The CY 2017 Outpatient PPS Payment System Proposed Rule: What You Need to Know
CY 2017 Outpatient PPS Timelines

• Proposed rule issued July 6
• Published in July 14 Federal Register
• Comments due by Sep. 6
• Final Rule will be issued around November 1
• Effective on Jan. 1, 2017
Agenda

- Proposed Implementation Section 603 Site-Neutral Payment Policy: Roslyne Schulman
- Section 603 Legislative and Grass Roots Activities: Lisa Kidder
- Other OPPS Proposed Rule Payment Policies: Roslyne Schulman
- Hospital Outpatient Quality Reporting Program Proposed Changes: Akin Demehin
- Proposed Changes to Electronic Health Record Policy: Diane Jones

Today's presentation will be available shortly at www.aha.org/oppswebinar
CMS proposes to implement Section 603 of the Bipartisan Budget Act of 2015. Requires,
- With exception of dedicated ED items and services,
- All items and services furnished in new off-campus provider-based departments (PBDs) (i.e. those that started billing under OPPS on or after Nov. 2, 2015)

 would,

- No longer be “covered outpatient department services” (that is, would not paid under OPPS)
- Instead, paid under other Part B “applicable payment systems”
- Starting Jan. 1, 2017
CMS proposes to implement Sec. 603 by

- Defining “excepted items and services” as those items and services that are excluded, or “excepted,” from Section 603 site neutral payment…therefore would still paid under OPPS as of Jan. 1, 2017.

- Defining “off-campus PBDs” and proposing requirements that allow certain off-campus PBDs to retain their “excepted” status.

- Establishing new payment policies for “non-excepted” items and services under another Part B “applicable payment system.”
Sec. 603: “Excepted Items and Services”

“Excepted items and services” include:

- Items and services furnished in dedicated ED
- Items and services that meet all of following:
  - PBD submitted bill under OPPS before Nov. 2, 2015,
  - Items and services furnished at same location the PBD furnishing services as of Nov. 1, 2015, and
  - Items and services are in same clinical family of services as those PBD furnished before Nov. 2, 2015
Sec. 603: “Excepted Items and Services”

• Dedicated EDs
  – Sec. 603 refers to EMTALA definition of ED
  – Defines an ED as: any on- or off-campus department/facility that meets at least one of following criteria:
    • Licensed by its State as an ED;
    • Held out to public as place that provides care for emergency medical conditions on urgent basis without requiring a previously scheduled appointment; or
    • During previous year, provided at least 1/3 of all its outpatient visits for treatment of emergency medical condition on urgent basis without requiring a previously scheduled appointment.

• Therefore, CMS proposes that ALL items and services furnished in a dedicated ED, regardless of whether or not they are emergency services, would continue to be paid under OPPS.
Sec. 603: “Excepted Items and Services”

• **On-campus Locations**
  – All on-campus PBDs, and items and services they furnish, excepted from site-neutral payment reductions.
  – Per law, “on-campus” defined using provider-based regulations definition (42 CFR 413.65)
    • “the physical area immediately adjacent to the provider's main buildings…located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.”

• **Within 250 yards of a “remote location of a hospital”**
CMS uses “snapshot” approach for excepted off-campus PBDs that make changes.
- Based on regulatory definition: “Department of a provider” includes *specific physical facility* and the *personnel and equipment* needed to deliver services at that facility.

