Issue Brief

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CMS Announces Final CY 2017 Hospital Outpatient PPS; ASC and Other Changes

KEY POINTS

- OPPS payment rate will increase by 1.65 percent or $773 million
- Implementation of Section 603 of the Bipartisan Budget Act of 2015 with modification from the proposed regulations
- ASC payment rate will increase by 1.9 percent or $177 million
- Hospital value-based purchasing program revisions

The Centers for Medicare & Medicaid Services has issued a final rule with a comment period to update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning Jan. 1, 2017.

A copy of the 1,378-page document is available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26515.pdf. Publication in the *Federal Register* is scheduled for Nov. 14. The above link will change upon publication.

A key item in this year's rule is the implementation of Section 603 of the *Bipartisan Budget Act of 2015*, which will affect how Medicare pays for certain items and services furnished by certain off-campus outpatient departments of a provider — hereinafter referenced as off-campus "provider-based departments" (PBDs). This item is of major concern to many hospitals. (See more information in the summary below.)

COMMENT

While the document contains a well written executive summary, there is much material that the executive summary simply does not provide or provide in sufficient detail.

Much of the summary material below is from the rule itself, and also a well written CMS fact sheet. The fact sheet is at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-01-3.html

Again, CMS still does not help the reader locate pertinent sections. The rule does not contain clear reference citations. With a table of contents extending some 28 pages, it is very difficult to locate cited material. CMS needs to provide more detailed reference points.

Unlike the recent CY 2017 ESRD and HHA PPS updates, this rule does not contain clear sections identifying the final actions CMS has taken with respect to its changes. Again, making it more difficult for the reader to clearly understand such final actions.

CMS notes that it received only 25 comments in response to the proposed rule.

This is also another rule with piggyback players attached. The material contains information on EHRs and organ transplants.

SUMMARY OF MAJOR PROVISIONS

OPPS PAYMENT PROVISIONS

OPPS Payment Update

For CY 2017, CMS is increasing the payment rates by a factor of 1.65 percent. This increase factor is based on the hospital FY 2017 inpatient marketbasket percentage increase of 2.7 percent for

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inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a multifactor productivity (MFP) adjustment of 0.3 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act.

Based on this update, CMS estimates that total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2017 will be approximately $773 million.

Rural Adjustment:
CMS is continuing the adjustment of 7.1 percent to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs). This adjustment applies to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

Cancer Hospital Payment Adjustment:
CMS is continuing to provide additional payments to cancer hospitals so that the cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. Based on those data, a target PCR of 0.91 will be used to determine the CY 2017 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.91 for each cancer hospital.

Comprehensive Ambulatory Payment Classifications (C-APCs) for 2017
A C-APC is an APC that provides for an encounter-level payment for a designated primary procedure(s) and generally, all adjunctive and secondary services provided in conjunction with the primary procedure. In 2016, there are 37 C-APCs, which mostly include procedures for the implantation of costly medical devices.

- For CY 2017, CMS is finalizing a proposal to create 25 additional C-APCs, resulting in a total of 62 C-APCs. These new C-APCs are primarily major surgery APCs within the various existing C-APC clinical families. CMS also is finalizing its proposals to establish three new clinical families to accommodate new C-APCs including nerve procedures, excision, biopsy, incision and drainage procedures, as well as airway endoscopy procedures.
- In addition, CMS is finalizing a proposal to develop a C-APC as well as a dedicated cost center for Bone Marrow Transplants (BMT). The creation of a new C-APC for BMT would allow all the costs for services on the same OPPS claim as a BMT to be packaged into the rate setting for the BMT. This would also allow for the payment for the BMT to be representative of payment for all services that are associated with the BMT procedure along with the BMT procedure itself.

Chronic Care Management (CCM)
CMS is making some minor changes to certain CCM scope-of-service elements.

Device-Intensive Procedure Policies
CMS is finalizing the following two policies regarding device-intensive procedures:

- Currently, device-intensive procedures are those procedures assigned to a device-intensive APC, which are APCs with a device offset greater than 40 percent. The device offset amount for an APC is the portion of the APC payment amount that is associated with the cost of devices

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used in procedures assigned to the APC. The device portion of a device-intensive procedure's payment is the same in both the hospital outpatient department and ASC setting. With the recent reorganization of the APCs to include a greater number of procedures, some APCs contain procedures that have high device costs but do not meet the 40 percent device-intensive threshold. Given this outcome, CMS is finalizing its proposal to change the device-intensive calculation methodology from calculating the device offset amount at the APC level and instead will calculate the device offset amount at the HCPCS code level so that device-intensive status is assigned to all device-intensive procedures that exceed the 40 percent threshold.

- CMS also is finalizing a proposal that the payment rate for any device-intensive procedure that is assigned to an APC with fewer than 100 total claims for all procedures in the APC be based on the median cost instead of the geometric mean cost. CMS believes that this approach will mitigate significant year-to-year payment rate fluctuations while preserving accurate claims-data-based payment rates for low volume device-intensive procedures.

Packaged Services Policy Refinements

CMS believes that a basic tenet of a prospective payment system is the packaging of all integral, ancillary, supportive, dependent, or adjunctive services into primary services. Under current policy, many ancillary services are conditionally packaged. For CY 2017, CMS is finalizing three policy refinements with respect to packaging:

- Packaging Based on Claim instead of Based on Date of Service: CMS is finalizing its proposal to align the packaging logic for all of the conditional packaging status indicators so that packaging will occur at the claim level (instead of based on the date of service).
- Expansion of Molecular Pathology Laboratory Test Exception to Include Certain Advanced Diagnostic Laboratory Tests (ADLTs): In CY 2014, CMS adopted a policy to exclude molecular pathology tests from its laboratory packaging policy because these tests may have a different pattern of clinical use than more conventional laboratory tests, which may make them less tied to a primary service in the hospital outpatient setting than the more common and routine laboratory tests that are packaged. CMS believes that this rationale also would apply to certain ADLTs. Therefore, CMS is finalizing its proposal to expand this laboratory packaging exclusion to ADLTs that meet the criteria of section 1834A(d)(5)(A) of the Act.
- Discontinuation of the 'L1' Modifier: In CY 2014, CMS implemented modifier L1 to allow for separate payment of laboratory tests for use when (1) laboratory tests were the only services on the claim, or (2) when the laboratory test or tests were "unrelated" to the other services on the claim, meaning that the laboratory test was ordered by a different physician for a different diagnosis than the other services on the claim. In CY 2016, CMS implemented status indicator Q4, which allows for automatic separate payment for laboratory tests when these are the only services on the claim without the use of the L1 modifier. For CY 2017, CMS is finalizing its proposal to discontinue separate payment for "unrelated" laboratory tests, and, therefore, discontinue the L1 modifier.

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Device Pass-Through Applications

For CY 2017, CMS evaluated three applications for device pass-through status. None of these applications were approved for device pass-through status.

Inpatient Only List

The Medicare inpatient-only (IPO) list includes procedures that are only paid under the IPPS. Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. For CY 2017, CMS is removing seven procedures from the IPO list. The procedures include five spine procedures as well as two laryngoplasty procedures.

Partial Hospitalization Program (PHP) Rate Setting

- Update to PHP Per Diem Costs: The CY 2017 OPPS/ASC final rule replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day.
- Community Mental Health Care (CMHC) Provider-Level Outlier Cap: The CMHC outlier payment cap is to be applied at the provider level. In any given year, an individual CMHC will receive no more than 8.0 percent of its CMHC total per diem payments in outlier payments
- PHP Payments under Section 603: The CY 2017 OPPS/ASC final rule adopts payment for non-excepted hospital-based PHPs under the Medicare Physician Fee Schedule (MPFS), paying the CMHC per diem rate for APC 5853, for providing 3 or more PHP services per day. CMS believes that paying for non-excepted hospital-based PHP services at the lower CMHC per diem rate is in alignment with Section 603, while also preserving access to the PHP benefit.

