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Medicare Outpatient Prospective Payment System (OPPS) CY 2018 Final Rule

Presenters:
- Mary Mullaney
- Susan Xu

November 30, 2017

Association of
American Medical Colleges

Office of the Federal Register

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Webinar Agenda

- Payment updates
- 340B hospitals and reimbursement for Part B drugs
- Changes to the Inpatient Only (IPO) List
- Packaging of low-cost drug administration add-on
- Quality provisions
- Payment to nonexempt off-campus provider-based departments (from MPFS)

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Payment Updates

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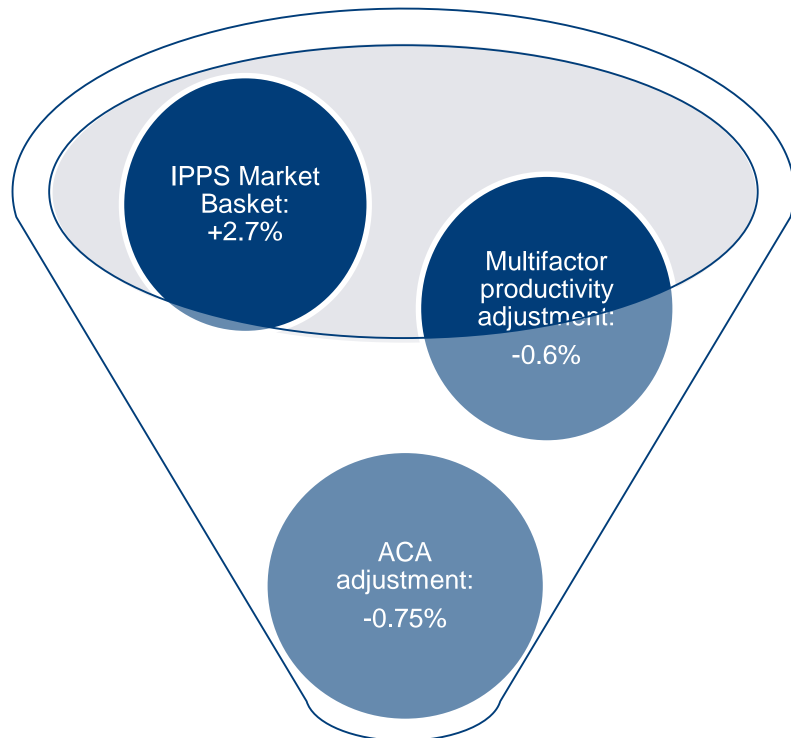
Payment Update CY 2018



Payment rate increase by conversion factor adjustment of 1.35%

- Impact on all hospitals: +1.5%
- Impact on major teaching hospitals: -0.9%

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340B Hospitals and Reimbursement Changes for Part B Drugs

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Cuts to Part B drugs for 340B hospitals beginning January 1, 2018

- Reduces reimbursement for non pass-through, separately payable Part B drugs purchased by DSH Hospitals under the 340B Program to ***ASP MINUS 22.5%***
- Requires modifier “JG” for drugs purchased under the 340B Program or Prime Vendor Program to effectuate payment at ASP minus 22.5%
- Excludes CAHs, hospitals paid under Maryland waiver, rural sole community hospitals (SCHs), children’s hospitals, and PPS-exempt cancer hospitals for CY18 from payment adjustments
  - Rural SCHs, children’s hospitals and PPS-exempt hospitals required to use modifier “TB”

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Overall Impact of 340B Cuts

CMS estimates savings of payment change

- $1.6 billion (budget neutral)
- Redistribution of savings for non-drug items and services across the OPPS
  - Increase of conversion factor across non-drug rates of 3.19%
- CMS estimated net impacts of cut and redistribution of savings:
  - Major teaching hospitals: -2.4%
  - For-profits: +2.7%

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AAMC 2018 OPPS Final Rule Impact Report

- Will include analysis of 340B policy
- Aim to release December

Estimate Payment Reduction to 340B Drugs

- AAMC 340B Impact Calculator

Estimate Payment Increase to Other Services

- 3.19% Increase to Other Services

Estimate Net Impact

- CMS estimated net impact of 340B policy
  - Major teaching hospitals: -2.4%

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340B Ongoing Efforts

Pursuing different options:

- AAMC joined with AHA and AEH in litigation
  - Policy exceeds statutory authority
- Legislative solution
  - H.R. 4392 – Protect the 340B Program

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Changes to the Inpatient Only (IPO) List

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Total Knee Replacement Removed from Inpatient Only List

- Clinical judgement determines site of service
  - CMS will not create or endorse specific guidelines
  - "2-midnight" rule continues to apply
- Recovery Audit Contractor (RAC)
  - 2 year moratorium on site of service review
- Impact on BPCI and CJR
  - CMS does not expect big shift to outpatient setting

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Estimate the Impact of Removing Total Knee Arthroplasty from Inpatient Only List

Identify Services Affected

- DRG 469 & 470, Knee Joint Replacement
- Short stays, w/o MCC

Payment Rates

- IPPS DRG rates with add-on (IME, DSH & UCP)
- OPPS APC rates: HCPCS 27447 paid under comprehensive APC (5115) with a national payment rate (not adjusted by wage index) of $10,122.22

Impact = Expected Inpatient Cases Shifting to Outpatient × Payment difference between IPPS and OPPS

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Use AAMC OPPS Impact Report to Estimate OPPS Rate for Knee Replacement

