ORHP Regulatory Update

TASC 90 Call

November 12, 2014

Physician Fee Schedule

On November 13, the 2015 Physician Fee Schedule Payments will be published in the Federal Register. Changes take effect January 1.

Rural-relevant provisions :

- Chronic Care Management services (CPT 99490), $40 monthly; ~~RHC/FQHC~~
- Expands telehealth services (AWV, psychotherapy, prolonged office service)
- Eliminates employment requirement for RHC/FQHC “incident to” services
- Begin reporting of hospital-owned physician practices with a claim modifier
- Value Modifier implementation
- Update PQRS implementation
- Implements the MU Hardship Exemption extension previously announced
- Updates Ambulance Fee Schedule geographic areas for the new OMB areas and RUCAs resulting from the 2010 Census
- Eliminate 10-day and 90-day global surgery payments in 2017 and 2018
- Enhance transparency in CPT/HCPCS code rate setting
- Updates ACO quality measures

OPPS

On November 10, the 2015 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rule was published in the Federal Register. The changes take effect for services furnished on or after January 1, 2015. Several provisions of the rule may interest rural stakeholders:

- Implementation of a single "packaged" payment via a comprehensive Ambulatory Procedure Code for certain ancillary services provided with a primary service.
- New and revised codes identifying covered services eligible for payment, including new technologies.
- Changes to the Hospital Outpatient Quality Reporting Program, including removal of two "topped-out" measures and a new claims-based colonoscopy measure.
- The 7.1% payment adjustment to rural Sole Community Hospitals will continue. Some commenters suggested it should be reassessed to see if it accurately reflects the differences between urban hospitals' costs and rural hospitals' costs.
- Overall the payment changes (mainly wage index adjustments and APC recalibration) will result in a 1.9% increase in payments to rural hospitals in 2015 compared to 2014. Urban hospitals will see a 2.3% increase.

Home Health Conditions of Participation

On October 9, CMS issued a proposed rule, the first update to the Medicare and Medicaid Conditions of Participation for home health agencies since 1989. The proposed changes would update data transmission requirements; focus the patient assessment requirement; and formalize communication and care coordination structures. Home health agencies would be required to maintain a quality assessment and performance improvement program, as well as require additional supervision and training when an agency suspects that home health aide skills are insufficient. CMS is accepting comments on the proposed rule for 60 days.

Fact sheet for the proposed rule

Basic Health Program

On October 21, CMS issued a proposed notice establishing the methodology for determining federal funding for the 2016 Basic Health Program (BHP). The BHP provides states with a voluntary option to establish a health benefits coverage program for lower-income residents with incomes too high to qualify for Medicaid through Medicaid expansion, as an alternative to Marketplace coverage under the ACA.

CMS proposes to use the same payment methodology as established for 2015, along with updated values for several factors.

OIG Report on CAH Outpatient Services

On October 8, the HHS OIG released a report examining Medicare beneficiary payments for outpatient services at CAHs. The report found that Medicare beneficiaries pay more in coinsurance at CAHs than they would if they received the same services at a PPS hospital. In CAHs, the required beneficiary cost share is 20% of the hospital's charge for the service, whereas it is 20-22% of Medicare rates at PPS hospitals. Most hospitals' charges (both CAH and PPS) are higher than the Medicare outpatient payment rates, so coinsurance at CAHs is usually higher than at PPS hospitals. Many people have Medigap policies that cover coinsurance, so many beneficiaries aren't paying the higher amounts directly.

Before the Outpatient PPS (OPPS) went into effect in 2000, outpatient coinsurance at all hospitals was 20% of charges. The OPPS established a different coinsurance calculation for PPS hospitals, but the CAH calculation remains set by statute. As such, Congress would need to change the law to change the amount of beneficiary cost sharing. Because CAHs receive cost-based Medicare payment, any reduction in beneficiary cost sharing would require an increase in Medicare payments to make up the difference (coinsurance plus Medicare payment equal to 101% of costs, reduced by the 2% sequester).

The OIG is an independent office within HHS that conducts audits, investigations, and evaluations of more than 300 HHS programs. OIG is a separate organization from CMS, which administers the Medicare and Medicaid programs.

MU Program and CEHRT Standards Updates

On September 4, CMS and ONC issued a final rule, effective October 1, modifying the Medicare and Medicaid EHR Incentive Programs and revising the Certified EHR Technology standards. Specifically, the rule includes the following:

Changes to the Meaningful Use Timeline (Updated Timeline Below)

- Stage 2 is extended through 2016 for certain providers unable to fully implement 2014 Edition CEHRT.
- Stage 3 begins in 2017, instead of 2016, for providers who first attested to MU in 2011 or 2012.
- Providers that first demonstrated MU Stage 1 in 2011 or 2012 must have begun Stage 2 in 2014.
- Other providers who remained at Stage 1 in 2014 must begin Stage 2 in 2015.
- All providers, except those in their first year of MU, must report on a full year in 2015.

Revisions to the CEHRT Definition

- Providers can use 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT in 2014.
- All providers are required to use 2014 Edition CEHRT for the full year in 2015.
- Providers are able to use 2011 Edition CEHRT, and have the option to attest to the 2013 stage 1 MU objectives and the 2013 definition CQMs.

Updated Meaningful Use Timeline

First Payment Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	2	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	2	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

MU Hardship Exception Extension

CMS reopened the application period for a hardship exception through **November 30**, giving certain eligible professionals and hospitals another opportunity to avoid 2015 payment penalties for not demonstrating meaningful use of electronic health records (EHRs). Under the extension, CMS will only consider applications from entities that were unable to fully implement a 2014 EHR due to delays in CEHRT availability, and were unable to attest by the applicable deadline under flexibility options provided in the recent 2014 Edition CEHRT Flexibility Rule.

For more information, please visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html