Alabama Gastroenterological Society
19 S. Jackson Street | Montgomery, AL 36104 | (334) 954-2500 | Fax (334) 269-5200

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scope...

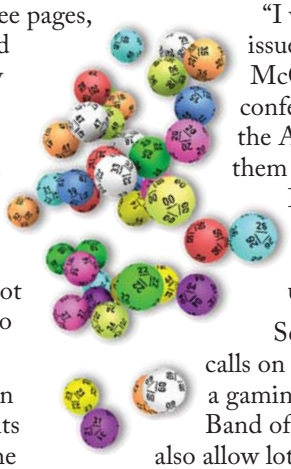
What's Inside

Special legislative session addresses Medicaid funding

Alabamamedicine.org (August 12, 2016)

Just a few days before the special session is set to begin, lawmakers will be faced with two prospective lottery bills, each aimed at fixing the state's ailing Medicaid budget. The competing bills could make for interesting debate.

Two weeks ago when Gov. Robert Bentley unveiled his legislation, he called it a "simple lottery." At only three pages, the proposed amendment would provide a seven-member lottery commission – appointed by the governor and confirmed by the Senate – to oversee what would be called the Alabama Lottery. All proceeds from the lottery would go to the general fund budget, yet the legislation did not include any provisions for casino gambling.



The proposal says "nothing in this amendment affects, prohibits or limits" any legal gaming in the state, including betting on horse and dog racing and "nonprofit, traditional bingo." If adopted, the amendment would put the phrase "traditional bingo" in the state Constitution for the first time, according to an article by *The Montgomery Advertiser*.

Earlier this week, Sen. Jim McClendon (R-Springfield), who intends to sponsor Gov. Bentley's legislation next week, announced his intent to introduce a second piece of legislation combining a lottery with gambling.

"I want to get the lottery issue before the people," Sen. McClendon said at a news conference Tuesday afternoon at the Alabama State House. "Let them vote and make the decision. I want to do something about sick kids that need medical care and are at risk of being underfunded."

Sen. McClendon's second bill calls on the governor to negotiate a gaming compact with the Poarch Band of Creek Indians. The bill would also allow lottery terminals – a type of machine resembling a slot machine but considered non-casino Class II gambling, like electronic bingo – and restricted to pari-mutuel betting facilities in the state, presumably the former VictoryLand in Macon County, GreeneTrack in Greene County, the Birmingham Race Course and the Mobile Greyhound Park. His bill would also earmark $100 million for education with the rest of the proceeds going to the general fund.

At stake next week is the $85 million shortfall left in Alabama Medicaid's budget at the end of the regular session. Monday, Aug. 1, marked the first cut to primary care physicians (pediatricians, family physicians and other physicians), which will make access to care more difficult for Medicaid patients and could force them to leave the program. The proposed cut translates to an average of 30 percent reduction in payment for basic care. Additional cuts are expected

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Smart & Safe partners with Walgreens for medication drop boxes

Alabamamedicine.org

The Smart & Safe prescription drug abuse awareness program recently partnered with Walgreens to bring awareness to medication drop boxes to allow residents to safely dispose of the unused medications.

Birmingham internist Darlene Traffanstedt, MD, was among the guest speakers at a news conference including Hoover Mayor Gary Ivey and Attorney General Luther Strange who addressed the problem of prescription drug use in Alabama.

"Young people who are full of promise but are somehow exposed to opiates… can face a lifelong struggle," Dr. Traffanstedt said. "Drug overdose deaths now outnumber car accident deaths. We as a state must make every effort to change the situation. We applaud Walgreens for giving our families a safe place to dispose of their medications that carry the potential for abuse."

The kiosks provide a free, safe and convenient way to dispose of unwanted, unused or expired prescriptions, including controlled substances, and over-the-counter medications. As part of Walgreens drug take-back program, the kiosks make the disposal of medications easier and are available year-round to help reduce the misuse of medications and the rise in overdose deaths.

Alabama is one of 21 states where the Walgreens Safe Medication Disposal Programs has been implemented.

The Alabama Gastroenterological Society is an official partner of Smart & Safe. Learn more about this effort to fight Alabama's prescription drug abuse problem at ***http://smartandsafeal.org***.

AGA Member Benefit: Patient Care Tool

AGA now offers a library of materials to make patient care more efficient and valuable with easy-to-read, practical information for your patients.

American Gastroenterological Association

As a GI in a busy practice, it is hard to ensure patients have the credible and unbiased information they need to manage their care. While getting a patient up to speed is an important part of high-quality care, it's often complicated by language barriers and low education levels.

Good news: AGA members may now access AGA's new (free) PatientINFO Center. Rely on this library of materials to make patient care more efficient and valuable with easy-to-read, practical information for your patients before, during and after their appointments.

AGA staff worked with clinician colleagues to create the materials, to make sure they are reliable. To improve patient understanding, everything is written at a low reading level, in both English and Spanish.

