Proposed OPPS Rule Takes Tough Site-Neutral Stand

Under a proposed rule issued last week by the Centers for Medicare & Medicaid Services (CMS), hospital services furnished in off-campus provider-based departments (PBD) that began billing Medicare for outpatient services on or after November 2, 2015 would no longer be paid under Medicare’s outpatient prospective payment system (OPPS). Instead, the services would be paid under the physician fee schedule (PFS), the basis for site-neutral rates which will cover the majority of services furnished in any new off-campus PBD. Specifically, CMS would pay physicians furnishing services in these departments at the higher “non-facility” PFS rate. There would be no payment made directly to the hospital. Services provided in a dedicated emergency department would continue to be paid under the OPPS.

Also, existing off-campus PBDs that expand their services to include those in new clinical families would receive the site-neutral rate for those services. In addition, any existing off-campus PBD that relocates after November 2, 2015 would lose its excepted status and be subject to the site-neutral payments and existing off-campus PBDs that undergo a change of ownership would only maintain their excepted status if the new owner accepts the existing Medicare provider agreement from the prior owner.

The changes were among a range of payment tweaks included in the OPPS proposed rule issued last week by CMS, in which the agency would update hospital OPPS rates by 1.55% in calendar year (CY) 2017 compared to CY 2016. Among other things, the proposed rule implements the site-neutral provisions the Bipartisan Budget Act of 2015. After considering all other policy changes included in the proposed rule, CMS estimates hospital OPPS payments would increase by 1.6% and ambulatory surgical center (ASC) payments would increase by 1.2% in 2017.

A clearly unhappy American Hospital Association (AHA) responded to the proposal saying that it ignores requests by hospitals, health systems and more than half of the House and the Senate that CMS provide reasonable flexibility when implementing the site-neutral payment requirements. AHA called the policies short-sighted and said that they aim “to freeze the progress of hospital-based healthcare in its tracks.” However, CMS did agree with AHA’s suggestions in proposing to offer greater flexibility in the meaningful use of electronic health records under the Medicare program. The proposal shortens the reporting period for 2016 from a full year to 90 days for all hospitals and physicians, as AHA urged. Beginning in 2017, two measures for eligible hospitals and critical access hospitals – computerized provider order entry and clinical decision support – would be removed and requirements for patients to view, download and transmit their information would be reduced from 5% to at least one patient.

Stage 3 of meaningful use would still be required by all hospitals in 2018. However, the thresholds for most measures would be reduced to the level required in Modified Stage 2. For the CY 2020 outpatient quality reporting program, CMS proposes seven new measures – hospital admissions and ED visits for outpatient chemotherapy patients, hospital visits following outpatient surgery, and five measures derived from a new Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems survey (OAS CAHPS), a 37-item survey intended to assess the experience of care for patients that have received surgeries and other procedures in hospital outpatient departments and ASCs. The proposed rule is to be published in the July 14 Federal Register and available online at http://federalregister.gov/a/2016-16098 and on www.gpo.gov/fdsys.
ALJ Hearing Procedures Could Change

The Department of Health and Human Services (HHS) has issued a proposed rule that would make changes to the procedures for Administrative Law Judge (ALJ) appeals of payment and coverage determinations for items and services provided to Medicare beneficiaries, in addition to other Medicare appeals. The proposed rule was issued just days before HHS’ July 1 deadline to respond in court to show progress in resolving the backlog of ALJ hearings as part of the American Hospital Association’s (AHA) lawsuit challenging the significant delays in ALJ hearings. However, the AHA is concerned that the proposal will barely scratch the surface toward resolving the ALJ backlog. Highlights of the proposed rule include:

- **Attorney Adjudicators.** These individuals would, in lieu of an ALJ, decide certain claim appeals based on the administrative record, without a hearing. HHS proposes that a decision may be made without a hearing by either an ALJ or an attorney adjudicator if (1) parties entitled to a hearing waive that right, or (2) the record supports a fully favorable finding for the appellant and no other party is entitled to a notice of hearing. A fully favorable finding on the record could not be made if CMS or one of its contractors elected to be a party to the hearing. HHS also proposes that the effect of an attorney adjudicator’s decision would be equivalent to that of an ALJ.

- **Precedential Final Decisions.** Currently, a decision by the Departmental Appeals Board (DAB) – the fifth level of Medicare appeals – is binding solely on the parties to that particular appeal, and does not establish legal precedent to be applied to future decisions. HHS now proposes to grant authority to the chair of the DAB to designate a decision of the DAB as precedential. The agency states this would provide a consistent body of final decisions for use by Medicare appellants in determining whether to seek appeals, and by adjudicators at all levels of appeal with clear direction on repetitive legal and policy questions.

- **Amount in Controversy.** HHS proposes to change how it calculates the “amount in controversy,” which is the threshold value that must be met or exceeded to be eligible for an ALJ hearing. Currently, the amount in controversy is calculated based on the amount charged to the Medicare beneficiary for the items and services in question. HHS instead proposes to calculate the amount in controversy based on the Medicare allowable amount, as measured by either the applicable Medicare fee schedule or the published contractor-priced amount. When an appeal involves an overpayment determination, the amount in controversy would be the amount of the overpayment specified in the demand letter. The agency states that this would help parties better approximate the amount at issue in an appeal.

- **Application of Part A and B Appeal Rules.** HHS proposes to clarify when certain Medicare Part A and B appeal provisions apply to appeals under Medicare Advantage and Utilization and Quality Control Review Quality Improvement Organization determinations.

For more details, see [http://federalregister.gov/a/2016-15192](http://federalregister.gov/a/2016-15192). Comments on the proposed rule will be accepted through August 29. If you have further questions, contact Melissa Myers, senior associate director of policy, at (202) 626-2356 or mmyers@aha.org, or Lawrence Hughes, assistant general counsel, at (202) 626-2346 or lhughes@aha.org.

