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Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

OVERVIEW

On July 6th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the CY 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule updates Medicare payment policies and rates for hospital outpatient departments, ASCs, and partial hospitalization services furnished by community mental health providers. The proposed rule also includes a proposal for site-neutral payments and modifications to the electronic health record incentive program and the hospital value-based purchasing program.

CMS will accept comments on the proposed rule until September 6th. This document summarizes several major provisions of the proposed rule. The full text of the proposed rule is available here.

OPPS PAYMENT UPDATE

CMS proposes to increase OPPS rates by 1.55 percent. This change is the net effect of a 2.8 percent market basket increase, reduced by both a 0.5 percentage point multifactor productivity adjustment and a 0.75 percentage point adjustment required by law.

ASC PAYMENT UPDATE

ASC payments are updated annually by the percentage increase in the Consumer Price Index for urban consumers (CPI-U). CMS proposes that ASCs would receive a 1.2 percent base payment increase. This change is a net effect of a 1.7 percent CPI-U update, reduced by a 0.5 percent multifactor productivity adjustment.

SITE-NEUTRAL PAYMENT PROVISIONS

CMS is proposing to implement a provision of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished in certain off-campus provider-based departments (PBDs) would no longer be paid under the OPPS beginning on January 1, 2017.

Currently, Medicare pays for the same services at a higher rate if those services are provided in a hospital outpatient department, rather than a physician's office. This proposal aims to ensure that Medicare beneficiaries do not pay more for care based on the setting in which care is received. CMS is seeking comments on the implementation of this provision.

Excepted Items and Services

CMS proposes that certain PBDs would be permitted to continue to bill for excepted items and services under the OPPS, including:

- All items and services furnished in a dedicated emergency department;
- Items and services that were furnished and billed by an off-campus PBD prior to November 2, 2015; and

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- Items and services furnished in a hospital department within 250 yards of a remote location of the hospital.

Of note, CMS proposes that items and services must continue to be furnished and billed at the same physical address of the off-campus PBD as of November 2, 2015 in order for the off-campus PBD to be considered accepted.

Non-Excepted Items and Services

For CY 2017, CMS is proposing that the Medicare Physician Fee Schedule (MPFS) be the applicable payment system for the majority of non-excepted items and services furnished in an off-campus PBD. CMS proposes that physicians would be paid based on the professional at the non-facility rate under the MPFS for services that they are permitted to bill. This would be a one-year transitional policy while CMS continues to explore operational changes that would allow an off-campus PBD to bill Medicare for its services under a Part B payment system other than OPPS beginning in 2018.

For CY 2018, CMS is seeking comments on the regulatory and operational changes that it could make to allow a non-excepted BPD to bill and be paid for its non-excepted item and services under an applicable payment system.

COMPREHENSIVE AMBULATORY PAYMENT CLASSIFICATIONS (C-APCS)

A C-APCS is an ambulatory payment classification (APC) that provides for an encounter-level payment for a designated primary procedure and usually, all adjunctive and secondary services provided in conjunction with the primary procedure. For CY 2017, CMS proposes adding 25 new C-APCs, many of which are major surgery APCs.

CMS proposes to add three new clinical families to accommodate new C-APCs including nerve procedures, excision, biopsy, incision and drainage procedures, and endoscopy procedures. CMS also proposes to develop a C-APC and dedicated cost center for bone marrow transplants.

QUALITY REPORTING PROGRAM CHANGES

Hospital Value-Based Purchasing Program

Beginning with the FY 2018 program year, CMS proposes to remove the HCAHPS survey pain management questions from the Hospital Value-Based Purchasing program, as these questions may incentivize providers to over-prescribe pain medication. CMS is developing alternative questions related to pain management to replace the HCAHPS survey questions.

Hospital Outpatient Quality Reporting (OQR)

Outpatient hospital departments are currently subject to a 2 percentage point payment reduction for failure to meet the requirements of the Hospital Outpatient OQR program.

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For the CY 2018 payment determination, CMS is proposing to begin publically displaying data on the Hospital Compare website. Hospitals would have approximately 30 days to review their data before it is publically reported.

CMS is not proposing any changes to the Hospital OQR program measure set for CY 2018 and 2019. CMS proposes to add seven measures to the OQR for the CY 2020 payment determination and subsequent years:

- Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy;
- Hospital Visits after Hospital Outpatient Surgery (NQF#2687); and
- Five proposed measures that are collected using the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey, which is used to measure patients' access to care and overall experience at the facility.

ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

CMS proposes a 90-day EHR reporting period in 2016 for all eligible professionals and eligible hospitals. The reporting period would be any continuous 90-day period between January 1, 2016 and December 31, 2016.

CMS proposes changes to objectives and measures of meaningful use for Modified Stage 2 and Stage 3. For eligible hospitals and critical access hospitals attesting under the Medicare EHR incentive program, CMS proposes to eliminate the Clinical Decision Support and Computerized Provider Order Entry objectives and measures. CMS also proposes to reduce the threshold for a subset of remaining objectives and measures in 2017 and 2018. This aims to reduce administrative burden and allow eligible hospitals that are attesting under this program to focus on providing quality patient care.

CMS also proposes a one-time significant hardship exception from the 2018 payment adjustment for certain eligible professionals who are new participants in the EHR incentive program in 2017. Eligible professionals who have not successfully demonstrated meaningful use in a prior year, who intend to attest to meaningful use for an EHR reporting period in 2017, and intend to transition to the Merit-Based Incentive Program (MIPS) can apply for a significant hardship exception for the 2018 payment adjustment.