A MEDICARE LEARNING NETWORK® (MLN) EVENT

OPPS and ASC Proposed Rule

Wednesday, August 14, 2019

Presenters:

David Rice
Terri Postma

Acronyms in this Presentation

- ASC: Ambulatory Surgical Center
- ALJ: Administrative Law Judge
- BFCC-QIO: Beneficiary Family Centered Care-Quality Improvement Organization
- CPL: Covered Procedures List
- IPO: Inpatient Only
- OPPS: Outpatient Prospective Payment System
- TKA: Total Knee Arthroplasty

Agenda

- Opening Remarks
- Price Transparency
- Site Neutrality
- Feedback Session

Submitting Your Comments

- See the proposed rule for information on submitting formal comments by September 27, 2019
- The proposed rule includes other proposed changes not covered during this presentation; see the proposed rule for complete information
- Feedback received during this listening session is not a substitute for your formal comments on the rule

Opening Remarks

Administrator Seema Verma

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

Price Transparency

Increasing Price Transparency of Hospital Standard Charges

- On June 24, the President signed an Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First:
  - Policy of the Federal Government to increase the availability of meaningful price and quality information for patients
  - Directed the Secretary of HHS to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information
- Proposed rule implements Section 2718(e) of the Public Health Service Act and improves upon prior agency guidance that required hospitals to make public their standard charges upon request starting in 2015 (79 FR 50146) and subsequently online in a machine-readable format starting in 2019 (83 FR 41144)
- Section 2718(e) requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act

Proposed Definition of ‘Hospital’

- Propose to define ‘hospital’ as an institution in any State in which State or applicable local law provides for the licensing of hospitals and which is licensed as a hospital pursuant to such law, or is approved by the agency of such State or locality responsible for licensing hospitals as meeting the standards established for such licensing:
  - A State would include each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands
  - Includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well as any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements)
  - Federally owned or operated institutions (for example, hospitals operated by an Indian Health Program, the US Department of Veterans Affairs, or the US Defense Department) which are not accessible to the general public, except in emergency situations, and already make their charges publicly available are deemed to have met the requirements of Section 2718(e)

Proposed Definition of Hospital 'Items and Services'

- Propose to define hospital "items and services" to include **all** items and services (including individual items and services and service packages) provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a charge

  Examples include: Supplies, procedures, room and board, use of the facility and other items (generally described as facilities fees), services of employed practitioners (generally described as professional charges), and any other items or services for which the hospital has established a charge

Proposed Definition of ‘Standard Charges’

- Proposing to define “standard charges” to mean the hospital’s gross charge and payer-specific negotiated charge for an item or service

- Hospitals would be required to make their standard charges public in two ways:
    1) Machine-readable file posted online containing all hospital standard charge information (both gross charges and payer-specific negotiated charges) for all items and services provided by the hospital
    2) Consumer-friendly format that displays and packages payer-specific negotiated charges for a limited set of ‘shoppable’ services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

Proposed Requirements for Making Public All Standard Charges for All Items and Services

- Proposing that hospitals make public their standard charges (both gross charges and payer-specific negotiated charges) for all items and services online in a single file that is machine-readable

- Propose the hospital must include the following corresponding data elements:
  - Description of each item or service provided by the hospital
  - Gross charge that applies to each individual item or service
  - Payer-specific negotiated charge that applies to each item or service; each list of payer-specific charges must be clearly associated with the name of the third party payer
  - Any code used by the hospital for purposes of accounting or billing for the service (e.g. CPT, HCPCS, DRG)
  - Revenue codes, as applicable

- Propose the following location and accessibility requirements:
  - Hospital may select an appropriate publicly available website for making the file public
  - File must be displayed in a prominent manner and clearly identified with the hospital location
  - Hospital must ensure the data is easily accessible and without barriers

Proposed Requirements for Making Public Consumer-Friendly Standard Charges for a Limited Set of ‘Shoppable Services’

- Display payer-specific negotiated charges for at least 300 shoppable services, including 70 CMS-selected shoppable services and 230 hospital-selected shoppable services. If a hospital does not provide one or more of the 70 CMS selected shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300.

- Propose to define ‘shoppable service’ as a service that can be scheduled by a health care consumer in advance.

