2017 IPPS and OPPS Final Rule

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Agenda

• IPPS Final Rule
  – 2,434 pages of pure joy.

• OPPS Final Rule
  – 331 pages of text…then add 12 addendum files and tables.
Spell Check is King

• Most misspelled words in New England:
  – Rhode Island: Cancelled
  – Connecticut: Desert
  – Vermont: Possible
  – New Hampshire: Diarrhea
  – Maine: Vacuum
  – Massachusetts: Wait for it….
Spell Check is King

• Massachusetts: Massachusetts

• Outside New England
  – Florida: Tomorrow
  – Colorado: Leprechaun
  – Nevada: Cousin
  – Texas: Niece
  – New York: Beautiful
IPPS

• Payment Updates:
  – Acute-care hospitals that report quality data will receive a .95% increase in operating payments net of:
    • Increase of 2.7% to the market basket.
    • 0.3% decrease for productivity.
    • 0.75% cut under Obamacare.
    • 1.5% reduction for the documentation and coding adjustment.
    • 0.8% inflation related to removing the two-midnight rule.
IPPS

• Quality Reporting.
  – After on-going feedback and comments from the proposed rule CMS reduced expectations related to electronic clinical quality reporting (eCQM).
  – Final rule requires data be reported on 8 available eCQMs.
  – 15 measures have been removed and 4 have been added.
    • 13 of the 15 are eCQMs.
IPPSS

• 2-midnight rule payment update.
  – CMS instituted a 0.2% cut related to the 2-midnight rule.
  – To offset that cut CMS made two adjustments in this final rule.
    • CMS added back the 0.2% to eliminate the 2-midnight rule impact. This is a permanent adjustment.
    • Additionally, 0.6% was added back to offset the impact of the 2-midnight rule from 2014-2016. This is a one time adjustment.
IPPSS

• Medicare DSH
  – The Affordable Care Act reduced traditional DSH spending by approximately 75% (49.9 billion).
  – Medicare DSH payments will decrease by $400 million in 2017 to approximately $6 billion.
  – CMS intended to use W/S S-10 to calculate DSH payments beginning in FFY2018, but...
Medicare DSH – S-10

– Between the proposed rule and final rule CMS decided to delay implementation of S-10 into factor 3 of the DSH calculation.
– Instead CMS will now clarify and reissue S-10 regulations to ensure greater consistency nationally.
– Consequently cost report periods beginning in FY2017 would be the first S-10 data utilized for DSH calculations for FFY2021.
Medicare DSH – S-10

– Except – CMS then stated future legislation could incorporate current S-10 data into payments for 2017-2021, and CMS will decide if this is appropriate at a later date.

– Where does this leave us?
Medicare DSH – S-10

– With comments from CMS that completely contradict each other.
– Protect this house…or hospital!
– Report S-10 data based on existing CMS regulations.
– If 2015 and 2016 data should be revised based on new interpretations it becomes your obligation to get those revisions to CMS to ensure they are considered by the MAC.
Medicare DSH – S-10

– Assume S-10 from cost report years 2014-2016 will influence DSH payments.

– Report data according to existing CMS rules, and have detailed support for all numbers.
  • As with any data included on a cost report the S-10 data must be auditable.
IPPS

- Hospital Acquired Conditions Reduction Program was updated with five payment revisions.

- Observation – MOON (Medicare Outpatient Observation Notice).
  - Requirement to provide oral and written notification to a Medicare patient who receives observation services in excess of 24 hours. CMS will provide a form to be used for written notification.
OPPS

• Payment updates:
  – OPPS rates are increasing by 1.7%. This is an estimated amount net of all adjustments except...
  – If OPPS quality reporting is not achieved a 2% reduction will be applied.
  – The rural adjustment for SCH will continue to be 7.1%.
OPPS

• Section 603
  – Effects off-campus provider-based departments that:
    • Did not furnish a service on, or before November 2, 2015.
    • Any off-campus provider-based department that relocates.
    • Any off-campus provider-based department that changes ownership.
      – If the new owner does not accept the provider agreement.
      – If the practice is the only thing changing ownership.
Section 603

• With Section 603 of the Bipartisan Budget Act of 2015 President Obama signed legislation that restricted Medicare reimbursement to selected off-campus provider-based departments.

• CMS set regulation to Section 603 in the 2017 OPPS final rule.
Section 603

• Excluded from this rule are:
  – On-campus provider-based departments.
    • The campus includes any practice within 250 yards of the main provider. Distance is measured as a crow flies from the point of the main provider that is closest to the practice.
  – An off-campus provider-based department that does not relocate or change ownership.
  – All services rendered in a dedicated emergency department.
Section 603

• Three significant considerations to qualify as excepted.
  – Furnished services prior to November 2, 2015.
  – Relocation.
  – Change of ownership.
Section 603

• Furnished services before November 2, 2015.

  – Previous requirement suggested a bill had to be submitted to CMS prior to November 2, 2015.

