

New Rules: MIPS, Physician Fee Schedule, Outpatient Rule and More!

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Overview

- News
- Physician Fee Schedule
- Clinical Lab Fee Schedule
- IPPS
- OPPS
- Quality Payment Program/MIPS
- OIG Work Plan

ALJ Backlog

- 12/5 Decision in AHA v. Burwell orders CMS to fix backlog.
- Chose not to order particular acts.
 - 30% by 12/31/17
 - 60% by 12/31/18
 - 90% by 12/31/19
 - Done by 12/31/20
- No default judgments ordered yet.

Exchange Premium Payments by ESRD Facilities

- New rule places some condition on these payments.
- Trade press reported the rule as being of general applicability.
- Seems clear hospitals can pay exchange premiums for patients.

What's Up With Health Reform?



**REPLY
HAZY. TRY
AGAIN LATER.**

Physician Fee Schedule

- 2017 Physician Fee Schedule (PFS) final rule was released 11/2/2016.
- PFS includes a wide range of changes to CMS payment policies for services furnished on or after January 1, 2017.
- Many changes are important to only a very limited audience.

Global Services Data Collection

- Under MACRA, CMS is required to collect data for valuation of surgical services paid as part of global packages.
- CMS's initial proposal for data collection:
 - Applicable to all practitioners providing 10- or 90-day global services.
 - Required reporting using new G-codes.
- Scaled back approach in the final rule.

Global Services Data Collection

- Reporting will be mandatory only for:
 - Practitioners in large practices (10 or more practitioners).
 - Practitioners located in nine states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, Rhode Island).
- Reporting will be voluntary for others.

Global Services Data Collection

- Practitioners will be required to report post-operative visits for high-volume or high-cost procedures.
 - Reporting is not required for pre-operative visits included in the global package.
- Reported using existing CPT 99024 documenting time spent providing patient care (instead of new G-codes).

Global Services Data Collection

- Reporting will apply for services related to global procedures furnished on or after July 1, 2017 (rather than January 1, 2017, as initially proposed).
- CMS will also require participation by practitioners selected for a survey in mid-2017 to gain additional info on post-operative activities.

Medicare Advantage Provider Enrollment

- Current regulations require Medicare Advantage (MA) organizations to screen contracted providers and suppliers.
- CMS revised regulations to require that providers and suppliers be actively enrolled in Medicare before contracting with MA organizations to provide services to Medicare beneficiaries.

Medicare Advantage Provider Enrollment

- Intended to create consistency with enrollment requirements for Medicare Parts A, B and D.
- MA organizations prohibited from paying individuals or entities excluded by the OIG or revoked by Medicare.
 - Regardless of the provider's network status with the MA organization.

Medicare Advantage Provider Enrollment

- Enrollment provisions will be included in CMS contracts with MA plans.
- Noncompliance may result in contract actions ranging from intermediate sanctions to contract termination.
- Requirements go into effect in November 2019; effective on the first day of the plan year.

Medicare Shared Savings Program

- Updates to ACO quality reporting requirements, including changes to:
 - Quality measures (current 34 measures will be reduced to 31).
 - Procedures for quality validation audits.
 - Permit eligible professionals in ACOs to report quality separately from the ACO.

Medicare Shared Savings Program

- Updates to align ACO reporting with PQRS and Quality Payment Program.
- Changes to assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their care.
 - Beneficiaries will be assigned to an ACO using current claims-based process, unless they voluntarily choose this option.

Telehealth Updates

- CMS continues to add new CPT codes to list of covered telehealth services.
- For 2017, CMS is adding the following:
 - ESRD-related services 90967 to 90970;
 - Advance care planning (CPT codes 99497 and 99498); and
 - Telehealth Consultations for Patient Requiring Critical Care Services (G0508 and G0509).

Telehealth Updates

- New place of service (POS) code for telehealth services.
 - POS 02: Telehealth (Descriptor: The location where health services and health related services are provided or received, through telecommunication technology).
- POS code would not apply to originating sites billing a facility fee.

Telehealth Updates

- Distant site practitioners using POS code for telehealth will be paid using facility PE RVUs, regardless of their location.
- New POS code will be used for services furnished by telehealth on or after January 1, 2017.

Moderate Sedation

- CMS finalized values for new CPT codes for moderate sedation used in endoscopic procedures.
 - New codes (CPT 99151-99157) to report sedation services when separately performed.
- Downward adjustment of RVUs for procedures that include moderate sedation as an inherent part of procedure.

