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CMS Proposes Additional Site-Neutral Payments

In its 2019 Proposed OPPS rule, CMS voiced several concerns toward the rate of increase in outpatient services, questioning both whether the increases were sustainable or necessary. Section 1833(t)(2)(F) of the Social Security Act instructs CMS to "develop a method for controlling unnecessary increase in the volume of covered outpatient services." Their concerns not only include off-campus emergency rooms and off-campus provider-based clinics, but also general increases in outpatient services.

Off-Campus Emergency Rooms

Although no particular proposal is related specifically to off-campus emergency rooms, CMS has proposed a new HCPCS modifier to track services provided at these locations. This modifier would apply to all services provided at the location, not just the emergency room visit. Emergency rooms were exempted from the off-campus site-neutral payment rules passed by Congress. Clearly, CMS seeks to subvert this exemption.

Grandfathered Off-Campus Locations

Site-Neutral Payments Proposed – For years, we have discussed how CMS, MedPAC, the OIG, and Congress do not understand why they would pay a clinic more when provider-based to a hospital – particularly when the services "could be provided in a lower cost setting."

Section 603 of the Budget Act of 2015 called for site-neutral payments to new provider-based off-campus locations of prospectively paid hospitals. For these non-grandfathered locations in 2018, services were paid at 40 percent of the APC amount, which, under the proposal, will continue for 2019.

CMS looks to use Section 1833(t)(2)(F) of the Social Security to further expand the use of "site-neutral payments," decreasing payments to all off-campus prospectively paid hospital based clinic payments billing HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient – this is the code that replaced CPT codes 99201 through 99205 and 99211 through 99215). This particular HCPCS code is the most frequently billed HCPCS code billed from off-campus provider-based locations.

Lower Payment for 340B Pass-Through Drugs Proposed – CMS also proposed to further address growth of hospital-owned clinics by extending the decreased payment for pass-through drugs purchased under the 340B program to these non-grandfathered locations.

Expansion of Services Limitation Proposed – CMS has brought back its original proposal of limiting the expansion of services at grandfathered locations based on clinical families of services. It would require a hospital to know the clinical family of services billed during the November 1, 2014 through November 1, 2015, time period for each grandfathered clinic location. For clinics granted the mid-build exception, the time period is the first 12 months starting with the day they opened.

Comments Needed

CMS is requesting comments on additional potential methods to use Section 1833(t)(2)(F) of the Social Security Act to control "unnecessary" increase in the volume of outpatient services. Specifically, they ask for feedback on the following:

- the **use of prior authorization** for certain services
- logic behind paying a higher amount to hospital-based clinics than to free-standing clinics
- utilization management tools
- whether there should be exemptions for services in specific rural areas (like HPSAs)
- the potential effects these proposals will have on the Medicare population

Please read through this summary, pull the proposed rule, read through their proposals, and **submit your comments to CMS by September 24, 2018**.

We have several concerns with the proposals and CMS's intent to find ways to further their rule-making reach by invoking Section 1833(t)(2)(F) of the Social Security Act.

Changes to Cost Report Submission Requirements

Certain items are required to be included when submitting cost reports to the MAC in order for the MAC to accept it. In its final 2019 IPPS rule, CMS finalized several cost report submission changes, effective for cost reports beginning on or after October 1, 2018. Any cost reports filed without the required information will be rejected.

Patient Days and Uncompensated Care Charges

Some hospitals are paid Medicare disproportionate share and uncompensated care payments, estimated using data as reported on the filed cost report. Currently, hospitals do not have to submit detail data to support Medicaid days or uncompensated care charges when submitting cost reports, although they are required to have the information available upon request. Moving forward, however, CMS will require the detail of both Medicaid eligible patient days and uncompensated care charges to be submitted with the cost report, with the detail exactly matching the amount claimed on the cost report. For uncompensated care charges, the patient's name, date of service, date of write-off, and insurance payors (if any) must be listed. CMS will design a standard reporting format for submission of this data at a later date. This is specific to those hospitals receiving disproportionate share payments and uncompensated care payments, including sole community hospitals and Medicare dependent hospitals.

Medicare Bad Debts

Hospitals can claim unpaid Medicare deductibles and coinsurance on their Medicare cost report subject to, and limited by, Medicare regulations (Medicare bad debts). To claim Medicare bad debts, a detail listing is required. Most MACs check the amounts claimed on the Medicare bad debt detail listing at the time the cost report is accepted, and adjust settlements to the amounts reflected on the detail list. Now, CMS requires the detail list (in the proper format), to be submitted with the cost report, and that amounts listed exactly match the filed cost report. If the listings do not match, the cost report will be rejected, requiring a new cost report submission.

Home Office Cost Reports

Hospitals owned by a parent or chain organization often have costs incurred on their behalf by the parent organization. Most organizations file a home office cost report but now, hospitals with parent organizations must file a home office cost report in order to claim these costs, and the costs must match the home office cost report. For hospitals with a different year end than the parent organizations, costs allocated from the home office must correspond to some portion of the amounts claimed on the provider's cost report.

Further, the home office cost report is now required to be submitted to the home office's MAC as well as each of the chain organization's MACs. A hospital's cost report can therefore be rejected if the home office fails to submit a copy of its home office cost report to the hospital's MAC and if the amount claimed varies from the filed home office cost report.

