Hogan Lovells

Overview of Selected Provisions of the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule for Calendar Year 2017

On November 1, 2016, the Centers for Medicare & Medicaid Services (CMS) released the hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system final rule for the calendar year (CY) 2017 (the "Final Rule"). It is scheduled to be published in the Federal Register on November 14, 2016,[1] and CMS will accept comments on certain provisions of it until December 31, 2016.

As of January 1, 2017, CMS will increase payment rates under the OPPS by 1.65 percent. This reflects a 2.7 percent increase in the hospital inpatient market basket, a -0.3 percent multifactor productivity adjustment (MFP), and a 0.75 percent reduction required by the Affordable Care Act (ACA).[2] Hospitals that fail to meet the hospital outpatient quality reporting requirements will continue to receive an update that is reduced by 2.0 percent.[3]

The addenda containing relative weights, payment rates, wage indices, and other payment information are available only on the CMS web site. Addenda relating to the OPPS are available at: https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1656-FC-2017-OPPS-FR-Addenda.zip. Addenda relating to the ASC payment system are available at: https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/ascpayment/downloads/CMS-1656-FC-2017-FR-ASC-Addenda.zip.

CMS finalized changes in the following areas:

(1) Packaging policies:
   a. Packaging threshold for drugs, biologicals, and radiopharmaceuticals
   b. Packaging high/low cost threshold for packaged skin substitutes
   c. Single packaging determination for Healthcare Common Procedure Coding System (HCPCS) codes that describe the same drug or biological but in different doses
   d. Change in conditional packaging logic
   e. Expansion of molecular pathology test exception
   f. Unrelated laboratory test exception

(2) Comprehensive Ambulatory Payment Classifications (C-APCs)

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[1] CMS, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital, CMS-1656-FC and IFC, 81 Fed. Reg. 49562 (Nov. 14, 2016), *available at*: https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdff. (hereinafter "Final Rule")

[2] 81 Fed. Reg. 49562.

[3] *Id.*

a. Creation of 25 new C-APCS

(3) Expansion of New Technology Ambulatory Payment Classifications (APC)

(4) Proposed APC consolidation

(5) Drugs, biologicals, and devices with expiring pass-through payment status in CY 2016 or with new or continuing pass-through status in CY 2017
   a. Drugs and biologicals
   b. Devices

(6) Proposals regarding transitional pass-through status
   a. Standardize duration of pass-through payment period to approximately three years, expiring on a quarterly basis, and have pass-through payment for devices begin on the date when payment is first made
   b. Cost-to-charge ratios (CCRs) for determining device pass-through payments
   c. Calculation of offset amounts for transitional pass-through payments

(7) Cancer hospital payment adjustments

(8) Proposed payment for drug administration services

(9) Payment for off-campus physician-based departments (implementation of section 603 of the Bipartisan Budget Act (BBA))

(10) Proposed treatment of new CY 2016 level II HCPCS and Category III Current Procedural Terminology (CPT®)[4] codes

(11) Changes to procedures that would be paid only as Inpatient Procedures or Permanently Office Based

(12) Revision of status indicator and comment indicator definitions

(13) Changes for payment for film x-ray

(14) Proposals regarding device-intensive procedures
   a. Proposal for HCPCS level device-intensive status and device edits
   b. OPPS payment adjustment for no cost/partial credit devices
   c. Proposed payment policy for low-volume intensive procedures
   d. Revision to methodology for identifying device-intensive procedures in the ASC

(15) Hospital Outpatient Quality Reporting (OQR) Program
   a. Newly proposed measures
   b. Implementation of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey
   c. Future measures
   d. Public reporting
   e. Data collection requirements for the OAS CAHPS survey
   f. Hospital OQR program reconsideration procedures

(16) ASC Quality Reporting (ASCQR) Program
   a. Newly proposed measures
   b. Implementation of the OAS CAHPS Survey
   c. Future measures for the ASCQR
   d. Public reporting of ASCQR data
   e. Data collection requirements for the OAS CAHPS survey

(17) Proposed changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program
   a. Changes to measures and measures thresholds
   b. Reporting periods and requirements
   c. Modifications for new participants

[4] CPT is a registered trademark of the American Medical Association (AMA).

d. Calculating meaningful use measures

(18) Proposed changes to the hospital value-based payment (VBP) program

No Changes were made for the following:

(a) *Payment for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status.* The payment rate would continue to be set at the statutory default of average sales price (ASP) + six percent.[5]

(b) *Payment for biosimilar biological products.* The payment rate would continue to be 100 percent of the biosimilar's ASP plus six percent of the reference product's ASP when the product has pass-through status. The same rate would apply to nonpass-through biosimilar biological products with costs that exceed the packaging threshold.[6]

(c) *Payment for drugs and biologicals with pass-through status, including policy-packaged drugs (contrast agents, diagnostic radiopharmaceuticals, anesthesia drugs; drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure and drugs; and biologicals that function as supplies when used in a surgical procedure), and diagnostic and therapeutic radiopharmaceuticals*. Payment would remain at ASP + six percent.[7]

(d) *Payment for specified covered outpatient drugs and other separately payable and packaged drugs and biologicals.* The payment rate remains unchanged and ASP + six percent.[8]

(e) *Payment for blood clotting factors.* Payment would continue to be made at ASP + six percent and a furnishing fee using an updated amount would continue to be provided.[9]

(f) *Blood and blood products*. Payment rates for blood and blood products would continue to be established using the agency's blood-specific CCR methodology. Because the costs of blood and blood products are reflected in the overall costs of C-APCs, CMS would continue not to make separate payments for blood and blood products when they appear on the same claims as services assigned to C-APCs.[10]

(g) *Brachytherapy Sources*. Payment rates would continue to be set for brachytherapy sources using CMS's established prospective payment methodology, based on geometric mean costs for each source.[11]

(h) *Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001) and Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, 8008).* Payment for these services would continue to be made using composite APC payment policies.[12]

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[5] 81 Fed. Reg.at 79673.
[6] *Id*. at 79674.
[7] *Id*. at 79663.
[8] *Id*. at 79673.
[9] *Id*. at 79675-76.
[10] *Id*. at 79577.
[11] *Id*. at 79576-580.
[12] *Id*. at 79588.

