PUBLICATION

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

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On July 15, CMS published its proposed [PDF] 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. Comments are due by September 6, 2016. Below are some of the highlights of the proposed rule.

OPPS Payment Update

Per the requirement for an annual review and update, CMS proposes increasing the OPPS rates by 1.55%. CMS bases the proposed increase on the 2.8% proposed hospital inpatient market basket increase, minus the Affordable Care Act's adjustment factor of .05, and minus the .05 proposed multifactor productivity adjustment. In addition, CMS proposes to continue the 2 point reduction in payments for those hospitals that fail to meet the outpatient quality reporting requirements.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS proposes adding 25 new C-APCs, most of which are major surgery APCs. CMS also proposes three new clinical families to address the new C-APCs.

Refining the Packaged Services Policy

CMS highlights its belief that packaging items and services together encourages efficiency and cost-containment. For 2017, CMS proposes packaging at the claim level instead of the date of service level. CMS contends this approach would “promote consistency and ensure that items and services that are provided during a hospital stay that may span more than one day are appropriately packaged according to OPPS” policy. (81 FR 45611).

Device-Intensive Procedures

CMS proposes revising the device-intensive calculation methodology to calculate the offset amount at the HCPCS code level. Further, to address significant rate fluctuations for low-volume device-intensive procedures, CMS proposes basing the payment rate on the median cost for device-intensive procedures assigned to APCs with fewer than 100 total claims for all procedures in the APC.

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

CMS proposes regulations to implement Section 603 of the BBA. That section affects how Medicare covers items and services furnished by provider-based departments. Section 603 specifies that off-campus sites that had not furnished services and submitted “provider-based” billings to Medicare as of November 1, 2015, would be considered “new” and, effective January 1, 2017, would no longer be able to bill Medicare under the OPPS.

Instead, Medicare would pay for services as if the locations were freestanding. Tom Coons sheds light on the Secretary's proposed regulations, as well as the numerous complications that could arise should the regulations be implemented – please see his detailed article here.

ASC Payment Update

CMS proposes increasing the payment rates for the ASC system by 1.2% for those ASCs that meet the quality reporting requirements. CMS bases its proposal on the projected 1.7% CPI-U update minus the Affordable Care Act's .5 productivity adjustment.

ASC Quality Reporting Program

CMS introduces proposals for the 2018, 2019 and 2020 payment determinations. Specifically, CMS proposes displaying data on the Hospital Compare website as quickly as possible following the submission of data. CMS also proposes giving ASCs around 30 days to preview the data. For 2019 and beyond, CMS proposes making May 15 the submission deadline for all CMS web-based tool submissions, though CMS would permit extensions for Extraordinary Circumstance Extensions and Exemptions requests.

In 2020 and subsequent years, CMS proposes adopting two measures collected via a CMS web-based tool and five survey-based measures:

The two proposed measures that require data to be submitted directly to CMS via a CMS Web-based tool are: (1) ASC–13: Normothermia Outcome and (2) ASC–14: Unplanned Anterior Vitrectomy. The five proposed survey-based measures are: (1) ASC– 15a: OAS CAHPS—About Facilities and Staff; (2) ASC–15b: OAS CAHPS— Communication About Procedure; (3) ASC–15c: OAS CAHPS—Preparation for Discharge and Recovery; (4) ASC–15d: OAS CAHPS—Overall Rating of Facility; and (5) ASC–15e: OAS CAHPS—Recommendation of Facility. (81 FR 45612).

Updates to the Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing (VBP) Program calls for CMS to make value-based incentive payments to hospitals based on performance. CMS proposes removing the HCAHPS Pain Management portion of the Hospital VBP Program as of fiscal year 2018. The concern is that linking pain management questions to the Hospital VBP Program would unduly pressure staff to prescribe added opioids. CMS decided to remove the Pain Management dimension questions and is testing alternative questions. CMS intends to publish additional requirements for the Hospital VBP Program in the FY 2017 IPPS/LTCH PPS final rule.

EHR Incentive Program

CMS proposes removing the Clinical Decision Support and Computerized Provider Order Entry objectives and measures for meaningful use Stage 2 and Stage 3. To respond to industry input, CMS also proposes lowering the reporting thresholds for a portion of the other objectives and measures. CMS' goal is to reduce the administrative burden on hospitals. Additionally, CMS proposes revising: (a) the reporting period in 2016 for eligible professionals, hospitals, and critical access hospitals; (b) the reporting requirements for eligible professionals, hospitals, and those critical access hospitals that are new participants in 2017; and (c) its policy regarding measure calculations for actions beyond the EHR reporting period. Lastly, for certain professionals who are new participants to the EHR incentive program and who are moving to the Merit-Based Incentive

Payment System in 2017, CMS proposes creating a significant hardship exception from the 2018 payment adjustment.