Payment Modifier for X-Ray Films

Section 502(b) of Division O, Title V of the *Consolidated Appropriations Act,* 2016 (Pub. L. 114-113) amended Section 1833(t)(16) of the Act by adding new subparagraph (F). New Section 1833(t)(16)(F)(i) of the Act provides that, effective for services furnished during 2017 or any subsequent year, the payment under the OPPS for imaging services that are X-rays taken using film (including the X-ray component of a packaged service) that would otherwise be made under the OPPS (without application of this paragraph and before application of any other adjustment) shall be reduced by 20 percent. CMS is requiring that, effective for services furnished on or after Jan. 1, 2017, hospitals are required to use a modifier on claims for X-rays that are taken using film. The use of this modifier will result in a 20-percent payment reduction for the X-ray service, as specified under Section 1833(t)(16)(F)(i) of the Act, of the determined OPPS payment amount (without application of paragraph (F) and before any other adjustments under Section 1833(t)). The new modifiers FX, for use on claims for imaging services that are X-rays taken using film that are furnished during CY 2017 and subsequent years.

Section 603 of the Bipartisan Budget Act of 2015

Payment for Non-Excepted Items and Services Furnished by Non-Excepted Off-Campus Departments of a Provider

CMS is implementing section 603 of the *Bipartisan Budget Act of 2015.* This provision requires that certain items and services furnished in certain off-campus PBDs shall not be considered covered OPD services for purposes of OPPS payment and those non-excepted items and services will instead be paid "under the applicable payment system" beginning Jan. 1, 2017.

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CMS is finalizing, with modification, the policies it proposed relating to which off-campus PBDs and which items and services furnished by such off-campus PBDs may be excepted from application of payment changes under this provision.

Excepted Items and Services – Excepted items and services are items and services furnished after Jan. 1, 2017:

- By a dedicated ED;
- By an off-campus PBD that was billing for covered OPD services furnished prior to Nov. 2, 2015, (i.e., the date of enactment of Section 603 of the Bipartisan Budget Act of 2015) that has not impermissibly relocated or changed ownership; or
- In a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital.

Service Expansions, Relocations and Changes of Ownership

- Service Expansion in an Excepted Off-Campus PBD – CMS proposed to limit the items and services that an excepted off-campus PBD could continue to bill under the OPPS beginning Jan.1, 2017, to those items and services within a clinical family that were furnished and billed as of Nov. 2, 2015. Under the proposal, additional items and services beyond those within the clinical families of services furnished and billed prior to that date would not be excepted items and services paid under the OPPS. However, in response to public comments on administrative burden and complexity and potential beneficiary access issues, CMS is not finalizing this proposal. CMS will monitor expansion of clinical service lines by off-campus PBDs and continue to consider whether a potential limitation on service line expansion should be adopted in the future.
- Relocation of Excepted Off-Campus PBDs – CMS is finalizing its proposal that items and services must continue to be furnished and billed at the same physical address of the off-campus PBD as was used as of Nov. 2, 2015, in order for the off-campus PBD to be considered excepted from Section 603 requirements. The final relocation policy includes a notable change from the proposal to allow excepted off-campus PBDs to relocate temporarily or permanently without loss of excepted status due to extraordinary circumstances outside of the hospital's control, such as natural disasters. Exceptions for extraordinary circumstances will be evaluated and determined by the applicable CMS Regional Office and are expected to be rare and unusual.
- Changes of Ownership of Excepted Off-Campus PBDs – CMS is finalizing its proposal to allow an off-campus PBD to maintain its excepted status under the other rules outlined in this regulation if the hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from the prior owner.

CMS is establishing interim final site-specific rates under the Medicare Physician Fee Schedule (MPFS) for the technical component of all non-excepted items and services. Hospitals will be paid under the MPFS at these newly established MPFS rates for non-excepted items and services, which will be billed on the institutional claim and must be billed with a new claim line modifier "PN" to indicate that an item or service is a non-excepted item or service. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate. Packaging, and certain other OPPS policies, will continue to apply to such services. CMS is seeking public comments on the new payment mechanisms and, based on these

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comments, will make adjustments as necessary to the payment mechanisms and rates through rulemaking that could be effective in CY 2017.

ASC Payment Provisions

ASC Payment Update

For CY 2017, CMS is increasing payment rates under the ASC payment system by 1.9 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on a projected CPI–U update of 2.2 percent minus a multifactor productivity adjustment required by the ACA of 0.3 percentage point. Based on this update, CMS estimates that total payments to ASCs (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2017 will be approximately $4,478 million, an increase of approximately $177 million compared to estimated CY 2016 Medicare payments.

Quality and Performance Program Changes

Hospital Outpatient Quality Reporting Program

For the Hospital OQR Program, CMS is establishing measures and policies for the CY 2018 payment determination, the CY 2019 payment determination and the CY 2020 payment determination and subsequent years. CMS did not propose any changes to the CY 2018 and CY 2019 Hospital OQR Program measure sets, which include 26 measures — 25 required and one voluntary.

For the CY 2018 payment determination and subsequent years, CMS is finalizing, as proposed, that it will publicly display data on the Hospital Compare website, or other CMS website, as soon as possible after measure data have been submitted to CMS. In addition, CMS is finalizing, as proposed, that hospitals will generally have approximately 30 days to preview their data. Lastly, CMS is finalizing, as proposed, that it also will announce the timeframes for the preview period on a CMS website and/or on its applicable listservs.

For the CY 2019 payment determination and subsequent years, CMS is finalizing, as proposed, an extension of the time for filing extraordinary circumstances extensions or exemptions (ECE) requests from 45 days to 90 days from the date that the extraordinary circumstance occurred.

For the CY 2020 payment determination and subsequent years, CMS is finalizing, as proposed, a total of seven measures: two claims-based measures and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based measures. The two claims-based measures are: (1) OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy and (2) OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687).

The five survey-based measures are: (1) OP-37a: OAS CAHPS - About Facilities and Staff; (2) OP-37b: OAS CAHPS - Communication About Procedure; (3) OP-37c: OAS CAHPS - Preparation for Discharge and Recovery; (4) OP-37d: OAS CAHPS - Overall Rating of Facility; and (5) OP-37e: OAS CAHPS - Recommendation of Facility.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

CMS did not propose any changes to the CY 2018 and CY 2019 ASCQR Program measure sets, which include 12 measures — 11 required and one voluntary. For the CY 2018 payment determination and subsequent years, CMS is finalizing, as proposed, that it will publicly display data on the Hospital Compare

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website, or other CMS website, as soon as possible after measure data have been submitted to CMS. In addition, CMS is finalizing, as proposed, that ASCs will generally have approximately 30 days to preview their data. Lastly, CMS is finalizing, as proposed, that it will announce the timeframes for the preview period on a CMS website and/or on its applicable listservs.

For the CY 2019 payment determination and subsequent years, CMS is finalizing its proposal to change the submission deadline to May 15 for all data submitted via a CMS Web-based tool. CMS is also finalizing, as proposed, the extension of the submission deadline for filing extraordinary circumstances extensions or exemptions (ECE) requests from 45 days to 90 days.

For the CY 2020 payment determination and subsequent years, CMS is finalizing, as proposed, a total of seven measures: two measures collected via a CMS Web-based tool and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based measures.

The two 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 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.

Hospital Value-Based Purchasing Program Update

Section 1886(o) of the Act requires the Secretary to establish a Hospital VBP Program under which value-based incentive payments are made in a fiscal year to hospitals based on their performance on measures established for a performance period for such fiscal year. CMS is removing the HCAHPS Pain Management dimension from the Hospital VBP Program, beginning with the FY 2018 program year.

Medicare and Medicaid EHR Incentive Programs

CMS is making changes to the objectives and measures of meaningful use for Modified Stage 2 and Stage 3 starting with the EHR reporting periods in CY 2017. Under both Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018, CMS is eliminating the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures, and lowering the reporting thresholds for a subset of the remaining objectives and measures, generally to the Modified Stage 2 thresholds.

The revised requirements focus on reducing hospital administrative burden, allowing eligible hospitals and CAHs attesting to CMS to focus more on providing quality patient care, as well as focus on updating and optimizing CEHRT functionalities to sufficiently meet the requirements of the EHR Incentive Program and prepare for Stage 3 of meaningful use. CMS is finalizing a policy that these changes to the objectives and measures apply for all eligible hospitals and CAHs that attest to CMS, including eligible hospitals and CAHs that are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs.

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Finally, CMS is making a one-time significant hardship exception from the 2018 payment adjustment for certain eligible professionals who are new participants in the EHR Incentive Program in 2017 and are transitioning to the Merit-Based Incentive Payment System in 2017.