Each topic is broken down into bite-size sections (such as testing options, diet suggestions, etc.), allowing you to choose what's appropriate for your patient at a specific moment, or you can access all of them in one document. View content online or via PDF documents that you can download and input into your EHR or print and provide directly to patients.

This is just the beginning. Look for more patient education materials, new topics and new tools for you to use in clinical practice. Take a look around and view the ***PatientINFO Center*** today.

The PatientINFO Center currently holds 25 GI-related topics covering various conditions, procedures, diet and medications. This content is a benefit of your AGA membership, so you'll need your login information.

- Barrett's esophagus
- Capsule endoscopy
- Celiac disease
- Cirrhosis
- Clostridum Difficile
- Colonoscopy
- Colorectal cancer
- Constipation
- CT colonography
- Diverticulitis
- Dyspepsia
- Eosinophilic esophagitis
- ERCP
- EUS
- Food Allergies and Intolerances
- Gallstones
- GERD
- Hemorrhoids
- Hepatitis C
- IBD
- Irritable bowel syndrome
- Low-FODMAP Diet
- Pancreatitis
- Peptic ulcer disease
- Upper GI endoscopy

Special session continued

unless more funding is appropriated to Medicaid before the start of the next fiscal year.

A coalition of physicians recently took to the media to express their concerns over the cut, which is forcing them to choose between accepting fewer patients, reducing staff, and in some cases, closing their practice. Combined, these changes will mean that for most Alabamians it will be more difficult to book an appointment with a doctor of their choice at a time convenient for their schedule.

The Legislature is set to convene for the special session on Aug. 15. Legislators would have to pass a version of a lottery amendment by Aug. 24 to get it on the November ballot, where voters would decide whether or not to approve it.

Vist AGS online at www.alagastro.org

CMS publishes HOPPS and ASC proposed rule

Comments due by Sept. 6

The following is a summary of a document distributed by the American Society for Gastrointestinal Endoscopy, the American College of Gastroenterology, and the American Gastroenterolocial Association. Read the full document on AGS's website, www.alagastro.org.

On July 14, the Centers for Medicare and Medicaid Services (CMS) published the CY 2017 Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Centers (ASC) ***Proposed Rule***. Provisions in the proposed rule describe recommended changes to the amounts and factors used to determine the payment rates for Medicare services paid under the HOPPS and ASC Payment Systems. **Comments on these provisions are due by Sept. 6, 2016.**

Key Provisions

Payment Policy

1. Restructuring of Ambulatory Payment Classification (APC)
2. Comprehensive Ambulatory Payment Classification
3. Proposed HOPPS Payment Update
4. ASC Payment update
5. Site Neutral Payments

Quality Programs

1. EHR Incentive Program Modifications for 2016 Reporting
2. Outpatient Quality Reporting Programs

PAYMENT POLICY

Ambulatory Payment Classification (APC) Adjustments

In CY 2016 CMS restructured the APCs for GI endoscopic and diagnostic procedures. For CY 2017, CMS is proposing additional modifications to APC payment that would increase payment rates for several GI endoscopic procedures.

Almost 200 GI procedures and diagnostic services are categorized into APCs. Of that, 35 services changed APCs. CMS proposed increases to all of the GI procedures APC except for Level 1 Upper GI Procedures. The table below highlights the APC changes proposed for CY 2017.

Proposed 2017 APC Payment Changes

APC	Title	Proposed Change
5301	Level 1 Upper GI Procedures	-10%
5302	Level 2 Upper GI Procedures	21%
5303	Level 3 Upper GI Procedures	26%
5311	Level 1 Lower GI Procedures	36%
5312	Level 2 Lower GI Procedures	16%
5313	Level 3 Lower GI Procedures	30%

Comprehensive APC (C-APC)

C-APC packages provide payments for services and supplies rather than providing separate payments for each individual service. C-APCs provide a single all-inclusive payment for the primary service with no additional reimbursement for additional adjunctive services and supplies used during the delivery of the primary service. C-APCs are described by a HCPCS code assigned to a C-APC as the primary service when the service is identified by OPPS status indicator "J1".

In CY 2016 CMS finalized C-APC 5331 "Complex GI procedures" as the first C-APC impacting 12 GI endoscopy procedures involving stent procedures. For CY 2017, CMS proposes adding three additional C-APCs for GI procedures impacting a total of 79 GI endoscopy procedures.

For CY 2017, CMS proposes to create 25 new C-APCs, bringing the total number to 62 as of Jan. 1, 2017.

Our societies remain concerned that in applying C-APCs CMS will not be able to accurately assess the cost of the adjunctive services over time. Last year, our societies urged CMS to require submission of this information by facilities. We will continue to urge CMS to work on methods and procedures that ensure fair appraisal of cost data

Proposed HOPPS Payment Update

CMS proposes to update the HOPPS payment rates by 1.55 percent. The change is based on the projected hospital market basket increase of 2.8 percent minus both a 0.5 percentage point adjustment for multi-factor productivity (MFP) and a 0.75 percentage point adjustment required by law. After considering all other policy changes proposed under the OPPS, including estimated spending for pass-through payments, CMS estimates a 1.6 percent payment increase for hospitals paid under the HOPPS in CY 2017.