(i) *Outlier payments*. The policy of estimating outlier payments to be 1.0 percent of the aggregate total payments under the OPPS would continue.[13]

(j) *Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium (HEU) Sources*. Additional payment of $10 would continue to be provided for radioisotopes produced by non-HEU sources.[14]

(k) *Hospital outpatient clinic and emergency department visits*. The existing methodology recognizing the existing five CPT codes for Type A emergency department visits as well as the five HCPCS codes that apply to Type B emergency department visits would continue to be used. HCPCS code G0463 will continue to represent any and all clinic visits under the OPPS.[15] The final payment rate for G0463 for CY 2017 is $106.56; the current CY 2016 rate is $102.12.

(l) *Process for new level II HCPCS codes that will be effective October 1, 2016 and January 1, 2017 for which CMS will be soliciting comments in the CY 2017 OPPS final rule*. CMS proposes to continue its established policy of assigning comment indicator "NI" in Addendum B to the OPPS final rule to those new Level II HCPCS codes that are effective October 1 and January 1 to indicate that CMS is assigning them an interim payment status that is subject to public comment.[16]

Details about each of the finalized changes are provided below.

(1) Packaging Policies

a. Packaging threshold for drugs, biologicals, and radiopharmaceuticals

CMS finalized its proposal to update the packaging threshold for drugs and biologicals from $100 to $110. Drugs and biologicals with a per-day cost less than or equal to $110 will be packaged in CY 2017 while drugs and biologicals with a per day cost greater than $110 will be paid separately.[17]

b. Packaging high/low cost threshold for packaged skin substitutes

CMS finalized its proposal to continue to determine the high/low cost threshold for packaged skin substitutes based on the weighted average mean unit cost (MUC) of $33 per cm^2 (proposed at $25 per cm^2) or the per day cost (PDC) of $719 (proposed at $729), rounded to the nearest $1.[18] Skin substitutes that exceed MUC or PDC will be considered part of the high cost group and those below it will be part of the low cost group. Where ASP is not available, CMS proposes that Wholesale Acquisition Cost (WAC) + six percent would be used instead. New skin substitutes without

[13] *Id*. at 79605.
[14] *Id*. at 79675.
[15] *Id*. at 79678.
[16] *Id*. at 79610.
[17] *Id*. at 79665.
[18] *Id.* at 79669-671.

pricing data automatically will be assigned to the low cost category. Table 37 contains the final assignments for skin substitutes in CY 2017.[19]

c. Single packaging determination for HCPCS codes that describe the same drug or biological but in different doses

CMS finalized it proposal to continue to make packaging determinations for HCPCS codes that describe the same drug or biological but in different doses on a drug-specific basis (as opposed to a HCPCS code basis) to avoid creating financial incentives to pick one HCPCS code over another. Table 38 provides a list of the HCPCS codes to which the CY 2017 drug-specific packaging determination methodology applies.[20]

d. Change in conditional packaging logic

CMS currently packages payment for some items and services provided on the same date of service while other items and services are packaged if billed on the same claim, regardless of whether the claim spans multiple days. CMS finalized its proposal without change to revise the packaging logic for all of the conditional packaging status indicators so that packaging would occur at the claim level (instead of based on the date of service).[21] This change would increase packaging throughout the OPPS.

e. Expansion of molecular pathology test exception

CMS currently conditionally packages certain clinical diagnostic laboratory tests that are listed on the Clinical Laboratory Fee Schedule (CLFS) into the primary services or services provided in the hospital outpatient setting on the same date of service as the laboratory test. CMS excludes from this conditional packaging policy all molecular pathology tests, including any new codes that describe molecular pathology tests. CMS finalized it proposal to expand this exclusion to include all advanced diagnostic laboratory tests that are offered and furnished only by a single laboratory and not sold for use by a laboratory other than the original developing laboratory (or a successor owner) and are an analysis of multiple biomarkers of DNA, RNA, or proteins combined with a unique algorithm to yield a single patient-specific result.[22]

f. "Unrelated" laboratory test exception

CMS finalized its proposal to discontinue the unrelated laboratory test exception. CMS currently pays separately for laboratory tests when they are considered "unrelated" laboratory tests. Unrelated laboratory tests are tests on the same claim as other hospital outpatient services, but are ordered for a different diagnosis than the other hospital outpatient services and are ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services. CMS proposes to

[19] *Id*. at 79691.
[20] *Id*. at 79672.
[21] *Id.* at 79594.
[22] *Id*. at 79593-594.

discontinue this exception and separate payment for these tests and proposes to package any and all laboratory tests if they appear on a claim with other hospital outpatient services.[23]

(2) *Comprehensive Ambulatory Payment Classifications*

For CY 2017, CMS will continue to implement the C-APC payment methodology made effective in CY 2015 with the following changes:

a. Creation of 25 new C-APCs

CMS finalized creation of the 25 proposed new C-APCs to be paid under the existing C-APC payment policy beginning in CY 2017. The finalized new C-APCs are listed below.