Miscellaneous Changes

Electronic Health Records

To avoid payment adjustments, hospitals must submit data using certified electronic health records technology (CEHRT). Beginning calendar year 2019, the 2015 CEHRT version will be required.

For years 2019 and 2020, reporting will continue to be any continuous 90-day period.

Physician Certification

Conditions of payment regulations require a qualified practitioner certify or recertify the necessity of a service. Currently, for payment to be made, the practitioner must certify the necessity of the service *and* the location of that statement must be documented in medical records. There have been concerns payment was being denied because supporting data was missing not the physician's certification, but rather a statement as to where that certification could be found. In response, CMS is removing the requirement to state the practitioner's certification location.

Chargemasters, Now Online

Beginning January 1, 2019, hospitals will be required to post the standard charges for their services in a "machine readable" format on the internet. A hospital can simply post its chargemaster, or design a more meaningful method to make public their standard charges for services. The document must be updated at least once a year (or more often, if necessary). CMS believes this will help

patients make decisions about their healthcare based on potential costs for services between various locations. However, as many opponents of the rule point out, the cost to the patient is more closely tied to what the insurance will pay and whether or not the provider is in or out of network, and, perhaps more importantly, whether the attending physician at an in-network hospital is also in-network. The hospital itself may be in-network for a patient, but when they arrive, the physician themselves could be out-of-network.
Gross charges will be important for self-pay patients to shop around, provided 1) they understand the chargemaster and all the codes necessary for their particular needs, and 2) they do not meet the hospital's charity care policy.

CMS Proposes Changes to Medicare Physician Fee Schedule Payments

Office Visit Codes

Currently, physician clinics bill codes 99201 through 99205 and 99211 through 99215 for evaluation and management (E/M) of a patient. Medicare physician fee schedule pricing for these varies for each code.

Medicare proposed to pay the level one E/M codes at a base amount, with the remaining at a combined amount. A clinic would still bill the appropriate E/M code, but payment amount would not vary between levels 2 through 5.

Specifically, they propose the following non-facility payment rates:

99201	$44
99202 through 99205	$135
99211	$24
99212 through 99215	$93

You will note the proposed amounts are in fact greater than the free-standing RHC rates currently in effect. If this proposal is finalized, the only feasible way to continue as a free-standing rural health clinic would be to have both a Medicaid rate and a utilization rate high enough to sustain the decrease in Medicare reimbursement.

MIPS Proposals

Category Weights – In the Budget Act of 2015, Congress allowed for a more gradual weighting of the resource use category. Initially, the resource use category (the cost of providing services) were to be phased in over a three-year period: for the first two years (2017 and 2018 reporting), the weight was set at zero – meaning 2019's reporting period would need to jump directly to a 30 percent weight. Now, resource use can be phased in over a five-year period.

Reporting for calendar year 2019 will affect a physician's 2021 payments. The weight of each of the four categories follows:

Quality performance	45 percent

Cost performance	15 percent
Promoting interoperability	25 percent
Improvement activities	15 percent

For quality and cost performance, reporting is the full calendar year; for interoperability and improvement activities, reporting is a 90-day period.

Added Eligible Clinicians – Medicare Access and CHIP Reauthorization Act (MACRA) requires a set group of practitioners to be part of the MIPS program if participating in Medicare. MACRA also allows CMS to expand said set group starting with the 2021 payment year (2019 reporting year). As such, CMS now proposes extending the eligible clinician definition to include physical therapist, occupational therapist, clinical social worker, and clinical psychologist.

Low-volume Criteria – Currently, eligible clinicians are automatically exempt from MIPS reporting if they meet any of the low-volume criteria. However, CMS believes eligible clinicians exist who would choose to report MIPS data (and therefore be subjected to MIPS adjustments), even if they meet the low-volume criteria. CMS has proposed to add a third criterion to the existing low-volume criteria, allowing physicians who otherwise meet the low-volume criteria to opt in to MIPS. However, once an eligible clinician chooses to opt in for the year, they cannot change their minds at a later date. Low-volume criterion, including the new proposed criteria, follows:

- 200 or fewer Medicare beneficiaries, OR
- $90,000 or less Medicare reimbursement, OR
- 200 or fewer covered professional services provided to Medicare beneficiaries (this is the new one)

Non Face-to-Face Physician Check-ins

CMS is proposing HCPCS code GVCII – brief communication technology-based service to be paid for a practitioner discussing patient care over the phone, with the goal of determining whether a face-to-face E/M is necessary.

To bill, the following requirements must be met:

- the patient must be an established patient
- it cannot be related to any E/M services within the prior seven days
- if an E/M is indeed scheduled for the next day (or next available appointment) the amount cannot be charged
- the patient must provide consent for the services, as there will be patient cost sharing

CMS specifically proposes this as a service RHCs can provide. If a visit is deemed necessary, the cost of the call is included in the all-inclusive rate; if a visit is not necessary, CMS proposes the call be billed separately beginning January 1, 2019.

Closing

If you have any questions, please contact your DZA representative, or Shar Sheaffer at 509.242.0874.