FORHP
Policy & Regulatory Update

TASC 90 Call

August 12, 2015

CAH Manual Updates

On June 26, the Centers for Medicare and Medicaid Services (CMS) published a Survey and Certification Letter (S&C 15-45-CAH) with updates and instructions for state survey agencies addressing how they will evaluate CAHs' location and distance from other hospitals to ensure that the CAHs are meeting the driving distance and rural location requirements for participation in Medicare. This guidance is also part of the State Operations Manual in Chapter 2 and in Appendix W and these documents will be updated.

- The CMS Regional Office determines if a CAH meets the rural location
- A CAH must meet the location and distance requirements at the time of its initial conversion to CAH status *and* at all times thereafter.
- CAHs must monitor their own rural status and take action if it changes (e.g. MSA changes).
- Primary roads are defined as any US Highway regardless of physical features of individual roads.
- CAHs on islands meet the distance requirement as long as the island is not connected by any road and there is no other hospital on the island.
- For the purpose of CAH eligibility and distance to another hospital, Indian Health Service (HIS)/Tribal hospitals and non-IHS/Tribal hospitals will be treated separately.
- Note that this is a new revision to the State Operations Manual, other changes were previously published in April.

Fiscal Year (FY) 2016 OPPS Proposed Rule

On July 1, CMS placed the 2016 Medicare Outpatient Prospective Payment System (OPPS) proposed rule on display at the Federal Register. The CMS fact sheet summarizes the proposed rule. The complete data files for the 2016 OPPS payment update are online.

- This proposed rule would update 2016 payments for hospital outpatient services, ambulatory surgical centers, and community mental health center partial hospitalization programs.
- The Emergency Department Transfer Communication (EDTC) measure developed by Stratis Health and the University of Minnesota is proposed as a new measure (called OP-34) to be collected by all hospitals in the Outpatient Quality Reporting Program starting in calendar year (CY) 2017.
- Update to the Two-Midnight rule: Hospital stays longer than two midnights will *continue* to be presumed inpatient. Hospital stays expected to be less than two midnights *may be* appropriate for inpatient admission and payment when the admitting physician judges that the patient requires inpatient-level care.
- Total payments under OPPS in 2016 would decrease by 0.2% or $43 million less than was paid in CY 2015. This is primarily due to a proposed reduction of 2% to address the inflation in OPPS payment rates resulting from excess packaged payment under the OPPS for laboratory tests starting in 2014. Total spending for OPPS services in 2014 was approximately $50 billion.
- The proposed rule is open for comment until August 31.

FY 2016 PFS Proposed Rule

On July 15, the Centers for Medicare & Medicaid Services (CMS) published the Calendar Year (CY) 2016 Medicare Physician Fee Schedule proposed rule. This would make several policy changes related to Medicare Part B payment:

- Authorize Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to provide chronic care management services beginning on January 1, 2016.
- Require RHCs to report all services using standardized coding systems, such as level I and level II of the Healthcare Common Procedure Coding System (HCPCS) beginning January 1, 2016.
- Extend payment add-ons for ambulance transportation services in rural areas.
- Establish a new exception to permit payment from a hospital, FQHC, or RHC to a physician to assist the physician in employing a non-physician practitioner in the geographic area.
- Apply the 2018 value modifier to all physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2 or more eligible professionals (EPs) or solo practitioners, with those that consist of only non-physician EPs (i.e., PAs, NPs, CNSs, CRNAs) not subject to downward adjustments in their value modifier.
- CMS is also seeking input through this proposed rule on an appropriate low-volume threshold for excluding certain eligible professionals from the Merit-based Incentive Payment System (MIPS).
- Public comments on the proposed rule will be accepted until September 8.