C-APC	Description
5072	Level 2 Excision/ Biopsy/ Incision and Drainage
5073	Level 3 Excision/ Biopsy/ Incision and Drainage
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures
5112	Level 2 Musculoskeletal Procedures
5113	Level 3 Musculoskeletal Procedures
5153	Level 3 Airway Endoscopy
5154	Level 4 Airway Endoscopy
5155	Level 5 Airway Endoscopy
5164	Level 4 ENT Procedures
5191	Level 1 Endovascular Procedures
5200	Implantation Wireless PA Pressure Monitor
5244	Level 4 Blood Product Exchange and Related Services
5302	Level 2 Upper GI Procedures
5303	Level 3 Upper GI Procedures
5313	Level 3 Lower GI Procedures
5341	Abdominal/Peritoneal/Biliary and Related Procedures
5373	Level 3 Urology & Related Services
5374	Level 4 Urology & Related Services
5414	Level 4 Gynecologic Procedures
5431	Level 1 Nerve Procedures
5432	Level 2 Nerve Procedures
5491	Level 1 Intraocular Procedures
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures

In response to concerns about the accuracy of rates for allogeneic hematopoietic stem cell transplantation (HSCT), CMS proposed to create a new C-APC 5244 (Level 4 Blood Product Exchange and Related Services) and to assign procedures described by CPT code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor) to this C-APC

[23] *Id*. at 79593.

and to assign status indicator "J1" to the code. CMS proposed the costs for all covered OPD services, including donor acquisition services, included on the claim would be packaged into the C-APC payment rate. CMS also proposed to create a new cost center for the recording of any acquisition costs related to allogeneic stem cell transplants.[24] In the Final Rule, CMS finalized its proposal with modification. Specifically, in response to comments that the proposed payment rate of $15,267 was significantly less than the cost of service, CMS decided to exclude claims from ratesetting that do not include donor acquisition costs reported with revenue code 0819 from ratesetting. As a result, the final payment rate for new C-APC 5244 for CY is $27,752.[25]

(3) Expansion of new technology APCs

CMS finalized it proposal, without modification, to expand the New Technology APC groups by adding three pairs of New Technology APC levels. The three pairs will have the same payment levels, ranging from $100,001 to $160,000, with one set subject to the multiple procedure payment reduction (status indicator T) and the other set not subject to the multiple procedure payment reduction (status indicator S).[26]

(4) Proposed APC Consolidation

CMS finalized it proposal, with modification, to restructure the imaging APC groupings by consolidating the 17 CY 2016 imaging APCs into seven CY 2017 APCs. CMS had proposed eight CY 2017 APCs. CMS also changed the titles of these APCs from "diagnostic radiology" to "Imaging."[27]

The finalized, consolidated APCs for CY 2017 are as follows:

Proposed CY 2017 APC	Proposed CY 2017 APC Group Title
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5572	Level 2 Imaging with Contrast
5573	Level 3 Imaging with Contrast

The following CY 2016 APCs are discontinued for CY 2017.

CY 2016 APC	CY 2016 APC Group Title
5521	Level 1 X-Ray and Related Services

[24] *Id.* at 79585-587.
[25] *Id.*
[26] *Id*. at 79614-615.
[27] *Id.* at 79633.

5522	Level 2 X-Ray and Related Services
5523	Level 3 X-Ray and Related Services
5524	Level 4 X-Ray and Related Services
5525	Level 5 X-Ray and Related Services
5526	Level 6 X-Ray and Related Services
5531	Level 1 Ultrasound and Related Services
5532	Level 2 Ultrasound and Related Services
5533	Level 3 Ultrasound and Related Services
5534	Level 4 Ultrasound and Related Services
5561	Level 1 Echocardiogram with Contrast
5562	Level 2 Echocardiogram with Contrast
5570	Computed Tomography without Contrast
5571	Level 1 Computed Tomography with Contrast and Computed Tomography Angiography
5572	Level 2 Computed Tomography with Contrast and Computed Tomography Angiography
5581	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast
5582	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast

In response to comments received with respect to assignment of specific CPT and HCPCS codes to the newly consolidated APCs, CMS made some APC reassignments. Table 19 in the Final rule summarizes CMS's actions with respect to requests to assign specific codes to higher level imaging APCs.[28] Table 20 summarizes CMS's actions with respect to requests to reassign specific codes to non-imaging APCs.[29]

(5) *Drugs, biologicals, and devices with expiring pass-through payment status in CY 2016 or with new or continuing pass-through status in CY 2017*

a. Drugs and biologicals

CMS finalized, without modification, its proposal to terminate the pass-through status of the fifteen drugs and biologicals listed below on December 31, 2016.[30]

CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR
C9497	Loxapine, inhalation powder, 10 mg
J1322	Injection, elosulfase alfa, 1 mg
J1439	Injection, ferric carboxymaltose, 1 mg
J1447	Injection, tbo-filgrastim, 1 microgram
J3145	Injection, testosterone undecanoate, 1 mg

[28] *Id.* at 79631
[29] *Id.* at 79632.
[30] *Id*. at 79662.

J3380	Injection, vedolizumab, 1 mg
J7181	Injection, factor xiii a-subunit, (recombinant), per iu
J7200	Injection, factor ix, (antihemophilic factor, recombinant), rixubis, per iu
J7201	Injection, factor ix, fc fusion protein, (recombinant), alprolix, 1 i.u.
J7205	Injection, factor viii fc fusion protein (recombinant), per iu
J7508	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg
J9301	Injection, obinutuzumab, 10 mg
J9308	Injection, ramucirumab, 5 mg
J9371	Injection, vincristine sulfate liposome, 1 mg
Q4121	Theraskin, per square centimeter

For CY 2017, 47 drugs and biological will have pass through status. Thirty-eight drugs and biological have continuing pass through status, and nine new drugs and biological were granted pass-through status starting January 2017.[31] New drugs and biologicals indicated with an asterisk (*).

[31] *Id*. at 79663.

