing or feedback that would enhance patient care

# Presenters

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