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Today, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System policy changes, quality provisions, and payment rates final rule with comment period (CMS-1656-FC). CMS is finalizing a number of OPPS and ASC policies that will improve the quality of care Medicare patients receive.

Additionally, CMS issued an Interim Final Rule with comment period (IFC) to establish Medicare Physician Fee Schedule (MPFS) rates for certain items and services furnished by certain off-campus outpatient departments of a provider (hereinafter referenced as off-campus provider-based departments (PBDs)) to address changes required by Section 603 of the Bipartisan Budget Act of 2015.

CMS also addressed comments made by health care providers on the patient experience survey questions about pain management and is finalizing the removal of the Pain Management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for purposes of the Hospital Value Based Purchasing Program.

This final rule with comment period is one of several rules for CY 2017 that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people.

SECTION 603 OF THE BIPARTISAN BUDGET ACT OF 2015

Site Neutral Payments Provision (“Section 603”)

CMS is implementing Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) in the final rule with comment period and is establishing interim final payment rates under the Medicare Physician Fee Schedule (MPFS) in an IFC described in more detail below. As required by the statute, the final rule with comment period provides that certain items and services furnished by certain off-campus PBDs shall not be considered covered outpatient department services for purposes of OPPS payment and shall instead be paid “under the applicable payment system” beginning January 1, 2017. CMS is finalizing several policies relating to which off-campus PBDs and which items and services are “excepted” from application of the payment changes under this provision and thus will continue to be paid under the OPPS.

Excepted Items and Services – CMS is finalizing its proposals that certain off-campus PBDs would be permitted to continue to bill for excepted items and services under the OPPS. Excepted items and services are items and services furnished after January 1, 2017:

- By a dedicated emergency department;
- By an off-campus PBD that was billing for covered OPD services furnished prior to November 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 January 1, 2017, to those items and services within a clinical family that were furnished and billed as of November 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 November 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.

Applicable Payment System – For CY 2017, CMS is finalizing the MPFS to be the "applicable payment system" for non-excepted items and services furnished in a nonexcepted off-campus PBD. In light of public comment on the proposals regarding hospital billing and payment, CMS is issuing an IFC to establish new interim final MPFS rates so that hospitals may be paid for these nonexcepted items and services in CY 2017.

CMS-1656-IFC— Establishment of Payment Rates under the MPFS for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital

In conjunction with issuing the CY 2017 OPPS and ASC final rule with comment period, CMS also issued an IFC. The changes implemented through this IFC are intended to provide a billing mechanism for hospitals to report and receive payment under the MPFS for nonexcepted items and services furnished by off-campus PBDs to Medicare beneficiaries in CY 2017. Physicians furnishing such services will continue to be paid on the professional claim and will be paid at the facility rate under the MPFS consistent with current payment policies for physicians practicing in an institutional setting.

Under this IFC, CMS is establishing interim final site-specific rates under the MPFS for the technical component of all nonexcepted items and services. Hospitals will be paid under the MPFS at these newly established MPFS rates for nonexcepted 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 nonexcepted item or service. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate (there are some exceptions that are spelled out in the IFC, including that payment for separately payable drugs will not be reduced). Packaging, and certain other OPPS policies, will continue to apply to such services. We are seeking public comments on the new payment mechanisms and rates detailed in the IFC and, based on these comments, will make adjustments as necessary to the payment mechanisms and rates through rulemaking that could be effective in CY 2017.

OTHER OPPS PAYMENT PROVISIONS

OPPS Payment Update

For CY 2017, CMS is updating OPPS rates by 1.65 percent. The change is based on the projected hospital market basket increase of 2.7 percent minus both a 0.3 percentage point adjustment for multi-factor productivity (MFP) and a 0.75 percentage point adjustment required by law. After considering all other policy changes finalized under the OPPS, including estimated spending for pass-through payments, CMS estimates a 1.7 percent payment increase (before taking into account changes in volume and case mix) for hospitals paid under the OPPS in CY 2017.

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. We also are finalizing our 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.
- *C-APC for Bone Marrow Transplants (BMT):* In addition, CMS is finalizing a proposal to develop a C-APC as well as a dedicated cost center for 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.

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 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 packaged according to OPPS packaging policies.
- *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 our 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.

Device-Intensive Procedure Policies

CMS is finalizing the following two policies regarding device-intensive procedures:

- *Methodology for Assignment of Device-Intensive Status*: 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 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.
- *New Payment Policy for Low Volume Device-Intensive Procedures:* CMS is also 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.