CY 2016 HCPCS CODE	CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR	CY 2017 STATUS INDICATOR	CY 2017 APC
A9586	A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	G	1664
N/A	A9588*	Fluciclovine f-18, diagnostic, 1 millicurie	G	9052
N/A	A9587*	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	G	9056
N/A	C9140	Injection, factor viii (antihemophilic factor, recombinant) (afstyla), 1 i.u.	G	9043
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
C9139	J7202*	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	G	9171
C9349	Q4172	Puraply or puraply am, per square centimeter	G	1657
C9447	C9447	Injection, phenylephrine and ketorolac, 4 ml vial	G	1663
C9460	C9460	Injection, cangrelor, 1 mg	G	9460
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
C9476	J9145	Injection, daratumumab, 10 mg	G	9476
C9477	J9145	Injection, daratumumab, 10 mg	G	9477
C9478	J9145	Injection, daratumumab, 10 mg	G	9478
C9479	J7342	Installation, ciprofloxacin otic suspension, 6 mg	G	9479
C9480	J9352	Injection, trabectedin, 0.1 mg	G	9480
C9481	J2786*	Injection, reslizumab, 1 mg	G	9481
C9482	C9482*	Injection, sotalol hydrochloride, 1 mg	G	9482
C9483	C9483*	Injection, atezolizumab, 10 mg	G	9483
N/A	J0570*	Buprenorphine implant, 74.2 mg	G	9058
J0596	J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	G	9445
J0695	J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg	G	9452
J0875	J0875	Injection, dalbavancin, 5 mg	G	1823
J1833	J1833	Injection, isavuconazonium, 1 mg	G	9456
J2407	J2407	Injection, oritavancin, 10 mg	G	1660
J2502	J2502	Injection, pasireotide long acting, 1 mg	G	9454
J2547	J2547	Injection, peramivir, 1 mg	G	9451
J2860	J2860	Injection, siltuximab, 10 mg	G	9455
J3090	J3090	Injection, tedizolid phosphate, 1 mg	G	1662
N/A	J7179*	Injection, von willebrand factor	G	9059

CY 2016 HCPCS CODE	CY 2017 HCPCS CODE	CY 2017 LONG DESCRIPTOR	CY 2017 STATUS INDICATOR	CY 2017 APC
		(recombinant), (vonvendi), 1 i.u. vwf:rco		
J7313	J7313	Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg	G	9450
J7503	J7503	Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg	G	1845
J8655	J8655	Netupitant 300 mg and palonosetron 0.5 mg	G	9448
J9032	J9032	Injection, belinostat, 10 mg	G	1658
J9039	J9039	Injection, blinatumomab, 1 microgram	G	9449
J9271	J9271	Injection, pembrolizumab, 1 mg	G	1490
J9299	J9299	Injection, nivolumab, 1 mg	G	9453
Q5101	Q5101	Injection, filgrastim (g-csf), biosimilar, 1 microgram	G	1822
Q9950	Q9950	Injection, sulfur hexafluoride lipid microspheres, per ml	G	9457
C9459	Q9982	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	G	9459
C9458	Q9983	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458

b. Devices

CMS finalized its proposal that the pass-through payment status for one category of devices, Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components (HCPCS code C2624), will expire on December 31, 2016. The pass-through payment status for this device category began on January 1, 2015.[32]

The pass-through payment status for the following three categories of devices will continue for CY 2017:[33]

CY 2017 HCPCS Code	Description
C2623	Catheter, transluminal angioplasty, drug-coated, non-laser
C2613	Lung biopsy plug with delivery system
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

(6) *Proposals regarding transitional pass-through status*

a. Standardize duration of pass-through payment period to approximately three years, expiring on a quarterly basis, and have pass-through payment for devices begin on the date when payment first is made.

[32] *Id.* at 79648.
[33] I*d*.

CMS finalized its proposal to allow for quarterly expiration of pass-through status for devices, drugs and biologicals ending on the quarter that is as close to three full years as possible after the devices, drugs or biologicals first received a pass-through payment. CMS finalized that pass-through status for devices would begin on the first day on which pass-through payment is made for the device; instead of the date CMS establishes a category.[34] Pass-through status for drugs and biologicals, by contrast, would start at the beginning of the next quarter following the approval of their application.[35] The new timeframe applies to pass-through payment status for devices, drugs and biologicals approved in CY 2017.[36]

b. Cost-to-charge ratios for determining device pass-through payments

For CY 2017, CMS finalized its proposal to use the "Implantable Devices Charged to Patients" CCR to calculate transitional pass-through payments for devices, instead of the average hospital-wide CCR. Where the "Implantable Devices Charged to Patients" CCR is not available at a given hospital, CMS will continue to use the average hospital-wide CCR.[37]

c. Calculation of offset amounts for transitional pass-through payments

For CY 2017, CMS finalized its proposal to calculate the offset amount for transitional pass-through payments at the HCPCS code level as opposed to the APC level. The offset amount is used to reduce the pass-through payment by the amount that CMS otherwise pays for the device through the OPPS. CMS believes that this change better reflects the costs associated with a device so that the pass-through payment can be appropriately adjusted.[38]

(7) *Cancer hospital payment adjustments.*

For CY 2017, CMS finalized its proposal to continue providing additional payments to the 11 OPPS exempt cancer hospitals so that the hospital's payment-to-cost ratio (PCR) after the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost report data. CMS finalized a target PCR of 0.91 for CY 2017 compared to its proposed PCR of 0.92. Cancer hospital payment adjustments are paid at cost report settlement.[39]

(8) Proposed payment for drug administration services

A chart comparing the CY 2016 drug administration payment rates to the CY 2017 final drug administration payment rates is provided below.

[34] *Id.* at 79654.
[35] *Id*. at 79662.
[36] *Id*.
[37] *Id*. at 79656.
[38] *Id*. at 79656-657.
[39] *Id*. at 79603.

