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CY2016 Medicare Outpatient Prospective Payment System (OPPS) Proposed Rule

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Lead

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Association of
American Medical Colleges

CY 2016 OPPS Proposed Rule

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- Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-07-08/pdf/FR-2015-07-08.pdf

- **Comments on the proposed rule are due August 31, 2015** → CMS will respond to comments in a final rule to be issued on or around November 1, 2015

- AAMC OPPS Resources: www.aamc.org/hospitalpaymentandquality

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Topics for Today's Teleconference

- Medicare IPPS: 2 Midnights, Short Stays, RAC Reforms
- Proposed changes to OPPS
  - Negative 0.1 percent payment update
  - Expanded packaging
    - Why lab packaging leads to 2 percent reduction?
  - 9 new comprehensive APCs (C-APCs)
    - New observation C-APC to replace composite APC for extended assessment and management
  - APC restructuring and consolidation
    - Assign hospital clinic visits to a different APC
    - Major restructuring of 9 APC clinical families
  - Payment for chronic care management services
  - OQR Quality Programs Update

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Topics for Today's Teleconference

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2 Midnights, Short Stays, RAC Reforms

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2 Midnights: What's the same?

- Stays of 2 midnights or more
- Rate reduction CMS made in FY 2014

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2 Midnights: What's different?

Stays of less than 2 midnights may be paid as inpatient

- Based on clinical judgment of admitting physician **and**
- Must be reasonable and necessary and supported by documentation in the medical record

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What's "rare and unusual"?

- Inpatient admission after minor surgical procedure or other treatment expected to keep patient in the hospital for only a few hours and not at least overnight

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Reviews Move from RACs to QIOs

- Not all stays of less than 2 midnights will be audited
- QIOs to review sample of post-payment claims and determine appropriateness of inpatient admission
  - Stays less than 1midnight prioritized for medical review
  - If sample shows problems, review will be expanded
  - Review process to begin 10/1/15 but review regulation changes effective 1/1/16

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When QIOs Refer to RACs

- Pattern of practices such as:
  - High denial rates
  - Consistent failure to follow 2 midnight rule
  - Failure to improve after educational interventions

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Request for Comments

- Should there be specific medical review criteria for inpatient stays of less than 2 midnights?
- Potential policy options regarding when a patient is appropriately admitted as an inpatient and when appropriately treated as an outpatient

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RAC Short Stay Moratorium Ending

- Ends 9/30/15
  - After that date will focus on referrals from QIOs and hospitals with high denial rates

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RAC Reforms: Next Contract Award Period

- **Look back period** for patient status reviews: 6 months from date of service if hospital submits claim within 3 months of date of service provided
- **Changes in ADR limits**: compliance with Medicare rules; diversified limits across all types of claims for a certain provider
- **30 days to complete complex review**, or lose contingency fee
- **30 day wait before sending claims to MAC** to allow for discussion period request to RAC

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Payment Update

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CY 2016 OPPS Conversion Factor Update

- Aggregate payment update: -0.1 percent
  - Market basket update: 2.7 percent
  - Less 0.6 percent multifactor productivity adjustment
  - Less 0.2 percent ACA reduction
  - Less 2 percent adjustment to correct overestimation of packaged lab tests
- Less 2 percent if hospital doesn't submit quality data

