PUBLICATION

CMS Releases the 2016 OPPS Final Rule [Ober|Kaler]

2016

On November 1, 2016, CMS published its final policy changes, quality provisions, and payment rates for 2017, as they relate to the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Below are some of the highlights of the final rule.

OPPS Payment Update

CMS will increase the OPPS payment rates by a factor of 1.65 percent for CY 2017. Considering other finalized policy changes, CMS anticipates a 1.7 percent payment increase for hospitals paid under OPPS in CY 2017. CMS based the final increase on a 2.7 percent increase for inpatient services paid under the IPPS, minus the .3 multifactor productivity adjustment, and minus the Affordable Care Act's .75 adjustment factor.

Further, CMS will continue:

- The 2 point reduction in payments for those hospitals that fail to meet the outpatient quality reporting requirements.
- The 7.1 percent adjustment to OPPS payments to rural sole community hospitals and essential access community hospital (excluding certain separately payable items and devices and items paid at charges reduced to cost).
- Making additional payments to cancer hospitals to ensure that their payment-to-cost ratios, with the additional payments, equate with the weighted average payment-to-cost ratio for other OPPS hospitals.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS finalized adding 25 new C-APCs, many of which are major surgery APCs. As of January 1, 2017, the total number of C-APCs will be 62.

Refining the Packaged Services Policy

In the proposed rule, CMS highlighted its belief that packaging items and services together encourages efficiency and cost-containment. CMS finalized its proposal to package at the claim level instead of the date of service level to help ensure appropriate packaging of services provided over a multi-day hospital stay.

Device-Intensive Procedures

To ensure that device-intensive status is properly assigned, CMS finalized the device-intensive calculation methodology to calculate the offset amount at the HCPCS code level, instead of the APC level. In addition, CMS will determine the payment rate for device-intensive procedures assigned to APCs with fewer than 100 total claims for all procedures using the median cost, rather than the geometric mean cost. CMS expects that its finalized approach will help address year-to-year payment rate fluctuations.

Provider-Based Changes: Implementation of Section 603 of the Bipartisan Budget Act (BBA) of 2015

CMS implemented section 603 of the BBA such that items and services furnished in select off-campus provider-based departments will not be covered by OPPS payments beginning January 1, 2017. Instead, those services will be covered by the newly established Medicare Physician Fee Schedule, addressed in an interim final rule with comment period. The Medicare Physician Fee Schedule rates apply to certain items and services furnished by certain off-campus provider-based departments.

ASC Payment Update

CMS finalized its proposal to increase the ASC payment rates. For CY 2017, the payment rates for those ASCs that meet the quality reporting requirements will be increased by 1.9 percent.

ASC Quality Reporting Program

CMS also finalized its proposals for 2018, 2019, and 2020 payment determinations. For CY 2018, CMS will publicly display data on its Hospital Compare web site, or another site, shortly after the measure data is submitted. ASCs will generally be given 30 days to preview their data. For CY 2019, CMS finalized its proposal to move the submission deadline to May 15, as well as its proposal to permit 90 day extensions for extraordinary circumstances. For CY 2020 and subsequent years, CMS finalized the seven proposed measures.

Updates to the Hospital Value-Based Purchasing Program

Through this final rule, CMS removed the HCAHPS Pain Management portion from the Hospital Value-Based Purchasing Program. In the proposed rule, CMS expressed concern that linking pain management questions to the Hospital Value-Based Purchasing Program would pressure staff to prescribe opioids. The removal will be effective at the start of the FY 2018 program year.

EHR Incentive Program

CMS finalized proposed changes to meaningful use objectives and measures for Modified Stage 2 and 3. For Stage 2 2017, and Stage 3 in 2017 and 2018, CMS eliminated the Clinical Decision Support and Computerized Provider Order Entry objectives and measures for eligible hospitals and CAHs. CMS also lowered the reporting thresholds for the other objectives and measures.

CMS expects the removal to result in reduce administrative burdens on hospitals and CAHs, which in turn allows them to focus on providing quality patient care and optimizing CEHRT functionalities.

CMS finalized several additional revisions to (a) the reporting period in CYs 2016 and 2017 for eligible professionals, hospitals, and CAHs, (b) the reporting requirements for eligible professionals, hospitals, and CAHs that are new participants in 2017, and (c) the policy regarding calculations for actions outside the EHR reporting period. Lastly, for eligible professionals who are new participants to the EHR incentive program and who are moving to the Merit-Based Incentive Payment System in 2017, CMA finalized a one-time significant hardship exception from the 2018 payment adjustment.