# Advisor Live®
# Hospital Outpatient Prospective Payment System and Physician Fee Schedule Proposed Rules

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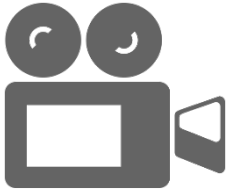

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# Faculty

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# Agenda

- Outpatient Prospective Payment System (OPPS)
  - APCs/Comprehensive APCs/Composite APCs
  - Packaged Items and Services
  - Drugs, Biologicals and Radiophramaceuticals
  - Inpatient Only Procedures
  - Off-campus Provider-Based Departments
  - Outpatient Quality Reporting
  - ASC Quality Reporting
  - Hospital Value-Based Purchasing
  - EHR Incentive Program
- Medicare Physician Fee Schedule (MPFS)
  - Telehealth Services
  - Care Management
  - Appropriate Use for Diagnostic Imaging
  - PQRS/Value Modifier Updates
  - Medicare Shared Savings Program
  - Diabetes Prevention Program

# Outpatient Prospective Payment System (OPPS)

# OPPS Proposed Rule

- Released July 6, published in July 14, *Federal Register*
- Projected market basket increase of 2.8%, but 1.6% update
  - 0.5% *decrease* due to productivity cut from ACA
  - 0.75% additional reduction due to ACA
  - 0.05% increase due to budget neutrality for packaging proposal and pass-through estimates
- Average payment increase of 1.7% for hospitals reporting quality measures
  - 1.6% for urban
  - 2.3% for rural
- Conversion Factor going from $73.725 to $74.909
- Increase of $671 million compared to CY 2016
- CMS will release final rule Oct 31, provisions generally in effect Jan 1, 2017
- **Comments due September 6, 2016**

# OPPS Proposed Rule: How to Submit a Comment

- CMS proposed rule for the OPPS/ASCs
  - Comments due 60 days from the date of display (September 6, 2016)

1. Go to proposed rule
2. Click “Submit a Formal Comment”, the green button on the right-hand side of the page below the title.

OR

1. Go to http://www.regulations.gov
2. Type “CMS-1656-P” into the search box
3. Find “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs…” (should be first selection)
4. Click on “Comment Now”, the blue button to the right of the title.

# CY 2017 Outpatient PPS: Recalibration of APC Relative Weights

- Expansion of packaging for lab services
- Addition of 23 new comprehensive APCs using previous criteria; reorganization of existing C-APCs results in 4 additional C-APCs; total of 62 C-APCs proposed for 2017
- No changes to recalibration methodology
  - Calculate the cost of each procedure only from **single procedure claims** and “pseudo” single procedure claims created from bills containing multiple codes, using date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to “pseudo” single procedure claims
- CMS bypasses the 194 **Healthcare Common Procedure Coding System (HCPCS) codes** (reported on claims in 2015 but were deleted for 2016) identified in Addendum N to the proposed rule.
  - Proposes to **delete six HCPCS codes** from the 2017
  - The complete bypass list in Addendum N is open to **public comment.**

# Recalibration of APC Relative Weights

- Calculations and use of cost-to-charge ratios:
  - CMS multiplies the charges by a hospital-specific cost-to-charge ratio (CCR) associated with each revenue code and cost center using the same basic approach used for APC rate construction for 2007 and each subsequent year.
  - CMS applies the appropriate hospital-specific CCR to the hospital's charges at the most detailed level possible based on a revenue code-to-cost center crosswalk containing a hierarchy, for each revenue code, of CCRs for estimating costs from charges.
- Budget neutral weight scaler:
  - Compare the estimated aggregate weight calculated using the proposed 2017 unscaled relative weights & service volume in the 2015 claims data to the aggregate weight calculated using the 2016 scaled relative weights & service volume in the 2015 claims data
- The proposed rule unscaled APC payment weights were adjusted by a weight scaler of **1.4059**
- Hospital Outpatient Payment Panel Recommendation:
  - (1) CMS provides the data subcommittee a list of APCs fluctuating significantly in costs prior to each Panel meeting. (2) The work of the data subcommittee will continue. (3) The current Chair will remain.

# Recalibration of APC Relative Weights

- Calculation of single procedure APC criteria-based costs
  - Propose to continue using blood-specific CCR methodology for **Blood and blood products:** calculate the procedure costs for setting the proposed 2017 payment rates using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and using a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.
  - Propose to continue to include blood and blood products in the comprehensive APCs
  - Brachytherapy sources: The proposed rule for 2017 would continue without change the policies used to set payment rates for brachytherapy sources; costs derived from the 2015 claims data would be used to set 2017 payment rates.

