CY 2019 Outpatient Prospective Payment System (OPPS) Proposed Rule Webinar

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Lead

AAMC Presenters:

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August 14, 2018

Association of American Medical Colleges

Important Information on Proposed Rule

The CY 2019 OPPS Proposed Rule was published in the *Federal Register* on July 31, 2018 (83 Fed. Reg. 37064).

Comments are due **September 24, 2018 at 5:00 pm EDT.**

AAMC OPPS Resources: https://www.aamc.org/initiatives/patientcare/277442/hospitalpaymentandquality.html.

Webinar Agenda

- Payment updates, outlier payments
- Site-neutral payment policy expansion
- Off-campus provider-based emergency department data collection
- Changes to the Inpatient Only (IPO) List
- 340B hospitals and reimbursement for Part B drugs
- Pass-through payments for drugs/biologics
- Requests for information
- Impact reports
- Hospital Outpatient Quality proposals / EHR RFI

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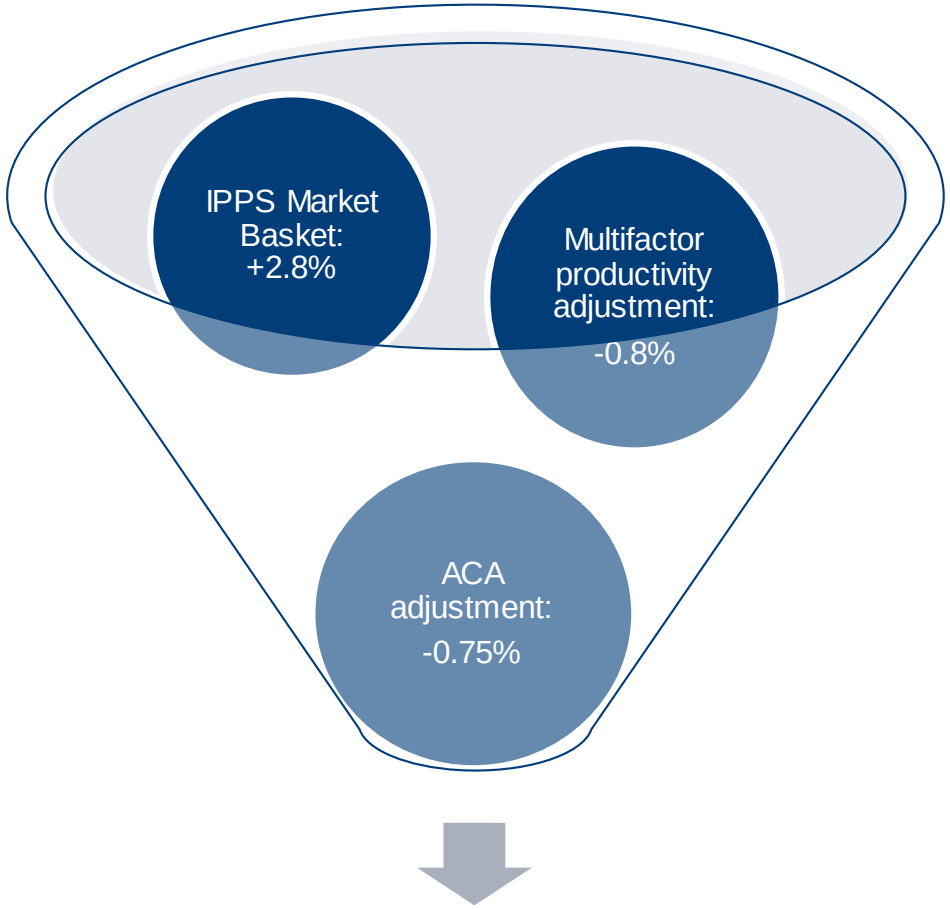
Payment Updates

Proposed Payment Update CY 2019



Payment rate increase by conversion factor adjustment of **1.25%**

- Impact on all hospitals: **-0.1%**
- Impact on major teaching hospitals: **-0.8%**

