

Centers for Medicare and Medicaid Services
Hospital Quality Open Door Forum
Moderator: Jill Darling
July 19, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Julie) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Hospital Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Julie). Good morning and good afternoon everyone. Welcome to today's Hospital Open Door Forum. I'm Jill Darling in the CMS Office of Communication. One brief announcement from me and then we'll get into today's agenda.

This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

I'll hand the call over to our chair Tiffany Swygert.

Tiffany Swygert: Hi everyone. This is Tiffany Swygert, the acting director of the Division of Outpatient Care within the Center for Medicare. And I wanted to welcome you all to this call today. We'll be covering the number of issues. Most

notably, we'll be covering the highlights from the Calendar Year 2018 Hospital Outpatient Perspective Payment System proposed rule.

Before we get started, I just wanted to know that the proposed rule was displayed at the Office of the Federal Register on July 13th and is subject to a 60-day public comment period that will close on September 11th. We're very eager to hear and see all of the public comments that are submitted on all of the proposals and comment solicitations that were included in that proposed rule. And we'll be taking all of those comments into consideration for the development of the final rule which is required by law to be issued on or around November 1st of this year.

Since we are in the public comment period, what we'll be discussing today is really just a highlight of the information that was already included in the proposed rule. We're not able to offer additional information or speculate on what policies may be finalized or how the final rule might be different from the proposed rule. So we do appreciate your recognizing that we are limited in some of the discussion that we can have today to the information that's already publicly available in the proposed rule and associated press materials already.

So, with that, I'll go through what the rate update is and then we'll cover some of the other issues and talk about a couple of other topics as well before we open up the line to question and answers.

So, the – in the proposed rule, CMS proposes to update the Hospital OPPS rates by 1.75 percent for 2018. And this is based on the proposed projected hospital market basket increase of 2.9 percent minus 0.4 percentage point adjustment for the multi-factor productivity adjustment as well as the 0.75 percentage point adjustment also required by law. And after considering all policy changes that were proposed in the rule, including an estimated spend for pass-through payments, but not including in estimate related to 340B payment for certain drugs. We estimate that the overall impact will result in a 2.0 percent payment increase for hospitals paid under the OPPS in 2018 relative to 2017.

Before I turn it over to Elisabeth Daniel to go over some of the details on the proposal related to payment for drugs that were required under the 340B Program, I just want to give a couple of highlights. And that is that CMS has long been looking at drug pricing and also looking at acquisition cost that hospitals incur in acquiring those drugs.

Under the 340B Program, which I want to be clear, is not a program that is under the jurisdiction of CMS, but that is administered by the Health Resources and Services Administration or HRSA, hospitals and other health care providers are afforded significant discounts on certain drugs. And we encourage you to read the proposed rule for more details about some of the concerns cited by numerous entities including MedPAC, the Office of the Inspector General, the Government Accountability Office with respect to the prices that which hospitals are acquiring drugs relative to the Medicare payment rate which currently, in this year, is the average sale price plus 6 percent regardless of the purchase price that the hospital was able purchase the drug.

So with that, I'll turn it over to Elisabeth Daniel to go over some of the more technical details and we'll cover more of the issues and we're happy to take your questions later on.

Elisabeth Daniel: Thank you, Tiffany. Good afternoon. Tiffany mentioned in her opening that we are proposing to apply a different payment methodology for drugs purchase under the 340B Drug Pricing Program beginning January 1, 2018. The proposed 340B Drug Payment Policy would apply to hospitals paid under the OPPS, so Critical Access Hospitals or CAHs are excluded from this proposal as they are paid at 101 percent of reasonable cost.

To be clear, the proposal affects OPPS payment for 340B drugs and does not otherwise change or alter the 340B program criteria and rules for participation. To give the payment proposal a bit of context, under the OPPS, all hospitals except CAHs are paid the same rate for separately payable drugs regardless of whether the hospital purchased the drug at a discount through the 340B Program. Likewise, Medicare beneficiaries are responsible for

copayment that is equal to 20 percent of the OPPS payment rate regardless of the 340B purchase price for the drug.