# C-APC Modifications

- In CY 2014, CMS proposed new “comprehensive APCs” (C-APCs) to prospectively pay for costly device-dependent services. Implementation was delayed until CY 2015, and C-APCs were expanded in 2016.
- **Defined** as a classification for providing a primary service and all adjunct services that support the delivery of the primary service.
- CMS selects HCPCS codes for primary services to be assigned to a C-APC and designates them by **status indicator “J1”.** C-APCs for which assignment is based on combination of services are represented by **status indicator “J2”. A single prospective payment** is made for the C-APC based on the costs of all reported services on the claim.
  - For claims reporting more than one primary service with status indicator J1 or multiple units, CMS identifies J1 service as the primary service based on **a cost-based ranking of primary services using comprehensive geometric mean costs for single unit J1 services.**
- Services excluded from the C-APC payment policy include those that are not covered OPD services; services excluded from the OPPS; and services that are required to be separately paid.
- Addendum J of the proposed rule details codes for C-APCs

# C-APC Modifications

- Combinations of codes (including certain add-on codes) can qualify for a “complexity adjustment” (higher payment)
- Criteria for code combinations to satisfy the complexity criteria:
  - Frequency of 25 or more claims reporting the code combination(frequency threshold);
  - Violation of 2 times rule, the comprehensive geometric mean cost of the complex code combination exceeds the comprehensive geometric mean cost of the lowest significant HCPCS code assigned to the comprehensive APC by more than 2 times (the cost threshold)
- For 2017, for combinations that meet the complexity criteria, CMS proposes to no longer test whether a code combination create a 2 times rule violation in the higher level or receiving APC.
- 30,423 code combinations were evaluated for a complexity adjustment; 275 code combinations qualified
- Addition of 23 new comprehensive APCs; reorganization of existing C-APCs results in 4 additional C-APCs; total of 62 proposed for 2017
- Propose a new C-APC 5244 (Level 4 Blood Product Exchange and Related Services, $15,267 payment rate) for allogeneic Hematopoietic Stem Cell Transplantation (HCST)

# Composite APC

- Use composite APCs to make a single payment for groups of services that are typically performed together during a single clinical encounter and result in provision of a complete service(since 2008)
- No new composite APCs proposed for 2017, but continue composite policies for **low dose rate (LDR) prostate brachytherapy, mental health services, and multiple imaging services.**
  - *LDR Prostate Brachytherapy Composite APC (APC 8001):* Using a partial year of 2015 claims data available for the 2017 proposed rule, CMS calculates a geometric mean cost for composite APC 8001 of approximately $3,581
  - *Mental Health Services Composite APC (APC 8010):* Propose to continue payment policy of limiting the combined payment for specified less intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which the agency considers to be the most resource intensive of all outpatient mental health treatment
  - *Multiple Imaging Composite APCs(APCs 8004, 8005, 8006, 8007, and 8008):* Propose to continue the multiple imaging composite APC policies that it has applied since 2009.

# Packaged Items & Services

- Two changes to **clinical diagnostic laboratory test packaging policy**:
  - Discontinue the unrelated laboratory test exception (package any and all laboratory tests that appear on a claim with other OPD services)
  - Expand the molecular pathology test exception to include all advanced diagnostic laboratory tests (ADLTs) that meet the criteria of section 1834A(d)(5)(A) of the Act (assign status indicator “A”)
- **Conditional Packaging Status Indicators** (identify packaged payment and separate payment) “Q1”&“Q2”:
  - For 2017, CMS proposes to change the logic for status indicators “Q1” and “Q2” so that packaging would occur at the claim level (instead of based on the date of service)

# Wage Index

- Wage Index – no new proposed methodology
  - Continues policy of adopting the final fiscal year IPPS post-classified wage index as the OPPS calendar year wage index for adjusting the OPPS standard payment amounts for labor market differences
  - Retain the OPPS labor-related share of 60%
  - Continues Frontier State wage index floor of 1.00.
  - Continues to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration wage adjustment if in “Section 505” out-migration county
  - 2017 is final year of the 3-year transition period for hospitals paid under the OPPS but not under the IPPS that are currently located in urban counties that would become rural under the new OMB delineations
  - Continues the extension of the imputed floor policy (both the original methodology and alternative methodology) for another year

# Special case hospitals

## Rural Adjustment

- Continue a budget neutral 7.1% payment increase for certain rural SCH (including EACHs) services, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs

## Cancer Hospitals

- Continue to provide additional payments to 11 cancer hospitals sufficient to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals(CMS makes an aggregate payment rather than a claims-based adjustment)
- **Propose target PCR of 0.92** to determine the CY 2017 cancer hospital payment adjustment to be paid at cost report settlement. using the latest available cost data (cost report periods with fiscal year ends ranging from 2014 to 2015)
- **1.0000 OPPS conversion factor** for the cancer hospital adjustment (aggregate cancer hospital adjustments would be largely unchanged in 2017 compared to 2016)

# Outliers

## Outliers – no new proposed methodology

- The OPPS makes outlier payments on a service-by-service basis when the cost of a service exceeds the outlier threshold.
- Continue to set aside **1.0 percent** of the estimated aggregate total payments under the OPPS for outlier payments
- To qualify for outlier payments in CY 2017 a service or procedure cost must exceed **1.75 times** the APC payment amount *and* also exceeds the APC payment rate plus **a $3,825 fixed-dollar threshold** (compared to $3,250 in 2016)
- Propose that a portion of the 1.0% outlier pool be allocated to Community Mental Health Centers (CMHCs) for partial hospitalization program outlier payments, in contrast with amounts of 0.49% for 2016 and 0.47% for 2015
- The inflation adjustment factors for CCRs and charges are the same as were used for the FY 2017 IPPS proposed rule.

