

# CY 2019 Outpatient Prospective Payment System (OPPS) Final Rule Webinar



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Serve

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Lead

## AAMC Presenters:

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**November 28, 2018**



Association of  
American Medical Colleges

# Important Information on the Final Rule

CY 2019 OPPS Final Rule published in the *Federal Register* on November 21, 2018 (83 *Fed. Reg.* 58818).

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

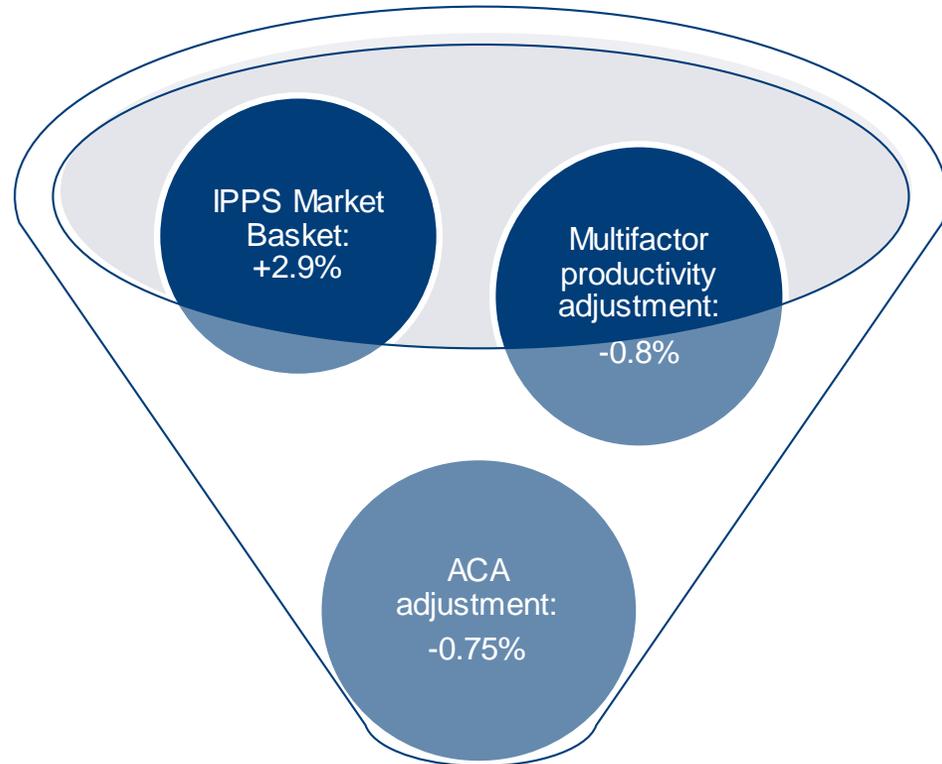
# Webinar Agenda

- ❖ 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
- ❖ Proposals *Not Finalized*
  - ❖ Clinical families of services
  - ❖ Public reporting of charges
  - ❖ Competitive Acquisition Program in Part B
- ❖ AAMC Hospital Impact Reports
- ❖ Hospital Outpatient Quality / EHR RFI

# Payment Updates

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# Final Payment Update CY 2019



Payment rate increase by conversion factor adjustment of **1.35%**

## Payment Impacts

- ❖ All Hospitals: **0.6%**
- ❖ Major Teaching Hospitals: **0.4%**

## Outlier Payment Threshold

- ❖ **1.75** Times APC
- ❖ **\$4,825** Fixed Dollar Threshold

# Site-Neutral Payment Policies

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# Finalized Expansion of Site-Neutral Payment Policy

## ❖ Policy Changes

- Outpatient clinic visits – HCPCS code G0463 – will be paid at PFS-equivalent rate (40% of OPPS full payment rate) in all off-campus PBDs
- Two-year phase-in
  - CY 2019 – payments reduced by 30%
  - CY 2020 – payments reduced by an additional 30%
- Not budget neutral
  - Claims “method to control unnecessary increases in volume of covered OPD services” not required to be budget neutral