  – Now documentation to validate a service was furnished prior to November 2, 2015 is the requirement.
Section 603

• Relocation of an excepted provider-based department.
  – The address of the excepted provider-based department on November 1, 2015 is vital.
  – Any change in the address moves the practice to non-excepted status.
    • This includes simply changing suite numbers.
Section 603

• Relocation – continued
  – Exception may be available for extraordinary circumstances beyond the hospitals control.
    • Unsafe building – public safety issues.
    • Building code requirement concerns.
    • Natural disasters.
  – Case by case basis evaluated by Regional Office.
  – Considered rare and unique.
Section 603

• Change of ownership of an excepted provider-based department.

  – The provider-based department will keep excepted status if the new owner accepts assignment the provider agreement.
  – Should the provider agreement be terminated the provider-based department moves to non-excepted status.
Section 603

- Expansion of services within an excepted provider-based department.
  - No limitation for 2017.
  - No guidance yet on expansion of space related to an expansion of services.
  - Stay tuned for further CMS guidance.
Section 603

- Mid-build opportunities in the 21st Century Cures Act.
  - Mid-build defined as a provider who had a binding written agreement with an outside, unrelated party for the construction of the new practice.
  - Requires a signed certification statement from the hospital CEO/COO that the practice location meets the mid-build standards along with a full attestation.
Section 603

• Mid-build opportunities in the 21st Century Cures Act-continued.
  – The attestation and certification statement are subject to audit by the Secretary.
  – If approved, that practice would receive the excepted payment (full OPPS) beginning in 2018.
Section 603

• Place of service indicators.

  – Freestanding (private physician office) = POS 11

  – On-campus provider-based department = POS 22

  – Off-campus provider-based department = POS 19
    • Both excepted and non-excepted.
Section 603

• Modifier for excepted off-campus provider-based departments.
  – Modifier PO effective January 1, 2016 for off-campus practices, and will continue to be used for excepted locations.
  • Required with every code of service billed from an excepted off-campus provider-based department.
Section 603

• Modifier for non-excepted off-campus provider-based departments.
  – New modifier PN for non-excepted off-campus practices.
    • Required with every code of service billed from a non-excepted off-campus provider-based department.
    • Triggers the APC payment to 50%.
Section 603

• Change in payments.
  – Excepted provider-based departments.
    • No change in payment for 2017.
  – Non-excepted provider-based departments.
    • New payment schedule that reimburses 50% of the APC.
    • No change to the professional payments.
• CMS estimate of impact now $50 million.
## Section 603

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
<th>2017 Freestanding Practice</th>
<th>2017 Excepted PBE Practice</th>
<th>2017 Non-Excepted PBE Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office Visit</td>
<td>$74</td>
<td>$158 ($52+106)</td>
<td>$108 ($52+(106x50%))</td>
</tr>
<tr>
<td>11100</td>
<td>Biopsy Skin Lesion</td>
<td>$98</td>
<td>$340 ($48+292)</td>
<td>$194 ($48+(292x50%))</td>
</tr>
</tbody>
</table>
Section 603

• 340B Concerns.
  – CMS confirmed that excepted provider-based departments will not experience any change in eligibility for the 340B Drug Program.
  – Further, CMS confirmed that non-excepted provider-based departments will remain on the Medicare cost report, and Section 603 alone should not impact the eligibility.
  – CMS referred providers to HRSA for further guidance.
Section 603

• Other considerations:
  – Attestations remain voluntary; however, be careful.
  – There is no electronic system available to CMS to cross reference attested provider-based departments with those that furnished a services prior to November 2, 2015.
  – Provider enrollment records (855s) will be used where necessary.
Section 603

• Other considerations – continued
  – Hospital outpatient supervision rules will apply to non-excepted locations.
  – Only applies to OPPS providers.
    • CAH excluded.
  – CMS acknowledges additional clarification is needed beyond just Section 603.
    • Definition of on-campus.
Section 603

- Effective January 1, 2017.

- CMS published Section 603 regulations as an “interim final rule”.

- Accepted comments until December 31, 2017.
Section 603

• CMS left the door slightly ajar to make additional regulatory changes effective in 2017.

• It is more likely CMS applies any new regulations to payments for 2018.

• Stay tuned because you never know…
OPPS

• Comprehensive Ambulatory Payment Classification (C-APC)
  – Generally payment for a primary level of service/procedure, and all secondary and supplemental services provided in connection with the primary procedure.
  – 25 new C-APCs have been added around major surgery APCs.
  – A new C-APC for bone marrow transplants is also being developed.
OPPS

• Packaging of Services
  – Proposal to package based on claim instead of date.
  – Expansion of certain lab tests including advanced diagnostic lab test.
OPPS

• Device-intensive policies
• Device pass-through applications
• Partial hospitalization rates
• Quality and performance
  – Removal of pain management from survey
• Organ transplant
OPPS

• Quality reporting program
  – Add 7 measurements – only 2 are specific to OPPS.
    • ER visit for patients receiving outpatient chemo.
    • Hospital visit subsequent to hospital O/P surgery.
Questions???
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