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CMS Releases Physician Payment Proposal for 2017

A proposed rule for the physician fee schedule for calendar year 2017, after application of the 0.5% payment increase required by the Medicare Access and CHIP Reauthorization Act of 2015 and other budget neutrality cuts, result in a 0.08% decrease in physician payment rates for 2017 compared to
In addition, CMS proposes to pay for new telehealth services, including end-stage renal disease-related services for dialysis, advance care planning services, and critical care consultations, and to expand the Center for Medicare & Medicaid Innovation Diabetes Prevention Program model. The agency also proposes a number of new codes to more accurately pay for primary care, care management and other cognitive specialties, including separate payments to primary care practices that use inter-professional care management resources to treat patients with behavioral health conditions.

With respect to Medicare Advantage (MA), CMS proposes to require healthcare providers and suppliers to be screened and enrolled in Medicare in order to contract with and provide items and services through a MA organization. The agency also proposes to release two new sets of data related to MA and Part D prescription drug plans: one including information on the bids that MA plans submit, which reflect their estimated costs of providing benefits to enrollees, and another including information on MA and drug plans’ medical-loss ratios.

Other proposals include changes to the quality measurement requirements of the Medicare Shared Savings Program (MSSP), including revisions to the measure set, data validation process and scoring methodology; a change to allow individual eligible professionals participating in MSSP to report quality data separately for the purposes of the Physician Quality Reporting System (PQRS), and to have that data used in PQRS in the event the MSSP accountable care organization fails to report quality data; and updates to the informal review process used in the physician value modifier program.

The proposed rule will be published in the July 15 Federal Register, and comments are due September 6.

**Reminder: 2016 Mid-South CAH Conference, August 17-19**

Don’t forget about the 14th Annual Mid-South Critical Access Hospital Conference coming up August 17-19 at the Omni Nashville Hotel in Nashville, TN. The conference is co-sponsored each year by state hospital associations in Arkansas, Alabama, Kentucky, Louisiana, Mississippi and Tennessee, along with the Arkansas, Louisiana and Mississippi Departments of Health. Arkansas is the host state for the 2016 meeting. The complete agenda for this conference, including registration information, is available at [http://www.arkhospitals.org/calendarpdf/August17-19,2016MidSouthCAH.pdf](http://www.arkhospitals.org/calendarpdf/August17-19,2016MidSouthCAH.pdf).

**Tax-Reform Blueprint Silent on Hospital Bonds**

House Republicans, led by Ways and Means Committee Chairman Kevin Brady (R-TX), have released a broad outline of their proposed changes to corporate and individual tax laws. The proposal contains no direct commentary on issues such as municipal or hospital bonds, or the current-law tax-exempt status of municipal bonds. It references a need to eliminate numerous deductions, exemptions and credits viewed as “special interest” provisions, but does not specify which ones. The plan also would eliminate the Alternative Minimum Tax for individuals and corporations, and reduce the corporate income tax rate to 20% and the slate of individual tax brackets to three (12%, 25% and 33%). Among other proposals, it would explicitly retain the mortgage interest deduction and charitable deduction for individuals.

Hospitals’ primary concern with any proposed restructure of the tax code is that it would result in elimination of tax-exemption for hospital bonds.
Oncology Care APM Began July 1

About 200 physician practices, including hospital-based practices, and 17 commercial insurers began participating July 1 in a CMS alternative payment model (APM) for fee-for-service Medicare beneficiaries undergoing chemotherapy. Practices in the five-year Oncology Care Model will receive a monthly payment of $160 per beneficiary to provide care coordination, patient navigation, 24/7 access to care and other enhanced services and a performance-based payment for each six-month episode of care. The model’s two-sided risk track will be an Advanced APM under the proposed Quality Payment Program for physicians, CMS said. For a list of participating practices and insurers, visit innovation.cms.gov/initiatives/Oncology-Care.

Correction to New Fire Safety Requirements

The updated fire safety standards for hospitals which CMS released in May already are being corrected. The May final rule adopted the National Fire Protection Association’s 2012 Life Safety Code (with minor amendments) and most chapters of its 2012 Health Care Facilities Code for hospitals and certain other facilities that participate in the Medicare and Medicaid programs. In a clarification, CMS states that hospital outpatient surgical departments must meet Life Safety Code provisions applicable to ambulatory healthcare occupancies, “regardless of the number of patients served.” The standards for ambulatory healthcare occupancies normally apply to facilities providing services simultaneously to four or more patients. The American Hospital Association and its American Society for Healthcare Engineering personal membership group are reviewing the impact of the clarification for members.

The AHA Calendar

July 2016
14 Building a Community Care Network for High Needs Patients – Webinar NE071416
19 Medicare Access and CHIP Reauthorization Act: Successful Implementation Strategies to Maximize Reimbursement – Webinar T3051
21 How Hospitals, Physician Practices, Nursing Facilities, Hospice and Palliative Care Programs can Help Each Other Succeed in the age of MACRA – Webinar T3054
21 Best Practices in Succession Planning: From Board Members to Senior Leadership - Webinar T3053
22 ASWHC 2016 Summer Conference, AHA Classroom, Little Rock
28 ASDVS 2016 Summer Conference, AHA Classroom, Little Rock
29 ArONE 2016 Summer Conference, Hilton Garden Inn West Little Rock

August 2016
2 Getting Ready: Operational Efficiency and Its Impact on Reimbursement – Webinar NE080216

Information on all AHA educational programs and activities is available at http://www.arkhospitals.org/events.

Editor’s Note: The Notebook will not be published on July 18, but will resume publication July 25, 2016.