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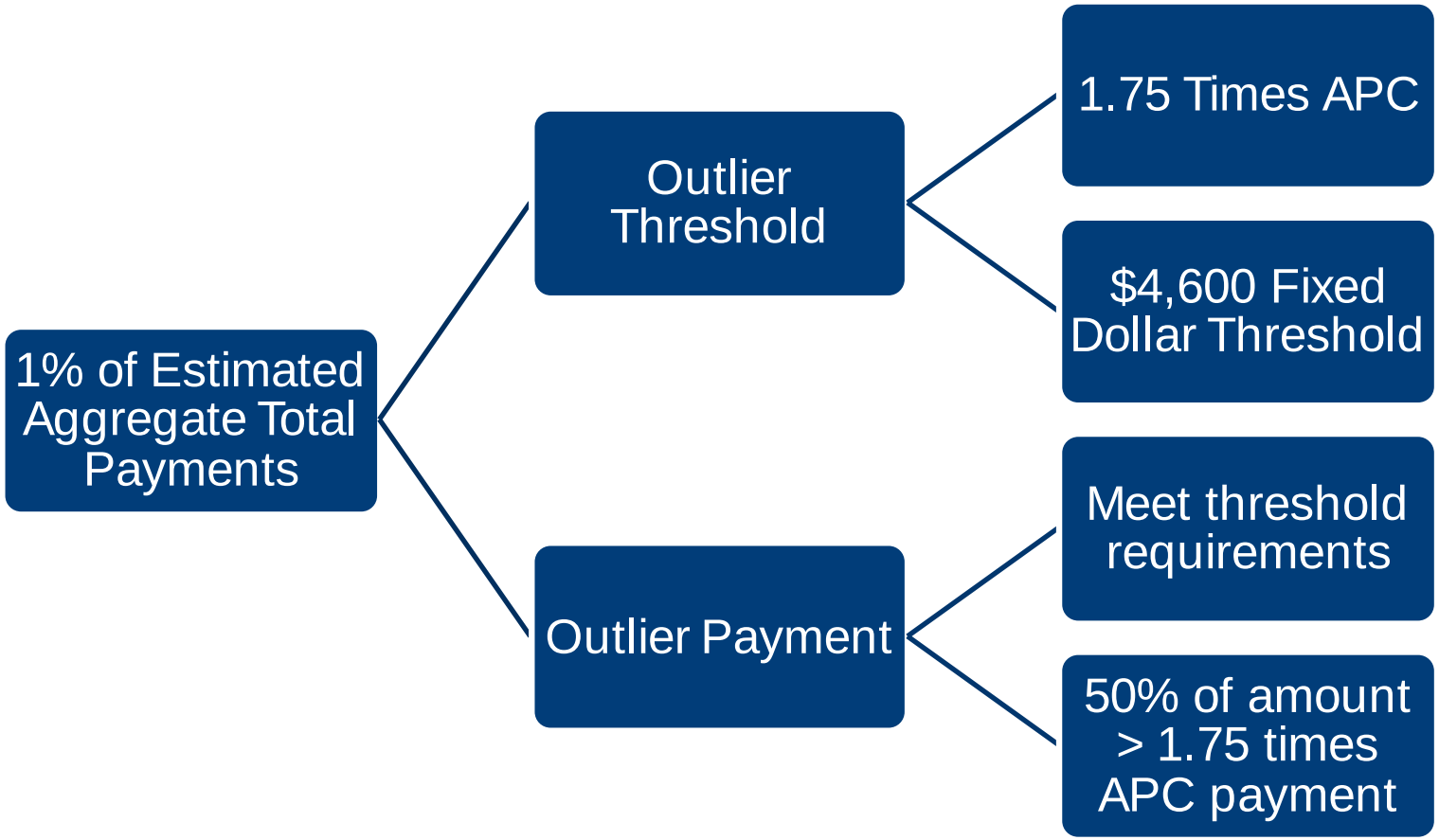
Hospital Outpatient Outlier Payments Proposal



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Site-Neutral Payment Policies

Expansion of the Site-Neutral Payment Policy Proposal

- Expands policy to **excepted** off-campus PBDs for HOPD clinic visits
- CMS equates outpatient spending increases with "unnecessary shift of services" to HOPDs from physician offices
- Justifies reducing rate as "an effective method to control the volume of these unnecessary services"
- G0463 (HOPD clinic visit) reduced by 40% (PFS-equivalent rate)
  - Clinic Payment: $116 → $46
  - Average Copayment: $23 → $9
- Begins January 1, 2019

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Site-Neutral Expansion Savings Estimate

- Proposal is **not** budget neutral
- FY 2019 President's budget estimate
  - Estimated savings -- $760 million split between:
    - Medicare: $610 million
    - Beneficiaries: $150 million