Other Proposed Rules

- On July 6, a proposed rule outlining the 2016 Medicare prospective payment rates for home health (HH) providers and launching a Home Health Value-Based Purchasing (HHVBP) model. Comments due September 4.
- On July 9, a new proposed rule on the Comprehensive Care for Joint Replacement (CCJR) Model for Acute Care Hospitals. Joint replacements in 75 metropolitan statistical areas (MSAs) would be paid under the model (see the list on the CCJR webpage), and most prospective payment system (PPS) hospitals in those selected MSAs would be required to participate. CAHs are not included. Comments due September 8.
- On July 16, a proposed rule to revise the requirements for long-term care (LTC) facilities participating in Medicare and Medicaid. The proposal introduces many new rules designed to promote person-centered care and improve quality of life and quality of care at LTC facilities. The rule would apply to CAHs providing skilled nursing facility (SNF)-level care in swing beds, but it maintains several existing CAH exemptions from patient data collection requirements. Comments due September 14.

MSSP Final Rule

On June 9, CMS published the Medicare Shared Savings Program (MSSP): Accountable Care Organizations (ACO) Final Rule. The rule:

- Encourages greater ACO participation in risk-based models (2-sided risk) by creating an alternative risk-based model ("Track 3") that includes a higher sharing rate, prospective attribution of beneficiaries, and the ability to use new care coordination tools.
- Establishes a waiver of Medicare payment rules and regulations related to 3-day qualifying hospital stays for SNF admissions for beneficiaries in ACOs under Track 3.
- Revises the beneficiary assignment process by including the claims from non-physician ACO professionals (NP, PA, and CNS), and clarifying how primary care services furnished in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will be considered.
- Streamlines the process for data sharing between CMS and ACOs on patient claims data necessary for health care operations.

FY 2016 IPPS Final Rule

On July 31, the Centers for Medicare and Medicaid Services (CMS) announced the FY2016 Hospital Inpatient Prospective Payment Systems and Policy Changes. The final rule makes several policy changes related to inpatient hospital payment and takes effect October 1.

- Medicare payment for inpatient hospital services will increase by 0.9%.
- CMS is continuing to evaluate the use of the Worksheet S-10 to measure a hospital's amount of uncompensated care. The rule states that the FY 2017 rule may create a timeline for implementing the use of S-10 for DSH payment adjustments.
- Implements the extension of the low-volume hospital (LVH) and Medicare dependent, small rural hospital (MDH) adjustments in the Medicare Access and CHIP Reauthorization Act.
- CMS is expanding the hardship exemption for electronic reporting of Inpatient Quality Reporting (IQR) measures. The final rule also adds seven measures, while removing 9 measures.
- The Rural Community Hospital Demonstration Program is ending its 5-year extension period under the Affordable Care Act (ACA), this phases out current participants (22 hospitals in 11 states).

Other Final Rules

The following final rules take effect October 1:

- On July 31, the CMS announced the FY2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. The final rule makes several policy changes related to hospice payment including a Service Intensity Add-On payment for care performed in the last seven days of a beneficiary's life by a registered nurse (RN) or social worker.
- On July 31, CMS announced the final rule for 2016 Prospective Payment Update for Inpatient Rehabilitation Facilities (IRF). CMS is implementing a new IRF-specific market basket; this year it is based on 2012 Medicare cost report data.
- The Medicare Inpatient Psychiatric Facilities (IPF) Prospective Payment System Update for FY 2016 was published August 5. The CMS Fact Sheet summarizes the final rule. CMS is adopting an IPF-specific market basket and the newest Office of Management and Budget (OMB) Core Based Statistical Areas (CBSAs) delineations for the FY 2016 IPF wage index.
- On July 30, the Centers for Medicare & Medicaid Services (CMS) announced the Final Rule for 2016 Prospective Payment for Skilled Nursing Facilities. The rule implemented requirements for data submission, including staffing information and a Quality Reporting Program (QRP), in which failure to report leads to a reduction of annual payment increases. The rule outlines policies and one quality measure for a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program.

Extra Policy Update

- Added after the August 12, 2015 TASC 90 webinar
- H.R. 876, the NOTICE Act, was signed into law on August 6. (Public Law 114-42). This law requires that a person receiving observation services in a hospital or CAH for more than 24 hours must be given notice within 36 hours of the start of treatment explaining the individual's status as an outpatient and not as an inpatient, the reasons for that status, and the implications of that status on services furnished, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility. Watch for future rulemaking from CMS implementing these provisions.