**Relocation of Excepted Off-campus PBDs**
- To be excepted, excepted PBD *must maintain same physical address it had as of Nov. 1, 2015* (including unit number).
- Any relocation would result in loss of “excepted” status.
- Exceptions possible: CMS requests comment for “clearly defined, limited relocation exceptions” for “extraordinary circumstances” outside of control of hospital. E.g. due to natural disaster.
Sec. 603: Proposed Policies for Changes to Excepted Off-campus PBDs

• Expansion of services at excepted off-campus PBDs.
  – OPPS rates available only for those items and services furnished and billed prior to Nov. 2, 2015.
  – CMS proposes: Any expansion of services beyond clinical families of service that were furnished before Nov. 2, 2015 would be paid according to the site-neutral payment policy.
    • Note: Only those items and services in new clinical families are proposed to be subject to site-neutral payment policy. Services furnished within existing “excepted” families of service would continue to be paid under OPPS.
## Sec. 603: Proposed Clinical Families of Services

<table>
<thead>
<tr>
<th>Clinical Families</th>
<th>APCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Imaging</td>
<td>5523-25, 5571-73, 5593-4</td>
</tr>
<tr>
<td>Airway Endoscopy</td>
<td>5151-55</td>
</tr>
<tr>
<td>Blood Product Exchange</td>
<td>5241-44</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>5771, 5791</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>5691-94</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>5721-24, 5731-35, 5741-43</td>
</tr>
<tr>
<td>Ear, Nose, Throat (ENT)</td>
<td>5161-66</td>
</tr>
<tr>
<td>General Surgery</td>
<td>5051-55, 5061, 5071-73, 5091-94, 5361-62</td>
</tr>
<tr>
<td>Gastrointestinal (GI)</td>
<td>5301-03, 5311-13, 5331, 5341</td>
</tr>
<tr>
<td>Gynecology</td>
<td>5411-16</td>
</tr>
<tr>
<td>Minor Imaging</td>
<td>5521-22, 5591-2</td>
</tr>
<tr>
<td>Musculoskeletal Surgery</td>
<td>5111-16, 5101-02</td>
</tr>
<tr>
<td>Nervous System Procedures</td>
<td>5431-32, 5441-43, 5461-64, 5471</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5481, 5491-95, 5501-04</td>
</tr>
<tr>
<td>Pathology</td>
<td>5671-74</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5611-13, 5621-27, 5661</td>
</tr>
<tr>
<td>Urology</td>
<td>5371-77</td>
</tr>
<tr>
<td>Vascular/Endovascular/Cardiovascular</td>
<td>5181-83, 5191-94, 5211-13, 5221-24, 5231-32</td>
</tr>
<tr>
<td>Visits and Related Services</td>
<td>5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841</td>
</tr>
</tbody>
</table>
Sec. 603: Proposed Policies for Changes to Excepted Off-campus PBDs

• Changes of Ownership and Excepted Status
  – CMS Proposal: Excepted status of off-campus PBDs can ONLY be retained if:
    • a hospital, in its entirety, has change of ownership and
    • new owner accepts the existing Medicare provider agreement from prior owner.
  – If provider agreement terminated, all excepted off-campus PBDs would no longer be excepted.
  – Individual excepted off-campus PBDs would not be permitted to be transferred from one hospital to another and retain excepted status.
CMS requesting input: Should hospitals be required to self-report certain information? Specifically:

- Separately identify all individual excepted off-campus PBD locations,
- The date that each excepted off-campus PBD began billing, and
- The clinical families of services that were provided by the excepted off-campus PBD prior to Nov. 2, 2015?
Sec. 603: Payment for Services Furnished in Non-excepted Off-campus PBDs

- Section 603 requires payment under another Part B “applicable payment system” for items and services furnished by non-excepted off-campus PBDs.
- For CY 2017, CMS proposes that the Medicare physician fee schedule (PFS) would be the “applicable payment system” for non-excepted items/services furnished in an off-campus PBD.
  - Physicians furnishing such services would bill on professional claim (CMS 1500 Form) and be paid at higher “non-facility” rate under PFS for services for which they are eligible to bill.
  