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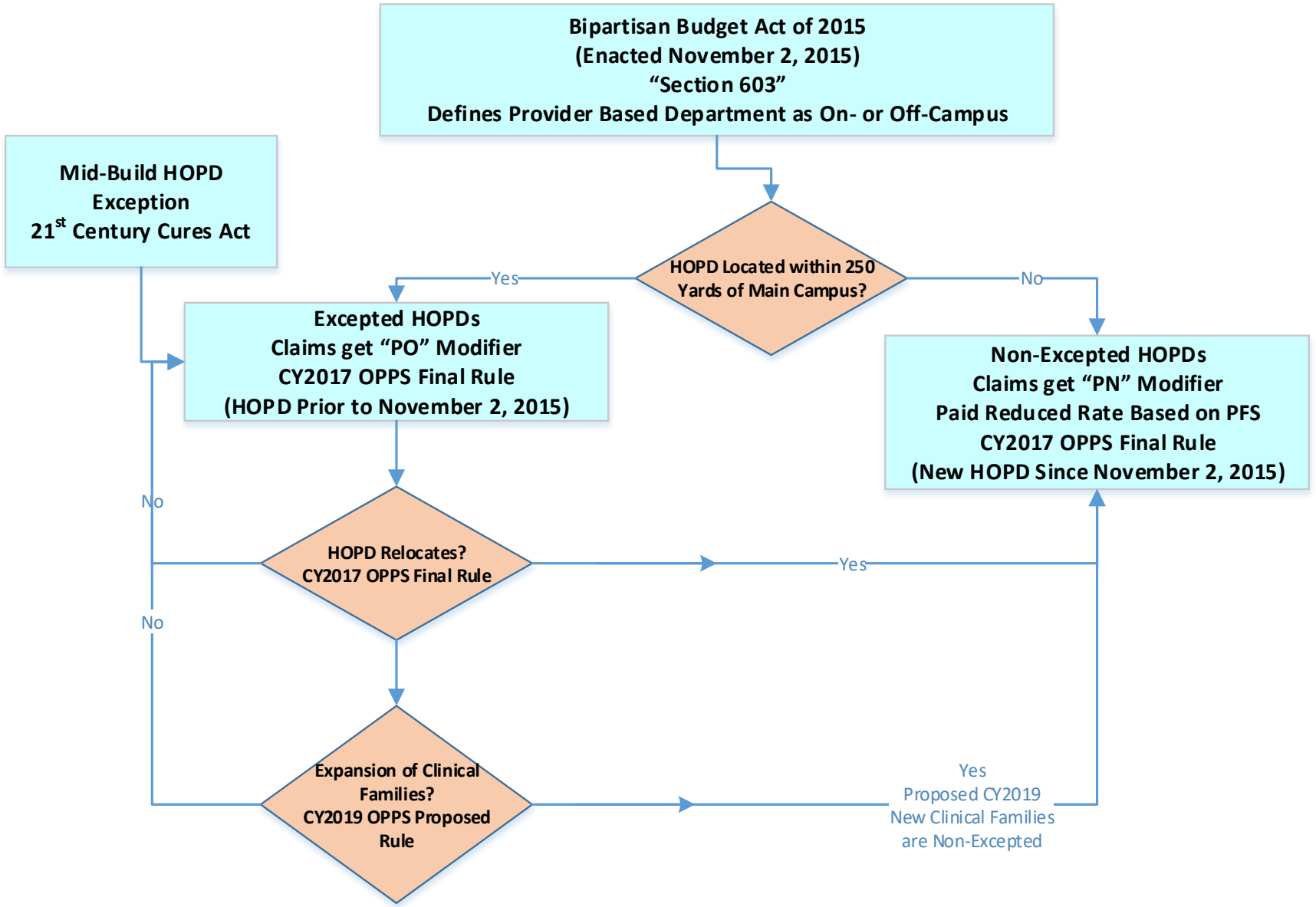

Request for Comment on "Controlling Unnecessary Services"

1) Should controlling for unnecessary services consider enrollment, severity of illness, and patient demographics?
2) Prior authorization seen as control?
3) Are there reasons to ever pay higher OPPS rate for services that can be performed in lower cost setting?
4) Should there be exceptions?

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Expansion of Clinical Families of Services Proposal

- Applies to **excepted** off-campus PBDs
- Distinction between expanding services and expanding clinical families of services
- CMS proposed similar policy in CY 2017, but did not finalize
- Proposal revises the definition of "excepted items and services" under 42 CFR 419.48
- Non-excepted services paid at PFS-equivalent rate (40% of OPPS)
- Begins January 1, 2019

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Table 32 from the Proposed Rule

TABLE 32—PROPOSED CLINICAL FAMILIES OF SERVICES FOR PURPOSES OF SECTION 603 IMPLEMENTATION

Clinical families	APCs
Airway Endoscopy	5151–5155.
Blood Product Exchange	5241–5244.
Cardiac/Pulmonary Rehabilitation	5771; 5791.
Diagnostic/Screening Test and Related Procedures	5721–5724; 5731–5735; 5741–5743.
Drug Administration and Clinical Oncology	5691–5694.
Ear, Nose, Throat (ENT)	5161–5166.
General Surgery and Related Procedures	5051–5055; 5061; 5071–5073; 5091–5094; 5361–5362.
Gastrointestinal (GI)	5301–5303; 5311–5313; 5331; 5341.
Gynecology	5411–5416.
Major Imaging	5523–5525; 5571–5573; 5593–5594.
Minor Imaging	5521–5522; 5591–5592.
Musculoskeletal Surgery	5111–5116; 5101–5102.
Nervous System Procedures	5431–5432; 5441–5443; 5461–5464; 5471.
Ophthalmology	5481, 5491–5495; 5501–5504.
Pathology	5671–5674.
Radiation Oncology	5611–5613; 5621–5627; 5661.
Urology	5371–5377.
Vascular/Endovascular/Cardiovascular	5181–5184; 5191–5194; 5200; 5211–5213; 5221–5224; 5231–5232.
Visits and Related Services	5012; 5021–5025; 5031–5035; 5041; 5045; 5821–5823.

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Expansion of Clinical Families of Services Proposal (cont.)

