American Hospital Association

Special Bulletin

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CMS Releases Final Rule for CY 2017 Hospital Outpatient/ASC Payment Systems

This bulletin is six pages.

On Nov. 1, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2017 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) final rule. In addition to standard updates to the OPPS and ASC payment systems, the rule implements the site-neutral provisions of Section 603 of the Bipartisan Budget Act of 2015 (BiBA), among other changes. Under the rule, CMS established the site-neutral payment rates for certain off-campus provider-based hospital outpatient departments (HOPDs). Specifically, in 2017, these HOPDs will be paid under the physician fee schedule (PFS) at newly established rates that will generally be 50 percent of the OPPS rate. CMS will accept comments on these payment rate policies through Dec. 31, 2016.

CMS's final rule appropriately recognizes that providing no payment to new off-campus hospital clinics for the services they provide to patients was an untenable policy. We will evaluate the new payment level to ensure that it is fair and reasonable, and review whether the agency will be able to implement it in an efficient manner for 2017. The AHA appreciates the modifications CMS made to its proposal to allow existing off-campus provider-based HOPDs to expand their services to meet the changing needs of their patients and communities without being penalized. However, we are alarmed that by penalizing hospitals that need to relocate their HOPDs, CMS continues to ignore the need for hospitals to modernize existing facilities so that they can provide the most up-to-date, high-quality services to their patients in locations that meet patients' needs.

Highlights of the Outpatient PPS Final Rule

Payment Update: CMS finalizes a market-basket update of 2.7 percent, as well as a productivity cut of 0.3 percentage points and an additional reduction of 0.75 percentage points, as required by the Affordable Care Act (ACA). **These payment adjustments, in addition to other changes in the rule, are estimated to result in a net increase in OPPS payments of 1.7 percent (approximately $5 billion) compared to CY 2016 payments.** For those hospitals that do not publicly report quality measure data, CMS will continue to impose the statutory 2.0 percentage point additional reduction in payment.

Site-neutral Payment Policies: Section 603 of BiBA requires that, with the exception of dedicated emergency department (ED) services, services furnished in "new" off-campus provider-based HOPDs (those that began billing for covered outpatient department services

furnished on or after Nov. 2, 2015 (BiBA's date of enactment) will no longer be paid under the OPPS; instead these services will be paid under other applicable Part B payment systems beginning Jan. 1, 2017. CMS estimates that implementation of the site-neutral payment provisions will reduce Medicare Part B expenditures by about $50 million in CY 2017.

Excepted Items and Services. CMS finalizes a policy allowing certain off-campus HOPDs to continue to bill for "excepted" items and services under the OPPS. Excepted items and services are those furnished on or after Jan. 1, 2017:

- by a dedicated ED, whether or not they are emergency services. This would apply to both existing and new off-campus HOPDs that are EDs;
- by an off-campus HOPD that was billing for covered outpatient department services furnished prior to Nov. 2, 2015, that has not relocated or changed ownership in a manner not permitted by the final rule (as described below); or
- by an HOPD that is located on the campus, or within 250 yards, of the hospital or a remote location of the hospital.

Applicable Payment System. In the final rule, CMS agreed with the AHA's analysis that it would be difficult for hospitals to form financial arrangements with physicians that would comply with the physician self-referral (Stark) and other fraud and abuse laws under the agency's proposal to make no direct payment to non-excepted HOPDs. As a result of this and other arguments the AHA made, the agency did not finalize this proposal. Instead, for CY 2017, CMS establishes the Medicare PFS as the "applicable payment system" for the majority of non-excepted items and services furnished in an off-campus HOPD. Specifically, CMS establishes new interim final PFS rates so that hospitals may bill and be paid directly by Medicare for these non-excepted items and services. Hospitals will continue to bill on the institutional claim using a new claim line modifier "PN" to indicate that the service is a non-excepted service. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate.

Additionally, the final rule lays out some exceptions to this payment policy. For instance, Part B drugs that are separately payable under the OPPS will still be paid separately under the newly established policy at their current rate, generally at Average Sales Price (ASP) plus 6 percent. Further, services currently paid at the PFS rates when they are furnished in an HOPD, such as mammography and therapy services, will continue to be paid at the full PFS rate. Non-excepted partial hospitalization program (PHP) services will be paid at the Community Mental Health Center (CMHC) rate. CMS is soliciting public comments on its interim final payment policy, with a Dec. 31 deadline.

