November 28, 2018

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

AAMC Presenters:
• Mary Mullaney, mmullaney@aamc.org
• Andrew Amari, aamari@aamc.org
• Susan Xu, sxu@aamc.org
• Phoebe Ramsey, pramsey@aamc.org
Important Information on the Final Rule


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
Final Payment Update CY 2019

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

- **IPPS Market Basket**: +2.9%
- **Multifactor productivity adjustment**: -0.8%
- **ACA adjustment**: -0.75%

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

❖ Collect data to assess the extent to which OPPS 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
Inpatient Only (IPO) List Finalized Changes

<table>
<thead>
<tr>
<th>Removal(s)</th>
<th>Addition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 31241 (nasal/sinus endoscopy with ligation of sphenopalatine artery)</td>
<td>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)</td>
</tr>
<tr>
<td>CPT 01402 (anesthesia for open/surgical arthroscopic knee joint procedures)</td>
<td></td>
</tr>
<tr>
<td>CPT 0266T (implantation or replacement of carotid sinus baroreflex activation device; total system)</td>
<td></td>
</tr>
<tr>
<td>CPT 00670 (anesthesia for extensive spine and spinal cord procedures)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Table 49 of CY 2019 OPPS final rule
340B Drug Payment Policy
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
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
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>
<thead>
<tr>
<th>Clinical families</th>
<th>APCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway Endoscopy</td>
<td>5151–5155.</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>5771; 5791.</td>
</tr>
<tr>
<td>Diagnostic/Screening Test and Related Procedures</td>
<td>5721–5724; 5731–5735; 5741–5743.</td>
</tr>
<tr>
<td>Drug Administration and Clinical Oncology</td>
<td>5691–5694.</td>
</tr>
<tr>
<td>Ear, Nose, Throat (ENT)</td>
<td>5161–5166.</td>
</tr>
<tr>
<td>General Surgery and Related Procedures</td>
<td>5051–5055; 5061; 5071–5073; 5091–5094; 5361–5362.</td>
</tr>
<tr>
<td>Gastrointestinal (GI)</td>
<td>5301–5303; 5311–5313; 5331; 5341.</td>
</tr>
<tr>
<td>Gynecology</td>
<td>5411–5416.</td>
</tr>
<tr>
<td>Major Imaging</td>
<td>5523–5525; 5571–5573; 5593–5594.</td>
</tr>
<tr>
<td>Minor Imaging</td>
<td>5521–5522; 5591–5592.</td>
</tr>
<tr>
<td>Musculoskeletal Surgery</td>
<td>5111–5116; 5101–5102.</td>
</tr>
<tr>
<td>Nervous System Procedures</td>
<td>5431–5432; 5441–5443; 5461–5464; 5471.</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5481, 5491–5495; 5501–5504.</td>
</tr>
<tr>
<td>Pathology</td>
<td>5671–5674.</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5611–5613; 5621–5627; 5661.</td>
</tr>
<tr>
<td>Urology</td>
<td>5371–5377.</td>
</tr>
<tr>
<td>Vascular/Endovascular/Cardiovascular</td>
<td>5181–5184; 5191–5194; 5200; 5211–5213; 5221–5224; 5231–5232.</td>
</tr>
<tr>
<td>Visits and Related Services</td>
<td>5012; 5021–5025; 5031–5035; 5041; 5045; 5821–5823.</td>
</tr>
</tbody>
</table>
## Clinical Families of Services Policy Not Finalized (Cont.)

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

<table>
<thead>
<tr>
<th>OVERALL IMPACT</th>
<th>CY2019</th>
<th>CY2018</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Estimated Total OPPS Payment</td>
<td>$82,648,206</td>
<td>$86,393,603</td>
<td>-4.34%</td>
</tr>
</tbody>
</table>

**Site Neutral Impact Tab**

Your Total CY2019 OPPS Payment Estimated by CMS

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

<table>
<thead>
<tr>
<th>CY2019 Impact of CMS’s Site-Neutral Policies on Your Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

Total Impact of All Site-Neutral Policy: -$6,327,113

% Impact of All Site-Neutral Policy: -7.11%

Total CY2019 OPPS Payment without CMS’s Site Neutral Policy: 88,975,319

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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, with
  ❖ Subject line: OPPS impact report
  ❖ Your name, institution, title, contact
Questions?
Quality & Promoting Interoperability
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 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
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
AAMC Contact Information, Upcoming Webinars

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