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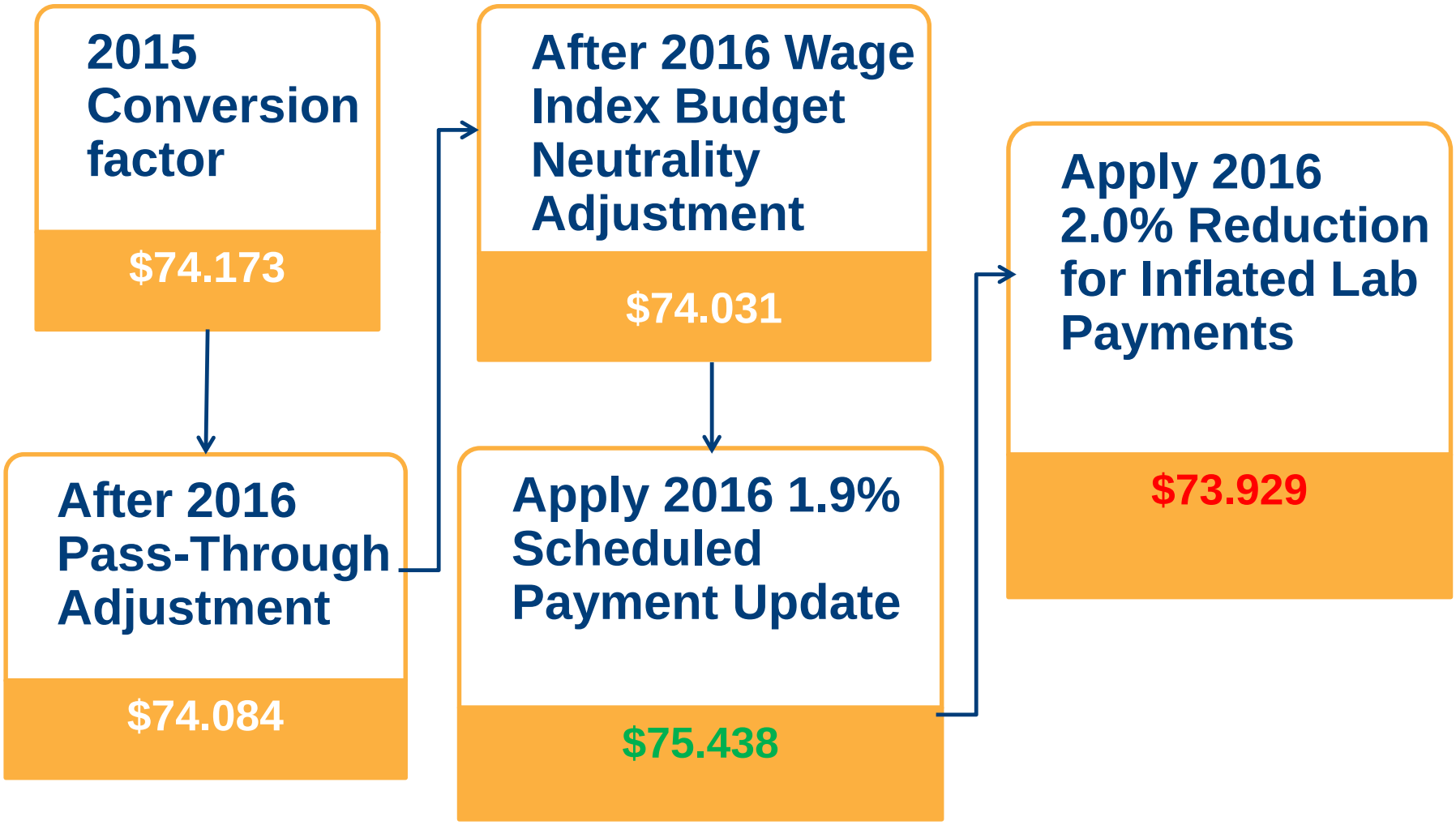
CY2016 OPPS Conversion Factor Update



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Estimated Impact of the Proposed Changes for CY2016 OPPS

Teaching status	# of Hospitals	APC Recalibra-tion % (all proposed changes)	New wage index and provider adjustments %	All budget neutral changes with market basket update and 2% cut for lab tests	All proposed changes %
Non-Teaching	2,758	0.0	0.0	-0.1	-0.2
Minor	709	0.1	0.0	0.0	-0.1
Major	324	-0.1	0.1	-0.2	-0.3

For hospital specific impact, please refer to the “2016 OPPS NPRM Facility-Specific Impacts” file on the CMS 2016 proposed rule website.