# Payment for Devices

- **Pass-Through Payments for Devices -** Expiration of transitional pass-through payments for certain devices:
  - Propose to package costs of device described by HCPCS code C2624 into costs related to the procedures with which the device is reported in the hospital claims data
  - Continue the pass-through status in 2017 for the other three devices(HCPCS code C2623, C2613, C1822)
- New Device Pass-Through Applications
  - CMS received three applications: *BioBag®, Encore™ Suspension System, Endophys Pressure Sensing System*
- **Device-Intensive Procedures:**
  - Propose a revised methodology that **the device-intensive determinations** would be **procedure-based** rather than APC-based
  - All procedures requiring the implantation of a medical device and having an individual HCPCS code-level device offset of greater than **40 percent** would be identified as device-intensive and would be subject to the device edit and no cost/full credit and partial credit device policies.
  - Consistently, CMS proposes to apply the **device claims editing policy** on a **procedure level** rather than APC level

# Drugs, Biologicals & Radiopharmaceuticals

- OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals & Radiopharmaceuticals:
  - Make transitional period 3 years for all pass through drugs, biologicals, and radiopharmaceuticals and expire status on a **quarterly basis**
  - Propose to terminate the pass-through payment status for 15 drugs & biologicals and continue status for 38 drugs, biologicals & radiopharmaceuticals
  - **ASP adjustment:** continue to pay for drugs and biologicals with pass-through status at average sales price plus 6 percent **(ASP+6)**
- OPPS Payment without Pass-Through Payment Status:
  - Packaged into payment for associated service; or separate payment
  - Continue to pay for all nonpass-through, separately payable therapeutic radiopharmaceuticals under the same ASP methodology that is used for separately payable drugs and biologicals
  - Additional $10 payment for radioisotopes produced by non-HEU sources
- **Packaging threshold** for drugs and biologicals is proposed at $110
- Continues policies for **biosimilar biological products**
- Estimate spending for total pass-through drug and device payments during 2017 is around $148.3 million, or 0.24% of total OPPS

# Other Proposed Policies

- Changes to the Inpatient Only (IPO) List
  - Continue to use the same methodology to review inpatient-only list
  - Propose to remove the six procedures (four spine procedures and two laryngoplasty codes) from the inpatient-only list for 2017
- CMS is seeking public comments on whether it should remove total knee arthroplasty (TKA) or total knee replacement procedure, CPT code 27447, from the IPO list.
  - First, just because the procedure is not on IPO list does not mean that the procedure cannot be performed on an inpatient basis
  - Second, the IPO status of a procedure has no effect on the MPFS payment for the procedure.
- CMS proposes no changes to the current clinic and emergency department (ED) hospital outpatient visits payment policies

# Outpatient Provider-Based Departments - Background

- Section 603 of the Bipartisan Budget Act of 2015, enacted on November 2, 2015, imposed new payment rules for certain off-campus outpatient provider-based departments (PBDs)
- Beginning January 1, 2017, items and services furnished by off-campus outpatient PBDs will no longer be paid under the OPPS; they will be paid under another Medicare Part B payment system
- The law provides exceptions for:
  - Off campus PBDs within 250 yards of a hospital facility (straight line from any point of a remote location)
  - PBDs billing prior to November 2, 2015
- **On** campus PBDs continue to be paid under the OPPS
- CMS makes proposals to implement the statute

# Off Campus PBD: Excepted Items and Services

- Furnished in a dedicated ED
- Furnished by an off-campus PBD that meets the all of the following:
  - Billed prior to **November 2, 2015**
  - Located in **same location** as on November 1, 2015
    - Moving would result in loss of excepted status
    - CMS seeks comment on limited relocation exception for disasters or extraordinary circumstances
  - **Same clinical family of items and services furnished** as items and services furnished by the PDS prior to November 2
    - CMS seeks comment on requiring a time period services had to be billed (e.g., 2013- Nov 1, 2015)
- Excepted status maintained for change in ownership if:
  - Main provider is also transferred
  - Medicare provider agreement is accepted by new owner
- Data Collection
  - Off-campus PBDs bill under hospital CCN; CMS cannot identify items and services specific to off-campus PBDs
  - CMS seeks comment on requiring hospitals to submit information

# Off Campus PBD: Payment for Nonexcepted Items and Services

- Generally paid under the Physician Fee Schedule
- Transitional payment policy for 2017
  - Physicians furnishing services in off-campus PBDs would be paid at the nonfacility rate based on professional claim
  - No separate payment to the facility
  - For 2018: CMS intends to develop a mechanism for PBDs to bill under Part B for nonexcepted services; CMS seeks comment on changes required to enrollment forms to accommodate nonexcepted PBDs
- Fraud and abuse: CMS recognizes the transitional policy may have an impact on several fraud and abuse laws and seeks comments
- Lab Services: Lab tests eligible for separate payment under the clinical laboratory fee schedule (CLFS) would continue to be paid under the CLFS.