Proposed ASC Payment Update

Using the Consumer Price Index for all urban consumers (CPI-U), CMS proposes two conversion factors: one for ASCs meeting quality reporting requirements of 1.2 percent and one for ASCs not meeting quality reporting requirements of -0.8 percent in calendar year (CY) 2017.

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Adoption of Site Neutrality for Off-Campus Hospital Provider Based Departments (PBDs)

The proposed rule includes a proposal to implement the site neutrality reductions adopted in 2015 for off-campus PBDs and ASCs in CY 2017. The site-neutrality proposal implements provisions of the Bipartisan Budget Act of 2015, which provided CMS the authority to equalize payments across the two settings. Specifically, the rule states that services provided in certain PBDs will no longer be paid pursuant to the OPPS beginning Jan. 1, 2017. Instead, PBDs will be reimbursed pursuant to the "applicable payment system", which will generally be the MPFS. The rule includes a grandfather clause that maintains OPPS reimbursement for outpatient departments that provided those services prior to Nov. 2, 2015.

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Proposed rule, continued

Although the legislation included a "grandfather" for off-campus PBDs that billed Medicare prior to Nov. 2, 2015, the proposed rules would impose a number of restrictions on these grandfathered facilities:

- A grandfathered off-campus PBD would lose its "grandfather status" if it relocates.
- A change in ownership of the grandfathered facility would result in loss of grandfather status if the ownership change does not impact the whole hospital.
- A grandfathered PBD would be eligible for payment under HOPPS only for procedures and services in the same "family" as those provided prior to Nov. 2, 2015.

In addition, CMS has indicated that it cannot put the needed systems changes in place that would be necessary for non-grandfathered off-campus PBDs that are not grandfathered to be paid under the PFS, using the operating systems now used by these facilities to bill under HOPPS. For 2017, CMS contemplates that services provided in non-grandfathered off-campus PBDs will be billed on a global basis by the physicians who provide services in the facilities. CMS contemplates in the proposed rule that if this alternative is chosen, the billing physicians will make a financial arrangement with the hospital to pay for the off-campus PBD's overhead and related costs. Alternatively, off-campus PBDs that do not have grandfather status could enroll as physician offices, bill for and obtain payment for physician services on a global basis, and pay the physicians for their professional services. CMS anticipates that, starting in 2018, a new enrollment system will be in place for these facilities, which will presumably facilitate enrollment and billing by off-campus PBDs that are not grandfathered.

QUALITY PROGRAMS

Changes for Returning Participants (CY 2016 Reporting year)

CMS proposes to change the Meaningful Use reporting period in 2016 for returning participants from the full CY 2016 to any continuous 90-day period within CY 2016. It means all eligible providers may attest to Meaningful Use for an EHR reporting period of any continuous 90-day period from Jan. 1, 2016, through Dec. 31, 2016. This impacts your 2018 reimbursement.

Meaningful Use Hardship for New Participants (CY 2018 Payment Year)

CMS is proposing to allow all eligible professionals to apply for a significant hardship exception from the 2018 payment adjustment. CMS is limiting this proposal only to eligible providers who have not successfully demonstrated Meaningful Use in a prior year, but intend to attest to Meaningful Use for the 2017 reporting year (when MIPS starts). Providers would need to report this hardship by Oct. 1, 2017, to avoid the 2018 payment adjustment.

Outpatient Quality Reporting Programs

The Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting Payment (ASC QRP) Reporting Program are pay for quality data reporting programs for outpatient hospital services.

In the CY 2017 OPPS/ASC Proposed Rule, CMS is proposing to add a total of seven measures to both programs the CY 2020 payment determination and subsequent years: Two claims-based measures, and five Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey-based measures. The seven measures are inclusive of five proposed measures to collect Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey, a patient experience of care survey which assesses patients' access to care, interactions with facility staff, and overall experience at the facility.

Additionally, beginning with the CY 2018 payment determination, CMS is proposing to publicly display data on the Hospital Compare Web site, or other CMS Web site, as soon as possible after measure data have been submitted to CMS. In addition, the agency is proposing that hospitals will generally have approximately 30 days to preview their data. CMS is also proposing to announce the timeframes for the preview period on a CMS Web site and/or on its applicable listservs.

More Information

Additional information on the proposed rule will be posted on our websites. In the meantime, questions should be directed to:

- Brad Conway, ACG vice president of public policy, (301) 263-9000 or ***bconway@gi.org***
- Joshua Keepes, AGA director of regulatory affairs, (240) 482-3223 or ***jkeepes@gastro.org***
- Lakitia Mayo, ASGE director of health policy and quality, (630) 570-5641 or ***lmayo@asge.org***

Read this full document on AGS's website, www.alagastro.org.

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*Send article submissions and comments to Charlotte Morris at **cmorris@alamedical.org** two weeks in advance. Scope is printed bimonthly. Comments and letters to the editor are welcome.*