Service Expansion in an Excepted Off-campus HOPD. Consistent with AHA's recommendations, CMS did not finalize its proposal to apply site-neutral payment to items and services furnished by an excepted off-campus HOPD that represent an expansion of the clinical families of services it furnished prior to Nov. 2, 2015. Instead, CMS states that it will

monitor expansion of clinical service lines by off-campus HOPDs and consider limiting expansion in the future.

Relocation of Excepted Off-campus HOPDs. CMS finalizes, with modifications, its proposal that an excepted off-campus HOPD must maintain the same physical address it had as of Nov. 2, 2015 in order to maintain its excepted status and continue to be paid at the OPPS rates. Unless the HOPD receives an exception, an excepted HOPD that relocates to another off-campus site would lose its excepted status and be subject to the site-neutral payment policy. However, CMS does establish a narrow exception to its relocation prohibition. That is, the agency will permit excepted off-campus HOPDs to relocate temporarily or permanently without loss of excepted status due to "extraordinary circumstances outside of the hospital's control," such as natural disasters, significant seismic building codes, or significant public health and public safety issues. Exceptions for extraordinary circumstances will be evaluated and determined by the applicable CMS Regional Office and are expected to be rare and unusual.

Changes of Ownership of Excepted Off-campus HOPDs. CMS finalizes its proposal to allow an off-campus HOPD to maintain its excepted status if its hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from the prior owner. However, individual excepted off-campus HOPDs will not be permitted to be transferred from one hospital to another and maintain their excepted status.

Changes in Calculating Hospital Value-Based Purchasing Scores: Starting with the fiscal year (FY) 2018 program year, CMS will no longer consider hospital performance on three pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey when calculating value-based purchasing (VBP) program scores. However, CMS will continue to collect and publicly report the results of the current HCAHPS pain management questions while the agency works on developing new questions that may be added to VBP in the future. The AHA had urged CMS to suspend these questions in the VBP program due to concerns over their perceived potential to encourage or pressure clinicians to prescribe powerful pain medications as the U.S. experiences a devastating opioid overdose epidemic. Delinking the pain questions from payment calculations sends the right message that CMS is not intending to encourage clinicians to prescribe opioids.

New Comprehensive Ambulatory Payment Classifications (APCs): There are currently 37 comprehensive APCs (C-APCs) that package together an expanded number of related items and services contained on the same claim into a single payment for a comprehensive primary service under the OPPS. For CY 2017, CMS will add 25 new C-APCs, many of which are major surgery APCs within the various existing C-APC clinical families. The agency also finalizes three new clinical families to accommodate new C-APCs, including nerve procedures; excision, biopsy, incision and drainage procedures; and airway endoscopy procedures. In addition, CMS finalizes a new C-APC and dedicated cost center for bone marrow transplants.

Packaging Policy Changes: CMS finalizes three policy refinements with respect to packaging:

Packaging Based on the Claim Instead of Date of Service. CMS will align the packaging logic for all of the conditional packaging status indicators so that packaging would occur at the claim level, instead of based on the date of service.

Expansion of Molecular Pathology Laboratory Test Exception to Include Certain Advanced Diagnostic Laboratory Tests (ADLTs). Since CY 2014, CMS has excluded molecular pathology tests from its laboratory packaging policy because the agency believes that these tests may have a different pattern of clinical use than more conventional laboratory tests, which may make them less tied to a primary service in the hospital outpatient setting than the more common and routine laboratory tests that are packaged. CMS believes that this rationale also applies to certain ADLTs and therefore will expand its laboratory packaging exclusion to ADLTs.

Discontinuation of the "L1" Modifier. In CY 2016, modifier L1 is used to allow for separate payment of laboratory tests when the laboratory tests are "unrelated" to the other services on the claim, meaning that the laboratory test is ordered by a different physician for a different diagnosis than the other services on the claim. For CY 2017, CMS will discontinue separate payment for such "unrelated" laboratory tests by discontinuing the L1 modifier. Laboratory tests that are the only services included on a claim are assigned status indicator "Q4" and will continue to be automatically paid separately under the Clinical Laboratory Fee Schedule.

Changes for Device-Intensive Procedures: For CY 2017, CMS will determine the payment rate for any device-intensive procedure that is assigned to an APC with fewer than 100 total claims for all procedures in the APC based on the median cost instead of the geometric mean cost. This is intended to mitigate significant year-to-year payment rate fluctuations while preserving accurate claims-data-based payment rates for low volume device-intensive procedures. In addition, the agency revises the device intensive calculation methodology by calculating the device offset amount at the HCPCS code level rather than at the APC level to ensure that device intensive status is properly assigned to all device-intensive procedures.