Comparison of Hospital OPPS Drug Administration Rates, CY 2016 to CY 2017

HCPCS Code	Short Descriptor	2017 Rates			2016 Rates			Change 2016-2017
		SI	APC	Payment Rate	SI	APC	Payment Rate	
90461	Im admin each addl component	B			B			
90471	Immunization admin	S	5692	53.15	S	5692	42.31	25.6%
90472	Immunization admin each add	N			N			
90473	Immune admin oral/nasal	S	5692	53.15	S	5692	42.31	25.6%
90474	Immune admin oral/nasal addl	N			N			
96360	Hydration iv infusion init	S	5693	179.69	S	5693	92.4	94.5%
96361	Hydrate iv infusion add-on	S	5691	34.76	S	5691	30.87	12.6%
96365	Ther/proph/diag iv inf init	S	5693	179.69	S	5694	173.18	3.8%
96366	Ther/proph/diag iv inf addon	S	5691	34.76	S	5691	30.87	12.6%
96367	Tx/proph/dg addl seq iv inf	S	5692	53.15	S	5692	42.31	25.6%
96368	Ther/diag concurrent inf	N			N			
96369	Sc ther infusion up to 1 hr	S	5693	179.69	S	5694	173.18	3.8%
96370	Sc ther infusion addl hr	S	5691	34.76	S	5691	30.87	12.6%
96371	Sc ther infusion reset pump	S	5692	53.15	N			
96372	Ther/proph/diag inj sc/im	S	5692	53.15	S	5692	42.31	25.6%
96373	Ther/proph/diag inj ia	S	5693	179.69	S	5693	92.4	94.5%
96374	Ther/proph/diag inj iv push	S	5693	179.69	S	5693	92.4	94.5%
96375	Tx/pro/dx inj new drug addon	S	5691	34.76	S	5692	42.31	-17.8%
96376	Tx/pro/dx inj same drug adon	N			N			
96379	Ther/prop/diag inj/inf proc	S	5691	34.76	S	5691	30.87	12.6%
96401	Chemo anti-neopl sq/im	S	5692	53.15	S	5693	92.4	-42.5%
96402	Chemo hormon antineopl sq/im	S	5692	53.15	S	5692	42.31	25.6%
96405	Chemo intralesional up to 7	S	5692	53.15	S	5692	42.31	25.6%
96406	Chemo intralesional over 7	S	5693	179.69	S	5694	173.18	3.8%
96409	Chemo iv push sngl drug	S	5693	179.69	S	5694	173.18	3.8%
96411	Chemo iv push addl drug	S	5692	53.15	S	5693	92.4	-42.5%
96413	Chemo iv infusion 1 hr	S	5694	279.33	S	5695	280.27	-0.3%
96415	Chemo iv infusion addl hr	S	5692	53.15	S	5692	42.31	25.6%
96416	Chemo prolong infuse w/pump	S	5694	279.33	S	5695	280.27	-0.3%
96417	Chemo iv infus each addl seq	S	5692	53.15	S	5692	42.31	25.6%
96420	Chemo ia push tecnique	S	5694	279.33	S	5695	280.27	-0.3%
96422	Chemo ia infusion up to 1 hr	S	5693	179.69	S	5695	280.27	-35.9%
96423	Chemo ia infuse each addl hr	S	5691	34.76	S	5692	42.31	-17.8%
96425	Chemotherapy infusion method	S	5694	279.33	S	5695	280.27	-0.3%
96440	Chemotherapy intracavitary	S	5694	279.33	S	5695	280.27	-0.3%
96446	Chemotx admn prtl cavity	S	5694	279.33	S	5695	280.27	-0.3%
96450	Chemotherapy into cns	S	5694	279.33	S	5695	280.27	-0.3%
96521	Refill/maint portable pump	S	5693	179.69	S	5694	173.18	3.8%

96522	Refill/maint pump/resvr syst	S	5693	179.69	S	5694	173.18	3.8%
96523	Irrig drug delivery device	Q1	5733	54.53	Q1	5733	55.94	-2.5%
96542	Chemotherapy injection	S	5693	179.69	S	5694	173.18	3.8%
96549	Chemotherapy unspecified	S	5691	34.76	S	5691	30.87	12.6%

(9) *Interim final rule for payment for off-campus physician-based departments (implementation of section 603 of the Bipartisan Budget Act)*

CMS finalized its proposals to implement section 603 of the BBA of 2015 relating to payment for items and services furnished by certain off-campus outpatient departments of a provider. As of January 1, 2017, payment for non-excepted off-campus provider-based departments (PBD) or non-excepted items or services at excepted off-campus PBDs would be made under the Medicare Physician Fee Schedule (MPFS) at non-facility rates.

CMS proposes that, generally, off-campus PBDs that were billing for services payable under the OPPS prior to November 2, 2015 (the "Enactment Date" of the BBA) will continue to be paid for those services under the OPPS provided the off-campus PBD maintains its excepted status. Additionally, CMS specifically excludes from this proposed policy items and services furnished by dedicated emergency departments whether they are located on or off the main hospital campus.

CMS finalized that the excepted status of an off-campus PBD:

- Generally would terminate with respect to all provided services if the excepted off-campus PBD relocates to a location that is different from the physical location the off-campus PBD occupied on or prior to the Enactment Date; (see discussion of exception, below)
- Would not apply to additional or new spaces at the same physical address occupied by the off-campus PBD on or prior to the Enactment Date.
- Would terminate with respect to all provided services if the excepted off-campus PBD changes ownership independently of the main provider; and
- Would be retained should the ownership of the main-provider and the excepted off-campus PBD both change and the single new owner accepts the existing Medicare provider agreement.

Relocation Exception: With respect to relocation of off-campus PBDs, CMS adopted an exceptions process whereby an excepted off-campus PBD may relocate temporarily or permanently due to extraordinary circumstances outside a hospital's control and maintain excepted status. CMS explains that extraordinary circumstances include natural disasters, "significant seismic building code requirements", or significant public health and public safety issues that necessitate moving to a new building. Exceptions to the relocation policy will be evaluated on a case-by-case basis by the appropriate CMS Regional Office and will be both limited and rare. CMS intends to issue subregulatory guidance on the extraordinary circumstances process.[40]

[40] *Id.* at 79699-709.

