Health Reform & Reimbursement Update
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CSAP Meeting
Milwaukee, Wisconsin
Saturday May 17th, 2014 9:00 – 11:00 AM

Disclosure

- Financial
  - ASHA Employee

- Non-financial
  - Ex-Officio to ASHA’s Health Care Economics Committee

Agenda

- ASHA Advocacy
  - GRPP Overview
- The Affordable Care Act
- Health Exchange Marketplaces
- Medicaid
- Coding- CPT/ICD
- Medicare
- Next Steps in Reform
- Questions & Discussion
ASHA: Government Relations & Public Policy

George Lyons - Director of Government Relations and Public Policy
- Tim Nanof - Director of Health Care Policy & Advocacy
- Ingrida Lusis - Director of Federal & Political Advocacy
- Janet Depp - Director of State Advocacy
- Michelle Mannsback - Director of Advocacy Communications & Administration

Speak Out Be Heard
Two Professions Advocating as One

Acronym Guide...

Medicare Physician Fee Schedule - MPFS
- Sustainable Growth Rate - SGR
- Relative Value Units - RVUs
- Electronic Health Records - EHR
- Value Based Modifier - VBM

Physician Quality Reporting System - PQRS
- Eligible Professionals - EPs
- Qualified Clinical Data Registry - QCDR

Sustainable Growth Rate - SGR

Merit-based Incentive Payment System - MIPS
- Qualified Entities - QEs
- Clinical Decision Support Tools - CDS
- Alternative Payment Models (APMs)
- Accountable Care Organizations - ACOs
- Performance Assessment - PA
- Performance Improvement - PI

ObamaCare

The Patient Protection and Affordable Care Act
- The Affordable Care Act (ACA) (Public Law 111-148)

What is it and what is it supposed to do?
Let’s Start with what it’s Not...

Well--- What DOES it do???

- Private Health Insurance
- Essential Health Benefits
- Medicaid Expansion
- Health Insurance Exchanges
- Individual & Employer Mandate

Consumers, Providers, Employers, Insurers

ACA Essential Health Benefits (EHBs)

<table>
<thead>
<tr>
<th>EHB Categories</th>
<th>Prescription Drugs</th>
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</thead>
<tbody>
<tr>
<td>Ambulatory patient services</td>
<td></td>
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<tr>
<td>Emergency Services</td>
<td>Rehabilitative and Habilitative Services and Devices</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
<td>Preventive and Wellness Services and Chronic Disease Management</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>Pediatric Services, Including Oral and Vision Care</td>
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ASHA Federal Legislative & Regulatory Advocacy

- Rehabilitative and habilitative services and devices
  - Affordable Care Act, Sec. 1302(b) (Public Law 111-148)

The Habilitation Coalition
http://habcoalition.wordpress.com

Advocacy Targets:

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Rehabilitation

- “Rehabilitation” was one term mandated in the law to be defined in the glossary.
  - Final Definition:
    - “Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.”

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Habilitation

- ASHA recommended that “habilitation”
  - Final Definition:
    - “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”
Health Exchange Marketplaces

• Red vs Blue—Yea or Nay?
• Exchange Developers:
  – Governors, Legislative Taskforces, Departments of Insurance/Insurance Commissioners, Family and Social Services Administrations, and State Medicaid Offices
• Federal Role:
  – 17 State-based Marketplaces; 7 Partnership Marketplaces; 27 Federally-facilitated Marketplaces

Medicaid

• Coverage & Reimbursement
• Challenges
• Politics & Money
• Expansion?

A look ahead…
Medicare

- G-Codes, Measures, MIPS--- Oh My!

Medicare 101

2012--- 51 million Medicare Beneficiaries

Medicare Parts

- Part A: Hospital Insurance
- Part B: Outpatient Medical Insurance
- Part C: Medicare Advantage
- Part D: Prescription Drug Coverage

Recent Changes

- SGR & Medicare Extenders (Therapy Cap) Patch
- Manual Medical Review
  - RACs vs MACs & Pre-payment vs Post Payment Review
    - Appeals
- Jimmo Settlement
  - Medical Necessity
    - Skilled vs. Unskilled Care
Documentation!

Welcome to the discussion...