HCPCS	Description	SI	APC	Weights
27447	TOTAL KNEE ARTHROPLASTY	J1	5115	128.7225

×

Your Hospital's OPPS Payment Rate

AAMC OPPS Impact Report (Factsheet Tab)

Wage Index Adjusted Conversion Factor				
Wage Index Adjusted Labor Related Rate		*Non-labor Related Rate*		*Your Wage Index Adjusted Conversion Factor (G)*
$46.587	+	$32.765	=	**$79.353**

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Use AAMC IPPS Impact Report to Estimate IPPS Rate for Knee Replacement

DRG	Description	DRG Weights
469	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.2011
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0544

×

Your Hospital's IPPS Payment Rate Per case

AAMC IPPS Impact Report (Summary Tab)

PER CASE RATES (excludes outliers and HAC reduction)	FY2018
Adjusted Base Rate	$7,166
IME add-on	$1,169
DSH add-on	$16
Readmissions and VBP adjustments	-$13
Per Case Rate with add-ons	**$8,337**

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Packaging Low-Cost Drug Administration Add-on Codes

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Packaging low-cost drug add-on codes

- CMS finalizes proposal to conditionally package low-cost drug administration services
  - APC 5691 (Level 1 Drug Administration)
  - APC 5692 (Level 2 Drug Administration)

- Vaccine administration continues to be paid separately

- Equitable payment between the physician office and the HOPD
  - Modifier 25 – *Significant, separately identifiable evaluation and management services by the same physician on the day of the procedure.*

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Changes to Hospital Outpatient Quality Provisions

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Quality Measures Hospital OQR Program

Beginning CY 2020, remove

- OP-21: Median Time to Pain Management for Long Bone Fracture
  - CMS concerned there may the potential for a misinterpretation of the intent of the measure, creating undue pressure for hospital staff to prescribe more opioids. Remove the measure in order to remove any potential ambiguity and to avoid misinterpretation of the intent of the measure.

- OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
  - Lack of evidence to support this measure's link to improved clinical quality. Requires hospitals to report on the volumes of surgical procedures performed at the facility. The information does not offer insight into the facilities' overall performance or quality improvement with regard to surgical procedures. Meets the criterion that measure does not result in better patient outcomes. Burden outweighs the value.

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Quality Measures Hospital OQR Program

Beginning CY 2020, remove

- OP-1: Median Time to Fibrinolysis
  - Measure assesses the median time from ED arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the ECG performed closest to ED arrival and prior to transfer. Meets criterion that the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic. Redundant reporting with OP-2: Fibrinolytic Therapy Received Within 30 minutes of ED Arrival which CMS provides meaningful and clinically relevant data on the receipt of fibrinolytic therapy.

- OP-4: Aspirin at Arrival
  - Measure assesses the rate of patients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department. Measure "topped out." Performance on this measure so high and unvarying that meaningful distinctions in improvement cannot be made. There is no distinguishable difference in hospital performance under this measure.

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Quality Measures Hospital OQR Program

Beginning CY 2020, remove

- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
  - Measure assesses the time from Emergency Department arrival to provider contact for patients. There is limited evidence linking the measure to improved patient outcomes. Validity concerns related to wait times and the accuracy of door-to-door time stamps. Potential for skewed measure performance due to disease severity and institution-specific confounders. Performance or improvement on a measure does not result in better patient outcomes. Collection burden outweighs the benefits.

- OP-25: Safe Surgical Checklist
  - Assesses whether a hospital employed a safe surgery checklist that covered each of the three critical perioperative periods (prior to administering anesthesia, prior to skin incision, and prior to patient leaving the operating room) for the entire data collection period. Measure "topped out." Measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

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OAS CAHPS survey-based measures

Delay – Beginning CY 2020

OP-37 a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures

- Measures assess patients’ experience with care following a procedure or surgery in a hospital outpatient department by rating patient experience.
- Lacks important operational and implementation data. CMS wants to ensure that the survey measures appropriately account for patient response rates, both aggregate and by survey administration method; reaffirm the reliability of national OAS CAHPS survey data; and appropriately account for the burden associated with administering the survey in the outpatient setting of care

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Public display of OP-18 measure

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

- Measures ED efficiency in the form of the median time from ED arrival to time of departure from the ED for patients discharged from the ED (also known as ED throughput
- Requires public reporting
- Psychiatric / mental health patient information displayed separately
  - OP-18c will not be publicly reported on *Hospital Compare*
  - CMS to publish data in downloadable form
  - Hospitals able to preview

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Accounting for Social Risk Factors

CMS acknowledges social risk factors play major role in health status

- Accounting for social risk factors in Hospital OQR Program
- Incentivize improvements to address disparities
- Limitations of claims data

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Payment to nonexempt off-campus provider-based departments (from MPFS)

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Payment for Off-Campus Provider-Based Hospital Departments ("site neutral")

Section 603 of Bipartisan Budget Act of 2015 excludes from OPPS coverage "applicable items and services" furnished on or after Jan 1, 2017 by certain off-campus PBDs

New payment rate policy does not apply to hospitals that were furnishing covered OPD services before November 2, 2015.

For 2017, Physician Fee Schedule became the "applicable payment system" and payment rates were set at 50% OPPS payment rates (inclusive of packaging)

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Finalized Changes for 2018

- Reduces payment rates for these items and services reduced to 40% of OPPS payment rate
- “PFS Relativity Adjuster”
- Nonexcepted off-campus PBD must report modifier “PN”
- Effective January 1, 2018

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Questions?

Please type your questions into the chat box.

Slides available

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