Device Pass-Through Applications

Device pass-through payments are intended to enable access to certain new medical devices that represent a substantial clinical improvement relative to existing diagnostic or therapeutic services. In response to stakeholder requests for greater transparency, in CY 2016, CMS adopted a policy to continue to accept and review device pass-through applications on a quarterly basis but to also include discussions of the preliminary pass-through applications in the next applicable OPPS proposed rule. 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. The CY 2017 OPPS/ASC final rule with comment period also includes responses to a comment solicitation regarding whether total knee arthroplasty (TKA) should be removed from the IPO list in a subsequent year. CMS will consider all of these comments in future policy making.

Partial Hospitalization Program (PHP) Rate Setting

The CY 2017 OPPS/ASC final rule with comment period updates Medicare payment rates for PHP services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). The PHPs are structured intensive outpatient programs consisting of a group of mental health services paid on a per diem basis under the OPPS, based on PHP per diem costs.

Update to PHP Per Diem Costs

The CY 2017 OPPS/ASC final rule with comment period replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day. These changes will provide more predictable PHP per diems, particularly given the small number of CMHCs, and will generate more appropriate payments for these services by avoiding the cost inversions that hospital-based PHPs experienced in the CY 2016 OPPS/ASC final rule with comment period.

CMHC Provider-Level Outlier Cap

The CY 2017 OPPS/ASC final rule with comment period implements a CMHC outlier payment cap to be applied at the provider level. In any given year, an individual CMHC will receive no more than 8 percent of its CMHC total per diem payments in outlier payments. This CMHC provider-level outlier cap is evidence of CMS's continued efforts to ensure appropriate outlier payments.

PHP Payments under Section 603

The CY 2017 OPPS/ASC final rule with comment adopts payment for non-excepted hospital-based PHPs under the 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 of Public Law 114-74, while also preserving access to the PHP benefit.

ASC PAYMENT PROVISIONS

ASC Payment Update

ASC payments are annually updated by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a MFP adjustment to the ASC annual update. For CY 2017, the CPI-U update is projected to be 2.2 percent. The MFP adjustment is projected to be 0.3 percent, resulting in an MFP-adjusted CPI-U update factor of 1.9 percent.

QUALITY AND PERFORMANCE PROGRAM CHANGES

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program, funded by a 2 percent reduction from participating hospitals' base operating Medicare-severity diagnosis-related group (MS-DRG) payments each year, requires CMS to redistribute a portion of the Medicare payments to hospitals for inpatient services based on performance on quality measures. In this CY 2017 OPPS/ASC final rule with comment period, CMS is finalizing its proposal to remove the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for purposes of the Hospital VBP Program, beginning with the FY 2018 program year. Other Hospital VBP Program requirements were established in the FY 2017 IPPS/LTCH PPS final rule, displayed on August 2, 2016 (81 FR 56761). For more information, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-02.html.

CMS received feedback that some stakeholders are concerned about the pain management dimension questions being used in the Hospital VBP Program, believing that the linkage of these particular questions to the Hospital VBP Program payment incentives creates pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension. Although CMS is not aware of any scientific studies that support an association between scores on the pain management dimension questions and opioid prescribing practices, we are finalizing the removal of the pain management dimension of the HCAHPS survey for purposes of the Hospital VBP Program in an abundance of caution. CMS is also developing and field testing alternative questions related to provider communications and pain in order to remove any potential ambiguity in the HCAHPS survey.

While CMS is developing alternative pain management questions, HCAHPS survey data on all dimensions of care, including pain management, will continue to be publicly reported under the Hospital Inpatient Quality Reporting (IQR) Program in recognition that pain control is an important aspect to delivering quality care. CMS believes this approach appropriately balances stakeholders' concerns that clinicians could face financial pressure to prescribe opioids without compromising the only source of nationally comparable data on pain management and pain management disparities.

Hospital Outpatient Quality Reporting (OQR) Program: Changes for CY 2018, 2019, and 2020 Payment Determinations and Subsequent Years

The Hospital OQR Program is a quality reporting program for outpatient hospital services. The Hospital OQR Program requires hospital outpatient facilities to meet administrative, data collection, and submission, validation, and reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update for failure to meet these requirements.