For 2018, we are proposing to amend our OPPS Drug Payment Methodology for 340B hospitals. That we believe would better, and more appropriately, reflect the resources and acquisition cost that these hospitals incur. Such changes would allow both beneficiaries and the Medicare program to pay less when hospitals participating in the 340B Program furnish these drugs to Medicare beneficiaries that are purchased under the 340B Program.

Specifically, we are proposing to pay for separately payable drugs and biologicals that are obtained with a 340B discount, other than drugs on pass-through status and vaccines at the ASP or Average Sales Price minus 22.5 percent. Said another way, drugs with status indicator “K” that are purchased through the 340B Program are proposed to be paid at ASP minus 22.5 percent. Separately payable drugs that are not purchased with the 340B discount will continue to be paid at ASP plus 6 percent.

As we mentioned in the proposed rule, while it's not a proposal, we intend to establish a claim level HCPCS modifier that would indicate that a separately payable drug was not purchased with a 340B discount. Details on the modifier and other technical guidance on billing for 340B purchased drugs will be communicated through either a sub-regulatory guidance document after the publication of the 2018 OPPS final rule or in the 2018 OPPS final rule.

Finally, as part of the 340B payment proposal, we invite comment on a few specific elements to include (1) whether a different payment rate to account for the average minimum discount of OPPS drug purchased under the program should be used; (2) whether to phase in the payment adjustment; (3) whether the 340B hospital should report their acquisition cost for OPPS drugs on the claim; (4) whether certain groups of hospitals such as cancer hospitals or sole community hospitals should be exempt from this proposal; and (5) whether there are certain types of drugs such as blood clotting factors that should be excluded from this proposal.

With respect to packaging, we want to highlight a comment solicitation on our OPPS packaging policy. As you've often heard us say on hospital ODFs and in rulemaking, packaging is a fundamental principle of a prospective payment system.

The OPPS like other prospective payment systems relies on the concept of averaging where the payment may be more or less than the estimated cost of providing a service or package of services for a particular patient, but with the exception of outlier cases, is adequate to ensure access to appropriate care.

As we continue to move the OPPS toward a more prospective payment system and away from separate fee schedule-like payments, we continue to hear concerns from stakeholders that our packaging policies may be hindering patient access or resulting in other undesirable consequences.

While we have not observed any significant fluctuations in our data that show a sharp decline in the volume of packaged services, nor have we heard from beneficiaries about any particular access issues, we are inviting comment on our packaging policies including our policy to package drugs that function as a surgical supply or in a diagnostic test or procedure. Nonetheless, in this 2018 OPPS proposed rule, we are soliciting comment on common clinical scenarios involving currently packaged items or services for which stakeholders believe that payment is not appropriate under the OPPS. Likewise, outside the framework of the existing packaging categories, we are interested in feedback on other common clinical scenarios involving separately payable services for which payment would be most appropriately packaged under the OPPS.

That concludes my brief overview of the 340B proposal and our packaging comment solicitation. And now I'll turn it over to Dave Rice.

David Rice: Thanks, Elisabeth. Hi, I'm David Rice and I'll be discussing the two-year moratorium on enforcement for the supervision of outpatient therapeutic services in critical access hospitals and certain small rural hospitals. In 2009 and 2010, OPPS rules, CMS clarified that direct physician supervision is generally required for hospital outpatient therapeutic services that are

furnished in hospitals, critical access hospitals and in provider-based department of hospitals.

For several years, there's been a moratorium on enforcement of the direct supervision requirement for CAHs and small rural hospitals either through administrative action or legislation with the latest legislation on a moratorium expiring on December 31st, 2016. Stakeholders have consistently requested that we continue the non-enforcement of direct supervision of hospital outpatient therapeutic services for CAHs and small rural hospitals that have 100 or fewer beds. Stakeholders have stated that some rural hospitals and CAHs have insufficient staff to furnish direct supervision primarily due to difficulty recruiting physician and non-physician practitioners to practice in rural areas.

