CMS Releases Proposed 2015 Physician Fee Schedule and Outpatient Prospective Payment System Rules

On July 3, 2014, the Centers for Medicare and Medicaid Services ("CMS") released its proposed Calendar Year ("CY") 2015 Physician Fee Schedule ("PFS") Proposed Rule, to be published in the Federal Register on July 11, 2014. The rule proposes the 2015 relative value units ("RVUs") for the PFS and other Medicare Part B payment policies, as well as a number of other changes, the most significant of which are summarized briefly in the list below.

Also on July 3rd, CMS released its CY 2015 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule, to be published in the Federal Register on July 14, 2014. The rule proposes revisions to the Medicare hospital outpatient prospective payment system ("OPPS"), including an outpatient department fee schedule increase of 2.1%. The rule also proposes revisions to the Medicare ambulatory surgical center ("ASC") payment system, including a rate increase of 1.2%. Other proposed changes of significance are summarized briefly below.

Comments on these proposed rules are due by September 2, 2014.

Additional Topics Covered in the 2015 PFS Proposed Rule

- Misvalued Codes. CMS identifies 65 proposed potentially misvalued CPT codes as part of a newly-established statutory category of codes that account for the majority of spending under the PFS. The proposed list includes skin biopsies, ultrasound therapy, hearing tests, and chest and knee x-rays.

- Telehealth. CMS proposes the addition of several new services to its list of covered telehealth services, including psychoanalysis, family psychotherapy, annual wellness visits (initial and subsequent visits), and prolonged services in an outpatient setting.

- Chronic Care Management. CMS proposes RVUs for chronic care management services (*e.g.*, 0.61 Physician Work RVUs), proposes to revise the physician supervision requirements for such services, and proposes to require chronic care management practitioners to utilize electronic health record technology certified to meet at least the 2014 Edition meaningful use criteria.

- Medicare Shared Savings Program Quality Metrics. CMS proposes to expand and modify the list of quality performance standards from the current 33 measure set to a 37 measure set by adding 12 new measures and retiring 8 measures in order to improve alignment with reporting requirements under PQRS and the EHR Incentive Program. Performance under the new measures would be assessed by CMS based on claims data or from a patient survey.

- Physician Quality Reporting System (PQRS). CMS proposes to require reporting on all available PQRS cross-cutting measures for eligible professionals or group practices using qualified registries to report PQRS measures. Eligible providers affiliated with Critical Access Hospitals will be able to report using all methods—including claims-based reporting—in 2015. CMS will change the annual reporting deadline from February 28th to March 31st following the end of the calendar year reporting period and is seeking comment on whether to propose more frequent data submissions during the reporting period.

- Physician Compare Website. CMS continues to increase the scope of publicly available physician performance data and will publicly report data in 2016 for physician groups with as few as two

physicians. CMS also seeks comment on the development of performance benchmarks using the methodology published in the 2011 Accountable Care Organization (ACO) Final Rule and composite performance scores derived from PQRS measures with respect to both physician groups and individual physicians.

- Sunshine Act Reporting Changes. CMS proposes to delete the definition of "covered device" as duplicative, proposes to remove the exclusion for speaker payments at continuing education events, proposes required reporting of marketed drug names, and proposes the required reporting of stocks, options, and ownership interests as distinct categories of payment.

- Services Furnished at Rural Health Clinics and Federally Qualified Health Centers. CMS proposes to remove the employment requirement for services furnished by nurses, medical assistants and other auxiliary personnel that are "incident to" Rural Health Clinic & Federally Qualified Health Center visits.

Additional Topics Covered in the 2015 OPPS Proposed Rule

- Packaging Policies. CMS proposes to conditionally package certain ancillary services when they are integral, ancillary, supportive, dependent or adjunctive to a primary service. Preventive services will continue to be paid separately. In addition, CMS is not proposing to package certain psychiatry and counseling-related services. CMS is also not proposing to package certain low cost drug administration services.

- Comprehensive APCs. CMS proposes to implement comprehensive Ambulatory Payment Classifications ("APC") with a set of 28 comprehensive APCs that provide a single Medicare payment and single beneficiary copayment for a primary service and all adjunctive services and supplies.

- Rural Adjustments. CMS proposes to continue the 7.1% adjustment to OPPS payments for certain rural sole community hospitals, including essential access community hospitals.

- Requests for Expansion of Physician-Owned Hospitals. CMS proposes to permit physician-owned hospitals to use data from certain internal or external data sources, in addition to HCRIS data, to support expansion requests.

- Physician Certification. CMS proposes to require physician certification for hospital inpatient admissions only for long-stay cases and outlier cases.

- Medicare Advantage and Part D Appeals Process. CMS proposes to establish a three level appeals process for Medicare Advantage organizations and Part D sponsors that would be applicable to CMS-identified overpayments associated with data submitted by such organizations and sponsors.

- Hospital Outpatient Quality Reporting (OQR) Program. CMS will impose a two percent reduction to unadjusted national OPPS rates and the minimum unadjusted and national unadjusted applicable payment rates for the full calendar year (CY) 2015 for hospitals that failed to meet the OQR reporting requirements. For the CY 2017 payment determination, CMS is not proposing new requirements for chart-abstracted data submission, but is adding an additional claims-based measure for colonoscopy. CMS is also proposing a four-month period for review and corrections of chart-abstracted data for the OQR Program following the close of the quarterly reporting period.

- Ambulatory Surgery Center Quality Reporting (ASCQR) Program. As with the OQR Program, CMS proposes adding a Medicare Fee for Service claims-based colonoscopy measure to the ASCQR Program for the CY 2017 payment determination and subsequent years. CMS also will continue to apply a 2.0 percentage point reduction to the annual update for ASCs that failure to meet the reporting requirements of the ASCQR Program.

Should you have questions regarding this Alert, please contact your usual Ropes & Gray advisor.