- In their display of shoppable services, hospitals would:
  - Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code (e.g. CPT/HCPCS/DRG)
  - Make sure that the charge information is displayed prominently on a publicly available webpage and clearly identifies the hospital (or hospital location)
  - Information must be easily accessible and without barriers, and searchable
  - Update the information at least annually

Proposals for Monitoring and Enforcement

- Proposing regulations for monitoring and enforcement of hospitals' compliance with these requirements

- CMS would have the authority to monitor hospital compliance with Section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites:
  - Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may provide a warning notice to the hospital, or a corrective action plan.
  - If the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital not in excess of $300 per day, and publicize these penalties on a CMS website
  - Also propose to establish an appeals process for hospitals to request a hearing before an Administrative Law Judge (ALJ) of the civil monetary penalty

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

Request for Information

- CMS is soliciting feedback on the best way to capture information on the quality of hospital inpatient care so that information can be provided to patients in a way that is useful for them when comparing care options

- Specifically, we are seeking comment on:
  - Improving availability and access to existing quality of health care information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services
  - Improving incentives and assessing the ability of health care providers and suppliers to communicate and share charge information with patients

Site Neutrality

Increasing Choices and Encouraging Site Neutrality

- Proposed rule includes policies that reduce payment differences between certain outpatient sites of service so that patients can:
  - Benefit from high-quality care at lower costs
  - Receive care that is provided safely and is clinically appropriate

Method to Control for Unnecessary Increases in Utilization of Outpatient Services

- Completing two-year phase-in by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting
  - Clinic visits are the most common service billed under the Outpatient Prospective Payment System (OPPS)
  - CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting
  - Proposed change would result in lower copayments for beneficiaries and savings for the Medicare program and taxpayers estimated to be a total of $810 million for 2020

Example: For a clinic visit furnished in an excepted off-campus provider-based department, average beneficiary cost sharing is currently $16 in CY 2019, but would be $23 absent this policy. With the completion of the two-year phase-in, that cost sharing would be reduced to $9, saving beneficiaries an average of $14 each time they visit an off-campus department for a clinic visit in CY 2020.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

Changes to the Inpatient Only List

- Proposing to:
  - Remove Total Hip Arthroplasty from the Inpatient Only (IPO) list, making it eligible to be paid by Medicare in both the hospital inpatient and outpatient setting
  - Establish a one-year exemption from medical review activities for procedures removed from the IPO list beginning in CY 2020 and subsequent years

Changes to the Inpatient Only List

- Proposing that Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) reviews of short-stay inpatient claims for procedures that have been removed from the IPO list within the first-year will not be counted against a provider in the context of the 2-midnight rule
  - BFCC-QIOs will have the opportunity to review such claims in order to provide education to providers and practitioners regarding compliance with the 2-midnight rule
  - These procedures would also not be eligible for referral to the Recovery Audit Contractor for a one-year period after their removal from the IPO list
  - CMS believes that a one-year postponement is an adequate amount of time to allow providers to update their billing systems and gain experience with:
    - Application of the 2-midnight rule to these procedures
    - Documentation necessary for Part A payment for those patients for which the admitting physician determines that the procedures should be furnished in an inpatient setting
    - Newly removed procedures eligible to be paid under either the Inpatient Prospective Payment System or OPPS, while avoiding potential adverse site of service determinations

ASC Covered Procedures List

- Covered surgical procedures:
  - Not expected to pose a significant risk to beneficiary safety
  - Beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure
- Ambulatory Surgical Center (ASC) Covered Procedures List (CPL): List of covered surgical procedures that are eligible for payment under Medicare when furnished in an ASC
- Proposing to add Total Knee Arthroplasty (TKA), knee mosaicplasty, and three additional coronary intervention procedures
- Soliciting comment on:
  - Whether there should be any additional limitations on the provision of TKA or other procedures in the ASC setting
  - How the agency could redesign the role of the ASC-CPL to improve physicians' ability to determine the setting of care as appropriate for a given beneficiary situation

CY 2020 ASC Rate Update

- In CY 2019, finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of 5 years

- CMS is not proposing any changes to its policy to use the hospital market basket update for ASC payment rates for CY 2020

- Using the hospital market basket, propose to update ASC rates for CY 2020 by 2.7 percent:
  - Update based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for multi-factor productivity
  - Help to promote site-neutrality between hospitals and ASCs by providing these two setting with the same rate update

Feedback Session

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Resources

- CY 2020 Proposed Rule
- Press Release
- Fact Sheet
- Hospital OPPS website
- ASC Payment website
- PriceTransparencyHospitalCharges@cms.hhs.gov

Thank You

Visit:

- MLN Events webpage for more information on our conference call and webcast presentations
- Medicare Learning Network homepage for other free educational materials for health care professionals

The Medicare Learning Network® and MLN Connects® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CPT Disclaimer – American Medical Association (AMA) Notice

CPT codes, descriptions and other data only are copyright 2018 American Medical Association. All rights reserved.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network