spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

# Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule

## OVERVIEW

On November 1st, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for the CY 2017 Hospital OPPS and ASC Payment System. The final rule updates Medicare payment policies and rates for hospital outpatient departments and ASCs. The final rule includes modifications for site-neutral payments, the electronic health record incentive program, and the hospital value-based purchasing program.

This document summarizes several major provisions of the final rule. The full text of the final rule is available here.

## OPPS PAYMENT UPDATE

CMS originally proposed to update the OPPS rates by 1.55 percent. In the final rule, CMS modified its proposal and is updating the OPPS rates by 1.65 percent. This change is the net effect of a 2.7 percent market basket increase, reduced by both a 0.3 percentage point multifactor productivity adjustment and a 0.75 percentage point adjustment required by law. CMS estimates a 1.7 percent payment increase for hospitals paid under the OPPS in CY 2017.

## ASC PAYMENT UPDATE

ASC payments are updated annually by the percentage increase in the Consumer Price Index for urban consumers (CPI-U). For CY 2017, CMS finalized that the adjusted CPI-U is projected to be 1.9 percent. This change is a net effect of a 2.2 percent CPI-U update, decreased by a 0.3 percent multifactor productivity adjustment. This marks a difference from the proposed rule, under which the CPI-U update was projected to be 1.7 percent.

## SITE-NEUTRAL PAYMENT PROVISIONS

CMS is finalizing its proposal to implement a provision of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished in off-campus provider-based departments (PBDs) will 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 provision aims to ensure that Medicare beneficiaries do not pay more for care based on which of the two settings care is received in.

### Excepted Items and Services

CMS finalized its proposal to allow certain PBDs to be permitted to continue to bill for excepted items and services under the OPPS, including:

- All items and services furnished in an off-campus dedicated emergency department;

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Items and services that were furnished and billed by an off-campus PBD beginning prior to November 2, 2015; and
- Items and services furnished in a hospital department within 250 yards of a remote location of the hospital.

CMS finalized its proposal 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 excepted. However, in response to comments, CMS has modified its proposal so that exceptions will be made for off-campus PBDs forced to temporarily or permanently relocate due to extraordinary circumstances outside of the hospital's control, such as natural disasters.

CMS is not finalizing its proposal to limit the expansion of services at this time. CMS had initially proposed to limit the items and services that an excepted off-campus PBD could continue to bill to those items and services within a clinical family that was furnished and billed as of November 2, 2015. CMS will monitor expansion of clinical service lines by office-campus PBDs and continue to consider whether a limitation on service line expansion should be adopted in the future.

### Non-Excepted Items and Services

For CY 2017, CMS finalized its proposal 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. Physicians will be paid based on the type of professional at the non-facility rate under the MPFS for services that they are permitted to bill.

In conjunction with this rule, CMS has issued an interim final rule that is intended to provide a billing mechanism for hospitals to report and receive payment under the MPFS for non-excepted items and services furnished by off-campus PBDs to Medicare beneficiaries in CY 2017. CMS is seeking public comment on the new payment mechanisms and rates detailed in the interim final rule. CMS will make necessary adjustments to the payment mechanisms and rates through rulemaking that could be effective in CY 2017, as needed.

## 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 finalized its proposal to add 25 new C-APCs, many of which are major surgery APCs.

CMS also finalized its proposal to add three new clinical families to accommodate new C-APCs including nerve procedures, procedures related to excision, biopsy, incision and drainage, and endoscopy procedures. Additionally, CMS has developed a C-APC and dedicated cost center for bone marrow transplants.

SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

# QUALITY REPORTING PROGRAM CHANGES

## Hospital Value-Based Purchasing Program

Beginning with the FY 2018 program year, CMS is finalizing its proposal to remove the Hospital Consumer Assessment of Healthcare Providers and Systems survey pain management questions from the Hospital Value-Based Purchasing program, as these questions may incentivize providers to over-prescribe pain medication.

## Hospital Outpatient Quality Reporting (OQR)

Outpatient hospital departments are currently subject to a 2.0 percentage point payment reduction for failure to meet the requirements of the Hospital Outpatient OQR program.

CMS finalized that it will begin to publically displaying outpatient data on the Hospital Compare website beginning with the CY 2018 payment determination. Hospitals will have approximately 30 days to review their data.

CMS did not propose any changes to the Hospital OQR program measure set for CY 2018 and 2019. CMS finalized the addition of 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 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 is finalizing a 90-day EHR reporting period in 2016 for all eligible professionals and eligible hospitals. This reduced reporting period was extended to include 2017 as well based on comments to the proposed rule. The reporting period will be any continuous 90-day period between January 1 and December 31 in each of 2016 and 2017.

CMS finalized changes to the 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 will eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures. CMS will 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

SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

on providing quality patient care. These changes will not apply to Medicaid-only eligible hospitals and critical access hospitals that attest to their State Medicaid Agency.

CMS finalized 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. EPs 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 from the 2018 payment adjustment.