- Only services furnished during "baseline period" are excepted
  - Baseline = November 1, 2014 to November 1, 2015; **or**
  - If services not provided on November 1, 2014, 12 months from day it started furnishing services prior to November 2, 2015; or
  - For providers that meet the mid-build requirement, 12 months from the date a service is first billed under the OPPS
- CMS seeks comment on appropriateness of baseline If excepted PBD furnished service from a clinical family during baseline period, furnishing that service would not count as a "service expansion"
- CMS seeks comments on:
  - Exclusions
  - Alternative methodologies
  - Capping OPPS payments to excepted off-campus PBDs

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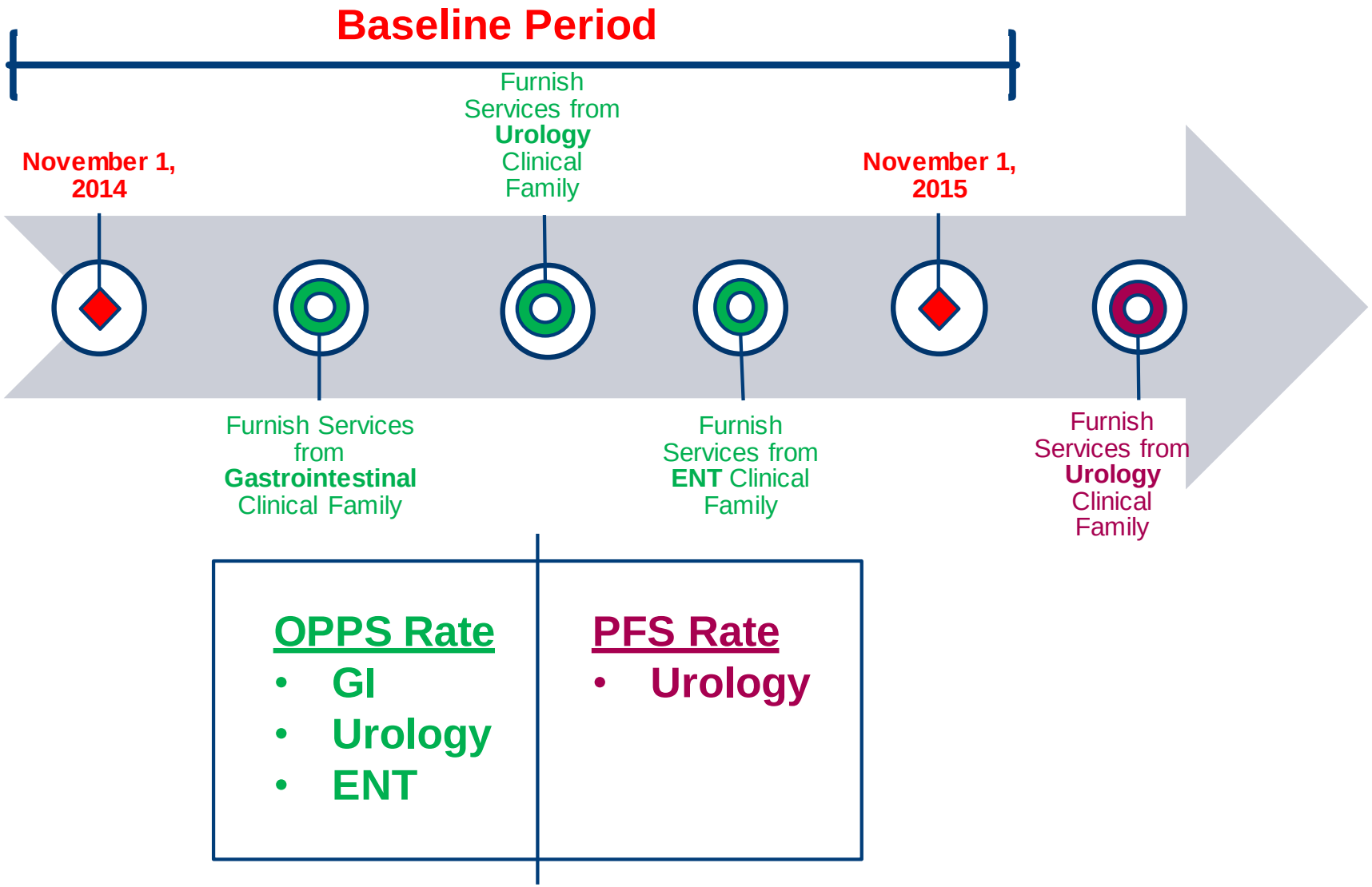
Baseline Period Example



Off-Campus Provider-Based Emergency Departments Data Collection

Data Collection on Services Furnished at Off-Campus Provider-Based Emergency Departments (OCPB EDs) Proposal

- Collect data to assess the extent to which OPPS services are shifting to OCPB EDs
- Implement a new HCPCS modifier (ER-items and services furnished by a provider-based off-campus emergency department)
- Must be reported with every claim line for outpatient hospital services furnished in OCPB EDs
- Reported on UB-04 form (CMS Form 1450)
- Beginning January 1, 2019
- Exempts critical access hospitals

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Inpatient Only (IPO) List

Inpatient Only (IPO) List Proposed Changes

- Removal(s):
  - **CPT 31241** (nasal/sinus endoscopy w/ ligation of sphenopalatine artery)
  - **CPT 01402** (anesthesia for open/surgical arthroscopic knee joint procedures)
- Addition(s)
  - **HCPCS code C9606** (percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel)

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340B Drug Payment Policy

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340B Drug Program Cuts Expansion Proposal