CMS did not finalize its proposal to limit the items and services payable under the OPPS for excepted off-campus PBDs. As of January 1, 2017, an excepted off-campus PBD will receive payments under the OPPS for all billed items and services, regardless of whether it furnished such items and services prior to the Enactment Date as long as the excepted off-campus PBD remains excepted.[41]

For CY 2017, the MPFS will be the "applicable payment system" for the majority of nonexcepted items and services furnished in an off-campus PBD. CMS will not use the rates as published in the MPFS, however; it will establish new payment rates for these items and services at 50 percent of the OPPS rates. These rates will include the OPPS packaging and billing policies, including packaging of drugs with status indicator "N" that are separately payable in the physician office setting.[42]

Nonexcepted off-campus PBDs will continue to bill on the institutional claim that will pass through the Outpatient Code Editor and into the OPPS pricer for calculation of payment under the MPFS.[43] Facilities must identify that such items and services are nonexcepted through use of claim line modifier "PN."[44] Physicians furnishing services in these nonexcepted departments will be paid based on the professional claim and will be paid at the facility rate for services that they are permitted to bill.[45]

CMS explains that it anticipates continuing to use this same method to determine MPFS payment amounts for nonexcepted items and services furnished by nonexcepted off-campus PBDs for CY 2018 in order to allow for the operational changes necessary to design and implement a long-term payment approach for nonexcepted off-campus PBDs under the MPFS.[46]

(10) Treatment of new CY 2016 level II HCPCS and Category III CPT codes

CMS finalized, without modification, the proposed APC payment rates and status indicator assignments for 19 Level II HCPCS codes and eight Category III CPT codes that were made effective April 1, 2016 and July 1, 2016. CMS adopted as final the APC payment rate for CPT code 0443T, but changed the status indicator from "T" to "N" because CPT code 0443T is an add-on code. These codes are listed in Tables 7 and 8 of the Final Rule.[47]

In the Final Rule, CMS solicits public comments on the CY 2017 interim status indicators, APC assignments, and payment rates for Level II HCPCS codes that were effective October 1, 2016 or will be effective January 1, 2017. These codes are listed in Addendum B of the Final Rule with comment indicator "N1".[48]

[41] *Id.* at 79707.
[42] *Id.* at 79720-79725
[43] *Id.* at 79722.
[44] *Id.* at 79719.
[45] *Id.*
[46] *Id.* at 79727.
[47] *Id.* at 79610-611.
[48] *Id*. at 79611-612

(11) *Changes to the list of procedures that will only be paid as inpatient procedures*

For CY 2017, CMS finalized its proposal to remove four spine and two laryngoplasty procedures from the inpatient only list because they relate to procedures that have previously been removed from the inpatient only list. In the Final Rule, CMS also removed CPT code 22585, which was not included in the Proposed Rule. The seven procedures removed from the inpatient only list are:

CY 2017 CPT Code	Description
22585	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (List separately in addition to code for primary procedure)
22840	Posterior non-segmental instrumentation (*e.g.*, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (*e.g.*, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
31584	Laryngoplasty; with open reduction of fracture
31587	Laryngoplasty, cricoid split

CMS thanked public stakeholders for the submission of detailed comments on the potential removal of total knee arthroplasty (TKA), as described by CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty), from the inpatient only list. CMS will consider these comments in future policy making. However, for CY 2017, CPT code 27447 will remain on the inpatient only list. A complete list of CPT codes that will be paid by CMS in CY 2017 as inpatient only procedures is included in Addendum E of the Final Rule.[49]

(12) *Revision of status indicator and comment indicator definitions*

CMS finalized its proposal to improve the definition precision of status indicator "E" by creating two status indicators, "E1" and "E2". New status indicator "E1" is specific to items and services not covered by Medicare, and new status indicator "E2" is exclusive to those items and services for which pricing information or claims data are not available.[50]

CMS finalized its proposal to create a new comment indicator "NC." The definition of comment indicator "NC" is: "New code for the next calendar year or existing code with

[49] *Id*. at 79696-797.
[50] *Id.* at 79731.

substantial revision to its code descriptor in the next calendar year as compared to current calendar year for which we requested comments in the Proposed Rule, final APC assignment; comments will not be accepted on the final APC assignment for the new code."[51]

(13) Changes for payment for film x-ray

The Consolidated Appropriations Act of 2016 (Pub. L. 114-113) requires that, effective January 1, 2017, the payment under the OPPS for imaging services that are X-rays taken using film must be reduced by 20 percent. To implement this requirement, CMS finalized its proposal to create a new modifier, "FX," that providers must append to indicate claims for imaging services that are X-rays taken using film. The use of modifier "FX" will result in a 20 percent payment reduction for an imaging service that is an X-ray taken using film (including the X-ray component of a packaged service).[52]

(14) Changes regarding device-intensive procedures

a. Proposal for HCPCS level device-intensive status and device edits

CMS finalized its proposed changes to its approach to determining whether a procedure is device-intensive. Starting in CY 2017, CMS will assign device-intensive status to all implantable device procedures for which the cost of the device is more than 40 percent of the HCPCS code, regardless of the APC assignment. CMS believes that assigning this status at the HCPCS code level will be more accurate than using an APC-wide average and will help remove inappropriate device-intensive status assignments. CMS amended 42 CFR § 419.44(b)(2) to effect this change.[53]

For new HCPCS codes describing implantation of medical devices, CMS will apply a default offset of 41 percent until sufficient data are available to calculate the offset more appropriately. CMS also may apply a higher offset for very costly implantable devices that would be based on pricing data from the manufacturer.[54]

