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# Medicare Outpatient Prospective Payment System (OPPS) CY 2018 Proposed Rule

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Lead

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Association of  
American Medical Colleges

# CY 2018 OPPS Proposed Rule

Published in Federal Register on July 20, 2017, (82 Fed Reg 33558)

Comments due: September 11

AAMC OPPS Resources: [www.aamc.org/hospitalpaymentandquality](http://www.aamc.org/hospitalpaymentandquality)

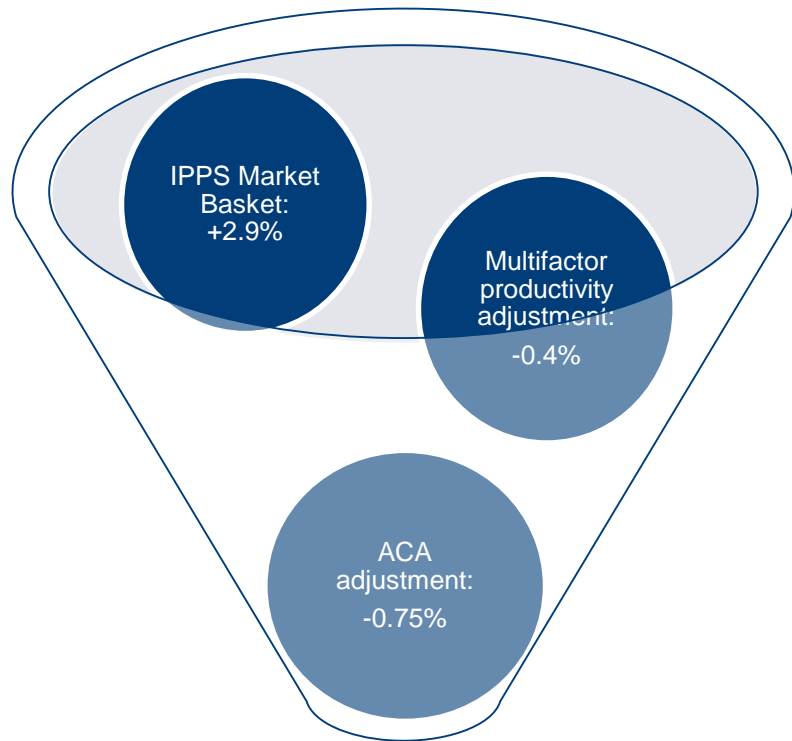
# Webinar Agenda

- ❖ 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)
- ❖ Request for information reducing regulatory burden

# Payment Updates

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# Payment Update CY 2018



Payment rate increase by  
conversion factor adjustment of  
1.75%

- ❖ Impact on all hospitals: +2.0%
- ❖ Impact on major teaching hospitals: +1.7%

# 340B Hospitals and Reimbursement Changes for Part B Drugs

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# Cuts to Part B drugs for 340B hospitals

Proposing to reduce reimbursement for non pass-through, separately payable Part B drugs purchased under the 340B program from *ASP + 6%* to

➤ ***ASP MINUS 22.5%***

CMS also proposes adding a modifier to better track 340B drugs

***The AAMC opposes the proposal!***



# 340B vs. non-340B hospital comparison

According to CMS, 340B DSH hospitals

- Prescribe more drugs (overutilization)
- Prescribe more expensive drugs
  - Spending at 340B hospitals more than double non-340B
- Not impacted by hospital characteristics or patients' health status
- Current payment methodology contributing to “overutilization”

*However*, data shows that 340B hospitals tend to be significantly larger than non-340B hospitals

# Savings estimate

CMS estimates savings of proposed payment change

- \$900 million (budget neutral)
- Basis for the savings estimate is unclear

Beneficiary benefit

- Coinsurance payments are more than the acquisition costs in some circumstances
- Savings may accrue to secondary payers (*i.e.*, MedSupp plans and Medicaid)

# Proposals to distribute savings

Apply all or part of savings to increase payments for specific services paid under OPPS or under Part B generally, rather than simply increasing the conversion factor

- Increase in non-drug OPPS payment rates by approximately 1.4% in CY 2018

Target savings to hospitals with large indigent / uninsured populations

Redistribution of savings results in increase in unnecessary covered services (volume)

- Across the board cut in Part B payments

# Preliminary thoughts on AAMC response

- Intent of 340B program – provides hospitals with funds to help fund care for vulnerable populations at almost no cost to taxpayers
- 340B hospitals tend to be significantly larger than non-340B hospitals
- AAMC exploring CMS authority to do this; also regarding distribution of savings
- Please continue to provide feedback
  - ***Thank you to those who already have!***