# Hospital Outpatient Quality Reporting Program
## Data Collection Summary

| Measure Category | CY 2016 | CY 2017 | CY 2018 |
|---|---|---|---|
| Chart-Abstracted | 10<br>9 Required<br>1 Voluntary | 10<br>9 Required<br>1 Voluntary | 10<br>9 Required<br>1 Voluntary |
| Claims-Based | 7 | 7 | 7<br>Add 2 |
| HAI | 1 | 1 | 1 |
| Web-Based | 8 | 8 | 8 |
| CAHPS | | | Add 5 |
| Totals Finalized (Proposed) | 26 | 26 | 26 (33) |

*CY refers to data collection not payment year. Collection in 2016 applies to payments in 2018, collection in 2017 applies to payment in 2019 and collection in 2018 applies to payment in 2020.

# OQR: Proposed Measure Additions for CY 2020 Payment Determination- Claims-Based Measures

- OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy
  - Patients 18 years and older as of the start of the performance period with a diagnosis of any cancer (except leukemia) who received at least one hospital outpatient chemotherapy treatment during the performance period
  - Within 30 days of chemotherapy treatment among cancer patients receiving treatment in a hospital outpatient setting, any of the following admissions/ED visits (two rates are reported):
    - One or more inpatient admissions
    - One or more ED visits for any of the following diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis
    - A patient can only be counted once, if meet criteria for both only counted in the inpatient admissions rate
- OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687)
  - Patients 65 years and older undergoing same-day surgery (except eye surgeries) in hospitals
  - After discharge or within 7 days of the surgery any of the following hospital visits: an inpatient admission directly after the surgery; or an unplanned hospital visit (ED visits, observation stays, or unplanned inpatient admissions)

# OQR: Proposed Measure Additions for CY 2020 Payment Determination- OAS CAHPS Measures

- Composite Survey-Based Measures
  - The proportion of  “top box” (yes or yes definitely) responses for each question are averaged
  - OP-37a: OAS CAHPS—About Facilities and Staff
  - OP-37b: OAS CAHPS—Communication About Procedure
  - OP-37c: OAS CAHPS—Preparation for Discharge and Recovery
- Global Survey-Based Measures
  - The proportion of “high-value” (9-10 or definitely yes) responses
  - OP-37d: OAS CAHPS—Overall Rating of Facility
  - OP-37e: OAS CAHPS—Recommendation of Facility

# OQR: Other Proposed Changes

- Future Measure Topics
  - Implementation of eCQMs
  - Safe Use of Opioids-Concurrent Prescribing (eCQM)

- Extending extraordinary circumstances exception (ECE) request deadline from 45 days to 90 days following an event causing hardship

- Codify existing practices related to public display of measures
  - Post on Hospital Compare as soon as possible, give hospitals 30 days to preview

# CY 2017 Ambulatory Surgical Center Payment Updates

- Average payment increase of 1.2%
- Consumer price index of 1.7%
- Productivity adjustment of -0.5%
- Conversion factor of $44.684
- Estimated increase in aggregate ASC payments of $39 million

# Ambulatory Surgical Center Quality Updates: Proposed Measure Changes for CY 2020 Payment Determination

- Two Web-Based Measures
  - Normothermia Outcome- percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within15 minutes of arrival in the post-anesthesia care unit
  - Unplanned Anterior Vitrectomy- the percentage of cataract surgery patients who have an unplanned anterior vitrectomy (removal of the vitreous present in the anterior chamber of the eye)
- Five ASC-CAHPS Measures
  - 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
  - OP-37e: OAS CAHPS—Recommendation of Facility

# ASCQR: Other Proposed Changes

- Measure for Future Consideration
  - Toxic Anterior Segment Syndrome (TASS) measure
- CMS Web-based Tool Data Submission
  - Proposed to change submission deadline from August 1 to May 15 of the year prior to affected payment determination year, beginning CY 2019 payment determination (aligns with OQR)
- Extending extraordinary circumstances exception (ECE) request deadline from 45 days to 90 days following an event causing hardship
- Codify existing practices related to public display of measures
  - Post on Hospital Compare as soon as possible, give ASCs 30 days to preview

# Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Proposed Changes

- 2016 Reporting Period for EP, EH, CAH
  - Reduce from one full year to any continuous 90-day period
  - Continuous 90-day period also applies for eCQM submission by attestation
- Modified Stage 2 in 2017
  - New participants reporting in 2017 must use modified Stage 2 objectives and measures regardless of CEHRT edition (2014, 2015 or combination)
- Significant hardship exemption for EPs
  - Overlap of MIPS-ACI and last year of MU- both have a 2017 reporting period
  - For EPs who have not previously attested to MU can request exemption to avoid reporting two reporting periods (90 day for MU and calendar year for MIPS-ACI)
- Measure Calculations and Reporting Periods
  - Numerator actions must occur in the reporting period or within the calendar year for shorter reporting periods (i.e. numerator actions occur in 2017 whether using a calendar year or 90-day reporting period)
- Modifications to Objectives and Measures for EH and CAH

# Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Proposed Changes for EH and CAH

| Stage 2 Objectives | Measure Name | Threshold Requirement | Proposed Change |
|---|---|---|---|
| Protect Patient Health Information | Security Risk Analysis Measure | Yes/No attestation | |
| CDS (Clinical Decision Support) | Clinical Decision Support Interventions Measure | Five CDS | Remove because measures are topped out |
| | Drug Interaction and Drug-Allergy Checks Measure | Yes/No | |
| CPOE(Computerized Provider Order Entry) | Medication Orders Measure | >60% | Remove because measures are topped out |
| | Laboratory Orders Measure | >30% | |
| | Radiology Orders Measure | >30% | |
| eRx (electronic prescribing) | e-Prescribing | >10% | |
| Health Information Exchange | Health Information Exchange Measure | >10% | |
| Patient Specific Education | Patient- Specific Education Measure | >10% | |
| Medication Reconciliation | Medication Reconciliation Measure | >50% | |
| Patient Electronic Access | Patient Access Measure | >50% | |
| | View, Download Transmit(VDT) Measure | At least 1 patient | Reduce threshold from 5% of patients to at least 1 patient |
| Public Health Reporting | Immunization Measure<br>Syndromic Surveillance Measure<br>Electronic Reportable Laboratory Result Measure | Public Health Reporting to 3 Registries | |

# Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Proposed Changes for EH and CAH

| Stage 3 Objective | Measure Name | Threshold Requirement | Proposed Change |
|---|---|---|---|
| Protect Patient Health Information | Security Risk Analysis Measure | Yes/No attestation | |
| eRx (electronic prescribing) | e-Prescribing | >25% | |
| CDS (Clinical Decision Support) | Clinical Decision Support Interventions Measure | Five CDS | Remove because measures are topped out |
| | Drug Interaction and Drug-Allergy Checks Measure | Yes/No | |
| CPOE (Computerized Provider Order Entry | Medication Orders Measure | >60% | Remove because measures are topped out |
| | Laboratory Orders Measure | >60% | |
| | Diagnostic Imaging Orders Measure | >60% | |
| Patient Electronic Access to Health Information | Patient Access Measure | >50% | Reduce threshold from 80% to 50% |
| | Patient-Specific Education Measure | >10% | Reduce threshold from 35% to 10% |
| Coordination of Care Through Patient Engagement | View, Download Transmit (VDT) Measure | At least 1 patient | Reduce threshold from 5% to at least 1 patient |
| | Secure Messaging | >5% | Reduce threshold from 25% to 5% |
| | Patient Generated Health Data Measure | >5% | |

# Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Proposed Changes for EH and CAH

| Stage 3 Objectives Con't | Measure Name | Threshold Requirement | Proposed Change |
|---|---|---|---|
| Health Information Exchange | Patient Care Record Exchange Measure | >10% | Reduce threshold from 50% to 10% |
| | Request/Accept Patient Care Record Measure | >10% | Reduce threshold from 40% to 10% |
| | Clinical Information Reconciliation Measure | >50% | Reduce threshold from 80% to 50% |
| Public Health and Clinical Data Registry Reporting | Immunization Registry Reporting Measure<br>Syndromic Surveillance Reporting Measure<br>Case Reporting Measure<br>Public Health Registry Reporting Measure<br>Clinical Data Registry Reporting Measure<br>Electronic Reportable Laboratory Result Reporting Measure | Report to 3 Registries or claim exclusions | Reduce threshold from 6 registries to 3 |

# Hospital Value-Based Purchasing Program Policies

- Remove HCAHPS pain management dimension from inpatient hospital VBP for FY 2016 reporting/FY 2018 payment
  - Concerns about influence of pain management questions and prescription opioid use
  - Questions remain in CAHPS but will not be scored
  - CMS is continuing to develop measures in this area- revisions to pain management survey questions and opioid prescribing measures
- HCAHPS scoring in VBP
  - Currently 9 dimensions scored at 10 points each and then multiplied by 8/9 for total possible score of 80 base points with 20 consistency points
  - Continue to score 8 dimensions at 10 points each (80 base points) and award up to 20 consistency points

# Medicare Physician Fee Schedule (MPFS)

# MPFS Proposed Rule

- Released July 7, published in July 15, *Federal Register*
- Proposed Conversion Factor  $35.7751 (2016 CF $35.8043)
  - Update Factor is 0.50 percent
  - Budget Neutrality Adjustment is 0.51 percent
  - Misvalued Codes Target Recapture Amount is 0 percent
  - Imaging MPPR Adjustment -0.07 percent
- Proposed Anesthesia CF is $21.9756 (2016 CF $21.9935)
- Specialty-specific impact on allowed charges
  - +3 percent : Family practice
  - +2 percent:  Allergy/Immunology, Endocrinology, General practice, Oncology, Internal medicine
  - -7 percent:  Interventional radiology (due in large part to PE changes)
  - -5 percent:  Independent laboratories (PE changes)
  - -2 percent:  Diagnostic testing facilities (PE changes)
- **Comments due September 6, 2016**

# MPFS Proposed Rule: How to Submit a Comment

- CMS proposed rule for the MIPS and APM Incentive
  - Comments due 60 days from the date of display (September 6, 2016)

1. Go to proposed rule
2. Click “Submit a Formal Comment”, the green button on the right-hand side of the page below the title.

