FY 2017 OPPS
Changes and More to Come

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Presentation Outline

- OPPS Overview
- Impact of the Final Rule
- Quality Matters
- Provider Based Changes
  - Prior to November 2, 2015
  - After November 2, 2015
  - American Cures Act
- Political Changes on the Horizon
- What providers should do.

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Revenues Trending IP vs. OP

- Inpatient revenues of 60 percent of charges but only 15 percent of the overall margin (IP and OP)
- 55 percent of charges are driven by Medicare and Medicaid
- 27 percent of charges are driven by managed care
- Managed care unit reimbursement at 209 percent of Medicare

- Outpatient revenues 40 percent of charges but 85 percent of the overall margin (IP and OP)
- 44 percent of charges are driven by Medicare and Medicaid
- 40 percent of charges are driven by managed care

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FY 2017 OPPS Overview

- CMS has proposed updating the OPPS rates by 1.55 percent in 2017. CMS arrived at its proposed rate increase through the following updates: a positive 2.8 percent market basket update, a negative 0.5 update for a productivity adjustment and a negative 0.75 percent update for cuts under the Affordable Care Act.
- After considering all other policy changes included in the proposed rule, CMS estimates OPPS payments would increase by 1.6 percent and ASC payments would increase by 1.2 percent in 2017.

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FY 2017 OPPS Overview

- The total increase in Medicare Expenditures for CY 2017 compared to CY 2016 will be approximately $177 million.

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FY 2017 OPPS Overview – Outliers

- The OPPS provides hospitals with a payment for cases that may result in high-cost and complex procedures where these costs could result in a significant financial loss to the hospital.
- Currently, the OPPS provides outlier payments on a service-by-service basis. It has been CMS's policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the OPPS.
- The current estimate of total outlier payments as a percent of the total CY 2015 OPPS payments, using available CY 2015 claims and the revised OPPS expenditure estimate from the 2017 President's Budget Mid-Session Review, is approximately 0.9 percent of the total aggregated OPPS payments. Therefore, for CY 2015, CMS estimates that it paid 1.0 percent below the CY 2015 outlier target of 1.0 percent of total aggregated OPPS payments.
- Using CY 2015 claims data and CY 2016 payment rates, CMS currently estimates that the aggregate outlier payments for CY 2015 will be approximately 0.96 percent of the total CY 2015 OPPS payments which is below the 1.0 percent target.
- The OPPS fixed-dollar threshold is $3,825 for CY 2017.

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FY 2017 OPPS Overview – Outliers

- For CY 2017, CMS did consider all of the public comments they had received and will continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. A portion of that 1.0 percent, an amount equal to 0.49 percent of outlier payments (or 0.0049 percent of total OPPS payments) would be allocated to CMHCs for PHP outlier payments. CMS also will continue to use their established methodology in setting the OPPS outlier fixed-dollar loss threshold for CY 2017.
- CMS estimated that a fixed-dollar threshold of $3,825 (CY 2016 $3,250), combined with the multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments.
- Further for CY 2017, CMS continues its longstanding policy that if a CMHC's cost for PHP services, paid under either APC 5853(*Level 1 Partial Hospitalization (3 services) for CMHCs*), exceeds 3.40 times the payment rate for APC 5853, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 5853 payment rate.
- CMS aggregated CY 2016 hospital outlier payments using the cost-to-charge ratios for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payments would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2017 OPPS payments.
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- CMS would continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the fixed-dollar threshold of $3,825 are met.

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FY 2017 OPPS Overview – Wage Index

- For CY 2017, the OPPS labor-related share will remain at 60 percent of the national OPPS payment.
- CMS will continue to use the provision it has used since CY 2011 with regards to Frontier State hospitals.
- Beginning in FY 2016 the Office of Management and Budget (OMB) issued revisions to the labor market area delineations on February 28, 2013 OMB Bulletin 13-01.
- These delineations were revised with OMB Bulletin 15-01, a copy of this bulletin may be obtained on the Web site at: https://www.whitehouse.gov/omb/bulletins_default.
- CMS implemented these revisions to the OMB statistical area delineations set forth in OMB Bulletin No. 15-01 to be effective January 1, 2017, beginning with the CY 2017 OPPS wage index values.

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FY 2017 OPPS Overview – Wage Index(cont'd)

- For CY 2017, CMS will also continue to apply the imputed floor policy
- CMS will also continue their policy of allowing non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (section 505 of the MMA).
- CMS refers readers to their website for the OPPS at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

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FY 2017 OPPS – Hospital Value Based Purchasing Program

- Beginning with the fiscal 2018 program year, CMS has proposed removing the pain management dimension of the HCAHPS survey for purposes of the Hospital Value-Based Purchasing Program.
- CMS decided to remove the pain management dimension after receiving feedback from industry stakeholders who believe linking patient satisfaction on pain management to VBP Program payment incentives puts pressure on hospital staff to prescribe more opioids. CMS said it is not aware of any scientific studies that support the belief that opioid prescribing practices are linked to the pain management dimension of the HCAHPS survey. However, CMS said it is proposing to remove the pain management questions in an "abundance of caution."

