2017 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Analysis

The table below discusses how CMS finalized those provisions on which ASCA submitted comments in the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule.

PROPOSED RULE	ASCA COMMENTS	FINAL RULE
Rescaling Adjustment		
Consistent with historic policy, CMS proposed to update the ASC relative payment weights based on the OPPS weights (and MPFS non-facility PE RVU amounts where applicable) and to then uniformly scale the ASC relative payment weights to make the system budget neutral. The proposed CY 2017 ASC scalar was 0.9030 and would apply to ASC relative payment weights for covered surgical procedures, covered ancillary radiology services, and certain diagnostic tests which are covered ancillary services. The scalar would only apply to payments rates that are based on the OPPS payment weights.	ASCA challenged continued application of the scaler, noting that it is contributing to the increasingly large payment differential between the ASC and OPPS payments. ASCA pointed out that the scaler has decreased the relative weights in the ASC system by an average of 7.0 percent per year since 2010. This trend suggests that the application of the scaler continues to erode the relationship between ASC and OPPS rates. ASCA also pointed out that policy changes that apply only to the OPPS system (e.g., comprehensive APCs) are further exacerbating gaps between the OPPS and ASC payment amounts. ASCA proposed two policy alternatives: ▪ Discontinue the ASC relative weight scaler; or ▪ Create a minimum relationship ratio of ASC to OPPS payments (set, for example, at 55 percent) for any services based on OPPS relative weights. ASCA asserted that CMS has the authority to implement either change.	CMS did not make any changes to its existing policy to uniformly scale the ASC relative payment weights to make the system budget neutral. CMS did not address the comments outlined in the ASCA comment letter. The finalized CY 2017 ASC scalar is 0.9000. It applies to ASC relative payment weights for covered surgical procedures, covered ancillary radiology services, and certain diagnostic tests which are covered ancillary services. The scalar only applies to payments rates that are based on the OPPS payment weights.
Conversion Factor		
For CY 2017, CMS proposed to increase payment rates under the ASC payment system by **1.2 percent** based on a projected CPI–U update of **1.7 percent** minus a multifactor productivity adjustment required by the Affordable Care Act (ACA) that is projected to be **0.5 percent**.	Similar to prior year's comments, ASCA again recommended that CMS replace the CPI-U with the hospital market basket (HMB) as the update mechanism for ASC payments. ASCA asserted that CMS has the authority to use a different metric. ASCA argued that having a different metric for ASC and OPPS payments is creating a divergence in payment rates between the two systems.	CMS held firm in its policy of updating the conversion factor by the CPI-U minus the multifactor productivity adjustment. The Agency stated that it still does not believe that the hospital market basket index represents ASC cost structure. Given that ASCs are not submitting cost data and the HMB is not appropriate, it is continuing to use "CPI-U as a reasonable approximation of price increases facing ASCs."