OR

1. Go to http://www.regulations.gov
2. Type “CMS-1654-P” into the search box
3. Find “Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model
4. Click on “Comment Now”, the blue button to the right of the title.

# Care Management: Proposed New Services

- Non-face-to-face prolonged E/M services (CPT codes 99358 and 99359)
  - Codes not used during complex care management and transitional care management services
- Complex chronic care management (CPT codes 99487 and 99489)
  - CPT codes 99487 (60 minutes of clinical staff time, per calendar month) and 99489 (additional 30 min)
  - Identical requirements for chronic care management
  - A beneficiary can receive either complex or non-complex chronic care management service for a given calendar month; only one practitioner
- Extensive face-to-face assessment for care planning (GPPP7)
  - Add-on code when initiating CCM and the billing practitioner performs extensive assessment and care planning outside the usual efforts described by the billed E/M code
  - Care plan must meet all the care plan requirements in the CCM
- Resource-intensive services for patients requiring mobility-assistive technology (GDDD1)
  - Add-on code to office/outpatient E/M codes

# Care Management: Proposed Requirements

- Initiating Visit
  - CMS proposes to require the initiating visit only for new patients or patients not seen within one year to allow practitioners with existing relationships with patients to initiate CCM services without furnishing a potentially unnecessary E/M visit
  - Currently required to initiate CCM during a comprehensive E/M visit, annual wellness visit, or initial physical exam

- CMS proposes revisions to the service elements required for comprehensive care management
  - 24/7 Access to Care (call sharing) and Continuity of Care (by care team)
  - Electronic Care Plan (timely sharing but not necessarily 24/7)
  - Clinical Summaries (exchange continuity of care documents)
  - Beneficiary Receipt of Care (copy of care plan)
  - Beneficiary Consent (medical record documentation)
  - Documentation (medical record documentation in any format)

# Care Management: Proposed New Services

- Behavioral Health Integration
  - General Behavioral Health Integration (BHI) (GPPPX) – Care Management services for behavioral health, at least 20 minutes of clinical staff time, directed by health care professional, per calendar month
  - Psychiatric Collaborative Care Management (GPPP1, GPPP2, and GPPP3)
    - GPPPI – Initial psychiatric collaborative care management, first month
    - GPPP2 – Subsequent psychiatric collaborative care
    - GPPP3 – Additional 30 minutes
  - Must obtain beneficiary consent (practitioner documents beneficiary consents and is informed of cost-sharing)
- Assessment and Care Planning for Patients with Cognitive Impairment (GPPP6)
  - Cognition and functional assessment using standardized instruments with development of recorded care plan for patient with cognitive impairment
  - CMS specifies required elements including functional assessment, standardized instruments to stage dementia, care plan including community referrals, advance care planning

# Additional Coverage Proposals

- Telemedicine Proposed Additions:
  - ESRD related services for dialysis (CPT codes 90967-90970) for less than a full month of service, per day
  - Advanced care planning (CPT codes 99497 and 99498)
  - Critical care (Proposed new codes GTTT1, initial and GTTT2, subsequent)
    - Services limited to once per day
    - Proposed elimination of “hands on” components of codes
- Diabetes Self-Management Training (DSMT)
  - CMS is concerned about the low utilization of services
  - Request comments about barriers that might limit access including specific information about time and intensity of services and supplies that should be included as PE inputs
  - CMS plans to clarify Chapter 15 of the Medicare Benefit Policy Manual about where DSMT services can be provided:
    - DSMT services that are furnished in a physician’s office can be provided as alternative practice locations used by the entity
    - DSMT services furnished by a hospital outpatient department cannot provide services in an alternate non-hospital location

# Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

- PAMA directed CMS to establish a program to promote the use of AUC for advanced diagnostic imaging services
- CY 2016 rulemaking related activities:
  - Advanced diagnostic imaging includes MRI, CT, PET, nuclear medicine and other services identified by stakeholders
  - Provider led entities(PLE to develop AUC – 11 identified 11 qualified PLEs
- The CY 2017 PFS proposed rule addresses:
  - Requirements and processes for specification of qualified clinical decision support mechanisms(CDSMs)
  - The initial list of priority clinical areas;
  - Exceptions to the requiring consultation with AUCs
- CMS anticipates reporting beginning as early as January 1, 2018
  - Anticipates requiring information on claim form
  - Requests comments about operational barriers

# AUC: Proposals for Implementation

- Definition of CDSM: interactive, electronic tool that communicates AUC information and assists the clinician from making the most appropriate diagnostic decision
  - Can be free-standing or incorporated into EHR
- CMS proposes requirements for CDSM that are not prescriptive about specific IT standards and functions on functionality
  - Applications from publication of final rule until January 1, 2017
- Priority Clinical Areas
  - Performed analysis of Medicare claims data using CMS Chronic Conditions Data Warehouse(CCW) as primary data source
  - Identified 8 clinical areas based on high total payment and high total services: Chest pain, Abdominal pain, Headache, Low back pain, Suspected stroke, Altered mental status, Cancer of the lung, Cervical or neck pain
- Exceptions
  - Exception for “emergency medical condition” and Part A payment
  - Proposed exception for EHR Incentive Program hardship
  - Doesn’t propose meaningful use exception for anesthesiology, radiology or pathology

