Executive Summary: CMS 2017 OPPS Proposed Rule

Key financial and operational impacts from the proposed 2017 hospital outpatient prospective payment system (OPPS) rule:

The 2017 OPPS proposed rule was made available on July 6, 2016. A detailed summary of the rule will be available here shortly.

1) **Conversion Factor Update**: In 2017 the proposed OPPS conversion factor would be $74.909 for hospitals that report quality data. For those that don't it would be $73.411.

2) **Outlier Threshold**: For the 2017, CMS provides that the outlier threshold would be met when a hospital's cost of furnishing a service or procedure exceeds 1.75 times the ambulatory payment classification (APC) payment amount, and also exceeds the APC payment rate, plus a $3,825 fixed-dollar threshold (compared to $3,250 in 2016).

3) **Overall Impact**: CMS estimates that, compared to 2016, policies in the proposed rule would increase total payments under the OPPS by $671 million, including beneficiary cost-sharing and *excluding estimated changes in enrollment, utilization, and case-mix.*

   The 1.55% increase in the conversion factor, coupled with other policy changes in the proposed rule are projected to increase OPPS payments by 1.7%. However, these policy changes will have varying degrees of impact on different categories of hospitals. The table below illustrates how the proposed changes would affect revenue for federal fiscal year 2017 (FY17) for different types of hospitals:

	Projected 2017 Impact
All Hospitals	+1.7%
All Facilities (includes CMHCs and cancer and children's hospitals)	+1.6%
Urban	+1.6%
Large Urban	+1.4%
Other Urban	+1.7%
Rural	+2.3%
Major Teaching	+1.2%
Type of ownership:	
Voluntary	+1.7%
Proprietary	+1.6%
Government	+1.5%
CMHCs	-8.4%

   When projected changes for enrollment, utilization, and case mix are factored, in OPPS payments are projected to increase by $5.1 B in 2017.

4) **Provider Based Issues**: The proposed rule attempts to implement section 603 of the Balanced Budget Act of 2015. With the exception of dedicated emergency department services, section

603 prohibits services provided in "new" off-campus provider based departments (began billing OPPS after November 2, 2015) from being billed and paid for under the OPPS.

In implementing Section 603, CMS proposes to define "excepted items and services" (those that can continue being billed under OPPS for off-campus provider-based departments after December 31, 2016) as those services:

a. Furnished in a dedicated emergency department (as defined in §489.24(b) of the regulations[1]), or
b. Furnished by an off-campus provider based departments (PBD) that meets all of the following requirements:
    i. The PBD submitted a bill for a covered outpatient department (OPD) service before November 2, 2015.
    ii. The items and services are furnished at the same location that the department was furnishing such services as of November 1, 2015.
    iii. The items and services are in the same clinical family of services as the services that the department furnished before November 2, 2015.

The proposed rule attempts to resolve a number of key issues that section 603 did not specifically address:

a. *Clinic Relocation*: CMS proposes a strict general rule that an excepted off-campus PBD would lose its excepted status if it is moved or relocated from the physical address (including a change in the unit number of the address) listed on the provider's hospital enrollment form as of November 1, 2015. CMS does not address the issue of relocations planned or begun (but not completed) by November 2, 2015.
b. *Expansion of Clinical Family of Services*: CMS believes the statute requires a reading that to maintain excepted status, an off-campus PBD is limited to offering services only within the clinical family of services it furnished before November 2, 2015. CMS proposes to clarify that services furnished that are not part of the clinical family of services furnished and billed before November 2, 2015, would not be payable under the OPPS.
c. Change in Ownership. CMS proposes that if a participating hospital, in its entirety, is sold or merged with another hospital, a PBD's provider-based status generally transfers to the new ownership if the transfer does not result in material change of the provider-based status. However, CMS also proposes that the excepted status of an off-campus PBD would transfer to new ownership only if (1) the main provider is also transferred, and (2) the Medicare provider agreement is accepted by the new owner. CMS also proposes that an individual excepted off-campus PBD that is transferred from one hospital to another would lose its excepted status.
d. Payment for Services Provided in Non-exempted Hospital Outpatient Departments (HOPDs): Payment for physician services in non-exempted off campus HOPDs will be made under the physician fee schedule at the non-facility rate. The proposed rule states that unless the HOPD converts to a freestanding provider type (e.g. physician clinic or ASC) there will be no payment made directly to the hospital for the next 12 months. CMS has not identified what the "applicable payment system" is for non-exempted off-campus HOPD departments. CMS

notes this proposal is a one-year transitional policy while it explores operational changes that would allow an off-campus PBD to bill Medicare directly for the services it provides under a Part B payment system other than the OPPS beginning in 2018.