## ❖ Effective January 1, 2019

# Unnecessary Increases in Outpatient Services

- ❖ Higher payment for clinic visit in an HOPD than a physician office results in “unnecessary increases” in outpatient services
- ❖ Equates outpatient spending increases with “unnecessary shift of services” to HOPDs from physician offices
- ❖ Claims reducing clinic visit payment as “an effective method to control the volume of these unnecessary services”
- ❖ Claims unnecessary increase impacts beneficiaries’ financial obligations as beneficiaries’ responsible for 20% coinsurance

# Site-Neutral Expansion Savings Estimate CY 2019

- ❖ Savings estimate in first year
  - Estimated savings -- \$380 million
    - Medicare: \$300 million
    - Beneficiaries: \$80 million
- ❖ Estimated savings based on FY 2019 President's Budget and includes the effects of estimated changes in enrollment, utilization, and case-mix
- ❖ CMS simulated PFS payment for "PO" claims to determine savings estimate

# Off-Campus Provider-Based Emergency Departments Data Collection

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

- ❖ Collect data to assess the extent to which OPSS services are shifting to OCPB EDs
- ❖ Requires 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)
- ❖ Exempts critical access hospitals
- ❖ **Effective January 1, 2019**

# Inpatient Only (IPO) List

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# Inpatient Only (IPO) List Finalized Changes

Removal(s)				Addition(s)
<p><b>CPT 31241</b> (nasal/sinus endoscopy w/ ligation of sphenopalatine artery)</p>	<p><b>CPT 01402</b> (anesthesia for open/surgical arthroscopic knee joint procedures)</p>	<p><b>CPT 0266T</b> (implantation or replacement of carotid sinus baroreflex activation device; total system)</p>	<p><b>CPT 00670</b> (anesthesia for extensive spine and spinal cord procedures)</p>	<p><b>HCPCS code C9606</b> (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)</p>

Source: Table 49 of CY 2019 OPPS final rule

# 340B Drug Payment Policy

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# 340B Drug Program Cuts Expansion Finalized

- ❖ Finalized the application of its 340B drug payment policy to **nonexcepted** off-campus PBDs
  - ASP plus 6% → ASP minus 22.5%
  - Biosimilars – based on biosimilar’s ASP not reference product’s ASP
  - Savings estimate for expansion – \$48.5 million
- ❖ Not budget neutral
  - Sites are NOT paid under the OPPS. Budget neutrality not required.
- ❖ Exempts children’s hospitals, **rural** SCHs, and PPS-exempt cancer hospitals from the current and **expanded** policy
  - Will **not** exempt **urban** SCHs or MDHs which are also not exempt from the **current** policy
- ❖ **Effective January 1, 2019**

# Pass-Through Payments for Drugs/Biologics, Packaging Threshold

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# Finalized Pass-Through Payments for Drugs/Biologics

- ❖ 60 drugs with pass-through payment status in 2019 (Table 38)
  - 23 drugs are losing pass-through status (Table 37)
- ❖ Finalizing proposal to provide pass-through payment for drugs without ASP at wholesale acquisition cost (WAC) plus 3%
  - Currently paid at WAC plus 6%
  - Finalized: if WAC not available, payment is 95% of most recent average wholesale price (AWP)
- ❖ If purchased under 340B Program, finalized:
  - WAC minus 22.5%
  - If WAC not available, 69.46% of AWP
- ❖ **Effective January 1, 2019**

## Packaging Threshold (non-pass-through status) Policy

- Finalized increase to \$125 in CY 2019 (\$120 in CY 2018)

# Proposals *Not Finalized* in Final Rule

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# Proposals *Not Finalized*

## ❖ **Definition of clinical families of services**

- Proposal to limit expansion of services in excepted off-campus provider-based departments

## ❖ **Requests for information (RFI)**

- Public reporting of standard hospital charges
- Competitive Acquisition Program (CAP Program) in Part B

