

OVERVIEW OF THE MEDICARE OPPTS AND ASC FINAL RULE CY 2017

SUMMARY OF CALCULATION ELEMENTS



Issued November 1, 2016
Rule to take effect January 1, 2017

OPPS UPDATE

OPPS fee schedule increasing payments by 1.65 percent

- Hospital IPPS market basket percentage increase of **2.7 percent**
- Minus the MFP adjustment of **0.3 percentage point**
- Minus a **0.75 percentage point** adjustment required by the ACA

Continuation of 2.0 percentage point reduction in payments for hospitals failing to meet outpatient quality reporting requirements

- An increase of \$5 million compared to CY 2016 OPPS payments

Estimated 15 percent decrease in CY 2017 payments to CMHCs from CY 2016 payments

- Only paid for partial hospitalization services under the OPPS

OPPS UPDATE

Rural Adjustment

- Continuing 7.1 percent adjustment to the OPPS payments to certain rural sole community hospitals (SCHs)
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Cancer Hospital Payment Adjustment

- Continuing to provide additional payments to cancer hospitals so that payment-to-cost ratio (PCR) after additional payments equals weighted average PCR for other OPPS hospitals
- Target PCR of 0.91 used to determine CY 2017 cancer hospital payment adjustment

OPPS UPDATE

Device-Intensive Procedures

- Payment rate for device-intensive procedures assigned to APC with <100 claims for all procedures to be based on median cost instead of geometric mean cost
 - Expected to mitigate significant year-to-year payment rate fluctuations while preserving accurate claims-data-based payment rates for low volume device-intensive procedures
- Calculating device offset amount at HCPCS code level rather than at APC level

Outpatient Laboratory Tests

- Discontinuing use of “L1” modifier
- Expanding laboratory packaging exclusion that applies to Molecular Pathology tests to all lab tests designated as advanced diagnostic laboratory tests (ADLTs) that meet certain criteria

OPPS UPDATE

Chronic Care Management (CCM)

- Minor changes applied to CCM furnished to hospital outpatients
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Packaging Policies

- Aligning the packaging logic for all of the conditional packaging status indicators so that packaging would occur at claim level (instead of based on the date of service)
-

Payment Modifier for X-Ray Films

- 20% payment reduction for X-rays taken using film that would otherwise be made under the OPPS
- Modifier used on claims to make reduction

OPPS UPDATE

Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Departments of a Provider

- Section 603 of the Bipartisan Budget Act of 2015
 - Requires that certain items and services furnished in certain off-campus PBDs shall not be covered OPD services for purposes for OPPS payment
 - Will instead be paid under the applicable payment system beginning January 1, 2017
- Medicare Physician Fee Schedule (MPFS) will be applicable payment system for majority of the nonexcepted items and services furnished by nonexcepted off-campus PBDs
 - Establishing new site-of-service payment rates under the MPFS to pay nonexcepted off-campus PBDs for nonexcepted items and services

ASC PAYMENT UPDATE

Increasing payment rates by 1.9 percent for ASCs that meet the quality reporting requirements under the ASCQR Program

CPI-U update of 2.2%

Minus

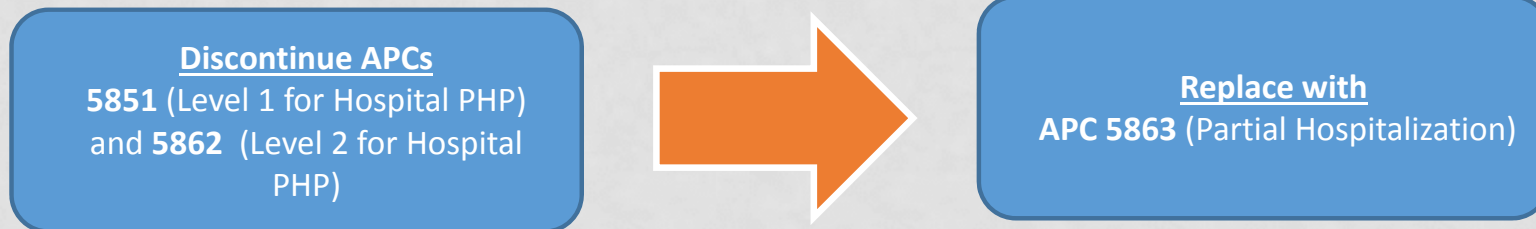
MFP adjustment of 0.3%

Range of impact in total payments by specialty groups for CY 2017 compared to CY 2016 between 12 percent for cardiovascular system procedures and -15 percent for hemic and lymphatic system procedures