Mammography Services

- New coding framework based on new CPT codes for mammography services.
 - Will be implemented in CY 2017 through use of G-codes.
- Valuation of technical component for these services will not change.
- Coding and payment changes will be implemented over several years.

Primary Care, Care Management, and Patient-Centered Services

- New and revised codes designed to improve payment accuracy for:
 - Primary Care and Care Coordination.
 - Mental and Behavioral Health.
 - Cognitive Impairment Care Assessment and Planning.

New and Revised Coding:

- Payment for non-face-to-face prolonged E/M services.
- Separate payment for behavioral health.
- Reducing administrative burden and increasing payment for chronic care management services.
- Assessment and care planning for patients with cognitive impairment.

Medicare Diabetes Prevention Program (MDPP)

- Expansion of prevention model from the CMS Innovation Center.
- Twelve month structured behavioral change intervention program:
 - 16 weekly core sessions in first six months followed by monthly maintenance sessions.
- Benefit begins January 1, 2018.

Medicare Diabetes Prevention Program (MDPP)

- Eligible Medicare Part B beneficiaries:
 - BMI thresholds;
 - No prior diagnosis of diabetes;
 - No ESRD patients; and
 - Pre-diabetic indicators.
- Supplier eligibility.
- Payment not yet determined.

Appropriate Use Criteria

- Program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services.
- AUC: Evidence-based criteria to assist professionals in making appropriate treatment decisions for specific clinical conditions.

Appropriate Use Criteria

- 2016 Final Rule:
 - Established AUC development process and provider-led entities.
- 2017 Final Rule:
 - Set priority clinical areas.
 - Set requirements for clinical decision support mechanisms (CDSM).
 - Hardship exception.

Appropriate Use Criteria

- **Priority Areas:**

1. Coronary artery disease (suspected or diagnosed);
2. Suspected pulmonary embolism;
3. Headache (traumatic and non-traumatic);
4. Hip pain;
5. Low back pain;
6. Shoulder pain (to include suspected rotator cuff injury);
7. Cancer of the lung (primary or metastatic, suspected or diagnosed); and
8. Cervical or neck pain.

Stark Updates: “Per-Click” Arrangements

- Response to *Council for Urological Interests v. Burwell*.
- Arrangements involving rental of office space or equipment.
- Re-issued prior regulatory provisions regarding per-unit service compensation formulas.

CLFS

- Laboratories, including physician office laboratories, must report private payor rate and volume data if:
 - It has more than \$12,500 in Medicare revenues from the CLFS; and
 - It receives more than 50% of its Medicare revenues from CLFS and PFS.
- Low expenditure threshold does not apply to ADLTs.

Data Reporting

- Reporting Entities:
 - Applicable laboratory = NPI level
 - Reporting entity = TIN entity
- Data reporting:
 - Initial data reporting:
 - January 1, 2016 through June 30, 2016
 - Report to CMS: March 31, 2017
 - Every three years thereafter for CLDTs
- New CLFS: Effective January 1, 2018

Data Reporting

- “Applicable information” is the private payor rate for each test for which final payment has been made during the data collection period, the associated volume for each test, and the specific HCPCS code associated with the test.
 - Exceptions for new tests and ADLTs.
- Civil monetary penalties of up to \$10,000 per day for failure to report.

Payment Reductions

- Restrictions on year over year reductions:
 - CY 2018-2020: 10 percent per year.
 - CY 2021-2023: 15 percent per year.

IPPS

- Final rule published in the Federal Register 8/22/2016
- Highlights:
 - Changes to Hospital Readmissions Reduction Program
 - Update on MOON
 - Update on the 2-midnight rule payment cut

Hospital Readmissions Reduction Program

- Goal of the program is to reduce readmissions by reducing payments to hospitals with excess readmissions
- Looks at the risk-adjusted readmission rate during a 3-year period for certain conditions
 - For FY 2017, July 1, 2012-June 30, 2015

Hospital Readmissions Reduction Program Changes

- Refining the measure for pneumonia readmissions
- Adding a measure related to CABG readmissions
- These two changes are expected to save Medicare \$528m in FY 2017 (\$108m more than in FY 2016)

Hospital Readmissions Reduction Program Changes (continued)

- Rule “reaffirms” CMS’s public reporting policy
- Excess readmission rates will be posted on the Hospital Compare website
- Data went up on the website in October, 2016; will be updated annually “as soon as feasible”