CMS believes these changes are responsive to additional stakeholder feedback received through both correspondence and in-person meetings and will result in continued advancement of certified EHR technology utilization, particularly among those eligible professionals, eligible hospitals and CAHs that have not previously achieved meaningful use, and result in a program more focused on supporting interoperability and data sharing for all participants under the Medicare and Medicaid EHR Incentive Programs.

Transplant Performance Thresholds
The Medicare Conditions of Participation for Organ Transplant programs at 42 CFR Sections 482.80 and 482.82 contain an outcome requirement standard for one-year patient and graft survival. A transplant program is out of compliance with this standard if all of the thresholds in the standard are crossed. One of the thresholds, the number of observed events divided by the number of expected events, is based on the program's outcomes in relation to the risk-adjusted national average. The threshold adopted in 2007 is 1.5. However, as national outcomes for organ transplants have improved over time, the margin for compliance and noncompliance has narrowed. CMS is finalizing measures to restore the CMS tolerance limit for patient and graft survival closer to the level allowed under the original 2007 rule by changing this threshold to 1.85. The changed threshold means that transplant programs would not be out of compliance unless the number of observed events (one-year patient deaths or graft failures) divided by the number of expected events exceeds 1.85.

Organ Procurement Organizations (OPOs) Changes
CMS is changing the current "eligible death" definition to be consistent with the OPTN definition; modifying CMS current outcome measures to be consistent with yield calculations currently utilized by the SRTR; and modifying current requirements for documentation of donor information which is sent to the transplant center along with the organ.

Information Sites
The Addenda relating to the OPPS are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

The Addenda relating to the ASC payment system are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/ASCPayment/index.html.

COMMENT

The discussion below follows the rule's order and is not reflective of major versus minor changes. This analysis does not repeat items addressed above except for clarification purposes.

II. UPDATES AFFECTING OPPS PAYMENTS

A. Recalibration of APC Relative Weights

The CY 2017 APC relative weights and payments are in Addenda A and B (which are available on the CMS website) are calculated using claims furnished on or after Jan. 1, 2015, and before Jan. 1, 2016.

continued

Calculation and Use of Cost-to-Charge Ratios (CCRs)

For CY 2017, CMS is continuing to use the hospital-specific overall ancillary and departmental cost-to-charge ratios (CCRs) to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk. The crosswalk is available for review and continuous comment on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Calculation of Single Procedure APC Criteria-Based Costs

1. Blood and Blood Products

CMS is continuing to establish payment rates for blood and blood products using its blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs.

CMS refers readers to Addendum B for the CY 2017 payment rates for blood and blood products (which are identified with status indicator "R").

2. Brachytherapy Sources

The CY 2017 payment rates for brachytherapy sources are included in Addendum B and are identified with status indicator "U".

CMS will assign new status indicator "E2" to HCPCS code C2644 (Brachytherapy cesium-131 chloride).

Additional Comprehensive APCs (C-APCs) for CY 2017

CMS will add 25 additional C-APCs to be paid under the existing C-APC payment policy beginning in CY 2017. The CY 2017 C-APCs are listed below. These are also shown in Addendum J.

CY 2017 C-APCs			
C-APC	CY 2017 APC Title	Clinical Family	New C-APC
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	EBIDX	*
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	EBIDX	*
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	*
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	*
5093	Level 3 Breast/Lymphatic Surgery & Related Procedures	BREAS	
5094	Level 4 Breast/Lymphatic Surgery & Related Procedures	BREAS	
5112	Level 2 Musculoskeletal Procedures	ORTHO	*
5113	Level 3 Musculoskeletal Procedures	ORTHO	*
5114	Level 4 Musculoskeletal Procedures	ORTHO	
5115	Level 5 Musculoskeletal Procedures	ORTHO	
5116	Level 6 Musculoskeletal Procedures	ORTHO	
5153	Level 3 Airway Endoscopy	AENDO	*
5154	Level 4 Airway Endoscopy	AENDO	*
5155	Level 5 Airway Endoscopy	AENDO	*
5164	Level 4 ENT Procedures	ENTXX	*
5165	Level 5 ENT Procedures	ENTXX	
5166	Cochlear Implant Procedure	COCHL	

continued

CY 2017 C-APCs			
C-APC	CY 2017 APC Title	Clinical Family	New C-APC
5191	Level 1 Endovascular Procedures	VASCX	*
5192	Level 2 Endovascular Procedures	VASCX	
5193	Level 3 Endovascular Procedures	VASCX	
5194	Level 4 Endovascular Procedures	VASCX	
5200	Implantation Wireless PA Pressure Monitor	WPMXX	*
5211	Level 1 Electrophysiologic Procedures	EPHYS	
5212	Level 2 Electrophysiologic Procedures	EPHYS	
5213	Level 3 Electrophysiologic Procedures	EPHYS	
5222	Level 2 Pacemaker and Similar Procedures	AICDP	
5223	Level 3 Pacemaker and Similar Procedures	AICDP	
5224	Level 4 Pacemaker and Similar Procedures	AICDP	
5231	Level 1 ICD and Similar Procedures	AICDP	
5232	Level 2 ICD and Similar Procedures	AICDP	
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	*
5302	Level 2 Upper GI Procedures	GIXXX	*
5303	Level 3 Upper GI Procedures	GIXXX	*
5313	Level 3 Lower GI Procedures	GIXXX	*
5331	Complex GI Procedures	GIXXX	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	*
5361	Level 1 Laparoscopy & Related Services	LAPXX	
5362	Level 2 Laparoscopy & Related Services	LAPXX	
5373	Level 3 Urology & Related Services	UROXX	*
5374	Level 4 Urology & Related Services	UROXX	*
5375	Level 5 Urology & Related Services	UROXX	
5376	Level 6 Urology & Related Services	UROXX	
5377	Level 7 Urology & Related Services	UROXX	
5414	Level 4 Gynecologic Procedures	GYNXX	*
5415	Level 5 Gynecologic Procedures	GYNXX	
5416	Level 6 Gynecologic Procedures	GYNXX	
5431	Level 1 Nerve Procedures	NERVE	*
5432	Level 2 Nerve Procedures	NERVE	*
5462	Level 2 Neurostimulator & Related Procedures	NSTIM	
5463	Level 3 Neurostimulator & Related Procedures	NSTIM	
5464	Level 4 Neurostimulator & Related Procedures	NSTIM	
5471	Implantation of Drug Infusion Device	PUMPS	
5491	Level 1 Intraocular Procedures	INEYE	*
5492	Level 2 Intraocular Procedures	INEYE	
5493	Level 3 Intraocular Procedures	INEYE	
5494	Level 4 Intraocular Procedures	INEYE	
5495	Level 5 Intraocular Procedures	INEYE	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5627	Level 7 Radiation Therapy	RADTX	
5881	Ancillary Outpatient Services When Patient Dies	N/A	
8011	Comprehensive Observation Services	N/A	

continued

C-APC Clinical Family Descriptor Key:
AENDO = Airway Endoscopy
AICDP = Automatic Implantable Cardiac Defibrillators, Pacemakers, and Related Devices.
BREAS = Breast Surgery
COCHL = Cochlear Implant
EBIDX = Excision/ Biopsy/ Incision and Drainage
ENTXX = ENT Procedures
EPHYS = Cardiac Electrophysiology
EXEYE = Extraocular Ophthalmic Surgery
GIXXX = Gastrointestinal Procedures
GYNXX = Gynecologic Procedures
INEYE = Intraocular Surgery
LAPXX = Laparoscopic Procedures
NERVE = Nerve Procedures
NSTIM = Neurostimulators
ORTHO = Orthopedic Surgery
PUMPS = Implantable Drug Delivery Systems
RADTX = Radiation Oncology
SCTXX = Stem Cell Transplant
UROXX = Urologic Procedures
VASCX = Vascular Procedures
WPMXX = Wireless PA Pressure Monitor

New Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) C-APC
Allogeneic hematopoietic stem cell transplantation (HSCT) involves the intravenous infusion of hematopoietic stem cells derived from the bone marrow, umbilical cord blood, or peripheral blood of a donor to a recipient.

CMS is finalizing its proposal for C-APC 5244 (Level 4 Blood Product Exchange and Related Services), with the modification to exclude claims that do not include donor acquisition costs reported with revenue code 0819 from rate-setting. In addition, for CY 2017 and subsequent years, CMS is finalizing the proposal to no longer use revenue code 0819 for the identification of stem cell acquisition charges for allogeneic bone marrow/stem cell transplants. CMS is establishing a final payment rate for new C-APC 5244 of $27,752 for CY 2017.