  - **No payment would made directly to the hospital by Medicare.**
Sec. 603: Payment for Services Furnished in Non-excepted Off-campus PBDs

• CMS intends, in the future, to provide a way for off-campus PBDs to bill and receive payment for non-excepted items and services.
  – But claims it can’t do it in 2017 due to “numerous complex system changes that would need to be made.”
  – CMS requesting comment on whether an off-campus PBD should be allowed to bill for non-excepted services on professional claim and receive payment under PFS.
Impact of other statutory and regulatory provisions

- Payment proposal may result in hospitals establishing new business arrangements with the physicians/NPPs who bill under PFS, so CMS requesting comment on impact of its payment proposal on other billing and claims submission rules, such as:
  - Fraud and abuse laws, reassignment of billing rights limitations, self-referral provisions, anti-kickback law.

Impact of CMS’s proposal on 340B drug pricing program eligibility
CMS notes: Hospital would have option to enroll non-excepted off-campus PBD as another type of provider or supplier.

- E.g., group practice, IDTF or ASC
- Would be able to bill for non-excepted items and services under the alternate payment system, as long as it met the requirements to bill as these types of providers/suppliers.
Sec. 603: Payment for Services Furnished in Non-excepted Off-campus PBDs

- Status of certain services not payable under the OPPS
  - Laboratory Tests
    - If a lab test is eligible for separate payment under the CLFS, the hospital may continue to bill and receive payment under the CLFS.
  - Partial Hospitalization Program Services
    - As community mental health centers (CMHCs) also furnish PHP services and are ineligible to be provider-based to a hospital,
      - A non-excepted off-campus PBD would be eligible for PHP payment if the entity were to enroll and bill as a CMHC for payment under the OPPS.
• The AHA is extremely dismayed by the short-sighted Section 603 site-neutral policies in the proposed rule.
• These proposals are unreasonable and do not reflect the reality of how hospitals strive to serve the needs of their communities.
• It appears that CMS is aiming to freeze the progress of hospital-based health care in its tracks.
• We will submit detailed comments to the agency urging them to revise these misguided policies so that hospitals can continue to provide the highest quality health care to their communities.
Section 603 Legislative and Grass Roots Activities

Lisa Kidder
Legislative Activities

- Calendar
- Hill Champions
- Dear Colleague
- Legislation
  - How pay for
  - Mid-build legislation
Grassroots Activities

• August - Virtual Advocacy Day
• September 13 – Advocacy Day in DC
• September 27 – GRON Meeting in DC
Other OPPS Proposed Rule Payment Policies

Roslyne Schulman
Proposed CY 2017 Payment Update

• CMS proposes a payment update of 1.55 percent for the CY 2017 OPPS.
  – Proposed payment update of -0.45 percent for hospitals that do not meet the Outpatient Quality Reporting program reporting requirements

• With this update and all other changes in the rule, hospitals would see a 1.7 percent increase in per-case payment
  – Urban hospitals, 1.4% increase
  – Rural hospitals at 2.3% increase

• CMS estimates a net increase in OPPS payments of about $671 million in CY 2017
Changes to the Inpatient-only List

• Six procedures proposed for removal from inpatient-only list in 2017; four spine procedure codes and two laryngoplasty codes

• CMS solicits comments on possible removal of Total Knee Arthroplasty (TKA), i.e. total knee replacement, from the inpatient-only list
  – Similar proposal made in 2013, but AHA and other opposed it, so CMS did not finalize.
  – CMS claims recent innovations make it safer to perform on an outpatient basis.
  – CMS requests comments on questions: e.g. how the agency could modify the CJR and BPCI models if the TKA procedure were removed from the list.
Comprehensive APCs (C-APCs)

• Currently 35 C-APCs in OPPS for CY 2016
  – C-APCs package an expanded number of related items and services contained on the same claim into a single payment for a comprehensive primary service (referred to as “J1” service).