# Changes to the Inpatient Only (IPO) List

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# Changes to the IPO List

## Proposal

- Removal of total and partial knee arthroscopy from the IPO List

## Solicitation of Comments

- Removal of total and partial hip arthroscopy from IPO List

# Appropriate setting for care

- Decision as to the appropriate care setting continues to rest with the treating physician
- 2 year prohibition on Recovery Audit Contractors (RACs) review of patient status for these procedures

# Impact on Bundled Payment Programs

CMS must adequately risk-adjust target prices

- Target price based on average episode payments during a baseline period

Reimbursement under OPPS and IPPS may significantly alter composition of patients of participating hospitals

- Unfairly hinder hospitals ability to generate savings

Moving younger, healthier patient to outpatient setting

- Potentially increases average episode payment for remaining inpatient cases

Shift to outpatient may reduce number of procedures eligible for BPCI and CJR

- Reduces volume to compensate for outliers



# Packaging Low-Cost Drug Administration Add-on Codes

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# Proposal to package low-cost drug add-on codes

Remove exception for certain drug administration services

- Conditionally package low-cost drug administration services (APC 5691, APC 5692)

May penalize providers that administer multiple drugs at one visit

# Comment solicitation for packaging

Revisiting proposal to package drug add-on codes

- Package drug administration add-on services (conditionally or unconditionally)
- Clinical drug protocols, different infusion times
- Encounter-based approach

# Changes to 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 be the potential for a misinterpretation of the intent of the measure, creating undue pressure for hospital staff to prescribe more opioids. Proposing to 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.

# Quality Measures Hospital OQR Program

## *Beginning CY 2021, 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.

# Quality Measures Hospital OQR Program

- **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. Topped out. Measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

# OAS CAHPS survey-based measures

## *Delay – Beginning With the 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. CMS proposing to delay implementation of the beginning with the CY 2020 payment determination (2018 data collection) and subsequent years. CMS has come to believe that they lack important operational and implementation data.
- Specifically, 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



# Public display of OP-18 measure

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

- Requires public reporting
- Psychiatric / mental health patient information displayed separately

# CMS acknowledges social risk factors play major role in health

## CMS seeking comments

- Accounting for social risk factors in Hospital OQR Program
- Appropriate methods or combination of methods
- Which risk factors to report
- Factors that could be used alone or in combination

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


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# Background: Payment for Off-Campus Provider-Based Hospital Departments

Section 603 of Bipartisan Budget Act of 2015 requires payment for services furnished by off-campus provider based departments under Part B system other than Hospital Outpatient Prospective Payment System (OPPS).

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

# 2017 Payment Rates for “Nonexcepted” Off Campus Outpatient Hospital Departments



For 2017, CMS made the Physician Fee Schedule the payment system and set payment rates based on a 50-percent reduction to the OPPS payment rates (inclusive of packaging).

The adjustment is referred to as the “PFS Relativity Adjuster

Must report a modifier “PN” on each UB 04 claim line to indicated nonexcepted items or service

# 2018 Proposed Payment Rates for Off-Campus Provider-Based Hospital Departments

CMS proposes to revise the PFS relativity adjuster to 75% reduction of the OPPS rate

Uses different methodology in 2018 to compare office and OPPS rates. Packaging payment rates and MPPR reductions still apply.

CMS seeks comments on whether it should adopt a different relativity adjuster, such as 40 percent of the OPPS rate.

# Other Off-Campus Hospital Provisions

CMS specifies that all beneficiary cost-sharing rules that apply under the PFS will continue to apply to all nonexcepted items and services furnished by off-campus OPDs

Supervision rules continue to apply to off campus departments that furnish nonexcepted services

# Clinical Service Line Expansion

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# Clinical Service Line Expansion

No limits to clinical service line expansion or volume increases at excepted off-campus PBDs

CMS will continue to monitor claims data for changes in billing patterns and utilization

Continue to invite public comment

***BUT***

Proposal in MPFS cuts reimbursement to nonexcepted off-campus PBDs from 50% of OPPS rate to 25%

# Reducing Regulatory Burden, RFI

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# Request for Information, public comment

## CMS flexibilities and efficiencies

- Payment system redesign, streamline reporting, aligning Medicare requirements with other payers

## Eliminating inappropriate payment differentials for similar services in inpatient and outpatient settings

- Appropriateness of inpatient 1-day stays

## Physician-owned hospitals

- Role of physician-owned hospitals



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