Calculation of Composite APC Criteria-Based Costs
(1) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC
CMS will continue to use the payment rate for composite APC 8001 to pay for LDR prostate brachytherapy services for CY 2017. CMS will use a geometric mean cost of approximately $3,598 for these procedures

(2) Mental Health Services Composite APC
CMS is adopting that when the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services exceeds the maximum per diem payment rate for partial hospitalization services provided by a hospital, those specified mental health services would be assigned to composite APC 8010 (Mental Health Services Composite).

(3) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)
CMS will continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite APC payment methodology.

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The rule's table 3 lists the HCPCS codes that would be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC proposed geometric mean costs for CY 2017.

Changes to Packaged Items and Services

(1). Change in Conditional Packaging Status Indicators Logic

CMS will align the packaging logic for all of the conditional packaging status indicators and change the logic for status indicators "Q1" and "Q2" so that packaging would occur at the claim level (instead of based on the date of service) to 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 packaging policies.

(2) Calculation of OPPS Scaled Payment Weights

For CY 2017, CMS will assign APC 5012 a relative payment weight of 1.00 and to divide the geometric mean cost of each APC by the geometric mean cost for APC 5012 to derive the unscaled relative payment weight for each APC.

For a detailed discussion of the weight scalar calculation, CMS refers readers to the OPPS claims accounting document available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

B. Conversion Factor Update

For CY 2017, CMS is using a conversion factor of $75.001 in the calculation of the national unadjusted payment rates for those items and services for which payment rates are calculated using geometric mean costs; that is, the OPD fee schedule increase factor of 1.65 percent for CY 2017, the required wage index budget neutrality adjustment of approximately 0.9999, the cancer hospital payment adjustment of 1.0003, the packaging of unrelated laboratory tests adjustment factor of 1.0004, and the adjustment of 0.02 percentage point of projected OPPS spending for the difference in the pass-through spending and outlier payments that result in a conversion factor for CY 2017 of $75.001. The current CF is $73.725

C. Wage Index Changes

The OPPS labor-related share remains at 60 percent of the national OPPS payment.

Frontier State hospitals will receive a wage index of 1.0000 if the otherwise applicable wage index (including reclassification, rural floor, and rural floor budget neutrality) is less than 1.0000.

CMS will use the FY 2017 hospital IPPS wage index for urban and rural areas as the wage index for the OPPS hospital to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2017.

D. Statewide Average Default CCRs

The rule's table 4 lists the CY 2017 default urban and rural CCRs by State.

E. Adjustment for Rural SCHs and EACHs under Section 1833(t)(13)(B) of the Act

CMS will continue its policy of a 7.1 percent payment adjustment that is done in a budget neutral manner for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

continued

F. OPPS Payment to Certain Cancer Hospitals

For CY 2017, CMS is continuing its policy to provide additional payments to 11 specified cancer hospitals so that each cancer hospital's final payment-to-cost ratio (PCR) is equal to the weighted average PCR (or "target PCR") for the other OPPS hospitals using the most recent submitted or settled cost report data that are available at the time of the development of this proposed rule.

Estimated CY 2017 Hospital-Specific Payment Adjustment for Cancer Hospitals To Be Provided at Cost Report Settlement		
Provider Number	**Hospital Name**	**Estimated Percentage Increase in OPPS Payments for CY 2016**
050146	City of Hope Comprehensive Cancer Center	25.8%
050660	USC Norris Cancer Hospital	14.0%
100079	Sylvester Comprehensive Cancer Center	32.4%
100271	H. Lee Moffitt Cancer Center & Research Institute	27.3%
220162	Dana-Farber Cancer Institute	49.8%
330154	Memorial Sloan-Kettering Cancer Center	50.4%
330354	Roswell Park Cancer Institute	30.0%
360242	James Cancer Hospital & Solove Research Institute	37.9%
390196	Fox Chase Cancer Center	16.6%
450076	M.D. Anderson Cancer Center	52.3%
500138	Seattle Cancer Care Alliance	58.7%

G. Hospital Outpatient Outlier Payment

For CY 2017, CMS will continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS. CMS paid approximately 0.96 percent of the total CY 2016 OPPS payments, in OPPS outliers.

A portion of the 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPPS payments) will be allocated to CMHCs for PHP outlier payments.

For CY 2017, CMS is applying the overall CCRs from the July 2016 OPSF file after adjustment (using the CCR inflation adjustment factor of 0.9688 to approximate CY 2017 CCRs) to charges on CY 2015 claims that were adjusted (using the charge inflation factor of 1.0984 to approximate CY 2017 charges).

These are the same CCR adjustment and charge inflation factors that were used to set the IPPS fixed-dollar thresholds for the FY 2017 IPPS/ LTCH PPS final rule. CMS says it simulated aggregated CY 2017 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payments will 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.

CMS estimates that a fixed-dollar threshold of $3,825, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of aggregated

continued

total OPPS payments to outlier payments. For CMHCs, if a CMHC's cost for partial hospitalization services, paid under APC 5853 exceeds 3.40 times the payment rate, the outlier payment will be calculated as 50 percent of the amount by which the cost exceeds 3.40 times APC 5853.

III. OPPS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES

A. OPPS Treatment of New CPT and Level II HCPCS Codes

(1) Treatment of New Level II HCPCS Codes Effective April 1, 2016 for Which CMS Solicited Public Comments in the CY 2017 OPPS/ASC Proposed Rule.

Final CY 2017 Status Indicator (SI) and APC Assignments for The New Level II HCPCS Codes that Were Implemented on April 1, 2016				
CY 2016 HCPCS Code	CY 2017 HCPCS Code	CY 2017 Long Descriptor	Final CY 2017 SI	Final CY 2017 APC
C9137	J7207	Injection, factor viii, (antihemophilic factor, recombinant), PEGylated, 1 i.u.	G	1844
C9138	J7209	Injection, factor viii, (antihemophilic factor, recombinant), (Nuwiq), 1 i.u.	G	1846
C9461	A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries	G	9461
C9470	J1942	Injection, aripiprazole lauroxil, 1 mg	G	9470
C9471	J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	G	9471
C9472	J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	G	9472
C9473	J2182	Injection, mepolizumab, 1 mg	G	9473
C9474	J9205	Injection, irinotecan liposome, 1 mg	G	9474
C9475	J9295	Injection, necitumumab, 1 mg	G	9475
J7503	J7503	Tacrolimus, extended release, (Envarsus XR), oral, 0.25 mg	G	1845

2. Treatment of New CPT and Level II HCPCS Codes Effective July 1, 2016 for Which CMS Solicited Public Comments in the CY 2017 OPPS/ASC Proposed Rule

Final CY 2017 Status Indicators (SI) and APC Assignments for the New Category III CPT and Level II HCPCS Codes Implemented on July 1, 2016

Final CY 2017 Status Indicators (SI) and APC Assignments for the New Category III CPT and Level II HCPCS Codes Implemented on July 1, 2016				
CY 2016 CPT/ HCPCS Code	CY 2017 CPT/ HCPCS Code	CY 2017 Long Descriptor	Final CY 2017 SI	Final CY 2017 APC
C9476	J9145	Injection, daratumumab, 10 mg	G	9476
C9477	J9176	Injection, elotuzumab, 1 mg	G	9477
C9478	J2840	Injection, sebelipase alfa, 1 mg	G	9478
C9479	J7342	Instillation, ciprofloxacin otic suspension, 6 mg	G	9479
C9480	J9352	Injection, trabectedin, 0.1 mg	G	9480

continued

Final CY 2017 Status Indicators (SI) and APC Assignments for the New Category III CPT and Level II HCPCS Codes Implemented on July 1, 2016				
CY 2016 CPT/ HCPCS Code	CY 2017 CPT/ HCPCS Code	CY 2017 Long Descriptor	Final CY 2017 SI	Final CY 2017 APC
Q5102	Q5102	Injection, Infliximab, Biosimilar, 10 mg	E2	N/A
Q9981	J8670	Rolapitant, oral, 1 mg	K	1761
Q9982*	Q9982	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	G	9459
Q9983**	Q9983	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458
0437T	0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to primary procedure)	N	N/A
0438T	0438T***	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance	T	5374
0439T	0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to primary procedure)	N	N/A
0440T	0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	J1	5432
0441T	0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	J1	5432
0442T	0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	J1	5432
0443T	0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	N	N/A
0444T	0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	N	N/A
0445T	0445T	Subsequent placement of a drug- eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	N	N/A

**HCPCS code C9459 (Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries) was deleted June 30, 2016, and replaced with HCPCS code Q9982 effective July 1, 2016.*

***HCPCS code C9458 (Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries) was deleted June 30, 2016, and replaced with HCPCS code Q9983 effective July 1, 2016.*

****HCPCS code C9743 (Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies) was deleted June 30, 2016 and replaced with CPT code 0438T effective July 1, 2016.*

continued

B. OPPS Changes – Variations within APCs

The following table lists the APCs that CMS will exempt from the 2 times rule for CY 2017.