• In CY 2017, CMS proposes 27 new C-APCs
  – Many are major surgery APCs within various existing C-APC clinical families
  – CMS proposes 3 new clinical families for new C-APCs
    • Nerve procedures, Excision/biopsy/incision/drainage procedures, Airway endoscopy procedures

• Proposal to develop a new C-APC and dedicated cost center for bone marrow transplants.
Proposed Changes to Packaging Policies: Laboratory Tests

• **Current OPPS packaging policy for lab tests:**
  
  – Costs of all laboratory tests are packaged unless:
    
    • Lab test is only service on claim
    • Unrelated tests on a claim – using “L1” modifier
    • Molecular pathology tests
    • Preventive tests

• **CY 2017 proposed changes**
  
  – Discontinue unrelated test exception (and “L1” modifier)
  
  – Expand molecular pathology tests exception to include all advanced diagnostic lab tests
Proposed Changes to Packaging Policy

• CMS proposes packaging at the claim level, instead of based on the date of service. Specifically,
  – Currently, status indicators “Q1” and “Q2” package the costs of items and services that occur on the same date of service.
  – For CY 2017, CMS proposes to align the packaging logic for all of its conditional packaging status indicators so packaging would occur at the claim level, rather than at the level of the date of service.
  – This change would expand the amount of packaging under OPPS.
Changes to Payment for Film X-Ray

- CMS proposes to implement provisions of the Consolidated Appropriations Act of 2016
  - CY 2017 and beyond: Reduces OPPS payment by 20% for X-rays taken using film
  - CY 2018-2022: Reduces OPPS payment by 7% for X-rays using computed radiography
  - CY 2023 and beyond: Reduces OPPS payment by 10% for X-rays using computed radiography
CMS proposes to increase drug packaging threshold to $110 per day
- Drugs costing more than $110/day separately paid under own APC; those costing less than $110 per day are packaged.

Exception for certain “policy-packaged” drugs
- Costs packaged regardless of cost per day

Separately paid drugs proposed to be paid at the rate of ASP plus 6%. 
Proposed Partial Hospitalization Program Payment

• Currently, there are four separate APCs for PHP services
  - Two APCs for each PHP setting – hospital-based and CMHC
    • One APC for PHP days with 3 services
    • One APC for PHP days with 4 or more services

• For CY 2017, CMS proposes to replace the two-tiered APC structure with a single APC for each provider-type
  - APC would be for PHP days with 3 or more services
HCAHPS & VBP Scoring Methodology

- Concerns about 3 pain-related questions in the HCAHPS survey

- CMS would no longer use questions in VBP calculations

- Questions will remain in the survey

- CMS is field testing new questions

AHA advocated for this approach and supports CMS’s proposal.
Hospital Outpatient Quality Reporting (OQR) Program Proposed Changes

Akin Demehin
Outpatient Quality Reporting Program

Seven Proposed New Measures for CY 2020

- Two claims-based measures (calculated by CMS)
  - OP-35: Admissions and ED Visits within 30 days of Outpatient Chemotherapy
  - OP-36: Hospital Visits within 7 days of outpatient surgery

- Five measures derived from new OAS CAHPS* Survey
  - OP-37a: OAS CAHPS – About Facilities and Staff
  - OP-37b: OAS CAHPS – Communication About Procedure
  - OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
  - OP-37d: OAS CAHPS – Overall Rating of Facility
  - OP-37e: OAS CAHPS – Recommendation of Facility

*OAS CAHPS = Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems
OAS CAHPS Survey Overview

• A 37-item survey intended to assess experience of patients undergoing surgeries and other procedures in HOPDs
  – Same family as HCAHPS, but different survey

• CMS would require reporting beginning with procedures on or after Jan. 1, 2018. Data would be collected monthly and submitted quarterly
  – Voluntary reporting began Jan. 1, 2016

• Hospitals must use CMS-approved survey vendors to collect and submit measure data. Survey can be collected using:
  – Mail only
  – Telephone only
  – Mixed mode (mail first with telephone follow up)
OAS CAHPS: Other Information

- Survey would be administered to random sample of all patients with relevant CPT/G codes

- Vendors would be expected to administer survey within 21 days of month when patient receives procedure
  - Patients have six weeks to reply
  - Vendors must make multiple attempts to contact