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		For CY 2017, CMS finalized the increase to payment rates under the ASC payment system by **1.9 percent** based on the CPI–U update of **2.2 percent** minus a multifactor productivity adjustment required by the ACA that is **0.3 percent**. The final ASC conversion factor is $45.030 for ASCs that meet the quality reporting requirements.
Alignment of Policies		
In prior rulemaking cycles, CMS had proposed restructuring numerous clinical families in order to: 1. Improve clinical homogeneity; 2. Improve resource homogeneity; 3. Reduce resource overlap in longstanding APCs; and 4. Provide greater simplicity and improved understandability of the OPPS APC structure While CMS had proposed significant APC restructuring in prior years, for 2017, CMS only proposed restructuring of one clinical family (imaging), consolidating 17 APCs to 8 APCs. .	ASCA expressed concern that the analysis used by CMS that led to the restructuring focused solely on the OPPS site of service and did not consider the implications of the proposed changes on the ASC payment system. ASCA requested that going forward, CMS take into consideration the implications of the APC restructuring not just on hospitals but also on ambulatory surgical centers and their payment rates.	CMS finalized its policy with minor modifications regarding restructuring the imaging APCs, consolidating from 17 APCs to 7 APCs (excluding the nuclear medicine APCs).
CMS implemented a comprehensive APC policy (C-APC) in 2015. The Agency did not propose any changes in its criteria or underlying policy for 2017, but proposed to create 25 new C-APCs for a total of 62.	ASCA noted that the C-APC policy indirectly impacts ASCs in two ways: ▪ Application of OPPS weights to ASC codes (the weights for comprehensive APCs changes with the creation of these bundles of services); and ▪ Application of the scaler that adjusts the ASC weights in order to make the system budget neutral. These policy changes have an indirect impact on the ASC payment system and create increased volatility in the ASC payment rates. ASCA urged CMS to more closely monitor the impact of changes to this policy on ASC payments.	CMS maintained its existing policy on C-APCs and finalized the list of C-APCs (25 new for a total of 62) for CY 2017. CMS did not discuss any plans to monitor the impact of C-APCs on ASC payments.
Device Intensive Procedures		
Currently, procedures are assigned device-intensive status if the geometric mean of the device costs of all procedures	ASCA agreed with this policy change and noted that this change should encourage migration of device intensive	For 2017, CMS finalized its policy to assign device-intensive status if the device percentage at the individual

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within an APC exceeds 40 percent. For 2017, CMS proposed to assign device-intensive status if the device percentage at the individual HCPCS code-level (rather than at the APC level) exceeds 40 percent.	codes to the ASC site of service. ASCA suggested a further adjustment to the policy: CMS should set the device intensive threshold to 30 percent rather than 40 percent.	HCPCS code-level (rather than at the APC level) exceeds 40 percent. CMS did not agree with the recommendation to set the device intensive threshold to 30 percent in the ASC setting. The Agency believes that taking such action – lowering the cost threshold – would create a disparity in the number of procedures labeled as device-intensive compared to the HOPD. It further noted that this policy would create a financial incentive to perform certain device-intensive procedures in the ASC setting rather than the HOPD setting.
Changes to List of ASC Covered Procedures		
CMS proposed to add the following 8 CPT codes to the list of ASC covered surgical procedures for CY 2017: ▪ 20936 ▪ 20937 ▪ 20938 ▪ 22552 ▪ 22840 ▪ 22842 ▪ 22845 ▪ 22851	ASCA supported the proposed addition of the 8 codes to the list of procedures payable in the ASC site of service but expressed concern that none of these codes are separately payable; all proposed added codes have payments bundled with other services. ASCA requested that CMS add the following additional codes to the ASC payable list: ▪ 22X81, 22X82, and 228X3 –Replacement codes for 22851, which CMS proposed to add to the ASC list; ▪ 63035, 63048, and 63047 – Add-on codes for additional level cervical and lumbar decompression and discectomy surgeries. ASCA recommended that there be only two lists: inpatient only and permitted in outpatient setting (both ASC and HOPD). ASCA requested that CMS consider adding 39 codes with high volume in the HOPD setting (more than 1,000 services provided in 2015) to the ASC list Finally, ASCA provided CMS with a list of common codes that members are currently performing safely in the ASC setting that are clinically similar codes that are on the approved list and for which ASCA is requesting consideration.	CMS finalized its policy to add the following 10 CPT codes for CY 2017: ▪ 20936 ▪ 20937 ▪ 20938 ▪ 22552 ▪ 22840 ▪ 22842 ▪ 22845 ▪ 22853 ▪ 22854 ▪ 22859 CMS removed 22851 from the list as it is being deleted effective January 1, 2017 and replaced it with 22853, 22854, and 22859 (the new codes discussed in the Proposed Rule). CMS finalized the payment status indicators for these newly added codes as "N1". These codes are all add-on services that are packaged under the OPPS, so CMS is assigning no payment rate in the ASC setting for these services. CMS noted that additional codes were requested to be