APC Exceptions to the 2 Times Rule for CY 2017	
CY 2017 APC	**CY 2017 APC Title**
5181	Level 1 Vascular Procedures
5521	Level 1 Imaging without Contrast
5732	Level 2 Minor Procedures
5735	Level 5 Minor Procedures
5771	Cardiac Rehabilitation
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

C. New Technology APCs

For the CY 2017 update, there are 48 levels of New Technology APC groups with two parallel status indicators; one set with a status indicator of "S" and the other set with a status indicator of "T."

The table below includes the list of the additional six New Technology APC groups for CY 2017.

Additional New Technology APC Groups for CY2017		
New CY 2017 APC	**CY 2017 APC Group Title**	**FinalStatus Indicator**
1901	New Technology - Level 49 ($100,001-$120,000)	S
1902	New Technology - Level 49 ($100,001-$120,000)	T
1903	New Technology - Level 50 ($120,001-$140,000)	S
1904	New Technology - Level 50 ($120,001-$140,000)	T
1905	New Technology - Level 51 ($140,001-$160,000)	S
1906	New Technology - Level 51 ($140,001-$160,000)	T

The payment rates for New Technology APC 1901 through 1906 can be found in Addendum A.

Retinal Prosthesis Implant Procedure

CMS is finalizing its proposal, without modification, to reassign CPT code 0100T from APC 1599 (New Technology - Level 48 ($90,001-$100,000)) to APC 1906 (New Technology - Level 51 ($140,001-$160,000)), which has a final payment rate of $150,000.50 for CY 2017. CMS notes this payment includes both the surgical procedure (CPT code 0100T) and the use of the Argus® II device (HCPCS code C1841).

D. OPPS APC-Specific Policies

COMMENT

There are numerous coding changes involving reassignments of codes and APCS. This material begins on page 236 of the display copy.

Without explanations or rationales of CMS' actions, below are some of the changes being made for CY 2017.

- CMS is finalizing its proposal to assign the procedures described by CPT code 33284 to APC 5071.
- CMS is reassigning the service described by CPT code 93229 to APC 5733.
- CMS is finalizing its proposal, without modification, to assign procedures described by CPT code 43284 to APC 5362.
- CMS is finalizing its proposal, without modification, to assign CPT code 43240 to APC 5303, which has a final CY 2017 APC geometric mean cost of approximately $2,581.
- CMS is finalizing the proposal to assign HCPCS codes G0105 and G0121, and CPT codes 44388 and 45378 to APC 5311.
- The rule's Table 11 shows the final APC reassignments for the tube and catheter placement and removal procedure codes that were assigned to APC 5301 in the proposed rule. CMS is reassigning all of the procedure codes listed in the table to APC 5181 (Level 1 Vascular Procedures), except for CPT code 61070 which CMS is reassigning to APC 5442.
- CMS is finalizing its CY 2017 proposal, without modification, to reassign CPT codes 69714, 69715, 69717 and 69718 to APCs 5115, 5116, 5114, and 5115, respectively. The rule's Table 13 lists the final status indicator and APC assignments, and payment rates for the four auditory osseointegrated procedures.
- CMS is finalizing its CY 2017 proposal, without modification, to reassign CPT codes 28297 and 28740 to C-APC 5114. The rule's table 14 lists the final CY 2017 OPPS status indicator and APC assignments, and payment rates for CPT codes 28297 and 28740.
- CMS is finalizing its proposal, without modification, to assign CPT codes 22853, 22854, and 22859 to status indicator "N" for CY 2017.
- CMS is finalizing its proposal, without modification, to reassign CPT codes 22513 and 22514 to APC 5114. The rule's Table 16 lists the final OPPS status indicator and APC assignments and payment rates for CPT codes 22513 and 22514 for CY 2017.
- CMS is we are finalizing its proposal, without modification, to revise the status indicator assignment for APCs 5101 and 5102 from "S" to "T" for CY 2017.
- CMS is finalizing its proposal, without modification, to assign CPT code 90869 to APC 5721 for CY 2017. In addition, CMS is adopting as final, without modification, the proposed APC assignments for CPT codes 90867 and 90868 for CY 2017. The rule's table 18 lists the final status indicator and APC assignments and payment rates for the three TMS CPT codes for CY 2017.

continued

- CMS is adopting as final, without modification, the APC assignment to APC 5443 for CPT codes 62263 and 62264 for CY 2017.
- CMS is finalizing its proposal, without modification, to assign CPT code 0268T to APC 5463, which has a final CY 2017 APC geometric mean cost of approximately$18,300.

Imaging

CMS is making further changes to the structure of the imaging APCs.

- CMS is finalizing its proposal, without modification, to reassign CPT code 75571 to APC 5521 as a result of the low geometric mean cost of the procedure. The payment rate for CPT code 75571 increases from $12.70 in CY 2016 to $59.84 in CY 2017.
- CMS is assigning HCPCS code G0296 to APC 5822. CMS is also finalizing its proposal, without modification, to assign HCPCS code G0297 to APC 5521 for CY 2017.
- CMS is finalizing its proposal, without modification, to assign CPT code 75563 to APC 5573.
- Refer to the rule's tables 19, 20, and 21 for additional specific imaging changes.
- CMS is finalizing its proposal, without modification, and reassigning CPT code 19298 to APC 5092.
- CMS is we are finalizing its proposal to reassign CPT code 77301 to APC 5613.
- CMS is finalizing APC structure and CPT codes 77370, 77280, and 77333 to APC 5611.
- CMS is finalizing its proposal, without modification, to assign HCPCS code C5277 to APC 5053 and CPT code 15277 to APC 5054.
- CMS is finalizing its proposal, without modification, to assign CPT code 52287 to APC 5373.
- CMS is finalizing its proposal, without modification, to assign dialysis circuit procedures to the APC and status indicators listed in the rule's table 28.
- CMS is modifying its proposal and reassigning CPT code 0398T to APC 1537 for CY 2017. In addition, CMS is finalizing its proposal, without modification, to reassign HCPCS code C9734 to APC 5114. Because CMS did not receive any public comments related to CPT codes 0071T and 0072T, CMS is finalizing its proposal, without modification, to continue to assign these codes to APC 5414.
- CMS is finalizing its proposal, without modification, to continue to assign CPT codes 99406 and 99407 to APC 5821.
- CMS is finalizing its proposal, without modification, to assign CPT code 58674 to APC 5362.
- CMS is finalizing its proposal, without modification, to continue to assign CPT code 97610 to APC 5051 and to assign CPT code 97610 to OPPS status indicator "Q1".

IV. OPPS PAYMENT FOR DEVICES

A. Pass-Through Payments for Devices

(1). Expiration of Transitional Pass-Through Payments for Certain Devices

There currently are four device categories eligible for pass-through payment: (1) HCPCS code C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), which was established effective Jan. 1, 2015; (2) HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser), which was established effective April 1, 2015; (3) HCPCS code C2613 (Lung biopsy plug with delivery system), which was established effective July 1, 2015; and (4) HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system), which was established effective Jan. 1, 2016.

The pass-through payment status of the device category for HCPCS code C2624 will end on Dec. 31, 2016. CMS will, beginning in CY 2017, package the costs of the device described by HCPCS code C2624 into the costs related to the procedure with which the device is reported in the hospital claims data.

(2). Applications Received for Device Pass-Through Payment for CY 2017

CMS received three applications.

- BioBag® (Larval Debridement Therapy in a Contained Dressing)
- Encore™ Suspension
- Endophys Pressure Sensing System (Endophys PSS) or Endophys Pressure Sensing Kit

None have been approved.