# Clinical Families of Services Policy *Not Finalized*

- ❖ **CMS' Rationale for Proposal**: Prevent “unnecessary increases” in services by reducing site-based payment differentials
- ❖ **CMS' Rationale for Not Finalizing**: Agreed with commenters that policy is operationally complex, unclear, and burdensome for all
  - ❖ Would have revised the definition of “excepted items and services” under 42 CFR 419.48
  - ❖ Would have applied to **excepted** off-campus PBDs
  - ❖ Would have paid non-excepted services at PFS-equivalent rate (40% of full OPPS rate)
  - ❖ Would have established baseline period to except clinical families billed during the baseline
  - ❖ Distinction between expanding services and expanding clinical families of services
  - ❖ Similar policy proposed in CY 2017 OPPS, but did not finalize

# Table 32 from the Proposed Rule

37150

Federal Register / Vol. 83, No. 147 / Tuesday, July 31, 2018 / Proposed Rules

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.

# Clinical Families of Services Policy *Not Finalized (Cont.)*

Comments	CMS Responses
❖ CMS has no authority (policy is arbitrary and capricious)	❖ Claims authority under Section 1833(t)(21)(B)(ii) of the Act
❖ Restricts hospitals' ability to address changing needs and technologies	❖ Policy offers flexibility to expand <i>within</i> clinical families
❖ Utilize volume/payment-based limitations	❖ Neutral on proposal. Claims authority under Section 1833(t)(21)(B)(ii) of the Act
❖ Policy operationally complex, unclear and burdensome	❖ Agreed with commenters

# Price Transparency RFI – *Not Finalized*

- ❖ Goal: Improve beneficiary access to provider and supplier charge information
  - 90 timely comments
  - Did not summarize or respond to comments
- ❖ Adopted similar policy in the FY 2019 IPPS rule
  - Make standard charges publicly available in a machine readable format

# Competitive Acquisition Program Part B Drugs RFI – *Not Finalized*

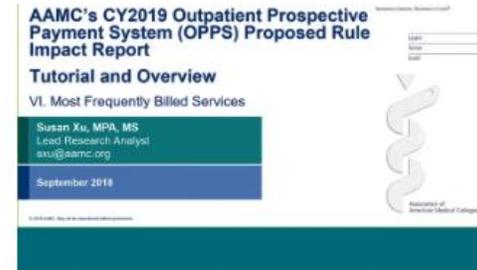
- ❖ Goal: Decrease prices for Part B drugs
  - 80 timely comments
  - Did not summarize or respond to comments
- ❖ Advanced Notice of Proposed Rulemaking
  - ❖ Released Oct. 25, 2018
  - ❖ Requesting further comment on a CAP-like model that indexes Part B drug prices to international prices

# Payment Impact

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# Update on AAMC OPPS CY2019 Final Rule Impact Report

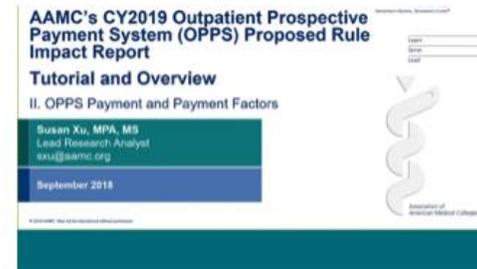
- ❖ Aim to release by mid-December
- ❖ Tutorial training videos
  - How to navigate the report
  - How to interpret key numbers
  - What's the policy change and its impact



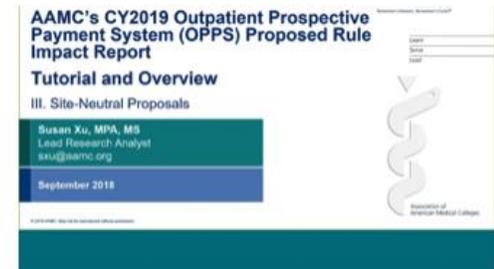
Part VI: Most Frequently Billed Services  
AAMC | 10 plays