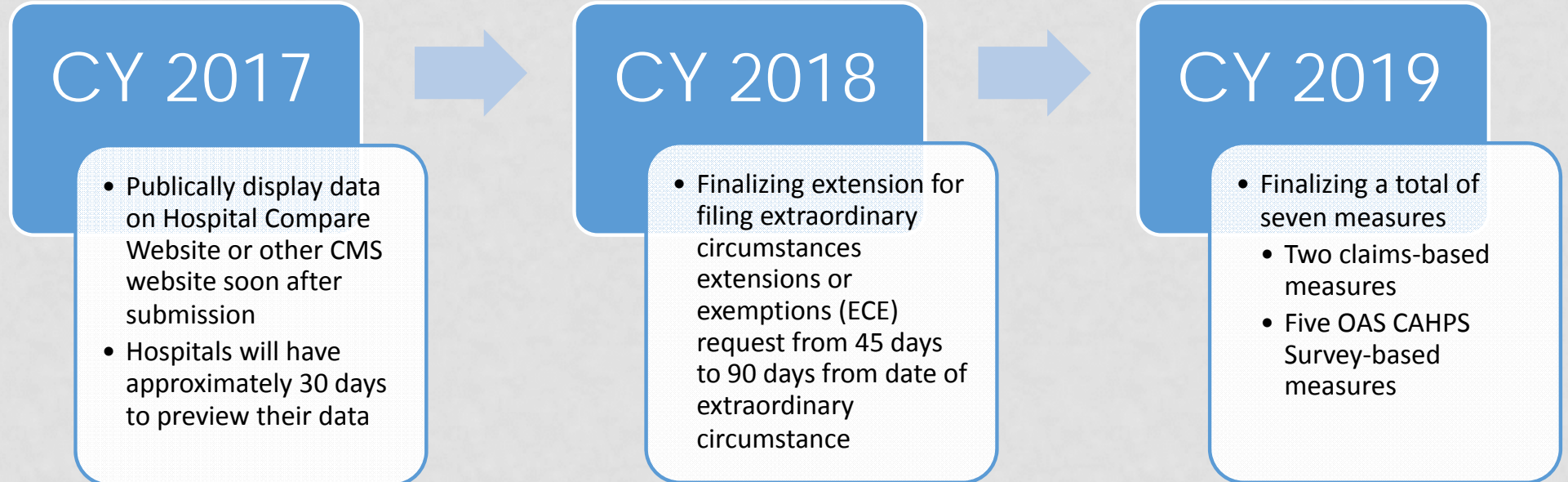
PAYMENT FOR PARTIAL HOSPITALIZATION

CMS has established a per diem payment methodology for PHP APCs

For CY 2017, CMS will combine Level 1 and Level 2 hospital-based PHP APCs into a single hospital-based PHP APC



HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM



AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM

CY 2017

- Publically display data on Hospital Compare Website or other CMS website soon after submission
- Hospitals will have approximately 30 days to preview their data

CY 2018

- Finalizing extension for filing extraordinary circumstances extensions or exemptions (ECE) request from 45 days to 90 days from date of extraordinary circumstance
- Finalizing proposal to change submission deadline to May 15 for all data submitted via a CMS web-based tool

CY 2019

- Finalizing a total of seven measures
 - Two measures collected via a CMS web-based tool
 - Five OAS CAHPS Survey-based measures

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM UPDATE

CMS removing HCAHPS Pain Management dimension, beginning with the FY 2018 program year

Response to public concern regarding prescription opioid overdose epidemic. CMS will continue to develop alternative to pain management questions.

Score will now be 0 to 80

HCAHPS Survey Dimensions for the FY 2018 Program Year
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Communication about medicines
Hospital cleanliness & quietness
Discharge information
3-item care transition
Overall rating of hospital

MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS

Under Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018

- **Eliminates the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures**
- **Lowers the reporting thresholds** for a subset of the remaining objectives and measures
- Revised requirements focus on **reducing hospital administrative burden**

MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS

Change to reporting period in CY 2016 and CY 2017 to 90 days

Change to reporting requirements for new participants in 2017

One-time significant hardship exception from the 2018 payment adjustment for certain eligible providers who are new participants in 2017 and are transitioning to MIPS in 2017

Change to policy on measure calculations for actions outside EHR reporting period

TRANSPLANT PERFORMANCE THRESHOLDS

Solid Organ Transplant Programs: Restoring the effective tolerance range for clinical outcomes that was allowed in 2007 rule

Outcome requirements in the Medicare Conditions of Participation (CoPs) have been affected by nationwide improvement in transplant outcomes

- Makes it more difficult for transplant programs to maintain compliance with increasingly stringent Medicare standards for patient and graft survival

ORGAN PROCUREMENT ORGANIZATIONS (OPOS)

- Changing the current **“eligible death” definition** to be consistent with the **OPTN definition**
- Modifying CMS current outcome measures to be consistent with **yield calculations currently utilized by SRTR**
- Modifying current requirements for **documentation of donor information** which is sent to transplant center with organ