(3). Proposal to Make the Transitional Pass-Through Payment Period 3 Years for All Pass-Through Devices and Expire Pass-Through Status on a Quarterly Rather Than Annual Basis

CMS is finalizing its proposal to amend § 419.66(g) such that it provides that the pass-through eligibility period begins on the first date on which pass-through payment is made.

CMS is finalizing, without modification, its proposal to allow for quarterly expiration of pass-through payment status for devices, beginning with newly approved pass-through payment devices in CY 2017 and subsequent calendar years, to afford a pass-through payment period that is as close to a full 3 years as possible for all pass-through payment devices.

V. OPPS PAYMENT CHANGES FOR DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS

A. OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals,and Radiopharmaceuticals

(1). Policy Change to Make the Transitional Pass-Through Payment Period 3 Years for All Pass-Through Drugs, Biologicals and Radiopharmaceuticals and Expire Pass-Through Status on a Quarterly Rather Than Annual Basis

CMS is finalizing its proposal, without modification, that beginning with pass-through drugs and biologicals newly approved in CY 2017 and subsequent calendar years, to allow for a quarterly expiration of pass-through payment status for drugs and biologicals to afford a pass-through period that is as close to a full 3 years as possible for all pass-through drugs, biologicals and radiopharmaceuticals.

continued

(2). Drugs and Biologicals with Expiring Pass-Through Status in CY 2016
CMS is finalizing that the pass-through status of 15 drugs and biologicals will expire on Dec. 31, 2016, as listed in the following table.

Drugs and Biologicals for which Pass-Through Status Will Expire Dec. 31, 2016			
CY 2017 HCPCS Code	CY 2017 Long Descriptor	Final CY 2017 Status Indicator	Final CY 2017 APC
C9497	Loxapine, inhalation powder, 10 mg	K	9497
J1322	Injection, elosulfase alfa, 1mg	K	1480
J1439	Injection, ferric carboxymaltose, 1 mg	N	N/A
J1447	Injection, TBO-Filgrastim, 1 microgram	N	N/A
J3145	Injection, testosterone undecanoate, 1 mg	N	N/A
J3380	Injection, vedolizumab, 1 mg	K	1489
J7181	Injection, factor xiii a-subunit, (recombinant), per iu	N	N/A
J7200	Factor ix (antihemophilic factor, recombinant), Rixubus, per i.u.	N	N/A
J7201	Injection, factor ix, fc fusion protein (recombinant), per iu	N	N/A
J7205	Injection, factor viii fc fusion (recombinant), per iu	K	1656
J7508	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg	N	N/A
J9301	Injection, obinutuzumab, 10 mg	N	N/A
J9308	Injection, ramucirumab, 5 mg	K	1488
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	K	1466
Q4121	Theraskin, per square centimeter	N	N/A

(3). Drugs, Biologicals, and Radiopharmaceuticals with New or Continuing Pass-Through Status in CY 2017
CMS will continue pass-through payment status in CY 2017 for 47 drugs and biologicals. The 47 drugs are displayed in the rule's Table 36.

(4). Provisions for Reducing Transitional Pass-Through Payments for Policy-Packaged Drugs and Biologicals to Offset Costs Packaged into APC Groups
The APCs to which a diagnostic radiopharmaceutical payment offset may be applicable are the same as for CY 2016. Also, the APCs to which a contrast agent payment offset may be applicable, a stress agent payment offset, or a skin substitute payment offset are also the same as for CY 2016.

1. CMS will continue to post annually on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html a file that contains the APC offset amounts that will be used for that year for purposes of both evaluating cost significance for candidate pass-through device categories and drugs and biologicals and establishing any appropriate APC offset amounts.

continued

B. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status

(1). Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals

a. Packaging Threshold
CMS will package items with a per day cost less than or equal to $110, and identify items with a per day cost greater than $110 as separately payable. The current amount is $100.

b. Packaging of Payment for HCPCS Codes That Describe Certain Drugs, Certain Biologicals and Therapeutic Radiopharmaceuticals under the Cost Threshold ("Threshold-Packaged Drugs")
Payment rates for HCPCS codes for separately payable drugs and biologicals are included in Addenda A and B.

c. High Cost/Low Cost Threshold for Packaged Skin Substitutes
The final CY 2017 mean unit cost (MUC) threshold is $33 per cm2 (rounded to the nearest $1) (proposed at $25 per cm2) and the final CY 2017 PDC threshold is $716 (rounded to the nearest $1) (proposed at $729).

The rule's Table 15 displays the CY 2017 high cost or low cost category assignment for each skin substitute product.

d. Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological but Different Dosages
CMS will continue its policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2017.

The packaging status of each drug and biological HCPCS code to which this methodology would apply is displayed in the rule's Table 38.

(2). Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable and Packaged Drugs and Biologicals
CMS will apply section 1833(t)(14)(A)(iii)(II) of the Act to all separately payable drugs and biologicals, including SCODs.

b. CY 2017 Payment Policy
For CY 2017 and subsequent years, CMS will continue its payment policy that has been in effect from CY 2013 to present and pay for separately payable drugs and biologicals at ASP+6 percent.

(3). Payment Policy for Therapeutic Radiopharmaceuticals

The CY 2017 payment rates for non-pass-through, separately payable therapeutic radiopharmaceuticals are in Addenda A and B.

(4). Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium Sources

CMS will continue the payment policy for therapeutic radiopharmaceuticals that began in CY 2010. That is, for CY 2017 CMS will continue to pay all non-pass-through, separately payable therapeutic radiopharmaceuticals at ASP+6 percent.

(5). Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium Sources

CMS will continue to provide an additional $10 payment for radioisotopes produced by non-HEU sources.

continued

(6). Payment for Blood Clotting Factors

For CY 2017, CMS will continue to pay for blood clotting factors at ASP+6 percent.

(7). Payment for Non-pass-Through Drugs, Biologicals and Radiopharmaceuticals with HCPCS Codes but Without OPPS Hospital Claims Data

The CY 2017 payment status of each of the non-pass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without OPPS hospital claims data is listed in Addendum B.

VI. ESTIMATE OF OPPS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS AND DEVICES

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals and categories of devices for a given year to an "applicable percentage" (currently 2.0 percent) of total program payments estimated to be made for all covered services under the hospital OPPS furnished for that year.

CMS estimates that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2017 and those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2017 is approximately $150.6 million (approximately $112.7 million for device categories and approximately $37.9 million for drugs and biologicals), which represents 0.24 percent of total projected OPPS payments for CY 2017. Therefore, CMS estimates that pass-through spending in CY 2017 will not amount to 2.0 percent of total projected OPPS CY 2017 program spending.

VII. OPPS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES

For CY 2017, CMS will continue with and did not propose any changes to its current clinic and ED hospital outpatient visits payment policies.

VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES (PHP)

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for individuals who have an acute mental illness.

CMS is proposed to create new CMHC PHP APC 5853 to pay CMHCs for partial hospitalization services provided to Medicare beneficiaries for providing three or more services per PHP service day to replace existing CMHC PHP APCs 5851 and 5852 for CY 2017 and subsequent years.

CMS also proposed to create new hospital-based PHP APC 5863 to pay hospital-based PHPs for partial hospitalization services provided to Medicare beneficiaries for providing three or more services per PHP service day to replace existing hospital-based PHP APCs 5861 and 5862 for CY 2017 and subsequent years.

continued

CMS is finalizing its proposals and the PHP APCs are shown in the tables below.

CY 2017 PHP APC Geometric Mean Per Diem Costs		
CY 2017 APC	Group Title	PHP APC Geometric Mean Per Diem Costs
5853	Partial Hospitalization (3 or more services per day) for CMHCs	$124.92
5863	Level 2 Partial Hospitalization (4 or more services) for CMHCs	$213.14

IX. PROCEDURES THAT WILL BE PAID ONLY AS INPATIENT PROCEDURES (IPO)

CMS is removing CPT codes 22585, 22840, 22842, 22845, 22858, 31584 and 31587 from the IPO list for CY 2017. The complete list of codes (the IPO list) that will be paid by Medicare in CY 2017 as inpatient only procedures is included as Addendum E.

X. NONRECURRING POLICY CHANGES

This section addresses implementation of Section 603 of the *Bipartisan Budget Act of 2015* Relating to Payment for Certain Items and Services Furnished by Off-Campus Provider-Based Departments of a Hospital. (See material reported earlier.) This is an extensive section comprising nearly 100 pages of explanations.

