Centers for Medicare and Medicaid Services
Hospital/Quality Initiative
Open Door Forum
Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is (Jack) 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 the Hospital 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'd like to ask a question during this time, simply press star then the number one on your telephone keypad. If you'd like to withdraw your question, press the pound key.

Thank you, Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Jack). Good morning. And good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to today's Hospital Open Door Forum. We have a pretty packed agenda today. So you'll just hear my brief announcement, and then I'll hand the call off to our Chair, Tiffany Swygert.

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.

Tiffany Swygert: Thanks, Jill. Hi, this is Tiffany Swygert, the Director of Division of Outpatient Care. And as Jill mentioned, we do have several items to cover for you today.

The first of which is the calendar year 2019 Hospital Outpatient Prospective Payment System final rule. We will go over some of the highlights and then a few other agenda items and then take your questions at the end.

So without further ado, I'll go ahead and get started with the OPPS final rule, which was finalized or which was released on November 2nd 2018.

We finalized several changes – several important changes to the Medicare program under the OPPS and the Ambulatory Surgery Center Payment System. These changes remove unnecessary and inefficient payment differences between providers so that beneficiaries can have more affordable choices and options in their care.

The final rule with comment period, updates and revises policies under the OPPS and ASC system. And these policies will, in part, advance the agency's priorities of creating a patient centered healthcare system. We're also significantly reducing burden in order for hospitals and ambulatory surgery centers to operate with better flexibility and efficiencies.

Today, we will highlight several of these policies. However, for full details on these and other policies, we encourage everyone to read the final rule.

With that, I will be changing – I will be passing the microphone over to David Rice. And just pardon any background noise that you hear as we had some technical difficulties and have – are having to use an actual microphone for you to hear us today. Thanks.

David Rice: Thanks, Tiffany.

In accordance with the law, CMS is updating the OPPS payment rate by 1.35 percent. This update is based on the hospital market basket increase of 2.9 percent, minus both a 0.8 percentage point adjustment for multifactor productivity. And a 0.75 percentage point adjustment required by law.

Overall, OPPS payments are expected to increase in calendar year 2019 by $5.8 billion with aggregate payments, including beneficiary cost sharing expected to be around $74 billion for 2019, compared to $68 billion for 2018.

I'll now pass it over to Josh McFeeters, to discuss new technology APC payment for low volume procedures.

Josh McFeeters: Thank you, Dave. CMS proposed to apply a (smoothing) methodology, based on multiple years of claims data, to establish more stable rate for services assigned to new technology APCs, with fewer than 100 claims per year under the OPPS.

The proposal will calculate the geometric mean costs, the median costs and the arithmetic mean cost. This proposal will allow one of the methodologies to be assigned the most representative payment for the service. Additionally, CMS proposed to exclude low volume services from bundling into a comprehensive APC.

CMS is finalizing the proposal to use up to four years of data to calculate the geometric means, the median and the arithmetic mean, and to adopt through rulemaking the method that should be used to establish payment for the new technology service for the upcoming year.

While – for the purposes of assigning the service to a new technology APC and ultimately to a clinical APC. The goal of such a policy is to promote transparency and predictability and payment rates for these low volume new technology procedures and to mitigate the wide variation in payment rates from year to year for such services.

Next, I'm going to talk about the payment for drugs, biological and radiopharmaceuticals. If ASP data are not available for C.Y. 2019, we are finalizing a proposal to pay separately – to pay separately payable drugs in biological products that do not have pass-through payment status and are not acquired under the 340B program at wholesale acquisition cost, otherwise known as WAC plus three percent instead of WAC plus six percent.

If WAC data are not available for drug or biological project – product – working and continuing our policy to pay separately payable drugs and biological project – products at 95 percent of the average wholesale price otherwise known as AWP.

Drugs and biologicals that are required under the 340B program will continue to be paid at ASP, minus 22.5 percent, WAC, minus 25 – 22.5 percent, or 69.46 percent of AWP as applicable.

Next we're going to talk about OPPS-related device pass-through policy.

Under the OPPS, a device that's typically packaged into the – into payment for the associated and surgical procedure.