Part I: Navigating Your Impact Report  
AAMC | 21 plays



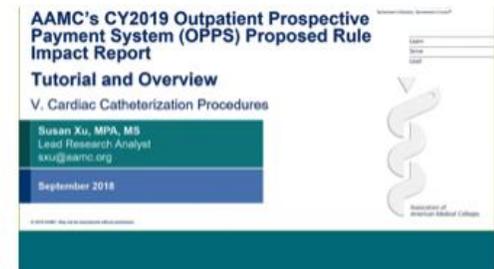
Part II: OPSS Payment and Payment Factors  
AAMC | 17 plays



Part III: Site-Neutral Proposals  
AAMC | 33 plays



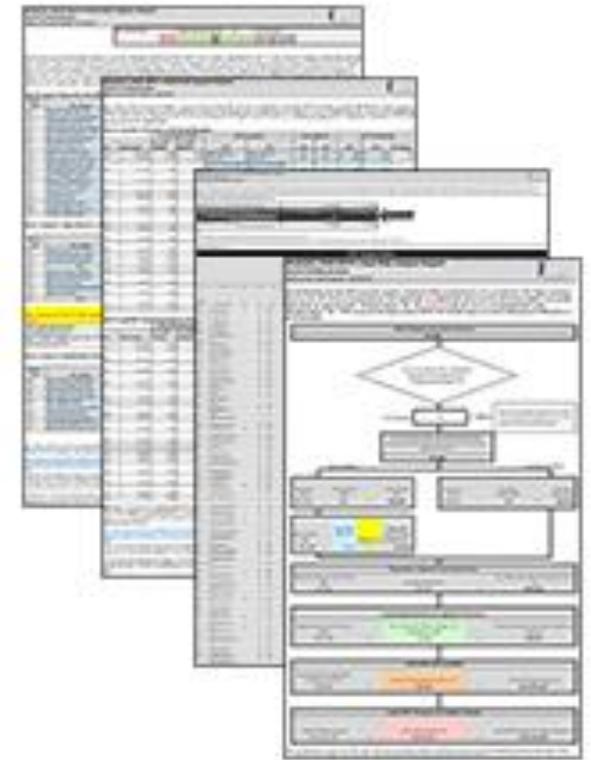
Part IV: 340B Payment Reduction  
AAMC | 29 plays



Part V: Cardiac Catheterization  
AAMC | 14 plays

# Key Changes in AAMC OPPS CY2019 Final Rule Impact Report

- ❖ Updated estimates based on final rule claim data
- ❖ Site-neutral:
  - Phase-in the payment reduction for E/M services at off-campus PBDs over 2 years
  - Withdrew the proposal to limit expansion of clinical families
- ❖ 340B: Raise the rate for biosimilars



# A Common Question

Hospital Impact Tab

OVERALL IMPACT		CY2019	CY2018	Percent Change
A	Estimated Total OPSS Payment <sup>4</sup>	\$ 82,648,206	\$ 86,393,603	-4.34%