CMS is implementing a set of MPFS payment rates that are specific to and can only be reported by hospitals reporting non-excepted items and services on the institutional claim form in CY 2017. CMS is using a rate that is 50 percent of the OPPS rate for each non-excepted item or service, with some exceptions, as the interim technical component of MPFS services for items or services provided at a non-excepted PBD.

CMS estimates that the implementation will reduce Medicare Part B expenditures by roughly $50 million in CY 2017. CMS says that "we estimate that, for CY 2017, scaling the OPPS payment rates by 50 percent will strike an appropriate balance that avoids potentially underestimating the relative resources involved in furnishing services in non-excepted off-campus PBDs as compared to the services furnished in other settings for which payment is made under the MPFS."

XI. CY 2017 OPPS PAYMENT STATUS AND COMMENT INDICATORS

The complete list of the payment status indicators and their definitions that CMS is applying for CY 2017 is displayed in Addendum D1.

The CY 2017 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B.

XII. UPDATES OF THE REVISED AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the ASC payment system.

continued

(1) Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

(1) Changes for CY 2017 to Covered Surgical Procedures Designated as Office-Based

CMS is adopting. as proposed, without modification, to designate the procedures described by CPT code 0377T as permanently office-based for CY 2017.

(2)ASC Device-Intensive Designation by HCPCS Code

CMS is adopting that a procedure with a HCPCS code-level device offset of greater than 40 percent of the APC costs when calculated according to the standard OPPS APC rate-setting methodology would be designated as ASC device-intensive and would be subject to all of the payment policies applicable to procedures designated as an ASC device-intensive procedure under its established methodology, including policies on device credits and discontinued procedures.

CMS also is finalizing its proposal, without modification, for CY 2017 to designate as device-intensive all procedures described by new HCPCS codes involving the implantation of a medical device that do not yet have associated claims data with a default device offset set at 41 percent, until claims data are available to establish the HCPCS code-level device offset for the procedure.

(3) Changes to List of ASC Covered Surgical Procedures Designated as Device-Intensive for CY 2017

CMS is designating the ASC covered surgical procedures displayed in Addendum AA as device-intensive and subject to the device-intensive procedure payment methodology for CY 2017.

(4) Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

For CY 2017, CMS will reduce the payment for the procedures listed in the ASC device adjustment file by the full device offset amount if a device is furnished without cost or with full credit.

In addition, for CY 2017, CMS will reduce the payment for the procedures listed in the ASC device adjustment file by one-half of the device offset amount if a device is provided with partial credit, if the credit to the ASC is 50 percent or more (but less than 100 percent) of the device cost.

(5) Additions to the List of ASC Covered Surgical Procedures

CMS is finalizing its proposal with respect to seven of the eight CPT codes that were proposed to be added to the list of ASC covered surgical procedures for CY 2017. CMS is not adding CPT code 22851 to the list.

In response to public comments, CMS is adding three additional procedures described by CPT codes 22853, 22854, and 22859 to the list of ASC covered surgical procedures for CY 2017.

The rule's table 51 contains the list of 11 newly added codes.

Calculation of the ASC Conversion Factor and the ASC Payment Rates

The final ASC conversion factor is **$45.030**, for ASCs that meet the quality reporting requirements. It is the product of the CY 2016 conversion factor of $44.190 multiplied by the wage index budget neutrality adjustment of 0.9996 and the MFP-adjusted CPI–U payment update of 1.9 percent.

For ASCs that do not meet the quality reporting requirements, CMS is reducing the CPI–U update of 2.2 percent by 2.0 percentage points and then applying the 0.3 percentage point MFP adjustment, resulting in a -0.1 percent MFP

continued

adjusted CPI–U update factor. The final ASC conversion factor is $44.330 for ASCs that do not meet the quality reporting requirements.

Addenda AA and BB display the updated ASC payment rates for CY 2017 for covered surgical procedures and covered ancillary services, respectively.

To derive the final CY 2017 payment rate displayed in the "Final CY 2017 Payment Rate" column, each ASC payment weight in the "Final CY 2017 Payment Weight" column was multiplied by the CY 2017 conversion factor of $45.030.

XIII. REQUIREMENTS FOR THE HOSPITAL OQR PROGRAM

(1). Hospital OQR Program Quality Measures for the CY 2020 Payment Determinations and Subsequent Years

For the CY 2020 payment determination and subsequent years, CMS is adding a total of seven new measures — two of which are claims-based measures and five of which are Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based measures.

The claims-based measures are: (1) OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy; and (2) OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687). The OAS CAHPS Survey-based measures are: (1) OP-37a: OAS CAHPS – About Facilities and Staff; (2) OP-37b: OAS CAHPS – Communication About Procedure; (3) OP-37c: OAS CAHPS – Preparation for Discharge and Recovery; (4) OP-37d: OAS CAHPS – Overall Rating of Facility; and (5) OP-37e: OAS CAHPS – Recommendation of Facility.

The following table outlines the Hospital OQR Program measure set for the CY 2020 payment determination and subsequent years, and includes both previously adopted measures and measures newly adopted in this rule.

Previously Finalized and Newly Finalized Hospital OQR Program Measure Set for the CY 2020 Payment Determination and Subsequent Years	
NQF #	**Measure Name**
0287	OP-1: Median Time to Fibrinolysis†
0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
0286	OP-4: Aspirin at Arrival†
0289	OP-5: Median Time to ECG†
0514	OP-8: MRI Lumbar Spine for Low Back Pain
N/A	OP-9: Mammography Follow-up Rates
N/A	OP-10: Abdomen CT – Use of Contrast Material
0513	OP-11: Thorax CT – Use of Contrast Material
N/A	OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
N/A	OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)
0491	OP-17: Tracking Clinical Results between Visits†

continued

Previously Finalized and Newly Finalized Hospital OQR Program Measure Set for the CY 2020 Payment Determination and Subsequent Years	
NQF #	**Measure Name**
0496	OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
N/A	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
0662	OP-21: Median Time to Pain Management for Long Bone Fracture
0499	OP-22: ED- Left Without Being Seen†
0661	OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
N/A	OP-25: Safe Surgery Checklist Use
N/A	OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures*
0431	OP-27: Influenza Vaccination Coverage among Healthcare Personnel
0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**
0659	OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use***
1536	OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery***
2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
1822	OP-33: External Beam Radiotherapy for Bone Metastases
N/A	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy****
2687	OP-36: Hospital Visits after Hospital Outpatient Surgery****
N/A	OP-37a: OAS CAHPS – About Facilities and Staff****
N/A	OP-37b: OAS CAHPS – Communication About Procedure****
N/A	OP-37c: OAS CAHPS – Preparation for Discharge and Recovery****
N/A	OP-37d: OAS CAHPS – Overall Rating of Facility****
N/A	OP-37e: OAS CAHPS – Recommendation of Facility****

† Note that NQF endorsement for this measure was removed.

** OP-26: Procedure categories and corresponding HCPCS codes are located at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244.*

*** Note that measure name was revised to reflect NQF title.*

****Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).*

*****New measure finalized for the CY 2020 payment determination and subsequent years.*

** OP-26: Procedure categories and corresponding HCPCS codes are located at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1196289981244 .*

*** Measure voluntarily collected as set forth in section XIII.D.3.b. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66946 through 66947).*

**** New measure for the CY 2018 payment determination and subsequent years.*

continued

COMMENT

There is much more to the issue and subject to quality than the above list. CMS has devoted nearly 200 pages discussing various operational and definitional aspects of the OQR system. Items include validations, risk adjustments, timing, survey collections and appeals.

XIV. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY-REPORTING (ASCQR) PROGRAM

ASCQR Program Quality Measures for the CY 2020 Payment Determination and Subsequent Years

CMS proposed to adopt a total of seven measures for the CY 2020 payment determination and subsequent years: two measures collected via a CMS Web-based tool and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based measures.

The two Web-based tool measures are (1) ASC-13: Normothermia Outcome; and (2) ASC-14: Unplanned Anterior Vitrectomy. The five survey-based measures (ASC-15a-e) are collected via the OAS CAHPS Survey.

The measure set for the ASCQR Program CY 2020 payment determination and subsequent years would be as listed below.