- CMS proposes to apply the 340B drug payment policy to nonexcepted off-campus PBDs
  - ASP plus 6% → ASP minus 22.5%
  - Savings estimate for expansion – $48.5 million
- Currently, non-excepted off-campus PBDs are paid ASP plus 6% for 340B drugs
- Effectively closes "loophole" that left non-excepted PBDs paid ASP plus 6% for 340B drugs; off-campus PBDs not paid under OPPS
- Exempts children's hospitals, rural SCHs, and PPS-exempt cancer hospitals
- Effective January 1, 2019

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Pass-Through Payments for Drugs/Biologics, Packaging Threshold

Pass-Through Payments for Drugs/Biologics Proposal

- 49 drugs with pass-through payment status in 2019 (Table 20)
  - 23 drugs are losing pass-through status (Table 19)
- Proposing to provide pass-through payment for drugs without ASP at wholesale acquisition cost (WAC) plus 3%
  - Currently paid at WAC plus 6%
  - If WAC not available, proposed payment 95% of most recent average wholesale price (AWP)
- If purchased under 340B Program proposal
  - WAC minus 22.5%
  - If WAC not available, 69.46% of AWP

Packaging Threshold (non-pass-through status) Proposal

- Proposing increase $125 in CY19 ($120 in CY18)

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Requests for Information

RFIs Included in Proposed Rule

- CMS included three requests for information (RFIs) in its proposed rule:
  - Price Transparency
  - Competitive Acquisition Program
  - Promoting Interoperability

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Price Transparency RFI

- Improve beneficiary access to provider and supplier charge information
- Similar to FY2019 IPPS proposed rule
  - CMS seeks comment on:
    - Defining "standard charge"
    - Most beneficial types of information to patient
    - How to best provide patients out-of-pocket cost information
    - What burden would be added if CMS required providers to supply information on what Medicare pays for a particular service
    - Improving Medigap patients' understanding of out-of-pocket costs

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Competitive Acquisition Program (CAP) RFI

- Competitive bidding program for Part B drugs
- Similar to HHS Blueprint on drug pricing
  - CMMI seeks comments on model design building upon the CAP, focusing on:
    - Model's scope
    - Included/excluded providers
    - Part B drugs included/excluded
    - Role of private sector vendors
    - Defined beneficiaries and beneficiary protections
    - Inclusion of other payers

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Impact Reports

Medicare 2018 OPPS Final Rule Impact Report

General Teaching Hospital

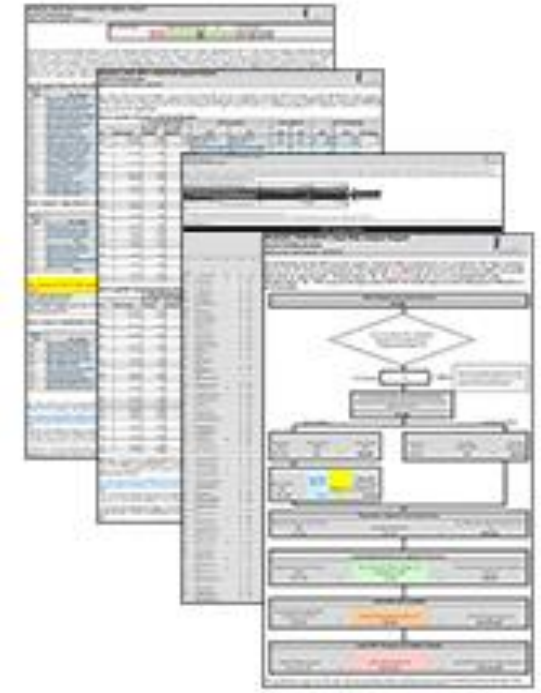
Medicare Provider Number: XXXXXX

					Benchmark Comparison [1]					
							Teaching Status [2]			Your State
Overall Impact		**CY2018**	**CY2017**	**Percent Change**	**National**	**COTH [3]**	**Major**	**Minor**	**Non-teaching**	**Pennsylvania**
A	***Estimated Total OPPS Payment*** [4]	$ 29,135,747	$ 29,658,528	-1.76%	1.51%	-1.13%	-0.90%	1.72%	2.94%	0.99%
Conversion Factor (equivalent to payment base rate)										
B	Conversion Factor [5]	$78.636	$75.001	4.85%	4.85%					
C	Are you a Rural Sole Community hospital or Essential Access Community Hospital?	No	No							
D	Conversion Factor after Adjusting for Rural Sole Community Hospital Status or Essential Access Community Hospital Status	$78.636	$75.001	4.85%						
Wage Index (Labor-related portion of the Conversion Factor is adjusted for wage index)					**National**	**COTH**	**Major**	**Minor**	**Non-teaching**	**Pennsylvania**
E	Wage Index	1.0821	1.1010	-1.72%	0.16%	0.05%	-0.07%	0.18%	0.29%	-0.21%
F	Labor-related Portion	60%	60%							
G	Wage Index Adjusted Conversion Faction (D*E*F+D(1-F)) [6]	$82.51	$79.55	3.73%	4.93%	4.87%	4.78%	4.94%	5.01%	4.69%
APC Factor (equivalent to the concept of average case mix)					**National**	**COTH**	**Major**	**Minor**	**Non-teaching**	**Pennsylvania**
H	Outlier Payment [7]		$396,008							
I	OPPS Payment w/o Outlier (A-H)	$28,739,739	$29,262,520	-1.79%						
J	Paid Lines/Number of APCs [7]		148,225							
K	APC Factor (I/G/J) [8]	2.3499	2.4818	-5.31%	-3.07%	-5.57%	-5.25%	-2.90%	-1.81%	-3.28%

File Layout | Documentation | 2018_OPPS_Factsheet | Hospital_Impact | 340B Impact Analysis | 340B Calculator Inst ...