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Expanded Packaging

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Proposed New Packaging Policies

- CMS proposes to package more services that have previously been separately paid:
  - Ancillary services: expand to conditionally package 3 APCs with geometric mean costs > $100
  - Drugs and biologicals: add 4 drugs to the policy of unconditional packaging
  - Lab tests: package lab tests in the same outpatient stay (vs. current policy of the same date of service as the primary service), except when a lab test is ordered for a different purpose by a different practitioner

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3 More Ancillary Services to be Packaged

	Proposed 2016	Current
Policy	Expand to package APCs with geometric mean costs > $100	Conditionally package only ancillary APCs with geometric mean costs ≤ $100
Services Packaged	Add 3 APCs: Level 4 Minor Procedures (Q1), Level 3 & Level 4 Pathology (Q2)	Primarily minor diagnostic tests and procedures often performed with a primary service
Exclusion	The same: preventive services, certain psychiatric and counseling-related services, and certain low-cost drug administration services	

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Expand packaging to 4 More Drugs

	Proposed 2016	Current
Policy	Add 4 drugs to the policy of unconditionally packaged drugs and biologicals • 2 drugs primarily used in PCI procedure • 1 in glaucoma surgery • 1 in cataract surgery	Unconditionally package all drugs and biologicals that function as supplies of a surgical procedure, including certain implantable medical devices, drugs, biologicals, or radiopharmaceuticals

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Expand to Package Lab Tests on the Same Claim

	Proposed 2016	Current
Policy	Conditionally package laboratory tests and only provide separate payment for a lab test when: (1) only service on a **claim** or (2) ordered by a different practitioner for a different purpose from the primary service on the claim	Conditionally package laboratory tests and only provide separate payment for a lab test when: (1) the only service on a given **date** or (2) on the same date with a primary service, ordered by a practitioner for a different purpose from the primary service

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Expand to Package Lab Tests on the Same Claim, cont'd

	Proposed 2016	Current
Implementation	• Continue to have hospitals report the "L1" modifier to identify any clinically "unrelated" lab tests • Implement claims processing edits through a new "Q4" code to automatically identify 13X bill type claims that only report lab tests and turn off "L1" on these claims	• Assigned SI "N" to describe unconditionally packaged lab tests • For separately payable lab tests - In 2015 OPPS final rule, suggested to use 14X bill type - In July 14, implemented modifier "L1" (separately payable lab test) to be used in lieu of the 14X bill type

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Expand to Package Lab Tests on the Same Claim, cont'd

	Proposed 2016	Current
Exclusion	• Exclude all molecular pathology tests, including any future new codes on molecular pathology test • Exclude preventive laboratory tests	Exclude molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479