Site Neutral Impact Tab

Your Total CY2019 OPSS Payment Estimated by CMS<sup>1</sup>

\$82,648,206

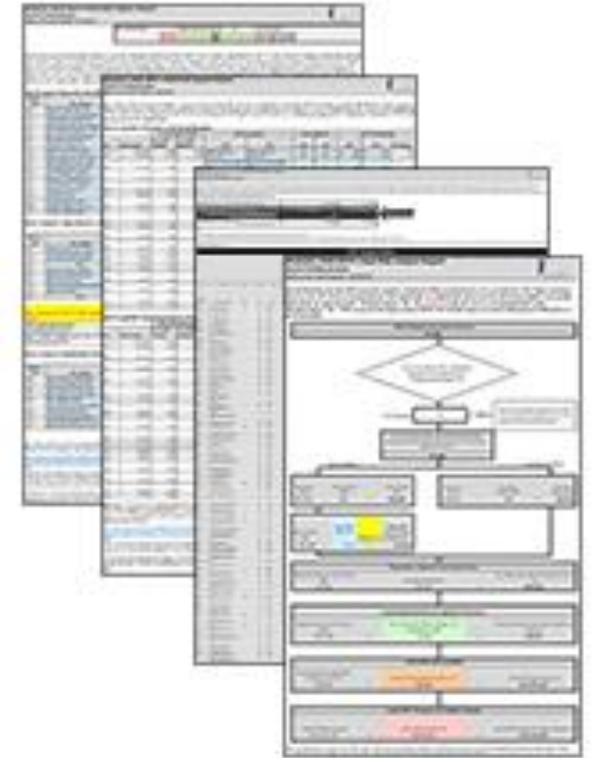
1. We assume CMS's estimate of CY2019 OPSS payment included impact of the proposed payment reduction to clinic visits provided at excepted/grandfathered off-campus PBDs.

## CY2019 Impact of CMS's Site-Neutral Policies on Your Hospital

Section	Proposed and Adopted Site-Neutral Policies	CY2019 Impact on Your Hospital <sup>2</sup>	
1	Proposed Payment Reduction to Clinic Visit at Excepted Off-Campus PBDs	-\$4,749,775	
2	Payment Reduction as a Result of Section 603 Proposed 40% Payment Adjuster	-\$1,577,337	?
<b>Total Impact of All Site-Neutral Policy</b>		<b>-\$6,327,113</b>	
<b>% Impact of All Site-Neutral Policy</b>		<b>-7.11%</b>	
Total CY2019 OPSS Payment without CMS's Site Neutral Policy <sup>4</sup>		88,975,319	

# AAMC OPPS Hospital-Specific Impact Report

- ❖ Free of charge to member institutions
- ❖ To get on the distribution list, send an email to [COth@aamc.org](mailto:COth@aamc.org), with
  - ❖ Subject line: OPPS impact report
  - ❖ Your name, institution, title, contact



# Questions?

# Quality & Promoting Interoperability

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# CY 2019 OPPS Final Rule Key Takeaways

## Hospital Outpatient Quality Reporting (OQR) Program

- Finalized removal of 8 of 10 measures proposed for removal:
  - 1 for CY 2020 payment determinations
    - 21 measures remain
  - 7 for CY 2021 payment determinations
    - 14 measures would remain
- No new measures

## Hospital Inpatient Quality Reporting (IQR) Program

- Finalized removal of HCAHPS “Communication About Pain” questions beginning with FY 2021 payment determinations
- No public reporting in the interim

## RFI: Promoting Interoperability through Possible Revisions to Requirements

# Hospital Outpatient Quality Reporting (OQR) Program

# 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*)

# Measure Removed (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

# Measures Removed (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

## ❖ 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

## Measures Removed (CY 2021), cont'd

### ❖ **Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients w/ History of Adenomatous Polyps – Avoidance of Inappropriate Use (OP-30)**

- Removal factor: costs outweigh benefits (unique documentation burden compared to OP-29, which was retained)
- Resource-intensive chart abstraction & preference for claims-based outcome measure (OP-32)
- Last reporting quarter is Q1 2019

### ❖ **Thorax CT – Use of Contrast 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

# Measures Removed (CY 2021), cont'd

## ❖ **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

# Measures Proposed for Remove but Retained (CY 2021)

## ❖ Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval in Average Risk Patients (OP-29)

- Critical measure; widely used by private payers
- Still have “demonstrated substantial overuse of surveillance colonoscopies of low-risk patients”
- Valuable information to beneficiaries about where high volumes of colonoscopies are performed

## ❖ Cataracts – Improvements in Patient’s Visual Function w/in 90 Days Following Cataract Surgery (OP-31)

- Will remain voluntary measure
- Core group of facilities reports this measure voluntarily – retention will allow public to track HOPD performance over time for this group

