Federal Affairs Liaison Update

In July, the Federal Affairs Liaison Committee discussed recent regulatory and congressional updates.

Regulatory Updates

On July 12, CMS released the CY 2019 Fee Schedule proposed rule, which included its proposed changes to Year 3 of the Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs).

Major MIPS changes impacting PTs in private practice in the proposed physician fee schedule rule: Initially, PTs will only be assessed on quality and clinical improvement activities. The cost and interoperability categories will be "zero-weighted," according to the proposed rule. MIPS has a "low volume threshold" that essentially exempts providers from reporting unless they meet 3 criteria: annual allowed charges for professional services of $90,000 or more; more than 200 Medicare Part B-enrolled individuals provided covered professional services; and more than 200 covered professional services provided to Part B enrollees. All 3 elements must be met. Practices of more than 15 eligible clinicians would need to report to MIPS electronically beginning in 2019.

AAPMs are a subset of alternative payment models (APM). To qualify as an AAPM in 2019, the model must meet the following 3 criteria: require at least 75% of all eligible clinicians to use Certified Electronic Health Record Technology (CEHRT) (this threshold is not required for Other Payer Advanced APMs until 2020) ; use quality measures that are comparable to those used in MIPS ; bear financial risk for underachieving—CMS is proposing that the risk would need to be equal to 8% of the average estimated total Medicare Parts A and B revenues of providers and suppliers in the APM or 3% of the expected expenditures that an APM entity is responsible for under the APM

For more information go to:*Webpages:*

http://www.apta.org/qpp/

http://www.apta.org/PQRS/

http://www.apta.org/Payment/Medicare/AlternativeModels/

Podcasts:

http://www.apta.org/VBC/Podcasts/

Fee Schedule Proposals

PTA Differential Modifier: CMS is establishing two new therapy modifiers to identify the services furnished in whole or in part by PTAs and OTAs. CMS notes that the Bipartisan Budget Act of 2018 requires that claims from all providers of PT and OT services furnished on and after January 1, 2020, will be required to include these new PT- and OT-Assistant therapy modifiers for services furnished in whole or in part by a PTA or OTA. These modifiers will be used in place of the GP and GO modifiers (modifiers currently used to identify PT and OT services furnished under an outpatient plan of care).

CMS proposes that all services that are furnished “in whole or in part” by a PTA or OTA are subject to the use of the new therapy modifiers. CMS proposes to define “in part” to mean any minute of the outpatient therapy service that is therapeutic in nature, and that is provided by the PTA or OTA

when acting as an extension of the therapist. Thus, a service furnished "in part" by a therapy assistant would not include a service for which the PTA or OTA furnished only non-therapeutic services that others without the PTA's or OTA's training can do, such as scheduling the next appointment, greeting and gowning the patient, preparing or cleaning the room.

CMS proposes to discontinue functional limitation reporting requirements for services furnished on or after January 1, 2019. APTA has advocated for elimination of FLR both to CMS as well as to Congress since its implementation.

CMS released its CY 2019 Home Health PPS proposed rule, which includes plans to replace the existing Home Health case-mix methodology, with an entirely new system dubbed the Patient-Driven Groupings Model (PDGM) to go into effect January 1, 2020. For more information: CMS Fact Sheet on Proposed Rule

On July 25, 2018, CMS released the CY 2019 Hospital Outpatient Prospective Payment System proposed rule. Comments are due September 24, 2018. For more information: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-25.html

APTA, AOTA, and ASHA will be meeting with CMS staff in August to discuss the proposed home health case-mix methodology, and the Patient-Driven Groupings Model. APTA, with AOTA, will be meeting with CMS staff in August to discuss its proposal related to the PTA and OTA differential and what is defined as "in part."

APTA has created template letters for members to use in responding to insurance claim denials. Simply insert your individual information where indicated. These member-protected letters can be found here:

http://www.apta.org/Payment/Medicare/DenialsAppeals/ http://www.apta.org/Payment/PrivateInsurance/

Congressional Update

Last week the Ways and Means Committee held a hearing to discuss the Stark Law. Eric Hargan, the Deputy Secretary at HHS, testified before the committee that the agency is open to legislative changes that would preserve the core part of the law while seeking a balance that will provide flexibility and innovation to create new models of care and at the same time preserve elements that prevent fraud and abuse.

PROSPER ACT: House of Representatives have written the higher education act reauthorization bill known as the PROPSER Act. APTA is working with four other groups to get rid of a capped aggregate loan amount a student can take out from the federal government, to get rid of the graduate loan amount they would cap at 28,500 a year, and other provisions.

Sports Licensure Clarity Act: Currently, the bill is on the Senate calendar with the amended language that APTA helped craft.

To become a key contact to a US Senator or Representative, or to host an event, contact SCAPTA Federal Affairs Liaison Cathy Arnot at arnot@mailbox.sc.edu or send a message to our office at southcarolina@apta.org and follow us on Twitter, Facebook, and Instagram @SCAPTA1.