Skilled Care

• Providers must ensure documentation reflects skilled care
  – Use terminology and reflects the clinician’s technical knowledge
  – Indicate rationale
  – Connect intervention to goals...
  – Report objective data
  – Specify feedback to patient
  – Explain decision making
  – Elaborate and evaluate patient or caregiver training

What is Unskilled Care?

• Unskilled services do not require the special knowledge and skills of a speech-language pathologist.
  – Performance reporting without describing modification, feedback, or caregiver training that was provided during the session
  – Repeat the same activities as in previous sessions without noting modifications or observations
  – Activity without connecting the task to goals
  – Observation of caregivers without providing education or feedback and/or without modifying plan.

Clarifying Question:
Can anyone else without your knowledge, skills, training and expertise do it?
Four New CPT SLP Evaluation Codes

New Codes:
- **92521** Evaluation of speech fluency (e.g., stuttering, cluttering)
- **92522** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
- **92523** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
- **92524** Behavioral and qualitative analysis of voice and resonance

Payment Rates for New Codes

<table>
<thead>
<tr>
<th>Medicare Physician Fee Schedule - 2014</th>
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<tbody>
<tr>
<td>Code 92521 Evaluation of speech fluency</td>
<td>$114.27</td>
</tr>
<tr>
<td>Code 92522 Evaluation of speech sound production</td>
<td>$92.78</td>
</tr>
<tr>
<td>Code 92524 Behavioral and qualitative analysis of voice</td>
<td>$96.72</td>
</tr>
<tr>
<td>Code 92525 Evaluation of speech sound production with evaluation of language</td>
<td>$192.73</td>
</tr>
</tbody>
</table>
Four New CPT SLP Evaluation Codes

Proceed with Caution:

Inappropriate use of multiple evaluations on the same day could result in restrictions through the National Correct Coding Initiative (CCI) edits.

CCI edits control specific code pairs that can or cannot be billed on the same day for Medicare and Medicaid services; CCI edits are also followed by many other third-party payers.

ASHA will closely monitor the CCI edits and inform members of any restrictions on same-day billing.

See the CCI edits at, www.asha.org/Practice/reimbursement/coding/CCI-Edit-Tables-SLP/

Four New CPT SLP Evaluation Codes

Q. What if I perform only a language evaluation?

A. If a patient is evaluated only for language, SLPs should bill 92523 with the -52 modifier, which is used when the services provided are reduced in comparison with the full description of the service.

ICD-10-CM is Coming!

• When?
  – October 1, 2014… 2015 (provisional)

• To be used by all providers in all settings

• Replaces the ICD-9-CM
Greater Specificity = More Codes!

ICD-9-CM 14,000
ICD-10-CM 68,000

ASHA Resources

ASHA’s ICD-10 website includes:
1. ICD-9 to ICD-10 Mapping Tool
2. ICD-9 to ICD-10 Mapping Spreadsheets
3. ICD-10-CM Code Lists

All resources developed by ASHA are free and tailored specifically for audiologists and SLPs.

www.asha.org/Practice/reimbursement/coding/ICD-10/

Mapping Tool
www.asha.org/icdmapping.aspx
Reporting Quality (Progress) and Outcomes

• The Centers for Medicare and Medicaid Services (CMS) utilizes G-codes for multiple reporting programs
  – Physician Quality Reporting System
    • Quality: Was the care provided using best practices/safe/efficient?
  – Functional Reporting Requirements
    • Patient outcomes: Was the treatment effective for reaching goals?

• Driven by Congress
• Expanding to other payers (Medicaid, private)

Physician Quality Reporting System (PQRS)

• Mandated in 2007 as an incentive-driven quality reporting program
• Affordable Care Act included transition from incentive to penalty for non-participation
• Proposed legislation sustains current program through 2018, and transitions to mixed bonus/penalty system
  – Rates providers on participation and quality
  – Bonus or penalty dependent on score
  – Non participation penalty is steeper
Why Participate?