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		added to the ASC payable list. The Agency declined to add other codes for the following reasons: ▪ Codes currently on the inpatient only list are not permitted to be performed in the ASC setting; and ▪ Codes did not meet the existing criteria for inclusion on the list. CMS noted that no specific details regarding the safety of these procedures in the ASC setting were provided. Finally, with respect to the unlisted codes, CMS reiterated its position of not permitting these codes in the ASC setting as it would have no way of knowing if the procedure performed under the unlisted code posed any significant risk to the beneficiary.
Total Knee Arthroplasty		
CMS solicited public comments on the possible removal of total knee arthroplasty from the inpatient only list. The Agency noted that "innovations in TKA care include minimally invasive techniques, improved perioperative anesthesia, alternative postoperative pain management, and expedited rehabilitation protocols." These changes have made it possible for this procedure and possibly other total joint replacement surgeries to be performed safely and effectively in an outpatient setting. Specifically, CMS requested responses to six questions to help inform its decision.	ASCA strongly supported removing TKA from the inpatient only list, and recommended that CMS add these procedures to the ASC list. ASCA submitted detailed responses to all six questions posed by CMS. ASCA also noted that the Advisory Panel on Hospital Outpatient Payment unanimously recommended that CMS remove TKA from the inpatient only list.	CMS noted that it received many detailed comments in response to its request for public input on the possible removal of total knee arthroplasty from the inpatient only list, and that "[t]he overwhelming majority of the commenters…supported removing TKA from the IPO list." CMS noted, "A few commenters representing professional organizations, health systems, and hospital associations, opposed the removal of a TKA procedure from the IPO list. These commenters believed that the increased likelihood that Medicare patients have comorbidities that require the need for intensive rehabilitation after a TKA procedure preclude this procedure from being performed in the outpatient setting. They also stated that most outpatient departments are not currently equipped to provide TKA procedures to Medicare beneficiaries, which require exceptional patient selection, exceptional surgical technique, and a carefully constructed postoperative care plan." CMS did not make any decision regarding TKA. Rather, the Agency simply noted that it would consider the comments in future policy making.

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Implementation of Section 603 of the Bipartisan Budget Act of 2015		
Section 603 requires that certain items and services furnished in certain off-campus provider-based departments (PBDs) not be considered covered outpatient services for purposes of OPPS payment. Those items and services would be eligible for payment "under the applicable payment system" beginning January 1, 2017. In this Proposed Rule, CMS outlined how it planned to operationalize this provision with the following proposals: ▪ CMS defined the criteria for qualifying as an off-campus provider based department that would continue to be reimbursed under OPPS. ▪ CMS proposed that PBDs that could continue to be reimbursed under OPPS could not get reimbursement under OPPS for clinical families of services that it was not providing prior to November 2, 2015. ▪ For those not eligible for reimbursement under OPPS, the applicable payment system for 2017 would be the Medicare Physician Fee Schedule. Physicians would be paid based on the non-facility rate for the services. This policy would be effective for only one year as CMS seeks to operationalize how to reimburse these outpatient departments under a payment system other than OPPS. ▪ CMS discussed instances where a facility could be reimbursed under a payment system other than the MPFS (e.g., if the HOPD enrolled as an ASC).	ASCA objected to using MPFS as the "applicable payment system" for the items and services furnished by PBDs subject to this provision. ASCA responded to the Agency's discussion regarding an outpatient department enrolling as an ASC for 2017 in order to receive payment under the ASC payment system. ASCA noted that while converting from an ASC to an HOPD is a relatively quick and easy process, the reverse is not true. Based on the current regulations and requirements around re-licensing and certification, the process of converting from an HOPD to an ASC can take 6 to 12 months.	CMS finalized how it will operationalize Section 603. With respect to payment for non-grandfathered (nonexcepted) services, CMS modified its proposal to instead allow hospitals to bill for the "technical" portion of the service, and by providing that Medicare will pay the hospital a rate that is 50 percent of the OPPS rate, with some exceptions (e.g., drugs and biologicals that are separately payable will continue to be paid ASP+6%, and will not be subject to this reduction). CMS noted that most of the hospital OPPS policies (e.g., special enhancements for outliers and sole community hospitals will not apply to the payment. Physicians furnishing services in these non-grandfathered departments will be paid based on the professional claim and will be paid at the facility rate for services for which they are permitted to bill. CMS discussed instances where a facility could be reimbursed under a payment system other than the MPFS (e.g., if the HOPD enrolled as an ASC) but did not address the challenges with converting from an HOPD to an ASC.
ASC Quality Reporting		
CMS proposed the following changes to the ASC Quality Reporting Program: ▪ Adding 7 new measures for the CY 2020 payment determination and subsequent years	ASCA commented as follows: ▪ ASCA endorsed the ASC Quality Collaboration's comments on the quality reporting sections; ▪ ASCA supported including ASC-13 and ASC-14 for	CMS finalized the following changes to the ASC Quality Reporting Program: ▪ Added 7 new measures for the CY 2020 payment determination and subsequent years