# Other Measure-Related Proposals Finalized

- ❖ **Measure update for CY 2021:** Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32)
  - Extends the performance period to three years (from one year) beginning with CY 2020 payment determinations.
  - Reporting period will 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
  - CMS **did not** include proposal to end delay

# Responses to Request for Comment re: Future OQR Measures and Topics

- ❖ Antibiotic-use related measures to assess inappropriate prescribing
- ❖ Focus on clinical & population-based outcome measures
- ❖ Cancer care measures
- ❖ Psychiatric care & behavioral health & substance use measures
- ❖ Rural health measures
- ❖ Access to care measures
- ❖ Measures to promote advance care planning & shared-decision making
- ❖ Ensuring measures are comparable between hospitals & ASCs

# Other Proposals Finalized 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

# Hospital Inpatient Quality Reporting (IQR) Program

# Removal of HCAHPS Pain Management Questions

- ❖ Finalized 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 begins with October 2019 discharges and is effective for FY 2021 payment determinations

# RFI: Promoting Electronic Interoperability

# Promoting Interoperability through Possible Revisions to Requirements

- ❖ CMS requested feedback on potential changes 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

# Questions?

# AAMC Contact Information, Upcoming Webinars

- ❖ Mary Mullaney, [mmullaney@aamc.org](mailto:mmullaney@aamc.org) (payment)
- ❖ Andrew Amari, [aamari@aamc.org](mailto:aamari@aamc.org) (payment)
- ❖ Susan Xu, [sxu@aamc.org](mailto:sxu@aamc.org) (impact reports)
- ❖ Phoebe Ramsey, [pramsey@aamc.org](mailto:pramsey@aamc.org) (quality)

## Upcoming Webinars

- ❖ 2019 Physician Fee Schedule (PFS) Final Rule
  - ❖ December 3, 3 pm EST
  - ❖ [Registration Link](#)
- ❖ 2019 Quality Payment Program (QPP) Final Rule
  - ❖ December 6, 1 pm EST
  - ❖ [Registration Link](#)
- ❖ Contact Kate Ogden ([kogden@aamc.org](mailto:kogden@aamc.org))

# OPPS Final Rule References

- ❖ Payment updates, outlier payments (83 Fed. Reg. **58861**)
- ❖ Site-neutral payment policy expansion (83 Fed. Reg. **59004**)
- ❖ Expansion of clinical families of services (83 Fed. Reg. **59022**)
- ❖ Off-campus provider-based emergency department data collection (83 Fed. Reg. **59003**)
- ❖ Changes to the Inpatient Only (IPO) List (83 Fed. Reg. **58999**)
- ❖ 340B hospitals and reimbursement for Part B drugs (83 Fed. Reg. **59015**)
- ❖ Pass-through payments for drugs/biologics (83 Fed. Reg. **58951**)
- ❖ Requests for information (83 Fed. Reg. **59139**)
- ❖ Hospital Outpatient Quality policies (**59080, 59140**) / EHR RFI (**59140**)

# AAMC Quality Resources

## Individual Institution Reports

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

## General Resources

- AAMC “Hospital Payment and Quality” Page - Contains previous IPPS and OPSS webinars ([www.aamc.org/hospitalpaymentandquality](http://www.aamc.org/hospitalpaymentandquality))
- AAMC Quality Measures/Timeline Spreadsheet (<https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx>)

**Hospital Outpatient Quality Reporting (OQR) Program**



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

Measures	Payment Year OQR Program					CY 2020
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	
P-1 Median Time to Fibrinolysis	X	X	X	X	X	Removed
P-2 Fibrinolytic Therapy Received Within 30 minutes of ED arrival	X	X	X	X	X	X
P-3 Median Time to transfer to another facility for acute coronary 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 Data 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) and Sinus Computer Tomography (CT)	X	X	X	X	X	X
P-15 Use of Brain Computed Tomography (CT) in the ED for Traumatic 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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