AAMC OPPS Hospital-Specific Impact Report

- Hospital-specific report outlines the payment impact of proposed policy changes under the CY 2019 OPPS proposed rule on your institution
  - Overall impact on OPPS payment in 2019
  - Payment impact of key policy changes
    - 340B
    - Section 603 (“site neutral”)
    - Payment reduction to clinic visits provided at off-campus HOPDs
  - Changes to high volume services



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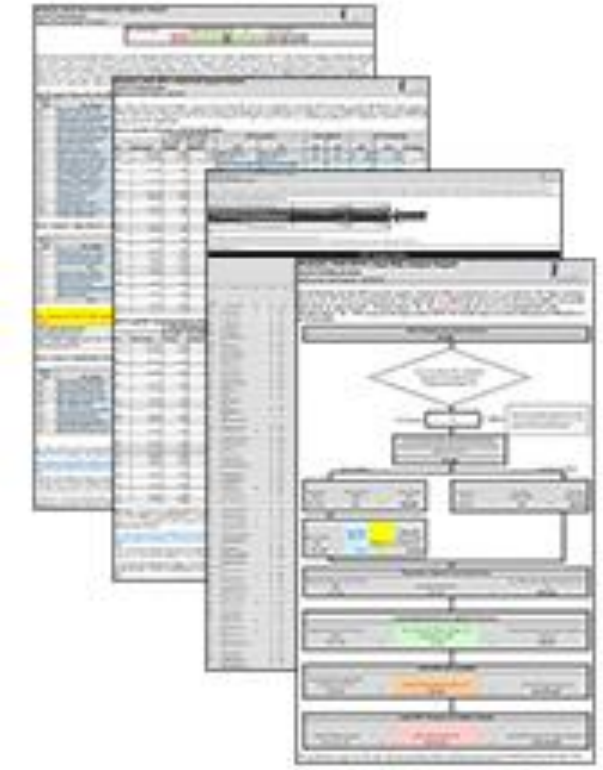
AAMC OPPS Hospital-Specific Impact Report

- Aim to release in ~ 1 month
- Free of charge to member institutions
- To get on the distribution list, send an email to COTH@aamc.org, with
  - Subject line: OPPS impact report
  - Your name, institution, title, contact
- Tutorial training videos



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Quality & Promoting Interoperability

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CY 2019 OPPS Proposed Rule Key Takeaways

Hospital Outpatient Quality Reporting (OQR) Program

- 10 measures proposed for removal:
  - 1 for CY 2020 payment determinations
    - 21 measures would remain
  - 9 for CY 2021 payment determinations
    - 12 measures would remain
- No new measures proposed

Hospital Inpatient Quality Reporting (IQR) Program

- Removal HCAHPS “Communication About Pain” questions beginning with FY 2024 payment determinations

RFI: Promoting Interoperability through Possible Revisions to Requirements

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Response to Feedback on Social Risk Factors

- No proposals to make any changes to account for SDS factors
- CMS will continue to work with ASPE, the public, and stakeholders (including NQF) to identify policy solutions that improve health equity while minimizing unintended consequences

Potential Steps CMS May Take in the Future:

- Increase transparency of disparities shown by quality measures among patient groups within and across hospitals
  - Separate announcement: hospitals will receive confidential HSRs to review two disparity methods that assess performance on the pneumonia readmission measure

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Hospital Outpatient Quality Reporting (OQR) Program

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Hospital Outpatient Quality Reporting Program - Background

CY 2019 Payment Determinations: 25 required measures and 1 voluntary measure

- Chart-Abstracted Measures: 10
- Claims-Based Measures: 7
- Web-Based: 8 *(9 including voluntary measure)*

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Measure Proposed for Removal (CY 2020)

- **Influenza Vaccination Coverage Among Healthcare Personnel (OP-27)**
  - Removal factor: costs outweigh benefits
  - Inpatient version of measure captures majority of hospital personnel
  - Last reporting period would be October 1, 2017 – March 31, 2018

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Measures Proposed for Removal (CY 2021)

- **Median Time to ECG (OP-5)**
  - Removal factor: costs outweigh benefits
  - Resource-intensive chart abstraction & minimal performance variation
  - Last reporting quarter is Q1 2019
- **Cataracts – Improvements in Patient's Visual Function w/in 90 Days Following Cataract Surgery (OP-31)**
  - Removal factor: costs outweigh benefits
  - Currently a *voluntary* measure (only 1.2% report)
- **Mammography Follow-Up Rates (OP-9)**
  - Removal factor: no longer aligns with clinical guidelines/current practice
  - Will investigate measure respecification to capture broader spectrum of mammography services including DBT
  - Last measurement period would be July 1, 2017 – June 30, 2018