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– ASC-13: Normothermia Outcome – ASC-14: Unplanned Anterior Vitrectomy – Five proposed survey-based measures (ASC-15a-e) to be collected via the OAS CAHPS Survey • ASC-15a: About Facilities and Staff; • ASC-15b: Communication About Procedure; • ASC-15c: Preparation for Discharge & Recovery; • ASC-15d: Overall Rating of Facility; and • ASC-15e: Recommendation of Facility ASC-13 and ASC-14 would be submitted via the web. To meet the OAS CAHPS Survey requirements for the ASCQR Program, CMS proposed that ASCs contract with a CMS-approved vendor to collect survey data for eligible patients at the ASCs on a monthly basis and report that data to CMS on the ASC's behalf by the quarterly deadlines established for data collection. ▪ Seeking feedback on adding a Toxic Anterior Segment Syndrome (TASS) measure for potential inclusion in the ASCQR program in future rulemaking. ▪ Changing the submission deadline from August 15 to May 15 for all data submitted via a CMS Web-based tool in the ASCQR Program for the CY 2019 payment determination and subsequent years.	CY 2020, and supported including the TASS measure via future rule-making; ▪ ASCA requested that CMS not finalize its proposal to have all web-based data submitted by May 15th given the historical technical issues/difficulties with Quality Net; ▪ ASCA sought clarification on which facilities may apply for or receive exemption for the proposed OAS CAHPS survey measures proposed for CY 2020; and ▪ ASCA asked CMS to refine the OAS CAHPS survey and proposed measures to ensure that the data can be submitted by the ASCs, and that the data collected is meaningful and actionable. – Give ASCs the option to submit the data electronically; – Decrease the number of required completed surveys from 300 to 100; and – Shorten the survey by focusing on the actionable aspects of the patient experience in the surgical centers.	– ASC-13: Normothermia Outcome – ASC-14: Unplanned Anterior Vitrectomy – Five proposed survey-based measures (ASC-15a-e) to be collected via the OAS CAHPS Survey • ASC-15a: About Facilities and Staff; • ASC-15b: Communication About Procedure; • ASC-15c: Preparation for Discharge and Recovery; • ASC-15d: Overall Rating of Facility; and • ASC-15e: Recommendation of Facility ASC-13 and ASC-14 will be submitted via the web. To meet the OAS CAHPS Survey requirements for the ASCQR Program, ASCs will contract with a CMS-approved vendor to collect survey data for eligible patients at the ASCs on a monthly basis and report that data to CMS on the ASC's behalf by the quarterly deadlines established for data collection. ▪ Changed the submission deadline from August 15 to May 15 for all data submitted via a CMS Web-based tool in the ASCQR Program for the CY 2019 payment determination and subsequent years. CMS acknowledged in the Final Rule the concerns regarding changing the submission date to May 15th. CMS noted technical issues that have occurred in the past but CMS believes that it has addressed those issues and does not foresee these challenges going forward. CMS also thanked commenters for their feedback on the Toxic Anterior Segment Syndrome (TASS) measure. It will keep the comments in mind should it decide to propose this measure in future rule-making.