However, Medicare law provides for temporary additional payments or devices that are approved by Medicare for device pass-through status for three years.

The intent of the – of transitional device pass-through payment is to facilitate access for beneficiaries to new and innovative devices by – one, for adequate payment for these new devices while cost data is collected, in order to include the cost for those – for these devices into the procedure payment.

There were seven device pass-through applications that were reviewed for the calendar year 2019 final rule or common period.

We are approving the remede system and Transvenous Neurostimulator for device pass-through payment (system) by calendar year 2019.

The remede system is an implantable phrenic nerve stimulator, indicated for the treatment of moderate to severe central sleep apnea in adult patients.

And we'll talk about OPPS issues related to skin substitutes. Skin substitute products are packaged into their associated surgical procedures, as a part of a broader policy to package all drugs and biological function as supplies when used in a surgical procedure.

Under current policy, (skin substitute) products are either placed into a high-cost group or a low-cost group in order to ensure adequate resource homogeneity among APC assignments for the skin substitute application procedures.

This involves the comparison of both the mean unit costs and the per day costs of these products. CMS is finalizing the proposal to continue our policy establish in calendar year 2018 to assign skin substitute to the low costs or high cost group.

At this point, I'll turn over the discussion to (Twi Jackson).

(Twi Jackson): Thanks, Josh.

Effective January 1, 2019, CMS is implementing HCPCS level modifier E.R. to be reported on all hospital outpatient claims, submitted by provider based, off campus emergency departments.

The implementation of this new modifier, which was previously recommended by (MedPAC) was – will allow CMS to collect data on the volume and acuity level or the services provided in these emergency departments and observe any significant shifts in the volume or service mix for services (finishing off) campus provider base emergency departments.

Additionally, in efforts to allow a greater number of procedures to qualify as device intensive for calendar year 2019, we are finalizing our proposal to modify the criteria for device intensive procedures.

Specifically, we are finalizing our policy that in order for a procedure to be device intensive, the device costs associated with that procedure must exceed a certain threshold of the total cost of the procedure among their criteria.

Currently, that threshold is 40 percent. For C.Y. 2019, we are finalizing the proposal to lower the device threshold to 30 percent in the – additionally in the ASC setting, the device portion of the payment for device-intensive procedure is based on cost reported under the – OPPS.

Reducing this threshold will allow procedures that use relatively high-cost devices to be better recognized in the ASG setting.

I will be turning it over to Steven Johnson.

Steven Johnson: Thanks, (Twi).

In previous years, CMS has updated the annual payment rates for ASCs by the percentage increase in the consumer price index for all urban consumers also known as CPI-U.

In the CY 2018 OPPS ASC proposed rule, CMS listed the recommendations and ideas on ASC payment system reform.

For the C.Y. 2019 OPPS ASC (proposed) rule, in response to the comments received, CMS proposed to update ASC payment rates using the hospital market basket rather than the CPI-U for 2019-2023.

CMS is finalizing this proposal to update ASC payment rates using the hospital market basket rather than CPI-U for calendar years 2019 through 2023.

The CY 2019 payment increase is 2.1 percent, which is the projected hospital market basket increase of 2.9 percent, minus a 0.8 percentage point adjustment for the multifactor productivity.

CMS believe this change will help to promote site neutrality between hospitals and ASCs by helping to address the disparity in payment between hospital payment rates and ASC rates for the same service.

We estimate that total payment to ASCs, including beneficiary cost sharing and estimated change in enrollment utilization and case mix, for CY 2019 will be approximately $4.85 billion, an increase of approximately $200 million compared to the estimated CY 2018 OPPS payments.

At this time, I will pass it over to Scott Talaga, to talk about the changes to the ASC-covered surgical procedures list.

Scott Talaga: Thank you, Steven. The ASC-covered procedures list, CPL, is a list of covered surgical procedures that are payable by Medicare when furnishing an ASC.

Covered surgical procedures are those procedures that are separately paid under the OPPS, which would not be expected to pose a significant risk to benefit your safety and would not typically be expected to require active medical monitoring and care at (midnight) following the procedure.

