



Policy Update for TASC-90 calls

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Proposed Rule: Hospital and Critical Access Hospital (CAH) Conditions of Participation (CoPs) (CMS-3244-P)

Overview

- Allowing CAHs to provide certain services, including laboratory and radiology services, under arrangement.
- Removing the requirement for a single Director of Outpatient Services.
- Allowing one governing body to oversee multiple hospitals in a single health system.
- Single, interdisciplinary care plan that supports coordination of care instead of requiring a separate stand-alone nursing care plan.



Proposed Rule: Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction (CMS-9070-P):

Overview

- Removing automatic deactivation of a provider or supplier who has not submitted a claim for 12 consecutive months.
- Updating e-prescribing technical requirements so Medicare Prescription Drug Plans meet current standards.



Links to Proposed Rules:

- Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction(CMS-9070-P):
<http://www.gpo.gov/fdsys/pkg/FR-2011-10-24/pdf/2011-27176.pdf>
- Proposed Reform of Hospital and CAH CoPs (CMS-3244-P):
<http://www.gpo.gov/fdsys/pkg/FR-2011-10-24/pdf/2011-27175.pdf>



Final Rule: CY 2012 Hospital Outpatient Prospective Payment Overview

Supervision:

- Extending notice of non-enforcement for CAHs and small rural hospitals with 100 or fewer beds through CY 2012.
- Establishes an independent advisory review process to consider requests that specific outpatient services be subject to a level of supervision other than direct supervision.
 - CMS will seek recommendations from Ambulatory Payment Classification (APC) Advisory Panel about appropriate supervision requirements.
 - CMS will add two small rural PPS hospital members and two CAH members



Final Rule: 2012 Physician Fee Schedule

Overview

Physician Value Modifier. Section 3007 of the Affordable Care Act requires the Secretary to "establish a payment modifier that provides for differential payment to a physician or a group of physicians" under the physician fee schedule "based upon the quality of care furnished compared to cost..."

The initial performance period will be CY 2013, for payment adjustments in CY 2015. For 2013, CMS expects that modifier measures will be based on PQRS and EHR MU incentive program quality measures, plus total per capita cost measures including costs for COPD, CHF, CAD, and diabetes.

Telehealth. CMS added smoking cessation services to the list of covered telehealth services, and relaxed the criteria for adding Category 2 services, to "whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient."



Final Rule: 2012 Physician Fee Schedule (continued)

Overview

3-Day/1-Day Payment Window. Expands the outpatient services subject to the rule, which applies to services furnished by a hospital, or an entity wholly owned or operated by the hospital, within 3 calendar days prior to an admission (1 day for certain non-IPPS hospitals). All diagnostic and clinically-related outpatient services (except ambulance and some dialysis services) now must be billed by the hospital as part of the Part A inpatient claim.

- Applies to outpatient services provided at a CAH that is wholly owned or operated by an IPPS hospital (not applicable to other CAHs)
- Applies to physician practices
- Does not apply to RHC or FQHC claims

The effective date of this change is delayed until July 1, 2012 to allow hospitals and applicable entities more time to coordinate efforts in ensuring proper billing.



Links to Final Rules:

- CY 2012 Final Outpatient Prospective Payment System (CMS-1524-FC and CMS-1436-F)
[http://www.ofr.gov/\(X\(1\)S\(gpqplkkfbr51aynaxnf4kma5\)\)/OFRUpload/OFRData/2011-28612_PI.pdf](http://www.ofr.gov/(X(1)S(gpqplkkfbr51aynaxnf4kma5))/OFRUpload/OFRData/2011-28612_PI.pdf)
- CY 2012 Final Medicare Physician Fee Schedule (CMS-1524-FC and CMS-1436-F)
[http://www.ofr.gov/\(X\(1\)S\(gpqplkkfbr51aynaxnf4kma5\)\)/OFRUpload/OFRData/2011-28597_PI.pdf](http://www.ofr.gov/(X(1)S(gpqplkkfbr51aynaxnf4kma5))/OFRUpload/OFRData/2011-28597_PI.pdf)



Telehealth in RHCs and FQHCs

RHCs and FQHCs are recognized "originating" (patient) sites and can bill Medicare for a site origination fee (about \$25), subject to beneficiary co-pay.

- Not a billable RHC/FQHC encounter, although the beneficiary can have an encounter on the same day for another medically-necessary purpose.

RHCs and FQHCs cannot bill Medicare as a "distant" (specialist) site during regular hours (RHCs can have non-RHC hours).

- RHC/FQHC not an authorized physician or practitioner under statute
- Can't bill Part B fee-for-service during regular hours
- Not face-to-face, so not a billable RHC/FQHC visit, either

Final Rule: Accountable Care Organizations

Overview

- October 20, 2011 CMS Released its Final Rule Relating To Accountable Care Organizations (ACOs).
- The Final Rules Will Be Published In The Federal Register On November 2, 2011, and are Effective January 1, 2012.
- CMS Received More Than 1,300 Comments On The Proposed Rule and Made Significant Changes.



Final Rule: Accountable Care Organizations

Overview

- Intent of MSSP is to promote accountability, improve coordination of FFS items and services, encourage investment in infrastructure and redesigned processes of care, and incent higher value care.
- As an incentive to ACOs that successfully meet quality and savings requirements, the Medicare program will share a portion of the savings with the ACO.
- Focus on achieving three-part aim:





Final Rule: Accountable Care Organizations Modifications to Proposed Rule

- In this final rule there are significant modifications intended to reduce burden and cost for participating ACOs. These modifications include:
 - Greater flexibility in eligibility to participate in the Shared Savings Program;
 - Multiple start dates in 2012;
 - Establishment of a longer agreement period for those starting in 2012;
 - Greater flexibility in the governance and legal structure of an ACO;
 - Simpler and more streamlined quality performance standards;
 - Adjustments to the financial model to increase financial incentives to participate;
 - Increased sharing caps;
 - No down-side risk and first-dollar sharing in Track 1;
 - Removal of the 25 percent withhold of shared savings;
 - Greater flexibility in antitrust review;
 - Greater flexibility in timing for repayment of losses; and
 - Additional options for participation of FQHCs and RHCs.

Final Rule: Accountable Care Organizations

Three Associated Documents Released Concurrently

- Final Waivers in Connection with the Shared Savings Program; a joint CMS & DHHS OIG interim final rule with comment period.
- IRS Notice 2011-20 & other applicable IRS guidance viewable at www.irs.gov.
- Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Shared Savings Program; issued by the FTC & DOJ.



Final Rule: Accountable Care Organizations Advance Payment Model

- Designed to support physician-owned and rural ACOs with upfront infrastructure investments.
- Providers will receive payments in advance that will be recouped as they achieve savings.
- Up to 50 small ACOs will qualify for up to \$170 million in advance payments.
- Eligibility is restricted to physician-owned and rural ACOs.





Links to the Final ACO Rules:

- Proposed Rule:
<http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>
- Final Rule:
http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf
- Medicare Shared Savings Program Final Waivers:
http://www.ofr.gov/OFRUpload/OFRData/2011-27460_PI.pdf
- DOJ /FTC Final Policy Statement of Antitrust Enforcement Policy Regarding ACOs:
http://www.justice.gov/atr/public/health_care/276458.pdf
- Advance Payment Model:
http://www.ofr.gov/OFRUpload/OFRData/2011-27458_PI.pdf
- Fact Sheets for the Proposed Rule:
<http://www.cms.gov/sharedsavingsprogram/>



Questions? Ask the Policy Team!

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