# AUC: Proposals for Implementation

- CDSM Qualifications and Requirements

1. Make available to ordering professionals, at a minimum, specified applicable AUC that reasonably encompass the entire clinical scope of all priority areas
2. Able to incorporate specified applicable AUC from more than one qualified PLE
3. Provide specified applicable AUC and related documentation supporting the appropriateness of the applicable imaging service ordered within the CDSM
4. Clearly identify the appropriate use criterion if the tool makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario
5. Provide to the ordering professional a determination, for each consultation, of the extent to which an applicable imaging service is consistent with specified applicable AUC or a determination of "not applicable" when the mechanism does not contain a criterion that would apply to the consultation
6. Provide to the ordering professional certification or documentation each time the CDSM is consulted
7. Include a unique consultation identifier
8. Update applicable AUC content at least every 12 months and have protocols to remove AUC that are determined by PLE to be dangerous or harmful to patients if implemented
9. Make AUC for new priority clinical areas available within 12 months of finalization by CMS
10. Meet privacy and security standards
11. Provide ordering professionals aggregate feedback
12. Comply with any modifications to requirements within12 months of effective date

# PQRS/ Value Modifier Updates

- ACOs that fail to report quality measures on behalf of EPs
  - Permit EPs that bill under the TIN of an ACO participant to report separately for purposes of the 2017 and 2018 payment adjustment when the ACO fails to report on behalf of the EPs who bill under the TIN of an ACO participant
  - Affected EPs can report as individuals or group
  - If group reporting, GPRO registration requirement is waived
  - For EPs affected in 2017 (2015 reporting period), propose to use 2016 as a secondary reporting period
- Informal Inquiry Process
  - Automatic classifications to avoid recalculating QRUR

| | **Scenario 1 TINS Moving from Category 2 to Category 1** | | **Scenario 2 Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS Payment Adjustment** | | **Scenario 3 Category 1 TINs with Widespread Quality Data Issues** | | **Scenario 4 Category 1 TINs with Widespread Claims Data Issues** | |
|---|---|---|---|---|---|---|---|---|
| **Composite Score** | Initial | Revised | Initial | Revised | Initial | Revised | Initial | Revised |
| **Quality** | N/A | Average | Low | Average | N/A | Average | Low | Average |
| | N/A | Average | Average | Average | N/A | Average | Average | Average |
| | N/A | Average | High | High | N/A | Average | High | High |
| **Cost** | Low | Low | Low | Low | Low | Low | Low | Low |
| | Average | Average | Average | Average | Average | Average | Average | Average |
| | High | Average | High | High | High | Average | High | Average |

# Medicare Shared Savings Program: Measure Changes

- Add 3 measures
  - ACO-12 Medication Reconciliation Post-Discharge (NQF #0097)
  - ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052)
    - CMS seeks comment on maintaining as pay for reporting for all three years given small case size
  - ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91)
- Remove 6 measures
  - ACO-39 Documentation of Current Medications in the Medical Record.
  - ACO-21 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented.
  - ACO-31 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).
  - ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%).
  - ACO-9 Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)
  - ACO-10 Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 )

# MSSP: Measure Changes

- Change Audit Process
  - Increase number of records audited per measure (currently 30) to achieve confidence match rate is within 5 percentage points of rate- anticipate no more than 50 records
  - Create a single step audit process- review all records and calculate match rate, no opportunity to resubmit for >10% mismatch
  - Calculate an overall audit match rate across all measures
  - If ACO fails audit (match rate <90%), CMS will adjust quality scores and require a corrective action plan
- Other Changes
  - No longer apply flat percentages (benchmarks for topped-out measures) to performance measures calculated as ratios
  - Respecify ACO-11 to assess use of CEHRT by all eligible clinicians rather than just PCPs
    - Treat as a new measure for 2017 and 2018 performance years
    - In pay for performance years, at least one EC participating in ACO must meet ACI requirements

# MSSP: Number of Measures and Total Points by Domain Proposed CY 2017

| Domain | Number of Measures | Measures for Scoring | Total Possible Points | Domain Weight |
|---|---|---|---|---|
| Patient/Caregiver Experience | 8 | 8 individual survey module measures | 16 | 25% |
| Care Coordination/ Patient Safety | 10 | 10 measures. Note that the EHR measure is double-weighted (4 points) | 22 | 25% |
| Preventive Health | 9<br>**8** | 9 measures | 18<br>16 | 25% |
| At Risk Population | 7<br>**5** | 6 individual measures, plus a 2-component diabetes composite measure, scored as one. | 12<br>8 | 25% |
| Total | 34 | 33 | 68 | 100% |
| Proposed | 31 | 30 | 62 | 100% |