In the CY 2017 OPPS/ASC final rule, CMS is finalizing the addition of seven measures to the Hospital OQR Program for the CY 2020 payment determination and subsequent years: two claims-based measures, and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures. The seven measures are:

- OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, which assesses the care provided to cancer patients and encourages quality improvement efforts to reduce the number of unplanned inpatient admissions and emergency department (ED) visits among cancer patients receiving chemotherapy in a hospital outpatient setting.
- OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687), which assesses variations in patient outcomes following surgery at a hospital outpatient department (HOPD).
- OP-37(a-e): Five measures that are collected using the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey, a patient experience of care survey that assesses patients' access to care, interactions with facility staff, and overall experience at the facility.

CMS sought public comment on a future electronic clinical quality measure concept for the Hospital OQR Program that addresses concerns associated with overlapping or concurrent prescribing of opioids or opioids and benzodiazepines. This measure concept is designed to reduce preventable deaths as well as reduce costs associated with the treatment of opioid-related ED use by encouraging providers to identify patients at high risk for overdose due to respiratory depression or other adverse drug events. The measure is still under development, and CMS will consider commenters' recommendations and concerns in our ongoing measure development and testing activities.

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.

Additionally, beginning with the CY 2018 payment determination, CMS is finalizing its proposal to publicly display data on the *Hospital Compare* website (https://www.medicare.gov/hospitalcompare/search.html), 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; CMS will announce the timeframes for the preview period on a CMS website and/or on its applicable listservs. Furthermore, beginning with the CY 2019 payment determination, CMS is finalizing its proposal to update the Extraordinary Circumstances Extensions or Exemptions (ECE) policy by changing the ECE request deadline from 45 days from the date that the extraordinary circumstance occurred to 90 days from the date that the extraordinary circumstance occurred.

Organ Transplant Enforcement

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 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.

Changes to the Conditions for Coverage for Organ Procurement Organizations (OPOs)

The Organ Procurement and Transplantation Network (OPTN) establishes the types and frequencies of the data to be submitted by the Organ Procurement Organizations (OPOs) to the Scientific Registry of Transplant Recipients (SRTR) through its policies. The OPTN/SRTR collect and analyze the data pursuant to the Health Resources Service Administration (HRSA) mission to increase organ donation and transplantation. Periodically, the OPTN revises its OPO data reporting policies based on methodologies and clinical practice improvements that enable them to draw more accurate conclusions about donor and organ suitability for transplantation.

CMS is finalizing changes to the definition of "eligible death" and the aggregate donor yield metric in the OPO Conditions for Coverage to align the definition and yield metric criteria with those set forth by the OPTN and SRTR. CMS does not want OPOs to have to submit two sets of numbers, some to the SRTR and some to CMS. CMS is also finalizing revisions to the OPO Conditions of Coverage that require certain documentation to be transported to the transplant center together with an organ. Blood type and infectious disease information, which are two of the most important pieces of information, will continue to be required in written format and sent along with the organ. Other donor information is now available to the transplant center electronically. This reduction in the amount of hard copy documentation that must be sent with the organ would allow OPOs better use of their time during the donation process.

Transplant Technical Correction and Other Proposed Revisions

CMS is also finalizing several revisions to the special procedures for approval and re-approval of organ transplant centers. These rule changes modify the time for organ transplant programs to notify CMS of their intent to request mitigating factors approval from 10 days to 14 calendar days; clarify that the time period for submission of the mitigating factors information is calculated in calendar days; and clarify CMS discretion regarding organ transplant Systems Improvement Agreements (SIAs).

Electronic Health Record (EHR) Incentive Program

90-Day EHR Reporting Period in 2016 and 2017

CMS proposed to change the EHR reporting period in 2016 to any continuous 90-day period within CY 2016 for all returning eligible professionals, eligible hospitals and critical access hospitals (CAHs) that have previously demonstrated meaningful use in the Medicare and Medicaid EHR Incentive Programs.

CMS is finalizing a 90-day EHR reporting period in 2016 and 2017 for all returning EPs, eligible hospitals and CAHs that have previously demonstrated meaningful use in the Medicare and Medicaid EHR Incentive Programs. CMS is extending the 90-day EHR reporting period to include 2017 in response to stakeholder comments indicating concerns with implementing API functionalities for Stage 3, program and systems changes in 2017, as well as to allow eligible clinicians time to transition to the Merit-based Incentive Payment System (MIPS), and to provide flexibility for all health care providers that are preparing for Stage 3 and the implementation of 2015 Edition Certified EHR technology (CEHRT). The EHR reporting period will be any continuous 90-day period between January 1st and December 31st in CY 2016 and CY 2017.