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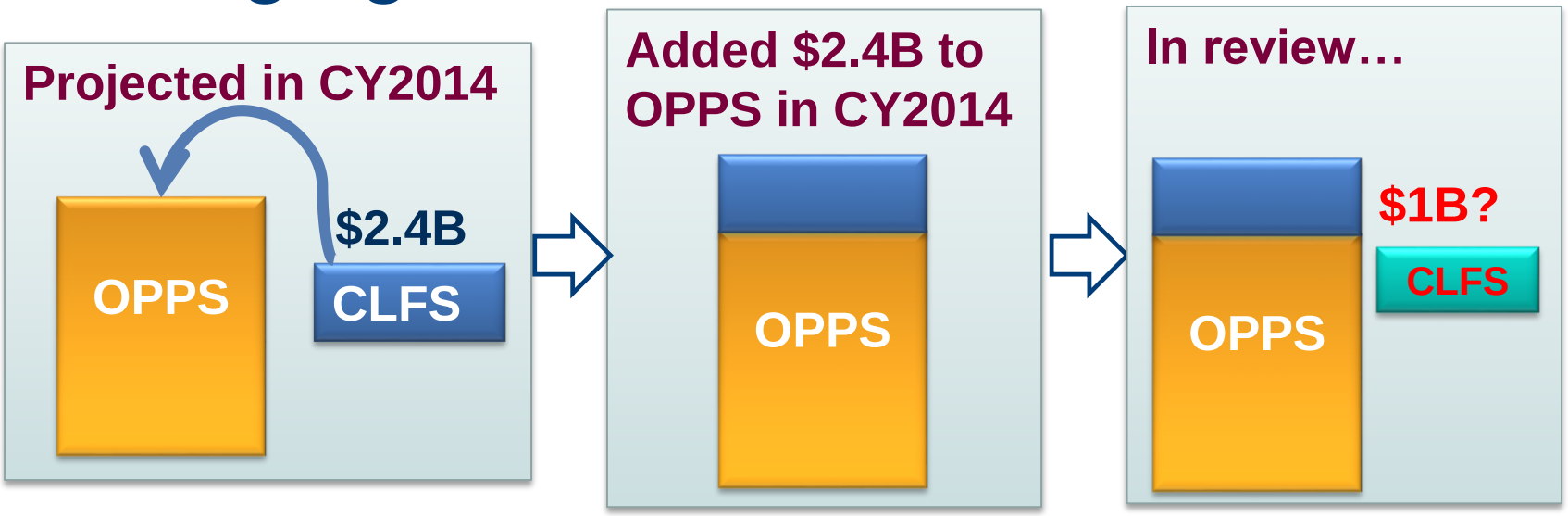
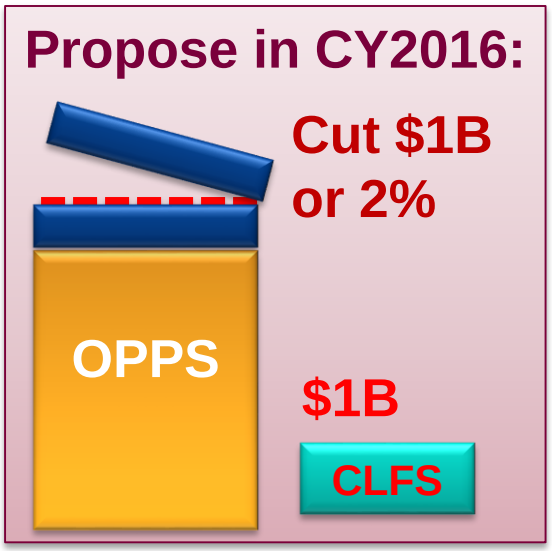
Proposed 2 Percent Reduction for Lab Test Packaging





- The 2 percent reduction ($1B) is to eliminate future overpayment
- This adjustment isn't to recoup overpayment in 2014 or 2015

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More C-APCs

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Propose 9 More C-APCs

- C-APCs: Package payment for all adjunctive services and procedures into the most costly primary procedure (SI=J1)
  - > 1 primary procedure, pay only the most expensive procedure
  - Complexity adjustment for certain pairs of primary procedures
- CY2016, continue current C-APC methodologies
- Propose 9 new C-APCs to add to the 25 introduced last year

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Propose New C-APC for Observation Stays

	Proposed 2016	Current
APC	APC 8011 (Comprehensive Observation Services)	APC 8009 (Extended Assessment & Management Composite)
Rate	$2,261	$1,234
Activation Criteria	The same: • No major procedure (SI=T) on the same day or 1 day prior and no status J codes on the claim • 8 or more units of G0378 (observation services, per hour) • A clinic visit HCPCS code G0463 OR a Level 4 or 5 Type A ED visit (CPT code 99284 or 99285) OR a Level 5 Type B ED visit (HCPCS code G0384) OR a direct referral for observation (G0379) OR critical care (CPT code 99291) provided by a hospital in conjunction with observation services	

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Propose New C-APC for Observation Stays, cont'd

	Proposed 2016	Current
Services Packaged	Under the C-APC packaging policy, diagnostic procedures, lab tests, uncoded services and supplies, DME as well as prosthetic and orthotic items when provided as part of the outpatient services are all regarded as adjunctive services	Services to activate APC8009 and certain conditional packaged services

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APC Restructuring and Consolidation

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Propose Large Restructuring of APC Grouping