5) **Composite APCs**: CMS proposes 25 additional composite APCs (C-APCs) to be paid under the existing C-APC payment policy beginning in 2017. Many of these are major surgical procedures. Table 25 (reproduced in Appendix I) provides a list of all C-APCs proposed for 2017.

6) **OPPS Quality**: For the CY20 payment adjustment CMS proposes seven new measures.

   a. Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy Treatment: This claims-based measure aims to reduce the number of potentially avoidable inpatient admissions and emergency department (ED) visits among cancer patients receiving chemotherapy in the OPD. It includes calculation of two mutually exclusive outcomes within 30 days of chemotherapy in the OPD:
      i. One or more inpatient admissions, and
      ii. One or more ED visits for any of ten diagnoses (anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia or sepsis).
   b. Hospital Visits after Hospital Outpatient Surgery (NQF #2687): This claims-based measure addresses hospital visits after same-day surgery in the OPD. The specific outcomes measured are inpatient admissions directly after the surgery and unplanned hospital visits defined as an ED visit, observation stay, or unplanned hospital admission within seven days of the surgery.
   c. Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems: Five outpatient and ambulatory surgery (OAS CAHPS-based measures are proposed for addition to the Outpatient Quality Reporting (OQR) program for 2020 payment.
      i. OP-37a: OAS CAHPS – About Facilities and Staff
      ii. OP-37b: OAS CAHPS – Communication About Procedure
      iii. OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
      iv. OP-37d: OAS CAHPS – Overall Rating of Facility
      v. OP-37e: OAS CAHPS – Recommendation of Facility.

   Hospitals would be required to contract with a CMS-approved vendor to collect survey data on a monthly basis for quarterly reporting to CMS. For the 2020 payment determination, data would be collected during CY18.

7) **Inpatient Only**: CMS proposes to remove the following procedures from the inpatient only list in CY17.

CPT Code	Code Descriptor	Proposed CY 2017 APC Assignment	Proposed CY 2017 Status Indicator
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation). List separately in addition to code for primary procedure.	N/A	N
22842	Posterior segmental instrumentation (eg, pedicle fixation,dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments. List separately in addition to code for primary procedure.	N/A	N
22845	Anterior instrumentation; 2 to 3 vertebral segments. List separately in addition to code for primary procedure.	N/A	N
22858	Total disc arthroplasty (artificial disc), anterior approach including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical. List separately in addition to code for primary procedure.	N/A	N
31584	Laryngoplasty; with open reduction of fracture	5165	J1
31587	Laryngoplasty, cricoid split	5165	J1

In addition, CMS asks for public comments on removing total knee arthroplasty (TKA) from the I/P only list at some point in the future.

8) **EHR/Meaningful Use**: CMS is proposing four changes to the electronic health record (EHR) Incentive Program:

a. Reporting Period: The proposed rule shortens the EHR reporting period to any continuous 90-day period between January 1, 2016, and December 31, 2016.
b. New Participants in 2017: eligible providers (EPs), eligible hospitals, and critical access hospitals (CAHs) that have not successfully demonstrated meaningful use in a prior year would be required to attest to Modified Stage 2 by October 1, 2017. Returning EPs, eligible hospitals, and CAHs will report to different systems in 2017, and therefore would not be affected by this proposal.
c. Hardship Exception for New Participants Transitioning to Merit-Based Incentive Payment System (MIPS): EPs who have not demonstrated meaningful use in a prior year can apply for a significant hardship exception from the 2018 payment adjustment if they:
    i. Intend to attest to meaningful use for an EHR reporting period in 2017.
    ii. Intend to transition to MIPS and report on measures specified for the advancing care information performance category under the MIPS, as proposed in 2017.
d. Modifications to Measures for Actions Outside of the EHR Reporting Period: The proposed rule changes the policy for measure calculations such that, for all meaningful use measures,

unless otherwise specified, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.

9) **Ambulatory Surgical Center (ASC) Conversion Factor**: The proposed ASC conversion factor is $44.684 for those that report quality data. For ASCs that do not report quality data the conversion factor is $43.801.

10) **ASC Overall Impact**: CMS estimates that payments to ASCs will increase by approximately $80m for CY17. Below is the projected impact of the payment update and related policy changes on the six largest ASC payment groups.