Changes for Outpatient Quality Reporting (OQR): For the CY 2020 OQR program, CMS adopts seven new measures:

- Hospital admissions and ED visits for outpatient chemotherapy patients within 30 days of receiving treatment;
- Hospital admissions and ED visits in the seven days following outpatient surgical procedures; and
- Five measures derived from a new Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey.

The OAS CAHPS is a 37-item survey intended to assess the experience of care for patients that have received surgeries and other procedures in HOPDs and ASCs. CMS will require OAS CAHPS data to be collected and submitted quarterly starting with visits on Jan. 1, 2018.

Changes to Partial Hospitalization Program (PHP) Rate Setting: CMS replaces the existing two-tiered APC structure for PHPs with a single APC by provider type (i.e., community mental health center (CMHC) and hospital-based). CMS believes that this change will provide more predictable PHP per diems, particularly given the small number of CMHCs, and will generate more appropriate payments for these services by avoiding the cost inversions that hospital-based PHPs experienced in the CY 2016 OPPS final rule.

Payment Modifier for Film X-rays: Consistent with the requirements of the Consolidated Appropriations Act of 2016, CMS finalizes that, effective for services furnished starting in 2017, the OPPS payment for X-rays taken using film (including the X-ray component of a packaged service) will be reduced by 20 percent. To implement this provision, CMS will require the use of a modifier on claims for X-rays that are taken using film.

Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program: CMS finalizes changes in the Medicare EHR Incentive Program. Specifically, CMS shortens the EHR reporting period for 2016 from a full year to 90 days for all eligible hospitals (EHs), critical access hospitals (CAHs) and eligible physicians (EPs). CMS also finalizes a 90-day reporting period for EHs and CAHs in 2017**.**

CMS finalizes a proposal to remove Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for Modified Stage 2 and Stage 3 for 2017 and subsequent years. CMS also finalizes a revised threshold for Modified Stage 2 and Stage 3 of the View, Download, Transmit (VDT) measure under the Patient Electronic Access objective.

In addition, CMS finalizes the reduction of several measure thresholds for select Stage 3 objectives: Patient Access to Health Information, Coordination of Care Through Patient Engagement, and Health Information Exchange objectives. For the Stage 3 Public Health and Clinical Data Registry Reporting objective, CMS finalizes the requirement to report to three registries, down from the final Stage 3 requirement to report to four registries.

The AHA is pleased to see some greater flexibility in the Meaningful Use program, particularly the 90-day reporting period for 2016 and 2017 and an adjustment in some of the reporting requirements. However, the changes do not sufficiently align the hospital requirements with those that physicians will face under the Medicare Quality Reporting Program. The AHA is disappointed that CMS finalized a mandatory start of Stage 3 in 2018 with a full year reporting period. Additionally, we remain concerned about requirements for providers to provide third-party access to their systems through application program interfaces without evidence that a relevant standard is ready for nationwide use and despite concerns that this will create security risks.

HIGHLIGHTS OF THE MEDICARE ASC PPS FINAL RULE

ASC Payment Update: ASC payments are updated annually for inflation by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U). For CY 2017, the CPI-U update is projected to be 2.2 percent. As required by the ACA, this update is reduced by a productivity adjustment, which is projected to be 0.3 percentage points, resulting in a 1.9 percent update for CY 2017.

Changes for ASC Quality Reporting (ASCQR): For the CY 2020 ASCQR program, CMS finalizes the addition of seven new measures:

- Normothermia outcome, which assesses the percentage of patients undergoing surgical procedures under general or neuraxial anesthesia whose body temperatures are normal within 15 minutes of arrival in post-anesthesia care units;
- Unplanned victrectomy, which assesses the percentage of cataract surgery patients who undergo unplanned anterior victrectomies (i.e., unplanned repairs of the mainly liquid portion of the eye); and
- The same five OAS CAHPS measures adopted for the OQR program.

NEXT STEPS

The OPPS/ASC final rule will be published in the Nov. 14 *Federal Register*. CMS will accept comments on certain, specified policies in the rule through Dec. 31, 2016. The rule will take effect Jan. 1, 2017. Watch for an AHA Regulatory Advisory with further details in the coming weeks.

If you have further questions, please contact Roslyne Schulman, AHA director of policy, at rschulman@aha.org or (202) 626-2273.