Finally, CMS finalized changes to its device edit policy introduced in CY 2015 to require that device codes be included on a claim that includes device-intensive HCPCS codes as opposed to device intensive APCs. Any device code will satisfy this edit.[55]

b. OPPS payment adjustment for no cost/partial credit devices

CMS finalized its proposal to reduce the OPPS payment for device-intensive procedures by any full or partial credit the provider receives for a device. This reduction applies only to procedures (1) involving implantable devices, (2) that were surgically inserted or remained in the patient's body after the procedure and (3) that are device-intensive.[56]

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[51] *Id.*
[52] *Id*. at 79730.
[53] *Id.* at 79657.
[54] *Id.* at 79658.
[55] *Id*. at 79658-659.
[56] *Id*. at 79660.

c. Proposed payment policy for low-volume intensive procedures

CMS finalized its proposal to calculate the payment rate for low-volume device-intensive procedures as the median cost instead of the geometric mean cost, in the same way as the payment rate is calculated for CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis). Low-volume device-intensive procedures are devices tied to a clinical APC with less than 100 claims for all procedures in the APC. CMS anticipates this change will reduce year-to-year rate fluctuations.[57]

d. Revision to methodology for identifying device-intensive procedures in the ASC

In CY 2016, CMS restructured many of the APCs under the OPPS, which resulted in some procedures with significant device costs not being designated as device-intensive. CMS believes it no longer is appropriate to designate ASC device-intensive procedures based on APC assignment because APC groupings of clinically similar procedures do not necessarily factor in device cost similarity. For example, this means that there are some surgical procedures that include high-cost implantable devices that are assigned to an APC with procedures that include the cost of significantly lower-cost devices or no device at all.

As of CY 2017, 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 ratesetting methodology will be designated as ASC device-intensive and will be subject to all of the payment policies applicable to procedures designated as an ASC device-intensive procedure under established methodology, including CMS's policies on device credits and discontinued procedures. In addition, for new HCPCS codes describing procedures requiring the implantation of medical devices that do not yet have associated claims data, CMS will apply device-intensive status with a default device offset set at 41 percent until claims data are available to establish the HCPCS code-level device offset more appropriately.[58]

(15) Hospital Outpatient Quality Reporting (OQR) Program

a. Newly proposed measures

For CY 2020 and subsequent years, CMS finalized seven proposed new measures: two claims-based measures and five measures based on the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey.

The claims-based measures are:

- OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy; and
- OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687).

[57] *Id*. at 79661.
[58] *Id*. at 79738-740.

The OAS CAHPS measures are:

- OP-37a: OAS CAHPS – About Facilities and Staff;
- OP-37b: OAS CAHPS – Communication About Procedure;
- OP-37c: OAS CAHPS – Preparation for Discharge and Recovery;
- OP-37d: OAS CAHPS – Overall Rating of Facility; and
- OP-37e: OAS CAHPS – Recommendation of Facility.[59]

b. Implementation of the OAS CAHPS Survey

CMS finalized the following proposed requirements for hospitals to administer the OAS CAHPS survey:

- Hospitals will have to contract with a CMS-approved vendor to administer the survey;
- Data collected through the survey will affect the payment determination year two years after the survey year; and
- Hospitals with less than 60 survey-eligible patients may request an exemption from the OAS CAHPS survey. May 15, 2018 is the deadline to request exemption for the CY 2020 payment determination.[60]

CMS also clarified that, under its finalized policy, hospitals will have the option to either survey a random sample of eligible patients each month and collect at least 300 surveys each twelve-month period *or* survey their entire OAS CAHPS eligible patient population. If a hospital does not anticipate receiving 300 completed surveys during the reporting period, and does not serve less than 60 survey-eligible patients, it must survey all eligible patients served during the reporting period.[61]

c. Future measures

CMS responded to solicited public comments on one possible measure, the Safe Use of Opioids-Concurrent Prescribing electronic clinical quality measure (eCQM), for future inclusion in the Hospital OQR Program. CMS indicated it is in early development of an eCQM for the Hospital IQR and OQR Programs that would capture concurrent opioid prescriptions in patients 18 years of age and older.[62] CMS also responded to solicited comments on the possible implementation of eCQMs as part of the hospital OQR program and possible future measures for the program more generally. CMS indicated that it will consider these comments as it develops an eCQM policy for the Hospital OQR Program.[63]

d. Public reporting

CMS finalized its proposal to publically post hospital OQR program data as soon as possible after the preview period for these data are over and generally to give hospitals approximately 30 days to preview their data before posting. CMS also finalized its proposal to publically announce the preview periods for hospitals to

[59] *Id.* at 79755-784.
[60] *Id*. at 79806.
[61] *Id.* at 79773.
[62] *Id.* 79787-788.
[63] *Id*. at 79785-790.

review their data on a CMS website or its applicable listservs, starting with the preview period associated with the CY 2018 payment determination.[64]

e. Data collection requirements for the OAS CAHPS survey

CMS proposes the following administrative requirements for the OAS CAHPS survey:

- Data collection must begin no later than 21 days after the patient's surgery or procedure and must be completed within six weeks of first contact;
- Hospitals must try to contact patients multiple times to collect survey data; and
- Data must be reported by the quarterly deadlines for each data collection period unless the hospital is exempt from the CAHPS survey.

CMS also finalized its proposal to change the period during which hospitals must request an extraordinary circumstances extension or exemption from the reporting requirements from within 45 days after the extraordinary event occurs to within 90 days.[65]

f. Hospital OQR program reconsideration procedures

CMS finalized its proposal to clarify its policy regarding hospital OQR program reconsideration procedures. Specifically, hospitals that do not submit timely reconsideration requests to CMS through the QualityNet website will not be able to file an appeal with the Provider Reimbursement Review Board.[66]

(16) Ambulatory Surgical Center Quality Reporting (ASCQR) Program

a. Newly proposed measures

For CY 2020 and subsequent years, CMS finalized its proposal to adopt seven additional measures, two of which would be reported via a CMS web-based tool and five OAS CAHPS Survey measures.