ASCQR Program Measure Set Previously Finalized and Newly Finalized for the CY 2020 Payment Determination and Subsequent Years		
ASC #	**NQF #**	**Measure Name**
ASC-1	0263	Patient Burn
ASC-2	0266	Patient Fall
ASC-3	0267	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4	0265†	All-Cause Hospital Transfer/Admission
ASC-5	0264†	Prophylactic Intravenous (IV) Antibiotic Timing
ASC-6	N/A	Safe Surgery Checklist Use
ASC-7	N/A	ASC Facility Volume Data on Selected ASC Surgical Procedures*
ASC-8	0431	Influenza Vaccination Coverage among Healthcare Personnel
ASC-9	0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
ASC-10	0659	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
ASC-11	1536	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**
ASC-12	2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
ASC-13	N/A	Normothermia Outcome***
ASC-14	N/A	Unplanned Anterior Vitrectomy***
ASC-15a	N/A	OAS CAHPS – About Facilities and Staff***
ASC-15b	N/A	OAS CAHPS – Communication About Procedure***
ASC-15c	N/A	OAS CAHPS – Preparation for Discharge and Recovery***
ASC-15d	N/A	OAS CAHPS – Overall Rating of Facility***

continued

ASCQR Program Measure Set Previously Finalized and Newly Finalized for the CY 2020 Payment Determination and Subsequent Years		
ASC #	**NQF #**	**Measure Name**
ASC-15e	N/A	OAS CAHPS – Recommendation of Facility***

† CMS notes that NQF endorsement for this measure was removed.

** Procedure categories and corresponding HCPCS codes are located at:* http://qualitynet.org/docs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2QnetTier2&cid=1228772475754.

*** Measure voluntarily collected effective beginning with the CY 2017 payment determination as set forth in section XIV.E.3.c. of the CY 2015 OPPS/ASC final rule with comment period (79 FR 66984 through 66985).*

****New measure finalized for the CY 2020 payment determination and subsequent years.*

COMMENT

Like the OPPS quality requirements, the ASCQR is long and detailed some 138 pages.

XV. TRANSPLANT OUTCOMES: RESTORING THE TOLERANCE RANGE FOR PATIENT AND GRAFT SURVIVAL

CMS is proposing to change the performance threshold at §§ 482.80(c)(2)(ii)(C) and 482.82(c)(2(ii)(C) from 1.5 to 1.85. *[Refer to the material in the Summary section at the beginning of this analysis.]*

XVI. ORGAN PROCUREMENT ORGANIZATIONS (OPOS): CHANGES TO DEFINITIONS; OUTCOME MEASURES; AND DOCUMENTATION REQUIREMENTS

CMS will replace the current definition for "eligible death" at § 486.302 with the upcoming revised organ procurement and transplantation network (OPTN) definition of "eligible death."

CMS will revise its regulations at § 486.318(a)(3) and § 486.318(b)(3) to be consistent with the current OPTN/Scientific Registry of Transplant Recipients (SRTR) aggregate donor yield metric.

XVII. TRANSPLANT ENFORCEMENT TECHNICAL CORRECTIONS AND PROPOSALS

[Refer material in the Summary section at the beginning of this analysis.]

XVIII. CHANGES TO THE MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAMS

CMS will eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program for Modified Stage 2 and Stage 3 for 2017 and subsequent years.

continued

CMS will reduce the thresholds of a subset of the remaining objectives and measures in Modified Stage 2 for 2017 and in Stage 3 for 2017 and 2018 for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program. These proposed changes would not apply to eligible hospitals and CAHs that attest to meaningful use under their State's Medicaid EHR Incentive Program.

Modified Stage 2 Objectives and Measures in 2017 for Eligible Hospitals and CAHs Attesting to CMS			
Objective	**Previous Measure Name/Reference**	**Measure Name**	**Threshold Requirement**
Protect Patient Health Information	Measure	Security Risk Analysis Measure	Yes/No attestation
*CDC (Clinical Decision Support)	Measure 1	Clinical Decision Support Interventions	Five CDS
	Measure 2	Drug Interaction and Drug-Allergy Checks	Yes/No
*CPOE (Computerized Provider Order Entry)	Measure 1	Medication Orders Measure	> 60%
	Measure 2	Laboratory Orders Measure	> 30%
	Measure 3	Radiology Orders Measure	> 30%
Electronic Prescribing	Measure	e-Prescribing	> 10%
Health Information Exchange	Measure	Health Information Exchange Measure	> 10%
Patient Specific Education	Eligible Hospital/ CAH Measure	Patient Specific Education Measure	> 10%
Medication Reconciliation	Measure	Medication Reconciliation Measure	> 50%
Patient Electronic Access	Eligible Hospital/ CAH Measure 1	Patient Access Measure	> 50%
	Eligible Hospital/ CAH Measure 2	*** View Download Transmit (VDT) Measure	At least 1 patient
Public Health Reporting	Immunization Reporting Syndromic Surveillance Reporting Specialized Registry Reporting Electronic Reportable Laboratory Result Reporting	Immunization Registry Reporting Syndromic Surveillance Reporting Specialized Registry Reporting Electronic Reportable Laboratory Result Reporting Measure	Public Health Reporting 3 Registries

** CMS notes that it is finalizing its policy to remove CDS and CPOE for eligible hospitals and CAHs attesting to CMS in section XVIII.C. of this final rule with comment period.*
*** CMS notes that, in the proposed rule (81 FR 45748), CMS referred to this objective as "eRx (electronic prescribing)."*

**** CMS notes that in the proposed rule (81 FR 45748), CMS referred to this measure as the "View Download Transmit Measure."*

Stage 3 Objectives and Measures for 2017 and 2018 for Eligible Hospitals and CAHs Attesting to CMS			
Objective	**Previous Measure Name/Reference**	**Measure Name**	**Threshold Requirement**
Protect Patient Health Information	Measure	Security Risk Analysis Measure	Yes/No attestation
Electronic Prescribing	Eligible hospital/ CAH Measure	e-Prescribing	>25%
*CDS (Clinical Decision Support)	Measure 1	Clinical Decision Support Interventions Measure	Five CDS
	Measure 2	Drug Interaction and Drug-Allergy Checks	Yes/No
*CPOE (Computerized Provider Order Entry)	Measure 1	Medication Orders Measure	>60%
	Measure 2	Laboratory Orders Measure	>60%
	Measure 3	Diagnostic Imaging Orders	>60%
Patient Electronic Access to Health Information	Measure 1	Patient Access Measure	>50%
	Measure 2	**Patient- Specific Education Measure	>10%
Coordination of Care through Patient Engagement	Measure 1	**View, Download Transmit (VDT)	>At least 1 patient
	Measure 2	Secure Messaging	>5%
	Measure 3	Patient Generated Health Data	>5%
Health Information Exchange	Measure 1	*** Send a summary of care	>10%
	Measure 2	**Request/Accept Patient Care Record Measure	>10%
	Measure 3	**Clinical Information Reconciliation	>50%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting Syndromic Surveillance Reporting Case Reporting Public Health Registry Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	Immunization Registry Reporting Syndromic Surveillance Reporting Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting Measure	Report to 3 Registries or claim exclusions

XIX. ADDITIONAL HOSPITAL VBP PROGRAM POLICIES

CMS will remove the Pain Management dimension of the HCAHPS Survey in the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain beginning with the FY 2018 program year. The FY 2018 program year uses HCAHPS performance period data from Jan. 1, 2016 to Dec. 31, 2016, to calculate each hospital's TPS, which affects FY 2018 payments.

continued

The performance standards for the other eight dimensions would remain unchanged, as the table below illustrates.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

Performance Standards for the FY 2018 Program Year			
HCAHPS Survey Dimension	Floor* (percent)	Achievement Threshold** (percent)	Benchmark*** (percent)
Communication with Nurses	55.27	78.52	86.68
Communication with Doctors	57.39	80.44	88.51
Responsiveness of Hospital Staff	38.40	65.08	80.35
Pain Management	N/A	N/A	N/A
Communication about Medicines	43.43	63.37	73.66
Hospital Cleanliness & Quietness	40.05	65.60	79.00
Discharge Information	62.25	86.60	91.63
3-Item Care Transition	25.21	51.45	62.44
Overall Rating of Hospital	37.67	70.23	84.58

** Floor is defined as the 0th percentile of the baseline (76 FR 26519).*

*** Achievement threshold is defined as the 50th percentile of hospital performance in the baseline period.*

**** Benchmark is defined as the mean of the top decile of hospital performance on each dimension.*