- Major restructuring and renumbering of APC groups
  - 663 APCs in 2016, compared to 766 in 2015
  - 200+ APCs with new APC number
- Please refer to Addendum Q to map CY2015 APCs to CY2016 APC

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Assign Hospital Outpatient Visits to a Different APC

- In CY2016, hospital clinic visits will be paid under APC 5012 (Level 2 Examinations and Related Services) for $102.19
  - Continue to use HCPCS code G0463 for all hospital clinic visits
  - Mapping change: reassign G0463 to APC 0632 (Level 2 Examinations and Related Services; $102.19) vs. current APC 0634 (Hospital Clinic Visits; $96.22)
  - Renumber APC 0632 as APC 5012

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Propose Major Consolidation and Restructuring of 9 APC Clinical Families

Clinical Family	# APCs 2016	2015
Airway Endoscopy Procedures	5	7
Diagnostic Tests and Related Services	4	19
Excision/Biopsy and Incision and Drainage Procedures	4	7
Gastrointestinal (GI) Procedures	13	23
Imaging Services	25	54
Orthopedic Procedures	9	24
Skin Procedures	5	8
Urology and Related Services Procedures	7	16
Vascular Procedures (Excluding Endovascular Procedures)	3	7

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Chronic Care Management Services

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Chronic Care Management Codes

- New code for care coordination, finalized in 2015 Physician Fee Schedule (PFS)
- Code was also included in 2015 OPPS, but CMS had not discussed or specified the hospital's requirements to bill for the CCM service code
- 2016 OPPS outlines proposals to make OPPS payment similar to PFS

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Proposed Payment for Chronic Care Management Services

Existing PFS Requirements (CPT 99490)	Proposed 2016 OPPS CCM Code Requirements (APC 0690)
• Clinical staff portion must have an established relationship with the patient and provide care and treatment to the patient during the course of illness.	• Hospital must have an established relationship with the patient in one of two ways: ○ patient is admitted as an inpatient or, ○ is registered as an outpatient within last 12 months.
• Proper documentation of informing patient and his/her authorization.	• Must document, in EMR, patient's agreement to have services provided. ○ Patient should be informed about 2 potential copayments
• Only one practitioner can furnish and be paid for providing CCM services during the calendar month	• Only one hospital can furnish and be paid for providing CCM services during the calendar month
• Use of certified EHR technology	• Use of certified EHR technology

CMS acknowledges that they did not previously specify hospital's requirements to bill for the CCM service code—now the requirements are consistent for both PFS and OPPS.

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Proposed Payment for Chronic Care Management Services

Service elements to track under the direction of a physician or appropriate non-physician practitioner

- Thorough recording of demographics, problems, medications, and allergies
- Access to care management services 24/7
- Continuity of care with a designated care team member
- Systematic assessment of medical, functional, and psychosocial needs
- Patient-centered care plan
- Written care plan provided to patient
- Management of care transition
- Coordination with home- and community-based clinical service providers
- Non face-to-face services (i.e. telephone, secure messaging, internet)

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Quality Measures/ Programs for CYs 2018 & 2019

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Quality Measures/Programs for CYs 2018 & 2019

- **Outpatient Quality Reporting (OQR) Program:**
  - Two new measures proposed for inclusion (OP-33 & OP-34)
  - One inactive measure proposed for removal since it does not align with changes to the clinical guidelines (OP-15)
- **Ambulatory Surgical Center Quality Reporting (ASCQR) Program:**
  - No proposed changes regarding the quality measures

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Hospital Outpatient Quality Reporting (OQR) Program

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Two New Measure Proposed

CY 2018

- OP-33: External Beam Radiotherapy for Bone Metastases
  - Web based measure that assesses percentage of patients who receive acceptable doses of external beam radiation therapy (EBRT)
  - NQF endorsed (#1822) and supported by the Measures Applications Partnership (MAP)
  - Measure submission deadline is May 15, 2017
  - Two ways to report:
    - Via the web based tool, or
    - submission of an aggregate data file through a vendor

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Two New Measure Proposed, Cont.