# MSSP: Other Proposed Changes

- Beneficiary Preference into ACO Assignment
  - CMS wants to include beneficiary attestation in ACO assignment, tested a “manual process in Pioneer ACO model
  - Propose to implement an automated approach to ask beneficiaries who is their “main doctor” through a system established by CMS
  - Beneficiaries would have ability to modify their designation at any time
  - If “main doctor” not affiliated with ACO then beneficiary is not attributed to ACO
  - Available in all Tracks of MSSP, unless automated system is not in place by spring 2017
- SNF 3-Day Rule Waiver
  - CMS is concerned about potential beneficiary financial liability for non-covered Part A SNF services that might be directly related to use of the SNF 3-day rule waiver
  - Propose to modify waiver to include 90-day grace period to allow CMS to notify the ACO of any beneficiary exclusions
  - SNF is not allowed to charge beneficiary for non-covered SNF services if SNF is affiliate of Track 3 ACO

# Diabetes Prevention Program Model Expansion

- Current CDC program which is a CMMI demonstration meets 1115A(b) requirements for expansion: improves quality of care without limiting beneficiary coverage or increasing costs
  - Expansion of CMMI model that is proposed as national program
  - Treated as preventive service – no beneficiary copayment
- Eligible beneficiaries
  - Enrolled in Part B
  - BMI of 25 or more
  - A1c value 5.7-6.4% or fasting glucose 110-125 mg/dL or 2-hour post glucose 140-199 mg/dL
  - No previous diagnosis of diabetes,  no ESRD
- Program Description
  - 12-month program using CDC-approved curriculum
  - 16 1-hour core sessions over 16-26 weeks
  - Option for monthly core maintenance over subsequent 6 months if beneficiary maintains weight loss
  - Possible virtual program

# Diabetes Prevention Program Model Expansion

- Suppliers
  - 800 organizations have preliminary or full recognition from CDC
  - Any recognized program eligible to apply for enrollment in Medicare on or after January 1, 2017
  - Seek comment on application process
  - Program coaches must obtain an NPI
  - Would need to meet  Medicare supplier requirements
- Reimbursement
  - Payment tied to number of services and achievement of 5% weight loss
  - E.g. Four sessions is $50 per beneficiary or $160  per beneficiary with a weight loss of 5%
  - Weight loss documented by attestation by suppliers
- Concerns about program integrity and seeks comments about related safeguards to minimize risks

# Transforming Healthcare TOGETHER

# Important Links

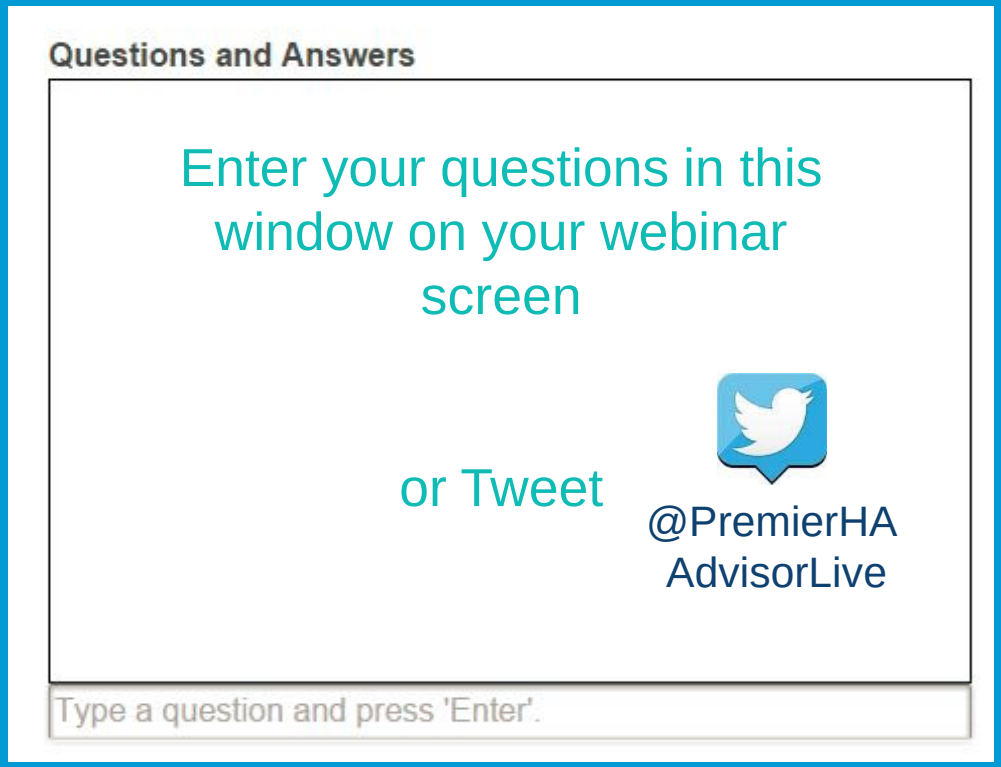
OPPS:

- Premier detailed summary
- Proposed rule
- CMS press release
- CMS fact sheet

MPFS:

- Premier detailed summary
- Proposed rule
- CMS press release
- CMS fact sheet

# Your questions



# Thank you for joining us!

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