Insight

CMS' Independence Day Regulation Rundown

BRITTANY LA COUTURE | JULY 14, 2014

Introduction

True to form, the Obama administration took advantage of the hustle and bustle of the 4th of July weekend to release healthcare related regulations. The Centers for Medicare & Medicaid Services (CMS) released 1,300 pages of proposed regulations of Home Health (HH) care, the Medicare Outpatient Prospective Payment System (OPPS), Medicare End Stage Renal Disease (ESRD) Prospective Payment System, and Medicare Physician Payment Fee Schedules. Here's our Reg Rundown.

Home Health[1]

Some in the Home Health industry are calling the July 3rd Proposed Rule 'fairly benign' because it *only* reduces HH payments by about $58 million in 2015. However, the overall effect will be to take a large amount of funding from a practice area with unusually narrow profit margins and exceptional cost-effectiveness. This proposed rule would affect the HH 60-Day National Episode Rate[2], the Face-to-Face Encounter Requirement, Case-Mix Recalibration, and Quality Data Reporting Requirements.

The 60-Day National Episode Rate Update is considered to be an 'economically significant' regulation. It changes the Non-Routine Medical Supplies (NRS) and national per-visit payment rates. The 60-day per-episode payment rate will be decreased by $80.95 per episode, and the NRS conversion factor will be reduced by 3.5 percent of national per-visit payment amounts recorded in CY 2010. The NRS cuts will range from $1.70 per visit (for HH aide services) to $6.34 per visit (for medical social services).

The HH market basket update will also be reduced. The market basket is the measure of all the goods and services needed for a specific organization or industry to purchase and provide care. The proposed rate begins at 2.6 percent after the ACA's mandatory 1 percent reduction. That number will be reduced by a multifactor productivity adjustment of 0.4 percent, leaving the final update at a 2.2 percent increase. Note that HH agencies that do not submit the required quality data (discussed below) will forfeit an additional 2 percent, therefore receiving only a 0.2 percent increase. Despite being an absolute increase of 2.2 percent, this rate update actually acts as a reduction.

The Proposed Rule would also update the Face-to-Face Encounter requirement to ease the regulatory burden on HH. The rule would eliminate the requirement that a physician providing the certification necessary for Medicare coverage of HH care provide a written narrative of the encounter with the certification, unless skilled nursing visits to evaluate or manage care are necessary. This would be an important update as most Medicare non-payments result from errors of 'insufficient documentation' in the form of a narrative portion of the face-to-face encounter lacking in some way. In the past providers have found the narrative requirement to be "excessive, redundant" and confusing; by largely eliminating this obstacle, more people may have access to Medicare HH.

This proposed regulation also provided some clarification about when documentation of a Face-to-Face encounter is needed. According to the rule, these encounters are only required for the original certification from a physician for admission to HH, or for a new certification after a patient has been released from HH services with no concurrent need for future HH care. Recertification at the end of the 90-day certification period for continued HH care does not require another face-to-face meeting with a certifying physician.

The case-mix reduction that was expected to come as part of the HH rule did not appear. Instead case-mix recalibration was used to make the proposal budget-neutral by uniformly lowering rates to 1.000.

Quality Data Reporting, which is a system that measures the quality of home health care services, was also addressed by the proposed rule. It proposed a 'Pay-for-Reporting' system where HHAs are paid for their submission of quality data. Compliance with that requirement would be measured by Quality Assessments Only, which measure the ratio of quality assessments submitted to total number of assessments. The goal of CMS is to reach 90 percent compliance from home health agencies over the next three years by incrementally increasing the reporting requirement by 10 percent in each reporting period.

The regulation also stated that updates to the selection of quality measures for the HH Quality Reporting Program will be selected with the help of input from the National Quality Forum and the Measure Applications Partnership. Any proposed updates that do not substantially change the nature of the measures used will come in the form of sub-regulatory guidance.

OPPS Payment and Services[3]

The proposed rule would update payment policies for the Outpatient Prospective Payment System and Ambulatory Surgical Centers (ASCs), adjust quality reporting measures, and changes Medicare Advantage and Part D policies for erroneous payments.

Each year more than 4,000 hospitals receive Medicare payments using the Outpatient Prospective Payment System. OPPS services include most outpatient hospital services, partial hospitalization services in hospital outpatient departments and partial hospitalization services in community mental health centers. The rule would increase payments to providers for OPPS services by 2.2 percent. CMS estimates that this payment increase will cost $56 billion over the next year, which is a $5.2 billion increase over 2014 payments.