The two measures to be reported via the web are:

- ASC-13: Normothermia Outcome (the percentage of patients undergoing anesthesia in a surgery of 60 minutes or more who return to a normal body temperature within fifteen minutes of entering post-anesthesia care); and
- ASC-14: Unplanned Anterior Vitrectomy (an adverse patient outcome that arises during cataract surgery).

The ASC CAHPS survey measures are:

- ASC-15a: OAS CAHPS – About Facilities and Staff;
- ASC-15b: OAS CAHPS – Communication About Procedure;
- ASC-15c: OAS CAHPS – Preparation for Discharge and Recovery;

[64] *Id*. at 79791.
[65] *Id*. at 79795.
[66] *Id*.

- ASC-15d: OAS CAHPS – Overall Rating of Facility; and
- ASC-15e: OAS CAHPS – Recommendation of Facility.67

b. Implementation of the OAS CAHPS Survey

CMS finalized its proposal to codify the OAS CAHPS survey requirements implemented as part of the ASCQR program at 42 CFR 416.310(e). These requirements are comparable to the administrative requirements for the OAS CAHPS Survey for hospitals discussed above.[68]

c. Future measures for the ASCQR

CMS responded to solicited public comments on one measure, the Toxic Anterior Segment Syndrome (TASS) measure, developed by the ASC Quality Collaboration for possible inclusion in a future rulemaking. TASS is an infection that arises following anterior segment eye surgery. CMS indicated it will take the received comments into consideration if it proposes to adopt the TASS measure for the ASCQR Program in the future.[69]

d. Public reporting of ASCQR data

CMS finalized its proposal to continue the same public reporting requirements for ASCQR data as it did for hospital data, discussed previously.[70]

e. Data collection requirements for the OAS CAHPS survey

CMS finalized its proposal that the same OAS CAHPS administrative requirements be applied as for the hospital OQR program discussed previously, to be codified at 42 CFR 416.310(e).

In addition, CMS finalized its proposal to change the ASCQR data submission deadline from August 15 to May 15 to better align with the hospital OQR program.[71]

(17) *Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program*

a. Changes to measures and measure thresholds

CMS finalized its proposal to remove the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and critical access hospitals (CAHs) under the Medicare EHR Incentive Program for Stage 2 and Stage 3. CMS also finalized its proposal to reduce some of the thresholds for eligible hospitals and CAHs attesting under the Program for Modified Stage 2 in CY 2017 and Stage 3 in CY 2017 and CY 2018.[72] The remaining Modified Stage 2 and Stage 3 measures with their new thresholds are summarized on page 79841 of the Final Rule.[73] These changes would not apply to the Medicaid

[67] *Id*. at 79817.
[68] *Id*. at 79824.
[69] *Id*. at 79817-818.
[70] *Id*. at 79819-820.
[71] *Id*. at 79822.
[72] *Id.* at 79839.
[73] *Id.* at 79841.

EHR Incentive Program which would continue to be evaluated under the 2015 EHR Incentive Program Rule.

CMS also finalized its proposal to introduce a new naming convention for the measures for easier reference and to align them with the measures in the Merit-based Incentive Payment System (MIPS), with minor refinements.[74] Following public comments about whether the above changes should apply to the Medicaid EHR Incentive Program, CMS finalized its policy that, in addition to Medicare-only hospitals, dual-eligible hospitals that participate in both Medicare and Medicaid EHR Incentive Programs and that submit an attestation to CMS will attest based on the revised objectives and measures adopted in the Final Rule. Dual-eligible hospitals may submit one attestation for both the Medicare and Medicaid EHR Incentive Programs to CMS and the attestation data will be shared with the appropriate State Medicaid agency. Medicaid-only hospitals and dual-eligible hospitals that attest directly to a State for the State's Medicaid EHR Incentive Program will continue to attest based on the measures and objectives as finalized in the 2015 EHR Incentive Programs Final Rule. Finally, CMS did not receive any responses to its request for comments on more stringent measures in future years.[75]

b. Reporting periods and requirements

CMS finalized its proposal to reduce the EHR reporting period in 2016 from full CY 2016 to any continuous 90-day period during CY 2016. In addition, CMS finalized its proposed 90-day reporting period for clinical quality measures (CQMs) in 2016. CMS does not require that eligible hospitals and CAHs report on the same 90-day reporting period for both of these programs.[76]

c. Modifications for new participants

CMS finalized its proposal that new participants that have not successfully attested to meaningful use in the EHR Incentive Program should report Modified Stage 2 objectives and measures. CMS also is finalizing its proposal that eligible providers can apply for a significant hardship exception if they have not successfully demonstrated meaningful use in the past, intend to attest in 2017, and also intend to move to attesting under the MIPS program in 2017.[77]

d. Calculating meaningful use measures

CMS finalized its proposal that for a reporting period covering the full calendar year, an action only can be included in the numerator if it also occurred in the same calendar year. For a 90-day reporting period, an action can be included in the numerator if it occurred at any time during the calendar year in which the reporting period occurred.[78]

[74] *Id.*
[75] *Id*. at 79851.
[76] *Id*. at 79852.
[77] *Id*. at 79853-854.
[78] *Id*. at 79855.

(18) Revisions to the hospital value-based payment (VBP) program

For FY 2018, CMS finalized its proposal to remove the Pain Management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) from the hospital VPB program because it may inadvertently incentivize hospitals to prescribe more opioids. CMS also is proposing to adjust the scoring methodology in the remaining HCAHPS categories to account for the removal of the pain management dimension. The performance standards for the other HCAHPS dimensions remain unchanged.[79]

[79] *Id*. at 79857-862.