MOON

- MOON = Medicare Outpatient Observation Notice
 - Must be provided no later than 36 hours after the observation services are initiated (or sooner if individual is transferred, discharged, or admitted as an inpatient)
 - Must be signed by the patient or the patient's representative (or document the refusal to sign)
 - Must be accompanied by a verbal explanation
- Can you provide it prior to 24 hours?
 - Yes, but don't provide too early (i.e., at the initiation of the observation services)

MOON (continued)

- Delayed implementation/enforcement:
90 days after MOON form released
 - IPPS expected the MOON to be complete 10/1/2016
 - MOON actually released 12/8/2016
- Enforcement begins 3/8/2017

Medicare Outpatient Observation Notice

Patient name:

Patient number:

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
 - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
 - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative

Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

2-Midnight Rule Rate Adjustment

- 2-midnight rule linked with reduction in IPPS rates on the counter-intuitive theory that the rule would create MORE inpatient encounters
- Court remanded the rule back to the agency
- CMS is now reversing the 3 years of cuts with a 1-time increase for FY2017

OPPS

- Final rule published in the Federal Register on 11/14/2016
- Highlights:
 - Hospital Outpatient Quality Reporting Program
 - EHR incentive program updates
 - Provider-based updates

Hospital Outpatient Quality Reporting

- Adds a handful of new quality measures
- “Formalizes” current practice of publishing quality measures on Hospital Compare website
 - 30 day preview period

EHR Incentive Program

- EHR incentive program is on its way out
 - Getting rolled up into MIPS; transition complete 12/31/2018
- Changes to the EHR incentive program rules for its last two years
 - Changes to MU attestation requirements
 - “Significant hardship” exception for certain new participants
 - Finalizing 2016 reporting period for returning participants (90 continuous days)

Meaningful Use Attestation 2017-2018

- Eliminated the clinical decision support and computerized provider entry objectives and measures
 - For eligible hospitals and CAHs
 - Change does NOT apply to attesting MU to states under state Medicaid EHR incentive programs
- Lowered thresholds for some other measures

Significant Hardship Exception

- For EPs to avoid 2018 payment reduction
- Available only to:
 - EPs
 - Have not have successfully demonstrated MU in a prior year
 - Intend to attest MU for a 2017 reporting period by 10/1/2017
 - Intend to transition to MIPS and report on measures specified for advancing care information performance category in 2017

Off-campus provider-based departments (PBDs)

- Bipartisan Budget Act of 2015 (BBA15)
- As of 1/1/2017, no OPPS payments for services for items and services furnished in “new” off-campus PBDs.
- Excepted and nonexcepted locations

Off-campus PBDs

- Excepted locations (paid under OPPS):
 - Off-campus PBD locations that furnished items and services prior to 11/2/2015 and timely billed for such services under the OPPS.
 - Check the 855A enrollment date.

Off-campus PBDs

- Nonexcepted locations are paid under the Medicare Physician Fee Schedule
 - 2017 payment rate = “50% of OPPS rate”
- Medicare will pay hospitals for nonexcepted items and services
 - Institutional claim with “PN” modifier

Off-campus PBDs

- Service expansion at excepted locations is not limited in final rule.
- Lose excepted status if move from physical address and suite number on 855A as of 11/2/2015 (some exceptions based on extraordinary circumstances).
- Lose excepted status upon sale, unless buyer assumes main provider's provider agreement and excepted location is transferred to new owner.

What is MIPS?

- Actually, the right question is “What is the Quality Payment Program”?
- Created by MACRA legislation.
- Consolidates components of the Physician Quality Reporting Program (PQRS), Value Based Payment Modifier (VM), Electronic Health Records Incentive Program (EHR).

Quality Payment Program

- Advanced Alternative Payment Models
- Merit-based Incentive Payment System
 - Quality
 - Clinical practice improvement activities
 - Resource use (i.e., cost)
 - Meaningful use of EHR
- 2017 first performance year; 2019 first payment year.

Who participates?

- For years 1 and 2 of the program, “MIPS eligible clinicians” are the following practitioners who bill more than \$30,000 per year **and** provide care to more than 100 Medicare patients per year.
 - Physicians
 - Physician Assistants
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetists

Who is excluded?

- Newly enrolled clinicians
- Clinicians below the low-volume threshold:
 - Part B charges < \$30,000 or
 - 100 or fewer Part B patients per year
- Clinicians participating in Advanced Alternative Payment Models (APMs)

Four tracks for Y1 of the QPP

1. Advanced APM participation
2. MIPS – Report on only one measure in each of the three categories (no payment adjustment, positive or negative)
3. MIPS – Report on at least one measure for each category and some additional measures in at least one category for a 90-day period or the full year (no negative adjustment, some positive adjustment)
4. MIPS – Report on all measures for each category for a 90-day period or the full year (no negative adjustment, possible maximum positive adjustment)

Advanced APMs

- CMS: “The Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.”