Removal of the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) Objectives and Measures and Reduction of a Subset of the Remaining Objectives and Measures

CMS proposed to 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 in an effort to reduce reporting burden. CMS also proposed to 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 to reduce administrative burden and enable hospitals and CAHs to focus more on patient care.

CMS is finalizing these proposed changes to the objectives and measures for all eligible hospitals and CAHs that attest to CMS, including hospitals that are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs (dual-eligible hospitals). These changes will not apply to Medicaid-only eligible hospitals and CAHs that attest to their State Medicaid Agency.

New Participants in 2017

After the publication of the 2015 EHR Incentive Programs Final Rule, CMS determined that, due to cost and time limitation concerns related specifically to 2015 Edition CEHRT updates in the EHR Incentive Program Registration and Attestation System, it is not technically feasible for eligible professionals, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in a prior year (new participants) to attest to the Stage 3 objectives and measures in 2017 in the EHR Incentive Program Registration and Attestation System. CMS is finalizing proposals that EPs, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in a prior year will be required to attest to Modified Stage 2 objectives and measures. Returning EPs, eligible hospitals, and CAHs will report to different systems in 2017 and therefore are not affected by this policy.

Significant Hardship Exception for New Participants Transitioning to MIPS in 2017

CMS is finalizing proposals that certain EPs, who are new participants in the EHR Incentive Program in 2017 and are transitioning to MIPS in 2017, can apply for a significant hardship exception from the 2018 payment adjustment as authorized under section 1848(a)(7)(B) of the Act using a CMS developed hardship exception application process specific to this policy.

Modifications to Measure Calculations for Actions Outside of the EHR Reporting Period

CMS is finalizing changes to the policy for measure calculations such that, for all meaningful use measures, unless otherwise specified, beginning in CY 2017, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

The ASCQR Program is a pay-for-reporting program that requires ambulatory surgical centers to meet administrative, data collection, and reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update for failure to meet the requirements.

In the CY 2017 OPPS/ASC final rule with comment period, CMS is finalizing the addition of seven measures to the ASCQR program measure set for the CY 2020 payment determination and subsequent years. The seven measures are:

- ASC-13: Normothermia Outcome, which assesses the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU).
- ASC-14: Unplanned Anterior Vitrectomy, which assesses the percentage of cataract surgery patients who have an unplanned anterior vitrectomy (removal of the vitreous present in the anterior chamber of the eye).
- ASC-15(a-e): Five measures that are collected using the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey, a patient experience of care survey which assesses patients' access to care, interactions with facility staff, and overall experience at the facility.

CMS also solicited public comment on one quality measure for future consideration in the ASCQR Program that addresses Toxic Anterior Segment Syndrome (TASS), a complication of anterior segment eye surgery. This measure assesses the number of ophthalmic anterior segment surgery patients diagnosed with TASS within two days of surgery. CMS will take commenters' comments and recommendations into account in deciding whether to propose to adopt this measure in the future.

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.

Additionally, beginning with the CY 2018 payment determination, CMS is finalizing its proposal to publicly display data on the *Hospital Compare* Web site (https://www.medicare.gov/hospitalcompare/search.html), or other CMS Web site, 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. CMS is also finalizing its proposal to announce the timeframes for the preview period on a CMS Web site and/or on its applicable listservs. Furthermore, beginning with the CY 2019 payment determination, CMS is finalizing its proposal to update the Extraordinary Circumstances Extension or Exemptions (ECE) policy by changing the ECE request deadline from 45 days from the date that the extraordinary circumstance occurred to 90 days from the date that the extraordinary circumstance occurred. CMS is also finalizing its proposal to implement a May 15 submission deadline for all data submitted via a CMS Web-based tool in the ASCQR Program beginning with the CY 2019 payment determination.

CMS will accept comments on both the CY 2017 OPPS/ASC final rule with comment period and the IFC through December 31, 2016 (60 days from the date of display in the ***Federal Register***).

The OPPS/ ASC Final Rule with comment period and the IFC are available on the *Federal Register* at https://www.federalregister.gov/public-inspection. For additional information, please review our press release at https://www.cms.gov/Newsroom/Newsroom-Center.html.

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