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FY 2017 OPPS – Electronic Health Record incentive program

- To offer greater flexibility in the meaningful use of EHRs, CMS has proposed a 90-day EHR reporting period in 2016 for all eligible professionals and hospitals. The reporting period would be any continuous 90-day period between Jan. 1, 2016, and Dec. 31, 2016.
- 10. Regarding meaningful use, CMS said it is not feasible for physicians and hospitals that have not demonstrated meaningful use in a prior year to attest to the Stage 3 objectives and measures in 2017. Under the proposed rule, these new participants would be required to attest to Modified Stage 2 by Oct. 1, 2017.

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FY 2017 OPPS – Hospital Quality Reporting Program

- For 2017, CMS has proposed adding seven measures to the Hospital Quality Reporting Program for the 2020 payment determination and subsequent years.

HCAHPS Survey Dimensions for the FY 2018 Program Year
Communication with Nurses
Communication with Doctors
Responsiveness of Hospital Staff
Communication About Medicines
Hospital Cleanliness & Quietness
Discharge Information
3-Item Care Transition
Overall Rating of Hospital

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Site Neutral Payment Provisions

- CMS proposed implementing the site-neutral payment provisions of Section 603 of the Bipartisan Budget of 2015, which states that off-campus provider-based departments (PBDs) that began billing under the OPPS on or after Nov. 2, 2015 would no longer be paid for most services under the OPPS. Instead, beginning Jan. 1, 2017, these facilities would be paid under other applicable Medicare Part B payment systems. CMS proposed that the physician fee schedule be the applicable payment system for the majority of services provided in new off-campus PBDs in 2017.
- . Under the proposed rule, services provided in a dedicated emergency department would continue to be paid under the OPPS.

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Site Neutral Provider

- ***Improved Clarity Implementing the 250-Yard Standard*** - The so-called 250-yard standard is the main method by which a PBD's on-campus status is determined. Given the new significance of on-campus designations to reimbursement for PBDs, there has been increased focus on precisely how 250 yards should be measured. The final rule does not expressly address the 250-yard standard for on-campus designations, but CMS did provide some insight into how the 250 yards should be measured. In discussing the exception for PBDs within 250 yards of a remote location of a hospital, CMS indicated that it would use an approach that is consistent with how it has "historically implemented the 250-yard criterion when making on-campus determinations." CMS stated that the 250 yards would be measured "from any point of the physical facility that serves as the site of services of the remote location to any point in the PBD." This approach appears to confirm that, for on-campus determinations, 250 yards should be measured from any point in the main hospital building(s) (i.e., the nearest wall or corner of the main hospital building) and "any point in the PBD." This would be a straight-line measurement, so it appears that a portion of the PBD could be further than 250 yards from the main hospital building as long as some part of the PBD does fall within the 250-yard measurement.

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Site Neutral Provider

- **Relocations Broadly Restricted, but Limited, Case-by-Case Exceptions may be Granted by Regional Offices Due to Extraordinary Circumstances -** CMS finalized its proposal that a relocation from the physical address in use on November 2, 2015 would cause a PBD to lose its excepted status. CMS did, however, indicate that a limited exceptions process would be created for use in extraordinary circumstances, including natural disasters, significant seismic building code requirements, and significant public health and public safety issues.

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Site Neutral Payments

- CMS proposed certain restrictions on off-campus PBDs that began billing under the OPPS prior to Nov. 2, 2015. For instance, these departments must continue to offer the same services and bill from the same physical address as they did on Nov. 2, 2015 to be excepted from the site-neutral payment provisions. However, CMS is requesting comment on whether there should be exceptions to this proposal for extraordinary circumstances that are outside the hospital's control

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Site Neutral Payments

- The American Hospital Association issued a statement expressing its disappoint with CMS' "short-sighted" proposal.
- "Hospitals and health systems and more than half of the House and the Senate requested that CMS provide reasonable flexibility when implementing Section 603 of the Balanced Budget Act of 2015 in order to ensure that patients have continued access to hospital care," Tom Nickels, executive vice president of government relations and public policy at the AHA, said. "Instead, the agency is actually proposing to provide no funding support for outpatient departments for the services they provide to patients. This does not reflect the reality of how hospitals strive to serve the needs of their communities. In addition, CMS' refusal to continue current reimbursement to hospitals that need to relocate or rebuild their outpatient facilities in order to provide needed updates and ensure patient access is unreasonable and troubling."

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21st Century American Cures Act

- 21st Century Cures Act signed into law on December 13, 2016 states among other items the mid-build requirement of this clause is, with respect to a department of a provider that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department the department would be eligible for OPPS rates after construction is complete and Medicare 855A and Attestation are completed and approved.

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What Actions Providers Should Take?

- Review all Outpatient Sites
- Ensure that the Hospital's 855 is current
- Complete Provider Based Attestations for all sites
- Be sure to be compliant with state regulations
- Perform cost studies to understand the impact of the payment changes
- Review Hospital campus for available square footage

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Future of the ACA

- ACA changes and the impact of OPPS reimbursement – Who Knows?

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Question & Answer

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