In this proposed rule, CMS is proposing to reinstate the non-enforcement of direct supervision, enforcement and instructions for outpatient therapeutic services for CAHs and small rural hospitals that have 100 or fewer beds for Calendar Years 2018 and 2019. These hospitals will continue to be subject to conditions of participation and other Medicare rules regarding supervision. And we've requested comments on the proposals.

Now, I'm going to pass it off to (Lela Strong) who will discuss Inpatient Only List.

(Lela Strong): Thank you, Dave. The Medicare Inpatient Only list includes procedures that are typically provided only in an inpatient setting and are only paid under the Hospital Inpatient Prospective Payment System. Every year, CMS uses established criteria to review the Inpatient Only list and determine whether or not any procedures should be removed from the list.

For 2018, CMS is proposing to remove total knee arthroplasty from the Inpatient Only list. The 2018 OPPS/ASP proposed rule also seeks comments regarding whether partial and total hip arthroplasty should also be removed from the Inpatient Only list.

Now, I'm going to turn it over to my colleague Sarah Shirey-Losso.

Sarah Shirey-Losso: Hi, I'd like to let you know that we are inviting comments on Potential Revisions to the Laboratory Date of Service Policy. Under the current date of service policy, if a test is ordered less than 14 days after the date of the patient's discharge from a hospital, the hospital bills Medicare for the test and then pays the laboratory that performed the test, if the laboratory provided the test under arrangement.

We've received feedback from stakeholders that the Date of Service policy creates unintentional operational burden for hospitals and laboratories that perform molecular pathology tests and certain advanced diagnostic laboratory tests. Therefore, we're considering potential modifications to the Date of Service policy that would allow laboratories to bill Medicare directly for molecular pathology tests and advanced diagnostic laboratory tests which are excluded from the OPPI packaging policy and ordered less than 14 days following the date of the patient's discharge from the hospital.

We are seeking information on whether these tests, by their nature, are appropriately separable from the hospital stay that preceded the test and therefore, should have a date of service that is the date of performance rather than the date of collection. We look forward to your comments.

Tiffany Swygert: Up next, Jim Poyer will talk about the quality-related portions of the rule.

James Poyer: Hi. Thanks Tiffany. I'll be walking through our program proposals for the Hospital Outpatient Quality Reporting Program as well as the Ambulatory Surgical Center Quality Reporting Program.

In both programs, we are proposing to remove several measures in our effort to balance the value of the quality data with efforts to limit provider burden. And so, for the Hospital Outpatient Quality Reporting Program we're proposing to remove six measures focusing on pain management to long bone fracture as well as several heart care and chest pain measures. And other measures that I would refer you to the CMS fact sheet for more information.

Again, we want to assess our measures that (re-assess) as we do annually in terms of the relative value to the consumers as well as room for improvement and (topped-up) status, relative to the burdened to providers and are expecting a burden savings of 150 – at least 150,000 hours for Calendar Year 2020 payment that would be in 2018 reporting and 300,000 plus hours with the Calendar Year 2021 payment determination measure set that would be reported in 2019.

We are also proposing to delay the mandatory implementation of the outpatient and ambulatory surgery survey on Consumer Assessment of Healthcare Providers and Systems known as the OAS CAHPS survey.

And to – and last year, we had finalized a policy to begin mandatory collections linked with payment starting with Calendar Year 2018. In this year's rule, an effort to assess burden as well as address in terms of – to fine tune survey to offer another year of voluntary reporting. So hence the proposal to differ 2018 Calendar Year mandatory collection.

