

PUBLICATION

CMS Issues CY 2016 Proposed Rule for OPPS, ASC Payment Systems and Quality Reporting [Ober|Kaler]

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On July 8, 2015, CMS published in the Federal Register [PDF] its proposed changes and updates to the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System policy changes, quality provisions, and new payment rates that would apply in calendar year (CY) 2016. Comments are due by August 31, 2015.

Below are some of the highlights of the proposed rule.

Two-Midnight Rule

The proposed update to the Two-Midnight Rule would change the standard by which inpatient admissions generally qualify for Medicare Part A payment, to emphasize the role of physician judgment.

For stays expected to last less than two midnights, the proposed rule makes inpatient admissions payable under Part A on a case-by-case basis based on the judgment of the admitting physician. Documentation must support that an inpatient admission is necessary. CMS reiterates that admissions for minor surgical procedures and other treatments for which patients are expected to be in the hospital for only a few hours, rarely should result in a stay spanning two midnights. Meanwhile, for stays over two midnights, the policy remains unchanged. Further, CMS has decided to use Quality Improvement Organizations (QIOs), rather than Medicare Administrative Contractors, to review inpatient short stays.

Proposed OPSS and ASC Payment Updates

The proposed rule updates the OPSS rates by -0.1 percent for hospitals paid under the OPSS in CY 2016. Similarly, the proposed rule makes a Medicare multifactor productivity adjustment to ASC payments, adjusting by a Consumer Price Index (urban) of 1.1 percent.

Laboratory Services

The proposed rule reduces the CY 2016 conversion factor by 2.0 percent to account for \$1 billion in inflation in the OPSS payments due to overestimated packaged payment under prior OPSS conversions. The proposed rule also changes the laboratory test packaging policy by adding a new conditional packaging status indicator for lab tests, so hospitals can receive separate payments for tests that are not tied to other OPSS services.

Restructuring of Ambulatory Payment Classifications (APCs)

The proposed rule will consolidate and reorganize many APCs, resulting in fewer APCs overall for nine clinical APC families:

- The proposed rule will add nine new Comprehensive APCs (C-APC), including some surgical APCs;

- CMS proposes to collect data through the use of a Healthcare Common Procedure Coding System modifier on all services related to a C-APC primary procedure reported on a separate claim; and
- The proposed rule will add a new C-APC for comprehensive observation services, to provide comprehensive payment for all services received while receiving comprehensive observation services (non-surgical encounters with a high level outpatient hospital visit and 8 or more hours of observation). Copayments are capped at inpatient deductible amounts.

Packaged Services

The proposed rule will conditionally package certain additional ancillary services, including certain minor procedures and pathology services, and also will conditionally package several drugs that are used as supplies in a surgical procedure.

Device Pass-through Process

In response to stakeholder requests for transparency and to align the process with the Inpatient Prospective Payment System, CMS proposes to include discussion of the preliminary decisions on the quarterly pass-through applications for payment (those approved and denied) for devices in the next OPSS proposed rule, and seeks comment on the proposed change. Further, the proposed rule adds new criteria for device pass-through applications, whereby any device that requires FDA approval or clearance would be considered a new device as evidenced by FDA approval or clearance that is no more than three years old.

Removal of Certain ASC Covered Ancillary Services Codes

The proposed rule would exclude radiation treatment using Co-60 stereotactic radiosurgery codes from the list of ASC covered ancillary services.

Partial Hospitalization Program (PHP) Per-Diem Update

The proposed rule updates Medicare payment rates for PHP services furnished in hospital outpatient departments and Community Mental Health Centers, to account for aberrant costs in the rate-setting process for PHPs. CMS is more clearly articulating the PHP rate-setting process to make it easier for providers to comprehend.

Hospital Outpatient Quality Reporting (OQR) Program Changes for 2017, 2018 and 2019 Payment Determinations

The proposed rule:

- Adds a measure for External Beam Radiotherapy for Bone Metastases;
- Adds a measure for Emergency Department Transfer Communication;
- Removes a measure for Use of Brain Computed Tomography in the Emergency Department for Atraumatic Headache; and
- Proposes policy changes to align with the Ambulatory Surgical Center Quality Reporting Program (ASCQR), including:
 - Changing the deadline for withdrawing the program from November 1 to August 31,

- Shifting the payment determination timeframe by requiring a one-time change in the timeframe, to cover three quarters instead of four,
- Changing the data submission timeframe for measures submitted using CMS's QualityNet Website, from July 1 through November 1, to January 1 through May 15, and
- Changing the reconsideration request deadline from the first business day in February to the first business day on or after March 17 for affected payment years

ASCQR - Request for Comments

The proposed rule requests comments on two outcome measures for future consideration:

- The Normothermia Outcome and
- The Unplanned Anterior Vitrectomy Outcome

CMS also proposes to exclude Indian Health Service hospital outpatient departments from ASCQR.