FORHP
Policy & Regulatory Update

TASC 90 Call

November 18, 2015

CMS Manual Updates

On August 21 CMS released a new exhibit for the State Operations Manual (SOM), Chapter 9, Critical Access Hospital (CAH) Recertification Checklist: Rural and Distance or Necessary Provider Verification. This document (Transmittal 145) lists the necessary items that must be checked at each CAH survey to ensure that the CAH meets the rural location and distance (or necessary provider) requirements to qualify as a CAH under Medicare. The exhibit also lists the procedures that CMS Regional Offices and state survey agencies will follow to check these items.

As a reminder, the revisions to the SOM that were announced June 26 in a Survey and Certification Letter were published as Transmittal 143. These revisions to the SOM took effect upon publication on July 31, 2015, and provide updated guidance on CAH location and distance requirements.

Discharge Planning Proposed Rule

On October 29 the Centers for Medicare & Medicaid Services (CMS) released a proposed rule to revise discharge planning requirements in the Conditions of Participation (COPs) under Medicare and Medicaid for hospitals, including critical access hospitals (CAHs), long-term care hospitals, and inpatient rehabilitation facilities, and home health agencies (HHAs). The proposed rule:

- Requires providers to develop and implement discharge planning processes that prepare patients to be active partners in post-discharge care, effectively transition patients from care settings, and reduce factors that lead to preventable readmissions;
- Solicits feedback on whether to require providers to consult state Prescription Drug Monitoring Programs to review patients' risk of non-medical use of controlled substances;
- Requires that the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan from HHAs;
- Implements sections of the Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113-185) that require facilities to take into account quality and resource use measures for post-acute care to assist patient decisions during the discharge planning process; and
- Requests comments on both the proposed COPs and the implementation timeline for CAHs since there are no CAH-specific discharge planning requirements in current regulations.
- See the CMS press release for more details. Comments are due **January 4, 2016**.

Methods for Assuring Access to Covered Medicaid Services Final Rule

On November 2, CMS issued a final rule with comment period that requires States to provide more information to better monitor, measure, and ensure Medicaid access to care within fee-for service reimbursement methodologies. In addition to the final rule, CMS is developing procedures to bolster the administrative record that is used to document compliance with the final rule and ensure that there is consistent national application of its requirements. CMS also issued a Request for Information (RFI) to obtain input into additional approaches that it and States may consider to better ensure compliance with Medicaid access requirements. The CMS Fact Sheet summarizes the final rule and RFI.

- Through the RFI, CMS is seeking feedback on whether and what core access measures, thresholds, and access resolution processes would be useful in ensuring access to care to Medicaid beneficiaries, including measuring access to long term care and home and community based services.
- The final rule takes effect January 4, 2016, and comments to the final rule and the RFI are also due January 4, 2016.

CY 2016 OPPS Final Rule

On October 30, CMS released a final rule updating Medicare payment rates for calendar year 2016 under the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment System. The rule finalizes several policy changes, including:

- A payment transition for former Medicare Dependent, Small Rural Hospitals (MDH) that no longer qualify for the MDH payment adjustment;
- Changes to the Two-Midnight rule for short inpatient stays to allow for inpatient admission for less than two midnights when medically necessary; and
- Nine new comprehensive APCs, including one for comprehensive observation services.
- The rule finalizes a -2.0 % adjustment to the payment update to correct the inflation in the OPPS payment rates resulting from excess packaged payment for laboratory tests that continue to be paid separately. The final OPPS rate update will be -0.3% for 2016.
- The policy and payment changes are effective on January 1, 2016. The CMS fact sheet provides more details on the rule.

CY 2016 PFS Final Rule

On October 30, CMS announced the Calendar Year 2016 Medicare Physician Fee Schedule final rule which was published November 16. This final rule makes several policy changes related to Medicare Part B payment. Among changes important to rural providers, the rule will:

- 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 HCPCS beginning April 1, 2016;
- Authorize Advance Care Planning services -- CPT codes 99497 (initial 30 minutes) and 99498 (subsequent 30 minutes) for explanation, discussion and completion of Advanced Directive forms for Medicare beneficiaries. This service can be delivered by providers including RHCs at the local level under the discretion of the Medicare Administrative Contractors;
- Apply the value modifier in the CY 2018 payment adjustment period to nonphysician eligible professionals (EPs) who are PAs, NPs, CNSs, and CRNAs in groups with two or more EPs, and to PAs, NPs, CNSs, and CRNAs who are solo practitioners; and
- Extend payment add-ons for ambulance transportation services in rural areas.
- Comments are due on **December 29, 2015**. The rule will take effect on January 1, 2016.

EHR Incentive Programs and Health IT Certification Final Rule

On October 16, CMS and ONC published the final rules for Stage 3 and Modifications to Meaningful Use 2015-2017 for the Medicare and Medicaid EHR Incentive Programs and the 2015 Edition Health IT Certification Criteria.

Both final rules focus on the interoperability of data across systems and make key changes to the EHR Incentive Programs including:

- Establishing a single, aligned reporting period for all providers based on the calendar year
- Allowing providers the option to start Stage 3 of meaningful use in either 2017 or 2018
- Aligning quality data for reporting via a single submission method for multiple CMS programs
- Simplifying meaningful use reporting requirements to eight objectives that focus on an advanced use of EHR technology and quality improvement
- Providers must report on all three patient engagement measures but successfully meet the thresholds of just two

Rural eligible professionals, eligible hospitals, and critical access hospitals (CAHs) should take a close look at the changes made to the reporting periods, patient engagement thresholds, and reporting requirements, and how these changes may impact your participation in the program. A fact sheet for both proposed rules can be found here.

Other Items

The following final rules take effect January 1, 2016:

- On November 6, CMS published a final rural updating the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for calendar year (CY) 2016. The rule updates Medicare payment rates for 2016 for facilities furnishing outpatient maintenance dialysis treatments and sets forth requirements for the ESRD Quality Incentive Program.
- On November 5, CMS published a final rule updating the Medicare prospective payment rates for home health agencies (HHAs). The rule reduces payments to HHAs by 1.4% in CY 2016; extends the 3% payment boost for services provided in rural communities through January 1, 2018; and launches a five-year Home Health Value-Based Purchasing (HH VBP) model authorized by the Affordable Care Act to begin January 1, 2016 for all Medicare-certified HHAs in MA, MD, NC, FL, WA, AZ, IA, NE, TN.

The following notices were published November 16:

- Calendar Year 2016 Medicare Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals
- Calendar Year 2016 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts
- Calendar Year 2016 Medicare Part B Premium Rates and Annual Deductible