Under current policy, covered surgical procedures include those described by certain common procedural terminology, CPT codes, that are within the surgical code range and other codes that directly crosswalk or are clinically (similar) to CPT codes within a surgical code range.

For calendar year 2019, CMS is finalizing the proposal to include additional CPT codes outside of the surgical code range that directly crosswalk or are clinically similar to procedures within the CPT surgical code range on the CPL.

As a result, CMS is finalizing its proposal to add 12 cardiovascular code – codes to the ASC CPL, and adding five additional codes as a result of stakeholder comments the agency received.

Additionally, CMS reviewed all procedures added to the ASC CPL within the past three years to reassess recent experience with the procedures in ASC and to determine whether such procedures should continue to be on the ASC CPL.

CMS is not finalizing any change to the ASC CPL, as a result of that review. I'll pass it over to (Au'Sha Washington), who will discuss our policy for non opioid drugs that function as a surgical supply in the ASC setting.

(Au'Sha Washington): Thank you, Scott. Thank you, Scott.

The President's Commission on combating drug addiction in the opioid crisis recommended that CMS review its payment policies for certain drugs that

function as a supply specifically non opioid pain management treating – treatments.

Drugs that function as a supply in surgical procedures or diagnostic tests are packaged under the OPPS and ASC payment systems. In response to this recommendation, as well as stakeholder requests and peer reviewed evidence.

For calendar year 2019. We are finalizing the proposal to pay separately at ASP plus six percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

Next I'll be handling – handing it over to (Elise Barringer), who will discuss methods to control for unnecessary increases and utilization of outpatient services.

(Elise Barringer): Thank you. (Au'Sha). CMS has been concerned that there's been an unnecessary increase in the volume of clinics as it's furnished in off-campus, provider-based department.

We believe that payment incentives in the form of higher payment amounts under the OPPS may have driven services from the physician's office to off-campus provider-based department PBDs.

To address this concern, we have finalized our proposal to pay for clinic visits furnished in off-campus PBDs that is otherwise paid under the OPPS that is – it is an accepted PBD at a physician fee schedule equivalent rate.

Paying for clinic visits for furnished and excepted off-campus provider-based departments at the PFS equivalent rate removes this payment incentive. We believe that this change will allow for greater physician and beneficiary choice on the site of service selection and will control unnecessary increases in volume for this covered outpatient department service.

We are phasing (in this) policy over two years to allow us to balance the immediate need to address the unnecessary increases in the volume of clinic

visits, with concerns that providers should have time to adjust to these payment changes.

This policy would result in an estimated combined $380 million and lower co-payments or beneficiaries and saving for the Medicare program and taxpayers for 2019.

For an individual Medicare beneficiary, current Medicare payment for clinic visit, is approximately $116, with $23 being the average co-payment. Our proposal to adjust this payment to the PFS equivalent rate would bring the payment down to $81 and the co-payment to $16, thus saving beneficiaries and average of $7 per visit in calendar year 2019.

I'll now turn it over to my colleague, (Juan Cortes).

(Juan Cortes): Thanks, (Elise). I'll discuss the expansion of services that (furnished by excepted) PBDs.

Section 603 of the Bipartisan Budget (Act) of 2015 produce Medicare payment for certain off-campus hospital departments by eliminating eligibility for payment under the OPPS effective January 1st, 2017.

Services furnished at – in certain types of locations, such as dedicated emergency departments where it stems from the reduced payment under the statutory provisions.

For C.Y. 2019, we proposed that if – an excepted off-campus PBD furnished (item) services from a clinical family of services that it did not furnish during the baseline period.

Generally those that began billing for hospital outpatient services after November 2, 2015, services for these new clinical family of services will not be covered OPD services.

Instead services within the clinical family of services will be paid under the PFS.

However, after consideration of the public comments we received, we are not finalizing this proposal at this time. We intend to monitor, the expansion of services in off-campus PBDs, and we propose to adopt the limitation on the expansion of services in future rulemaking.

I will now – I will now discuss the policy to apply that 340B Drug Policy to non-accepted off-campus PBDs.