Advanced APMs

- For 2017 . . .
 - Comprehensive ESRD Care Model (Two sided risk)
 - Shared Savings Program (Track 2)
 - Comprehensive Primary Care Plus
 - Next Generation ACO Model
 - Oncology Care Model (Two-sided risk)

Future Advanced APMs

- Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review Physician-Focused Payment Models.
- CMS anticipates the following will be Advanced APMs after 2017:
 - CJR
 - Voluntary Bundled Payment Model
 - Advancing Care Coordination through Episode Payment Models Track 1
 - ACO Track 1+
 - Vermont Medicare ACO Initiative

What is MIPS? (weights for 2017)

 Quality	 Improvement Activities	 Advancing Care Information	 Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

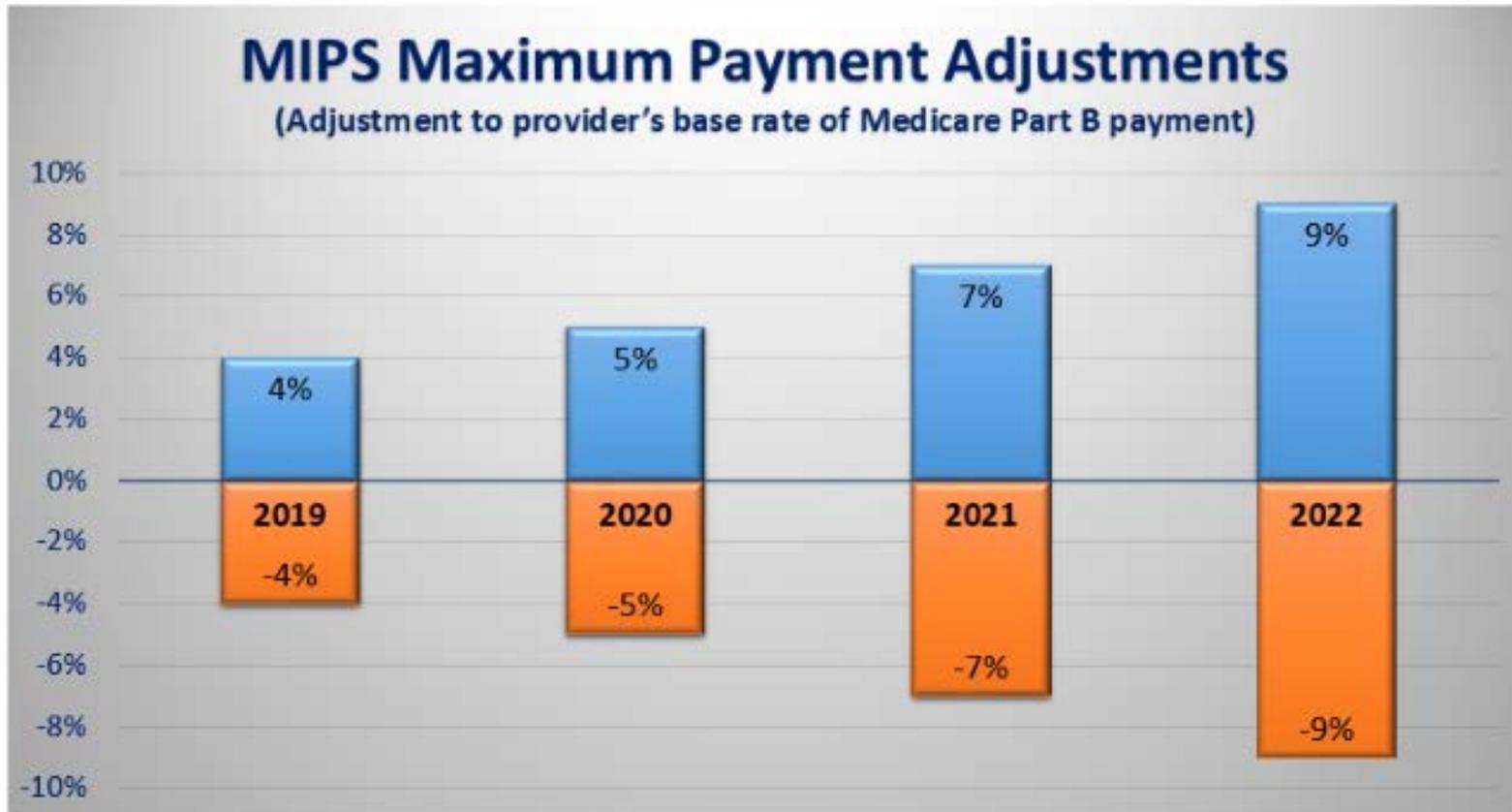
60%

15%

25%

0%

What's at stake?



