Executive Summary: CMS 2017 OPPS Final Rule

Key Financial and Operational Impacts from the Final 2017 Outpatient Prospective Payment System (OPPS) Rule:

The 2017 OPPS final rule was made available on November 1st. A detailed summary of the rule will be available on HFMA's Regulatory Resources Page.

1) **Conversion Factor Update**: In 2017, the final OPPS conversion factor is $75.001 for hospitals that report quality data. For those that don't, it is $73.526.

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). This remains unchanged from the proposed rule.

3) **Overall Impact**: CMS estimates that, compared to 2016, policies in the final 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 1.65% increase in the conversion factor, coupled with other policy changes in the final 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 final changes will effect revenue for fiscal year 2017 (FY17) for different types of hospitals:

Hospital Type	2017 Final Rule Impact
All Facilities	1.70%
Urban	1.80%
Large Urban	1.70%
Other Urban	1.80%
Rural	2.20%
Major Teaching	1.50%
Type of Ownership	
Voluntary	1.90%
Proprietary	1.80%
Government	1.60%
CMHCs	-13.70%

   When projected changes for enrollment, utilization, and case mix are factored in OPPS payments are projected to increase by $5.0 B in 2017. However, this figure does not include an estimated $50 million in program savings resulting from the proposed implementation of section 603 of the Bipartisan Budget Act of 2015.

4) **Provider Based Issues**: The final 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 defines "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 department (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 final rule attempts to resolve a number of key issues that section 603 did not specifically address:

   a. *Clinic Relocation*: CMS finalizes a 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. However, the final rule also adopts an extraordinary circumstances policy to account for the need to relocate that is beyond a hospital's control. Exceptions to the relocation policy will be evaluated on a case-by-case basis by the appropriate CMS Regional Office. CMS will release sub-regulatory guidance that provides further details.
   b. *Expansion of Clinical Family of Services*: In response to guidance from HFMA and others, CMS reversed its proposed prohibition on expanding the services provided in a non-exempted provider based clinic. Non-exempt provider based clinics may now add new "clinical families" of services that will be paid under OPPS. However, CMS notes in the final rule that it will monitor this activity.
   c. Change in Ownership: CMS finalizes its proposal 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. CMS, in the final rule, reiterates 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 finalizes 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): The proposed rule stated that unless a non-exempted HOPD converts to a freestanding

provider type (e.g. physician clinic or ASC) there would be no payment made directly to the hospital during CY17 because it had not identified the "applicable payment system" is for non-exempted off-campus HOPD departments. Based on feedback from HFMA and other stakeholders, CMS states in the interim final rule with comment period that it will pay claims for services delivered in non-exempt provider based departments. Hospitals will continue to bill on a UB using claim line modifier "PN" to indicate that the service was provided in a non-exempt provider based setting. Most services provided during CY17 will be paid at 50% of the OPPS rate, and the packaging policies that exist under OPPS will remain in effect. A major exception to this policy is separately payable Part B drugs which will continue to be paid at average sales price +6%.

e. 340B Impact: Facility costs for nonexcepted items and services will continue to be billed and reflected as reimbursable costs on the Medicare hospital cost report. CMS will issue sub-regulatory guidance on the cost report treatment of these items. However, CMS refers readers in the final rule to Health Resources and Services Administration for questions related to the "child-site" status of non-exempt HOPDs.

5) **Comprehensive APCs**: CMS adds 25 additional Comprehensive Ambulatory Payment Classification (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 finalized for 2017.

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

   a. Admissions and Emergency Department Visits for Patient 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, or
      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 7 days of the surgery.
   c. Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems: Five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)-based measures are final for addition to the hospital Outpatient Quality Reporting 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 removes the six proposed procedures from the inpatient only list in CY17. Additionally, in response to comment, it removes CPT 22585 from the list.

CPT Code	Code Descriptor	Final CY 2017 APC Assignment	Final CY 2017 Status Indicator
22585	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (List separately in addition to code for primary procedure)	N/A	N
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

8) **EHR/Meaningful Use**: CMS is proposing four changes to the Electronic Health Record (EHR) Incentive Program:
   a. Reporting Period: The final rule shortens the EHR reporting period to any continuous 90-day period between January 1, 2016, and December 31, 2016, for eligible hospitals (EHs), critical access hospitals (CAHs), and physicians. The final rule also provides EHs and CAHs at 90 day reporting period in 2017.
   b. New Participants in 2017: Eligible providers (EPs), eligible hospitals, and 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 final in 2017.

d. Modifications to Measures for Actions Outside of the EHR Reporting Period: The final 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) **ASC Conversion Factor**: The final ASC conversion factor is $45.030 for those that report quality data. For ASCs that do not report quality data, the conversion factor is $44.330.

10) **ASC Overall Impact**: Below is the projected impact of the payment update and related policy changes on the six largest ASC payment 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	$469	6%
Genitourinary system	$180	0%
Integumentary system	$133	-2%

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

C-APC	2017 APC Title	Clinical Family	Final 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	
5212	Level 2 Electrophysiologic Procedures	EPHYS	

C-APC	2017 APC Title	Clinical Family	Final New C-APC
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	*
5303	Level 3 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	*
5462	Level 2 Neurostimulator & Related Procedures	NSTIM	

C-APC	2017 APC Title	Clinical Family	Final New C-APC
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