Eligible providers who do not participate in PQRS will realize decreases in submitted claims

- 2013 participation = -1.5% on all Medicare Part B services provided in 2015
- 2014 participation = -2.0% on all Medicare Part B services provided in 2016

2014 PQRS Measures

- Speech-Language Pathology:
  - Measure #130: Documentation of Current Medications in the Medical Record
  - Measure #131: Pain Assessment and Follow-Up
  - See more at: http://www.asha.org/practice/reimbursement/medicare/PQRS-
    Measures-Available-for-CEPs-to-Report-on-Claims/WithQA/2014.jsp

- Audiology:
  - Measure #261: Acute or chronic dizziness
  - Measure #130: Documentation and verification of current medications in the medical record
  - Measure #134: Screening for clinical depression and follow-up plan
  - See more at: http://www.asha.org/Advocacy/Audiology-PQRS-
    FAQs/Whatmeasuresreport

Measure Applicability Validation (MAV) Process

Benchmarks for Participation

<table>
<thead>
<tr>
<th>Avoid Penalties +2.0% 2014</th>
<th>Report 50% of qualifying patients for 3 measures (or as many as available)</th>
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<tbody>
<tr>
<td>Receive Incentive +0.5%</td>
<td>Report 50% of qualifying patients for 9 measures, including 3 quality domains (or as many as available)</td>
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Functional Reporting G-Codes

- Applicable to Medicare Outpatient Part B Services
  - Start of Treatment
    - Current Status
    - Projected Goal
  - 10th Treatment Day
  - Change in Status
  - Discharge

8 G-codes and 7 Severity Modifiers
Swallowing, Motor Speech, Expression, Comprehension, Attention, Memory, Voice, Other
Percentage Impaired: 100-1, 80-99=2, 60-79=3, 40-59=4, 20-39=5, 1-19=6, 0-7

http://www.asha.org/Practice/reimbursement/medicare/G-Codes-and-7-severity-modifiers-for-outcomes-reporting/

ASHA's Functional Communication Measures

- NOMS-- 15 FCM's

  Individual vs Facility-based Participation
  Public Domain
  Protected Health Information (HIPAA)
  Collaboration
  Cost

The Future of Health Care

Evidence-Based Medicine (Practice)
Quality & Outcomes-Based Reimbursement

- Medicare
  - Sustainable Growth Rate (SGR)= Fee for Service
  - PQRS, VBP
  - MIPS (Merit-based Incentive Payment System)
  - Process, Best Practices, Public Health, Quality, Outcomes
  - PCORI, CMMI
- All-payers
  - Evidence, Outcomes, Comparative Effectiveness, Bundled Payments, Episodic, Alternative Payment Mechanisms...

Quality and Outcomes Reporting: 3 and/or 1...

- Physician Quality Reporting System
  - (PQRS Registries vs. Claims-based Reporting)
- PQRS Registry Based Reporting Option
  - (QCDR)
- Medicare Physician Fee Schedule Reform
  - (CDR or QCDR)

Merit-based Incentive Payment Program (MIPS)

- SGR Reform
  - Legislative Proposal (Finance, Ways & Means, Energy & Commerce)
  - Repeal SGR related to MPFS
- MIPS
  - New Medicare value-based purchasing proposal for 2018/2020 to 2023 based on a provider's 'quality/performance' score in four areas: quality measures; efficiency measures; meaningful use of electronic health records; and clinical practice improvement activities. While the legislation provides parameters for each category, the detail work is left to CMS.
The Four Categories for Calculating MIPS Performance Assessment

<table>
<thead>
<tr>
<th>Category</th>
<th>PS 2014 Weight</th>
<th>PS 2015 Weight</th>
<th>PS 2016 Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>30%</td>
<td>10%</td>
</tr>
<tr>
<td>Resource</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical practice immergence</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>EHR meaningful use</td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
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• Providers scoring below the threshold will be subject to payment reductions. These negative payment adjustments will be capped at 4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023.
• Providers scoring above the threshold will receive ‘unspecified’ payment updates.

How do they propose to pay for it?

• Eliminate and Repurpose Penalties
  — PQRS (Practitioner)
  — VBM (Group)
  — EHR (Physician, LLP)
• Zero % Updates Through 2023*
• Ensuring Accurate Payment
  — 1% Fee Schedule Reduction of RVUs
    • 2016, 2017, 2018
      • “Total downward relative value unit (RVU) adjustments for a service of 20 percent or more (as compared to the previous year) would be phased-in over a two-year period.”
• Appropriate Use Criteria
  — Clinical Decision Support (CDS) Tools
  — Advanced Imaging and Electrocardiogram
    • “Based on the experience with this program, the Secretary could expand the use of appropriate use criteria to other services.”

Questions & Discussion?

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