What Are the Quality Measures? (Y1, 60% weight)

- List found at 81 FR 77558.
- Full: 6 measures or one specialty/subspecialty set.
- Minimum: 1, unless you use CMS Web Interface, then more.

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description ^y	Measure Steward
1	N/A/398	N/A	Effective Clinical Care	Registry	Outcome	Optimal Asthma Control: Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.	Minnesota Community Measurement

Resource Use (Y1, 0% weight)

- Calculated from claims.
- Total per costs per capita for all attributed beneficiaries and Medicare Spending per Beneficiaries (MSPB) with minor technical adjustments (like Value Based Modifier payment).
- Compared to other care episodes.
- Converted to points.

Improvement Activities (Y1, 15%)

- Full: 4 improvement activities (90 choices).
- E.g., Care coordination, shared decision making, safety checklists, improved access, emergency preparedness, beneficiary engagement
- Minimum: 1.

Advanced Care Information (Y1, 25%)

- FKA Meaningful Use.
 - Patient electronic access, eRx, care coordination, clinical data registry participation, health information exchange
- Full: 5 measures.
- Minimum: 1.
- Weight likely to fall as EHR becomes norm.

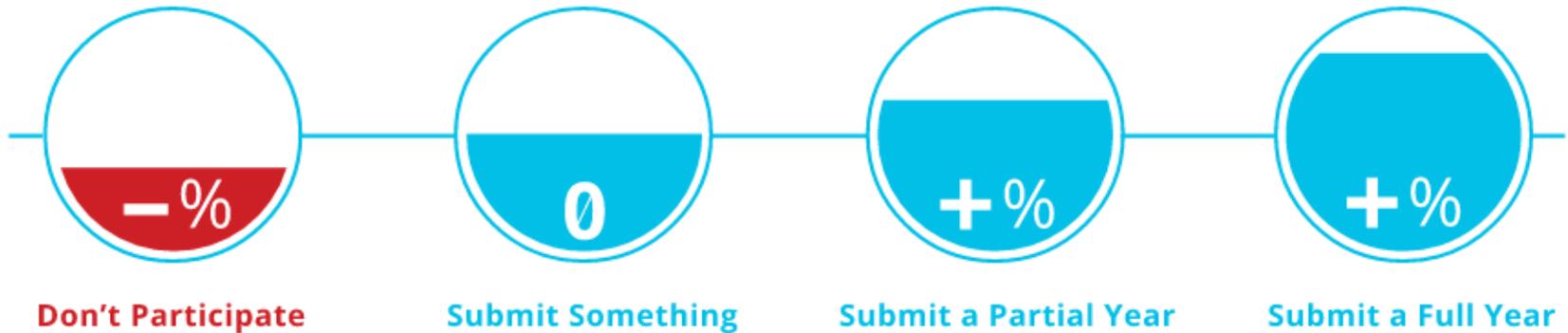
Composite Performance Score (CPS)

- Each criterion is converted to points.
- Possible adjustments for small or rural practices, non-patient facing practices.

MIPS 2017 data/2019 payment



How does it work?



Not participating in the Quality Payment Program:

If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:

If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:

If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

Full:

If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

OIG WORK PLAN 2017

- Use of work plan?
 - Acronyms.
 - Broad areas of interest.
- Describes forthcoming reports and audits.
- Updates on status of past reports.

New Areas

- Hyperbaric oxygen therapy services – provider reimbursement.
- Incorrect medical assistance stays claimed by hospitals.
- Inpatient psychiatric facility outlier payments.
- Case review of inpatient rehabilitation hospital patients not suited for intensive therapy.
- Hospice.
- Clinical diagnostic lab.
- Drug wastage of single-use vials.

New Areas

- Transitional care management.
- Chronic care management.
- Services after patient death.

Oldies But Goodies

- Outlier payments.
- Replaced medical devices.
- Provider-based v. free standing.
- 2 midnight rule.
- Patients with Kwashiorkor.

Questions?

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