CY 2019

- OP-34: Emergency Department Transfer Communication (EDTC)
  - Web based measure that assesses percentage of ED patients transferred to another facility whose medical record was communicated to the receiving facility
    - Includes 7 subcomponents, consisting of 27 distinct elements
  - NQF endorsed (#0291) and was supported by the MAP
  - Submission deadline is May 15, 2018 and two ways to report:
    - Via the web based tool, or
    - submission of an aggregate data file through a vendor

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EDTC Measure Additional Details

7 Subcomponents:

- Administrative Communication (2 elements)
- Patient Information (6 elements)
- Vital Signs (6 elements)
- Medication Information (3 elements)
- Physician or Practitioner Generated Information (2 elements)
- Nurse Generated Information (6 elements)
- Procedures and Tests (2 elements)

Example: Six Component Elements for **Patient information**

- Name
- Address
- Age
- Gender
- Significant others contact information
- Insurance

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EDTC Measure Additional Details, Cont.

Measure Scoring:

- Hospitals must successfully record and transfer all elements in order to receive credit for each subcomponent
  - Hospitals receive a “0” if any element missing or “1” if all elements recorded and transferred
  - Subcomponents are added together for a score between “0” and “7” for each case
  - The facility score (reported on Hospital Compare) will be a percentage consisting of all cases achieving a “7” divided by the total number of eligible cases

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Measure Proposed for Removal in CY 2017

- OP-15: Use of Brain Computed Tomography in the Emergency Department for Atraumatic Headache
  - Measure was adopted in CY 2012, but reporting was immediately deferred. Not used for payment determination
  - Concerns that measure does not align with current clinical guidelines or practice, prompting CMS to propose its removal

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Measure Topics for Future Consideration

- CMS exploring use of outpatient electronic measures
- Considering voluntary electronic reporting of **OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients** in the future
- Only outpatient measure currently specified as an eCQM

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Proposed Changes: APU Determinations

- APU determinations are based on chart abstracted data for Q3 of the 2 years prior to the payment determination (PD) through Q2 of the year prior to the PD
- Starting CY 2018, CMS proposes that APU determinations would begin in Q2 of the 2 years prior to PD through the next Q1, moving up the data submission timeline from November 1 to August 1
- This will not affect how or when hospitals report data

APU DETERMINATION TRANSITION

[CY 2016 Payment Determination (Current State)]

Patient encounter quarter	Clinical data submission deadline
Q3 2014 (July 1–Sept. 30) ...	2/1/2015
Q4 2014 (Oct. 1–Dec. 31)	5/1/2015
Q1 2015 (Jan. 1–March 31)	8/1/2015
Q2 2015 (April 1–June 30) ...	11/1/2015

[Proposed CY 2017 Payment Determination (Future State—Transition Period)]

Patient encounter quarter	Clinical data submission deadline
Q3 2015 (July 1–Sept. 30).	2/1/2016
Q4 2015 (Oct. 1–Dec. 31).	5/1/2016
Q1 2016 (Jan. 1–March 31).	8/1/2016

[Proposed CY 2018 Payment Determination and Subsequent Years (Future State)]

Patient encounter quarter	Clinical data submission deadline
Q2 2016 (April 1–June 30).	11/1/2016
Q3 2016 (July 1–Sept. 30).	2/1/2017
Q4 2016 (Oct. 1–Dec. 31)	5/1/2017
Q1 2017 (Jan. 1–March 31).	8/1/2017

Page 39337 in the CY 2016 OPPS Proposed Rule

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Additional Proposed Changes

Data Submission Timeline

- For measures reported via the web-based tool, hospitals currently submit data between July 1 and November 1 of the year prior to the PD
- In order to align with the ASCQR Program, CMS proposes to change submission timeframe to between **January 1 and May 15**

Reconsideration and Appeals

- Hospitals currently must submit a reconsideration request no later than the first business day in February of the affected payment year
- Starting CY 2018, CMS proposes to move the deadline to no later than the first business day on after March 17 of the affected payment year

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QUESTIONS?

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