In the C.Y. 2019 OPPS ASC final rule with common period, CMS is finalizing a policy to pay ASP minus 22.5 percent for 340B acquired drugs furnished by non-accepted off-campus PBDs paid under the Physician Fee Schedule.

To effectuate this payment adjustment for 340B acquired drugs, hospital stayed under the OPPS and not accepted off-campus PBDs of a hospital paid under the PFS are required to report modifier J.G. on the same claim line of the drug code to identify as reported acquired drug.

For C.Y. 2019, rural sole community hospitals, children's hospitals and PPS-exempt cancer hospitals will be excepted from the 340B payment adjustment. These hospitals will be required to report informational modifier T.B., for 340B acquired drugs and will be paid ASP plus six percent for 340B acquired drugs under the PFS.

Jill Darling: All right. Thank you, (Juan) and thank you to all of our speakers.

Up next, we have Don Thompson, who will go over the requirements for hospitals to make a public list of their standard charges via the Internet.

Don Thompson: All right. In the fiscal 2015 IPPS/LTCH rulemaking, CMS noted that Section 2718 of the Public Health Service Act, which was enacted as part of the Affordable Care Act requires that each hospital operating in the United States for each year established and update and made public, in accordance with guidelines developed by the Secretary, a list of the hospital's standard charges for items and services provided by the hospital.

In the recent fiscal 2019 IPPS/LTCH rulemaking, CMS updated its existing guidelines in order to make this information more easily and widely accessible.

Effective January 1, 2019, hospitals are required to make this information available via the Internet in machine readable format and to update this information, at least annually, or more often as appropriate.

CMS has issued a Frequently Asked Questions document which can be found by searching for the term “chargemaster” from the CMS home page.

(Kadie Derby): Good afternoon, everyone. My name is (Kadie Derby) and I work on the IRF payment policy team here at CMS. I just wanted to share two brief announcements that we have IRF providers on today's call.

The first being that we now plan on having at least one representative from the IRF payment policy team attend each hospital ODF.

Moving forward, we've heard from providers that it would be helpful to have an IRF representative on the calls to answer any payment policy-related questions that might come up and we are certainly happy to be available and to do so.

The second announcement is a simple reminder that we will be hosting a National Provider call for IRF this Thursday, November 15th from 1:30 to 3 P.M. There is still time to register, if you haven't already, and would like to do so you can register on our IRF website.

For your convenience, if you go to cms.gov and type in IRF PPS. The first link that comes up will direct you to our IRF website.

At the top of the website in the spotlight box, you'll see all of the information you'll need to register.

Lastly on Thursday's call, we'll be doing a brief overview of the IRF coverage requirements, going over some of the finalized updates from the fiscal year

2019 IRF PPS final rule and having a live Q&A to help answer any questions that IRF might have regarding our payment policies.

Jill Darling: OK, thank you Kadie. And last, we have Fred Rooke, who has a reminder about an MLN Special Edition article 18023.

Fred Rooke: Thank you. This is Fred Rooke, and I just want to create an awareness that we have published an MLN special edition article, regarding the activation of systematic validation (edits) for OPPS providers with multiple service locations.

Additional information is found in the article. And as a reminder, this article was created with stakeholder input and request to be published, based on the stakeholder input. And also we wanted to create the awareness of the existence of that article, again, based on stakeholder input.

So we wanted to let all of those stakeholders that are on the line or their representatives know about this article, and to please let all stakeholders become aware of it. Thank you. Back to you.

Jill Darling: Hi, everyone. This is Jill Darling. Thanks for joining us today. If your question – if you cannot get your question in the queue today, or if you were waiting, please send it into the hospital ODF email – its hospital_odf@cms.hhs.gov. Thanks, everyone. Have a great day.

Operator: Thank you for participating in today's Hospital Open Door Forum Conference Call.

This call will be available for replay beginning at 5 P.M. Eastern Standard Time, the 13th of November 2018 through 11:59 P.M. Eastern Standard Time, November 15th 2018.

The conference I.D. number for the replay is 355-30-114. The number to dial for the replay is 855-859-2056.

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

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