Summary of Table 31: Aggregate Proposed 2017 Medicare Program Payments by Surgical Specialty, for the six largest groups		
Surgical Specialty Group	**Estimated 2016 ASC Payments (in Millions)**	**Estimated 2017 Percent Change**
Total	**$4,020**	**2%**
Eye and ocular adnexa	$1,567	1%
Digestive system	$819	-1%
Nervous system	$692	3%
Musculoskeletal system	$469	6%
Genitourinary system	$180	0%
Integumentary system	$133	-2%

Appendix I: 2017 C-APC List: Includes Newly Proposed C-APCs

C-APC	2017 APC Title	Clinical Family	Proposed New C-APC
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	EBIDX	*
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	EBIDX	*
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	*
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	*
5093	Level 3 Breast/Lymphatic Surgery & Related Procedures	BREAS	
5094	Level 4 Breast/Lymphatic Surgery & Related Procedures	BREAS	
5112	Level 2 Musculoskeletal Procedures	ORTHO	*
5113	Level 3 Musculoskeletal Procedures	ORTHO	*
5114	Level 4 Musculoskeletal Procedures	ORTHO	
5115	Level 5 Musculoskeletal Procedures	ORTHO	
5116	Level 6 Musculoskeletal Procedures	ORTHO	
5153	Level 3 Airway Endoscopy	AENDO	*
5154	Level 4 Airway Endoscopy	AENDO	*
5155	Level 5 Airway Endoscopy	AENDO	*
5164	Level 4 ENT Procedures	ENTXX	*
5165	Level 5 ENT Procedures	ENTXX	
5166	Cochlear Implant Procedure	COCHL	
5191	Level 1 Endovascular Procedures	VASCX	*
5192	Level 2 Endovascular Procedures	VASCX	
5193	Level 3 Endovascular Procedures	VASCX	
5194	Level 4 Endovascular Procedures	VASCX	
5200	Implantation Wireless PA Pressure Monitor	WPMXX	*
5211	Level 1 Electrophysiologic Procedures	EPHYS	

C-APC	2017 APC Title	Clinical Family	Proposed New C-APC
5212	Level 2 Electrophysiologic Procedures	EPHYS	
5213	Level 3 Electrophysiologic Procedures	EPHYS	
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	
5224	Level 4 Pacemaker and Similar Procedures	AICDP	
5231	Level 1 ICD and Similar Procedures	AICDP	
5232	Level 2 ICD and Similar Procedures	AICDP	
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	*
5302	Level 2 Upper GI Procedures	GIXXX	*
5313	Level 3 Lower GI Procedures	GIXXX	*
5331	Complex GI Procedures	GIXXX	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	*
5361	Level 1 Laparoscopy & Related Services	LAPXX	
5362	Level 2 Laparoscopy & Related Services	LAPXX	
5373	Level 3 Urology & Related Services	UROXX	*
5374	Level 4 Urology & Related Services	UROXX	*
5375	Level 5 Urology & Related Services	UROXX	
5376	Level 6 Urology & Related Services	UROXX	
5377	Level 7 Urology & Related Services	UROXX	
5414	Level 4 Gynecologic Procedures	GYNXX	*
5415	Level 5 Gynecologic Procedures	GYNXX	
5416	Level 6 Gynecologic Procedures	GYNXX	
5431	Level 1 Nerve Procedures	NERVE	*
5432	Level 2 Nerve Procedures	NERVE	*

C-APC	2017 APC Title	Clinical Family	Proposed New C-APC
5462	Level 2 Neurostimulator & Related Procedures	NSTIM	
5463	Level 3 Neurostimulator & Related Procedures	NSTIM	
5464	Level 4 Neurostimulator & Related Procedures	NSTIM	
5471	Implantation of Drug Infusion Device	PUMPS	
5491	Level 1 Intraocular Procedures	INEYE	*
5492	Level 2 Intraocular Procedures	INEYE	
5493	Level 3 Intraocular Procedures	INEYE	
5494	Level 4 Intraocular Procedures	INEYE	
5495	Level 5 Intraocular Procedures	INEYE	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5627	Level 7 Radiation Therapy	RADTX	
5881	Ancillary Outpatient Services When Patient Dies	N/A	
8011	Comprehensive Observation Services	N/A	

CLINICAL FAMILY DESCRIPTOR KEY:

C-APC Clinical Family Descriptor Key:

AENDO = Airway Endoscopy

AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices.

BREAS = Breast Surgery

COCHL = Cochlear Implant

EBIDX = Excision/ Biopsy/ Incision and Drainage

ENTXX = ENT Procedures

EPHYS = Cardiac Electrophysiology

EXEYE = Extraocular Ophthalmic Surgery

GIXXX = Gastrointestinal Procedures

GYNXX = Gynecologic Procedures

INEYE = Intraocular Surgery

LAPXX = Laparoscopic Procedures

NERVE = Nerve Procedures

NSTIM = Neurostimulators

ORTHO = Orthopedic Surgery

PUMPS = Implantable Drug Delivery Systems

RADTX = Radiation Oncology

SCTXX = Stem Cell Transplant

UROXX = Urologic Procedures

VASCX = Vascular Procedures

WPMXX = Wireless PA Pressure Monitor