The rule would make some major changes to outpatient ASCs as well. In 2014, CMS introduced the comprehensive Ambulatory Payment Classification (APC), where services would be packaged together under a single payment under OPPS, but implementation of this policy was delayed until 2015. In regard to ASC payments, the proposed rule also increases rates by 1.2 percent. The increase to these centers will increase CMS payments by $243 million, totaling $4.1 billion for 2015. Along with increases in payments, CMS updated quality reporting measures for outpatient services and ASCs. The Hospital Outpatient Quality Reporting Program (OQR) would be updated under the proposed rule by removing three quality measures, and include two new measures. There would also be adjustments to the ASC Quality Reporting Program (ASCQR), where some of the ambulatory center quality reporting measures would be adjusted to align better with the ASC reporting requirements with those of the OQR.

Another potential change in the proposed rule allows for CMS to recover certain payments to Medicare Advantage (MA) and Medicare Prescription Drug (Part D) plans. MA and Part D erroneous payments procedures were altered slightly to allow for CMS to recover erroneous payments about which MA or Part D plans fail to notify the agency. This change would also necessitate an appeals process for MA and Part D plans

to recoup payments from CMS.

End Stage Renal Disease Prospective Payment System[4]

ESRD is a bundled payment system for Medicare services for individuals in need of renal dialysis services. The July 3rd proposed rule includes the annual update of the ESRD payment system for 2015, as well as changes to the ESRD quality incentive program for 2017 and 2018. The current base payment rate is $239.02 per treatment, and CMS' proposed update to that payment is $0.0.

As a result of anticipated increases in utilization, CMS payments for ESRD services will increase by 0.3 percent for stand-alone facilities. Coupled with a corresponding 0.5 percent absolute increase for hospital facilities, this will cost an additional $30 million. CMS is also planning to increase beneficiary co-payments by 0.3 percent, which would save $10 million.

This proposed regulation also includes quality measurement requirements, adjustments for the ESRD quality incentive program for 2017 and 2018, and changes to the way durable medical equipment is paid for by the Medicare competitive bidding program. The rule would adjust fee schedule amounts in areas where CBP is not yet incorporated. CMS estimates that these changes will save $7 billion over five years, beginning in 2016.

Physician and Other Payment Fee Schedules[5]

CMS is concerned that the time and input factors used to calculate payment rates for services rendered by physicians are inaccurate. In 2014, CMS proposed using hospital payment rates for similar services as a payment benchmark for physician payment, but commenters were adamant that this was a bad idea and the rule was never finalized. CMS is still making efforts to collect better data before proposing updated physician payment rates.

Under the proposed rule Medicare telehealth services would cover annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services. Some telehealth services, such as cervical exams, psychological testing, and urgent wound care were rejected for lack of clinical evidence to support the validity of providing these services remotely. Some other services were rejected because they are already billable through existing Medicare codes, which demonstrates the general confusion about what qualifies as 'telehealth'.

Chronic Care Management Services (CCM) programs will receive a monthly billable amount of $41.92 per qualified patient under the proposed regulation. CCM eligibility requires that the patient has 24/7 access to care, though the staff providing the care need not be employed or supervised by a practicing physician. CCM practices will be required, though, to implement electronic health record systems.

Medicare Shared Savings Programs (MSSPs and ACOs) requirements are the most significantly impacted area of physician payment under the proposed rule. In the aggregate, the proposed changes will cost eligible physicians between $125 and $233 million per year. The rule proposes that in 2015 eligible professionals that do not successfully demonstrate meaningful use of certified HER technology will be subject to a downward payment adjustment beginning at -1 percent and increasing each year up to a maximum of -5 percent. MSSPs will be rated according to a quality improvement incentive system based on the 5 star rating system currently being used by Medicare Advantage.

Finally, the rule proposes that in 2017, the Value-Based Modifier will apply to all physicians in the Medicare

program, and the amount of payment at risk will increase from 2 percent in 2016 to 4 percent in 2017.

[1] CMS Proposed Rule, RIN 0938-AS14, Jul. 3, 2014. http://www.ofr.gov/OFRUpload/OFRData/2014-15736_PI.pdf.