We offer in the hospital outpatient program as this is a hospital call. Several other administrative proposals, soliciting public comment on an electronic clinical quality measure as well as several other administrative proposals. So, that concludes my presentation and we look forward to seeing your comments in the Federal Register. Thank you.

Tiffany Swygert: Thank you, Jim. This is Tiffany Swygert again. I also wanted to talk about some of the request for information that were included in the proposed rule. There were three of them. One was related to site-neutral payments and that was also included in the Inpatient Prospective Payment System rule. Another one is related to physician on hospitals and was also included in the IPPS rule.

The third one which I'll talk about a little bit more was included in the IPPS rule and other proposed rules that have gone out. And it's a request for information on flexibilities and efficiencies that can be achieved and this relate to better transparency, flexibility, program simplification and innovation. Specifically we're looking for ways that CMS can reduce burden for clinicians, providers and patients in a way that increases the quality of care

and decreases cost at the same time. We're also interested in making health care more affordable while maintaining program integrity and preventing fraud and abuse.

In responding to the request for information-- this is for all of the requests for information-- commenters should provide CMS with clear and concise proposal that include data and specific examples where appropriate. In addition, we wanted to let you know that CMS will not be responding to public comments related to the RFIs in the final rule. However, we will be actively considering all input in developing future regulatory proposals or sub-regulatory guidance and we very much are interested in any and all ideas that you put forth in those public comments to us.

So, that concludes the presentation related to the highlights of the OPPS proposed rule and I'll turn it back to Jill so we can move on with the agenda.

Jill Darling: Thanks Tiffany. The next two agenda topics come from Don Thompson. First is the Change Request 10026.

Don Thompson: Thanks. So we just want to remind hospitals of a few upcoming deadlines. On June 30th, 2017 we issued Change Request 10026. One aspect of that change request was an instruction to the MACs to allow hospitals to revise the Worksheet S-10 data that was submitted with their Fiscal Year 2015 cost reports. This is similar to an exercise that we did last year where we allowed hospitals to resubmit revised Worksheet S-10 submitted with their 2014 cost reports.

The deadline for this year, for hospital, if they wish to read, you know, Part II and if they wish to revise their Worksheet S-10 uncompensated care data submissions, the deadline for that is September 30th, 2017. Again, similar to last year.

In addition, we also receive request to allow an additional round or revisions for the 2014 cost report data. So subsequent to the instruction allowing the 2015 come out, we've also instructed the Medicare Administrative Contractors

to accept 2014 revisions to the Worksheet S-10 as well. So an additional opportunity to revise the 2014 data.

Hospital should have received--they'll be receiving in the near future some provider education surrounding this. And if you have any questions, you can direct that to your MACs. But again, for hospitals that resubmitted in 2014, the process is similar to what it will be for this year for the additional submissions of 2014 and additional revisions for 2015.

Another deadline that we switching gears a bit and the deadline that we wanted to talk about was the upcoming deadline with respect to the Fiscal 2019 Wage Index. So by September 1st, that is the deadline for hospitals to request revisions for their Worksheet S-3 wage data as well as their Calendar Year 2016 occupational mix data that they submitted to us.

The public use file for the Worksheet S-3 for 2019 that was released back in May. And on July 12, we recently released the 2016 occupational mix survey data. So the deadline for hospital to review both of those and again, submit any revisions based on those files in September 1st 2017. That's it.

Jill Darling: All right. Thank you, Don and to all of our speakers today. Thank you everyone for joining us today, for the Hospital Open Door Forum. And the next one is scheduled to be announced, so please look out in your e-mail for the next agenda. So thanks everyone, have a great day.

Operator: Thank you for participating in this Hospital Quality Open Door Forum Conference Call. This call will be available for replay beginning today at 5:00 p.m. Eastern through midnight on July 21st. There conference ID number for the replay is 59214429. The number to dial for the replay is 855-859-2056. Again, that's 1 – 855-859-2056.

This concludes today's conference call. You may now disconnect.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Page 11