WAGE INDEXES

- Update of wage indexes based on FY 2017 IPPS final rule wage indexes
 - No change for urban hospitals
 - 0.3 percent increase for rural hospitals under OPPS
- Wage indexes include the continued implementation of the OMB labor market area delineations
- Wage index budget neutrality adjustment of approximately 0.9999
 - Cancer hospital payment adjustment of 1.0003
 - Packaging of unrelated lab tests adjustment factor of 1.0004
 - Adjustment of 0.02 percent of projected OPPS spending for the difference in the pass-through spending and outlier payments results in a conversion factor of \$75.001 for CY 2017

OPD FEE SCHEDULE INCREASE FACTOR

OPD fee schedule increase factor of 1.65 percent to conversion factor for CY 2017 will mitigate the impacts of other budget neutrality adjustments



**Urban hospitals:
1.7percent**



**Rural hospitals:
2.2 percent**

C-APCS

Apply frequency and cost criteria thresholds to determine combination of primary care codes that qualify for complexity adjustment

- Code combinations qualifying for complexity adjustment will no longer create a 2 times rule violation

25 additional C-APCs being added under existing APC payment policy

- Brings total number of C-APCs to 62

COMPOSITE APCS

Packaged cost criterion will continue to be based on geometric mean cost

Composite APCs to pay for LDR prostate brachytherapy services, mental health services, and multiple imaging services

- No new composite APCs created for prostate brachytherapy services or multiple imaging services
- For mental health services, APC 5861 and APC 5862 will be combined and replaced with APC 5863

CHANGES TO PACKAGED ITEMS AND SERVICES

- Discontinue unrelated laboratory test exception
- CMS will package any and all lab tests if they appear on claim with other hospital OP services
 - “L1” modifier no longer used to self-designate an exception to lab test packaging under “different physician, different diagnosis” criteria
- Expand lab packaging exception that applies to molecular pathology to apply to all ADLTs that meet criteria of section 1834A(d)(5)(A) of the Act
 - Assign status indicator “A” to ADLTs once a lab test is designated an ADLT under the CLFS
- Align packaging logic for all conditional packaging status indicators; change logic for status indicators “Q1” and “Q2” so that packaging would occur at claim level

HOSPITAL OUTLIER PAYMENTS

OPPS provides hospitals with a payment for cases that may result in significant financial loss to hospital due to high-cost, complex procedures

CMS will continue policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS

OPPS fixed-dollar threshold is \$3,825 for CY 2017

APC GROUP POLICY

Finalizing without modification the APC assignments and status indicators of new HCPCS codes that were implemented on April 1, 2016

Adopting the proposed APC and/or status indicator assignments for:	<ul style="list-style-type: none">• Category III CPT codes 0437T, 0438T, 0439T, 0444T, and 0445T• Level II HCPCS codes C9476, C9477, C9478, C9479, C9480, Q5102, Q9981, Q9982, and Q9983• Modifying the OPPS status indicator for CPT codes 0443T from “T” to “N” because this is an add-on code
Excepted from the 2 times rule:	<ul style="list-style-type: none">• 3 of the 4 proposed APCs from the 2 times rule (5521, 5735, 5771)• 4 additional APCs (5181, 5732, 5821, 5823)
No longer meets criteria for exception to the 2 times rule:	<ul style="list-style-type: none">• APC 5841 (Psychotherapy)

APC GROUP POLICY

48 new levels of New Technology APC groups with two parallel status indicators

- One set with a status indicator of “S” and the other with status indicator of “T”

Established 6 new groups of New Technology APCs (1901-1906)

- Procedures assigned to status indicator “T” subject to the multiple procedure payment reduction
- Procedures assigned to status indicator “S” not subject to the multiple procedure payment reduction

OPPS PAYMENTS FOR DEVICES

Currently four devices with traditional pass-through payment status

- HCPCS codes C2623, C1822, and C2613 will remain
- HCPCS code C2624 will expire on December 31, 2016

Starting in CY 2017, quarterly expiration will be put in place for pass-through payments

- Only applies to newly approved devices in CY 2017
- Will not retro back to previously approved devices

OPPS PAYMENT CHANGES TO DRUG, BIOLOGICALS, AND RADIOPHARMACEUTICALS

For CY 2017,
CMS has set a
\$110 drug
packaging
threshold
payment for
drugs

CMS will put in
place
quarterly
expiration for
pass-through
payments
starting CY
2017

For CY 2017,
the pass-
through status
of 15 drugs
and biologicals
will expire
December 31,
2016

CMS estimates
that pass-
through
spending will
not amount to
2.0 percent of
total projected
OPPS CY 2017
program
spending

CHANGES TO INPATIENT ONLY LIST

CMS removing six CPT codes from inpatient-only list: 22840, 22842, 22845, 22858, 31584, and 31587

CPT codes 22840, 22842, 22845, and 22858 are spine procedure add-on codes per regulations at 42 CFR 419.2(b)(18) and will be packaged with the associated procedure and assigned a status indicator of “N”

CPT codes 31584 and 31587 are laryngoplasty procedures and will be assigned to APC 5165 (Level 5 ENT Procedures) with status indicator “J1”

NEW HEALTH ANALYTICS

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