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Measures Proposed for Removal (CY 2021)

- **Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval in Average Risk Patients (OP-29)**
  &
  Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients w/ History of Adenamatous Polyps – Avoidance of Inappropriate Use (OP-30)
  - Removal factor: costs outweigh benefits
  - Resource-intensive chart abstraction & preference for claims-based outcome measure (OP-32)
  - Last reporting quarter is Q1 2019
- **Thorax CT – Use of Contract Material (OP-11)**
  &
  Simultaneous Use of Brain CT and Sinus CT (OP-14)
  - Removal factor: measures are topped out
  - Last measurement period would be July 1, 2017 – June 30, 2018

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Measures Proposed for Removal (CY 2021)

- **The Ability of Providers with HIT to Receive Lab Data Electronically into CEHRT as Discrete Searchable Data (OP-12)**
  &
  Tracking Clinical Results Between Visits (OP-17)
  - Removal factor: performance or improvement doesn't result in better outcomes
  - Measures address functionality of HIT and not patient outcomes
  - Last reporting period would be CY 2018

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Other Measure-Related Proposals

- **Measure update for CY 2021**: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32)
  - Extend the performance period to three years (from one year) beginning with CY 2020 payment determinations.
  - Reporting period would be January 1, 2016 – December 31, 2018 for CY 2020 payment determinations
- OAS-CAHPS implementation will **remain voluntary in CY 2019**
  - CY 2018 OPPS rule finalized delay of mandatory implementation beginning in CY 2018 and for subsequent years until further rulemaking
  - CY 2019 OPPS proposed rule **does not** include proposal to end delay
- Request for public comment on future measure topics for the OQR Program

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Other Proposals for the OQR Program

- Update the factors considered when removing measures from the program
  - Adds measure removal factor 8 – costs outweigh benefits
  - Modifies wording of factor 7 – leads to unintended consequences "other than patient harm"
  - Clarify calculations for factor 1 regarding topped out measures
- Reduce the frequency of updates to the OQR Program Specifications Manual beginning CY 2019
- Remove the Notice of Participation (NOP) form
  - Hospitals would still need to (1) register on QualityNet site, (2) identify and register a QualityNet security administrator, and (3) submit data

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Hospital Inpatient Quality Reporting (IQR) Program

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Proposed Removal of HCAHPS Pain Management Questions

- Proposal to remove the “Communication About Pain” Questions
  - Questions began in the field January 1, 2018 to replace previously adopted pain management questions removed in FY2018 IPPS final rule
  - Removal would begin with January 2022 discharges and be effective for FY 2024 payment determinations

- *Alternative Proposal*: retain questions, but delay public reporting (currently scheduled to start October 2020)

- Requesting feedback on any potential implications on patient care related to removing these questions

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RFI: Promoting Electronic Interoperability

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Promoting Interoperability through Possible Revisions to Requirements
(83 FR 32709-32711)

CMS is requesting feedback on potential change to hospital Conditions of Participation (CoPs) to require interoperability (similar to RFI in the IPPS proposed rule):

- Require hospitals to electronically transfer medically necessary information upon patient discharge/transfer
- Require hospitals to electronically send discharge information to a community provider when possible
- Require hospitals to make information electronically available to patients, or a specific third-party application, if requested

What are your recommendations?

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Questions?

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Contact Information, Resources, Upcoming Webinars

AAMC Contact Information, Upcoming Webinars

- Mary Mullaney, mmullaney@aamc.org (payment)
- Andrew Amari, aamari@aamc.org (payment)
- Phoebe Ramsey, pramsey@aamc.org (quality)
- Susan Xu, sxu@aamc.org (impact report)

Upcoming Webinars

- 2019 Physician Fee Schedule (PFS) Proposed Rule
  - August 15, 2 pm EDT
- 2019 Quality Payment Program (QPP) Proposed Rule
  - August 16, 2 pm EDT
- FY 2019 IPPS Final Rule **PAYMENT** POLICIES
  - August 28, 3 pm EDT
- FY 2019 IPPS Final Rule **QUALITY** POLICIES
  - August 29, 3 pm EDT

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OPPS Proposed Rule References

- Payment updates, outlier payments (42 Fed. Reg. **37072**)
- Site-neutral payment policy expansion (42 Fed. Reg. **37138**)
- Expansion of clinical families of services (42 Fed. Reg. **37146**)
- Off-campus provider-based emergency department data collection (42 Fed. Reg. **37137**)
- Changes to the Inpatient Only (IPO) List (42 Fed. Reg. **37136**)
- 340B hospitals and reimbursement for Part B drugs (42 Fed. Reg. **37143**)
- Pass-through payments for drugs/biologics (42 Fed. Reg. **37111**)
- Requests for information (42 Fed. Reg. **37208**)
- Impact reports
- Hospital Outpatient Quality proposals / EHR RFI