- CMS requires at least 300 complete surveys within 12 month reporting period
  - Exception available for HOPDs with fewer than 60 patients meeting inclusion criteria
  - Other hospitals would be expected to report as many completed surveys as possible
Proposed Changes to Electronic Health Record (EHR) Policy

Diane Jones
Proposed Changes to EHR Incentive Program for Hospitals and Critical Access Hospitals

• CMS proposes several changes to the EHR Incentive Program:
  – Revise the objectives and measures for EHs and CAHs for Modified Stage 2 and Stage 3 starting with the EHR reporting periods in CY 2017.
  – Change the EHR reporting period in CY 2016 for EHs, CAHs and EPs
  – Revise the reporting period for EHs, CAHs and EPs that are new program participants in CY 2017.
  – Clarify the policy on measure calculations for actions outside the EHR reporting period.
  – Revise the significant hardship exception from the 2018 payment adjustment for new EPs in the EHR Incentive Program in CY 2017
EHR Incentive Program: Positive Proposals for Modified Stage 2

- A proposed reporting period of any 90 days for all EHs, CAHs and EPs in 2016.
  - Any 90 day reporting period for eCQMs in 2016.

- A proposed revised the Modified Stage 2 Patient Electronic Access measure from five percent of all unique patients to at least one unique patient.

- A proposal to remove the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and associated measures from Modified Stage 2 in CY 2017.
EHR Incentive Program:  
Positive Proposals for 2017

• CMS proposes to allow EPs to apply for a significant hardship exception from the 2018 payment adjustment if they have not successfully demonstrated meaningful use in a prior year, intend to attest to meaningful use for an EHR reporting period in CY 2017 by October 1, 2017 and intend to transition to MIPS and report on measures specified for the advancing care information performance category under the MIPS in CY 2017
EHR Incentive Program: Positive Proposals for Stage 3

• Proposal to reduce seven measure thresholds for the requirements included in Stage 3.
  – Patient Access Measure: CMS proposes to reduce the threshold to more than **50 percent** of all unique patients, down from the final Stage 3 threshold of 80 percent.
  – Patient-Specific Education Measure: CMS proposes to reduce the threshold to more than **10 percent** of all unique patients, down from the final Stage 3 threshold of 35 percent.
  – View/Download/Transmit Measure: CMS proposes that **at least one unique patient** must engage with the certified EHR to view/download or transmit or access their health information through the use of an API that can be used by applications of the patient’s choice, down from 10 percent.
EHR Incentive Program:
Positive Proposals for Stage 3

– Secure Messaging: CMS proposes that for more than five percent of all unique patients discharged a secure message is sent or received, down from the final Stage 3 threshold of 25 percent.

– Patient Care Record Exchange Measure: CMS proposes that for more than 10 percent of transitions of care and referrals a summary of care is created and exchanged using the certified EHR, down from the final Stage 3 threshold of 50 percent.
Request/Accept Patient Care Record Measure: CMS proposes that for more than 10 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, an electronic summary of care is incorporate, down from the final Stage 3 threshold of 40 percent.

Clinical Information Reconciliation Measure: CMS proposes that for more than 50 percent of transitions or referrals, the EH or CAH performs a clinical information reconciliation for three clinical information sets: medications, allergies and current problem list, down from the final Stage 3 threshold of 80 percent.
EHR Incentive Program: Areas of Concern

- Continuation of the all or nothing approach where providers must meet each objective and several measure thresholds within each objective to successfully meet program requirements.

- Retain several unrealistic Stage 3 requirements:
  - The required use of application program interfaces (APIs) to connect any app of the patient’s choice to the EHR in support of the patient engagement and coordination of care through patient engagement objectives.
  - The required incorporation into the EHR of patient generated health data or data from a non-clinical setting for more than five percent of all unique patients.
Questions?

Roslyne Schulman
rschulman@aha.org

Lisa Kidder
lkidder@aha.org

Akin Demehin
ademehin@aha.org

Diane Jones
djones@aha.org

Today's presentation will be available shortly at
www.aha.org/cy17opps