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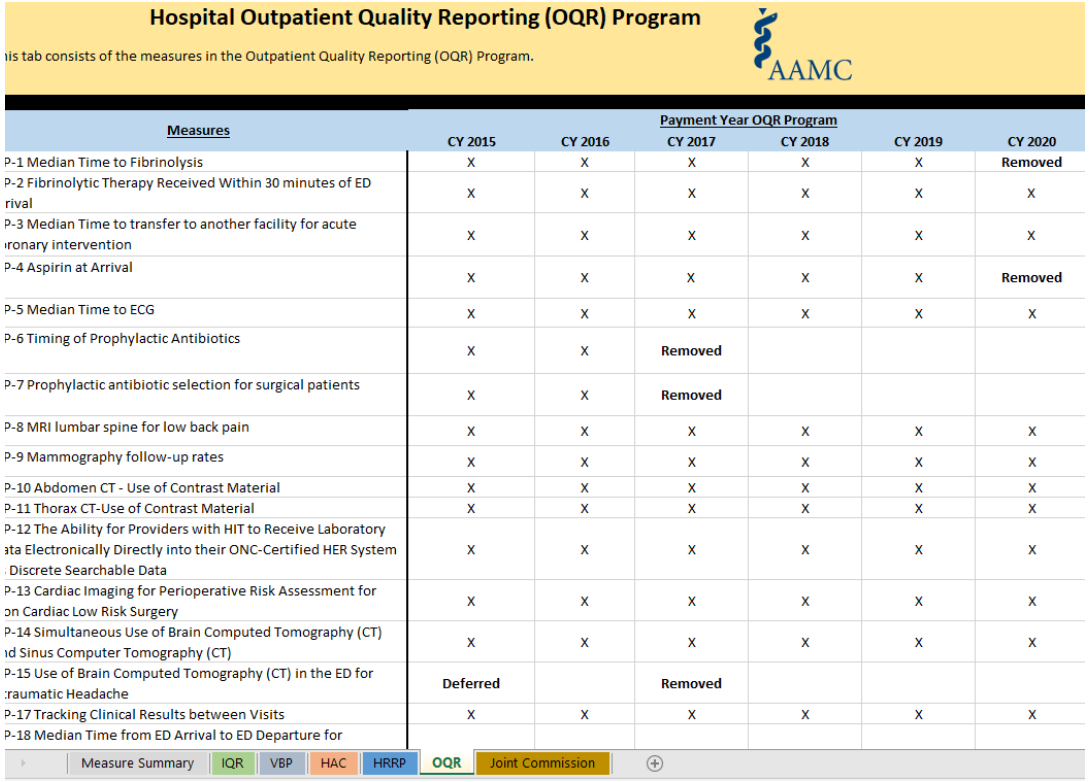
AAMC Quality Resources

Individual Institution Reports

- AAMC Hospital Medicare IPPS Impact Report (mbaker@aamc.org)
- AAMC Hospital Compare Benchmark Report (pramsey@aamc.org)
- AAMC Medicare Pay-for-Performance Inpatient Quality Programs Report (mbaker@aamc.org)

General Resources

- AAMC "Hospital Payment and Quality" Page - Contains previous IPPS and OPPS webinars (www.aamc.org/hospitalpaymentandquality)
- AAMC Quality Measures/Timeline Spreadsheet (https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx)



Hospital Outpatient Quality Reporting (OQR) Program

is tab consists of the measures in the Outpatient Quality Reporting (OQR) Program.

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Measures	Payment Year OQR Program					
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
P-1 Median Time to Fibrinolysis	X	X	X	X	X	Removed
P-2 Fibrinolytic Therapy Received Within 30 minutes of ED rival	X	X	X	X	X	X
P-3 Median Time to transfer to another facility for acute ronary intervention	X	X	X	X	X	X
P-4 Aspirin at Arrival	X	X	X	X	X	Removed
P-5 Median Time to ECG	X	X	X	X	X	X
P-6 Timing of Prophylactic Antibiotics	X	X	Removed			
P-7 Prophylactic antibiotic selection for surgical patients	X	X	Removed			
P-8 MRI lumbar spine for low back pain	X	X	X	X	X	X
P-9 Mammography follow-up rates	X	X	X	X	X	X
P-10 Abdomen CT - Use of Contrast Material	X	X	X	X	X	X
P-11 Thorax CT-Use of Contrast Material	X	X	X	X	X	X
P-12 The Ability for Providers with HIT to Receive Laboratory ata Electronically Directly into their ONC-Certified HER System Discrete Searchable Data	X	X	X	X	X	X
P-13 Cardiac Imaging for Perioperative Risk Assessment for on Cardiac Low Risk Surgery	X	X	X	X	X	X
P-14 Simultaneous Use of Brain Computed Tomography (CT) d Sinus Computer Tomography (CT)	X	X	X	X	X	X
P-15 Use of Brain Computed Tomography (CT) in the ED for raumatic Headache	Deferred		Removed			
P-17 Tracking Clinical Results between Visits	X	X	X	X	X	X
P-18 Median Time from ED Arrival to ED Departure for						

Measure Summary | IQR | VBP | HAC | HRRP | OQR | Joint Commission

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