CMS Updates

Alaska HFMA
August 2015

You Give Healthcare a Band-Aid

Presented by:

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Outline

- Legislative changes
- Miscellaneous hospital updates
- Two-midnight rule
- Physician fee schedule, rural health clinics, and federally qualified health centers
- Electronic health records
- Office of Inspector General

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Background

- Debt ceiling to re-emerge
- Current budget resolution through September 2015
- Republicans take control of Congress
- Presidential elections in 2016

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President's Budget

- Estimated 1.8 trillion reduction to nation debt over 10 years.
  - Noted as health, tax, and immigration reform
- Would end the sequester

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President's Budget

- Further reform Medicare physician payments
- Expand beneficiary assignment in ACOs
- Implement bundled payments for post-acute care
- Reduce payments for Medicare bad debts to 25%
- Change CAH payment from 101% to 100%
- Remove CAH designation for those fewer than 10 miles from another hospital
- Decrease DSH allotments

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Groundhog's Day

- *Middle Class Tax Relief and Jobs Creation Act of 2012*
  - Early 2012
- *American Taxpayer Relief Act of 2012*
  - Late 2012
- *Protecting Access to Medicare Act of 2014*
  - Most provisions expired 3.31.15

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List of Extensions

- Delays physician fee schedule cuts
- Extends rural ambulance add-ons
- Therapy cap exceptions process
- Extends low-volume hospital payments
- Geographic Practice Cost Indices (GPCI) floor of 1
- Extends Medicare Dependent Hospital Program
- Rural home health add-on

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Payments for Extensions

- Give and take with temporary extensions
- Sometimes get paid for with permanent cuts
- Smaller extended items are usually attached to fixes to the sustainable growth rate

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Medicare Bad Debt Reminder

- Cut payment for Medicare bad debts
- All reimbursed at 65%
  - January – August year ends are at 76% in 2015, 65% in 2016
  - September – December year ends at 65%

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Sustainable Growth Rate

- Purpose: to limit growth of Medicare payments to physicians
- Method: formula designed to adjust payments to keep a total target amount
- Spending has exceeded target since 2002

Sustainable Growth Rate (continued)

- Each year (or period) Congress delays fee schedule cuts (often around 30% cuts)
- How to change
- Tag alongs

Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- Removes SGR methodology
- Payment through June 30, 2015 at 0%
- July 1 – December 31 at .5%

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Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- New Merit-based Incentive Payment System (MIPS)
  - Combines EHR, PQRS and VBPs program reporting and incentives
- Alternative payment methods (APMs)
- Annual payment increase (or decrease) based on performance

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Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- Payment adjustments
  - 2016 – 2019 = .5%
  - 2020 – 2025 = 0%
    - MIPS: Negative capped at 4-9% (depending on year, positive is 3x the respective cut amount
      OR
    - APM: Automatic 5% bonus for participation in qualifying APM
      - Will require financial risk
      - Examples: ACOs, medical homes, bundled payment systems
  - 2026
    - MIPS = .5% annual update
    - APM = 1% annual update
    - Plus the other requirements of the programs

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Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- CMS' role
  - Develop quality measures to assess professionals
  - Develop merit based system linked to an individuals annual payment increases or decreases based on performance

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Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- 2015 at 2014 rates through June 30
- 2015 starting July 1 at .5% increase
- 2016-2019 at .5% increase over prior year
- 2020 – 2025 0% increase and choose APM or MIPS
- 2026 – .5% if MIPS 1% if AMP

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List of Extensions

- Extended through 2017 *calendar* year
  - Extends rural ambulance add-ons
  - Therapy cap exceptions process
  - Rural home health add-on
  - Geographic Practice Cost Indices (GPCI) floor of 1
- Extended through 2017 *fiscal* year
  - Extends low-volume hospital payments
  - Extends Medicare Dependent Hospital

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Permanent Extensions

- Qualifying individual program
- Transitional medical assistance program

Medicare Access and CHIP Reauthorization Act of 2015

- Paid for by:
  - NOT budget neutral CBO estimates adding 141 billion to the deficit over 10 years
    - CMS actuary estimates 102.8 billion, what's 29 billion?
  - Income related premium adjustments (part B and D) – starts at $85,000 & 35%
  - Payment updates for post-acute providers
  - Payment updates for inpatient hospital rates
  - Medicaid DSH reductions

Medicare Access and CHIP Reauthorization Act of 2015 (continued)

- Medicaid DSH changes to reductions

	Prior Reduction	New Reduction
2017	1,800,000,000	-
2018	4,700,000,000	2,000,000,000
2019	4,700,000,000	3,000,000,000
2020	4,700,000,000	4,000,000,000
2021	4,800,000,000	5,000,000,000
2022	5,000,000,000	6,000,000,000
2023	5,000,000,000	7,000,000,000
2024	4,400,000,000	8,000,000,000
2025		8,000,000,000
	35,100,000,000	43,000,000,000

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Proposed Acts

- H.R. 876 – NOTICE Act, awaiting President's signature
- H.R. 596 – appeal ACA, passed House in February
- S. 1461 – extends enforcement of outpatient therapeutic supervision through 2015
- S. 607 – extends rural community hospital demonstration for an addition 5 years
- S. 1347 – EHR fairness to pull ACS patient data from EP encounters
- H.R. 169 – removes the 96-hour physician certification requirement (not reported to committee)

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Proposed Cost Report Changes

- IPPS rule **proposes** to eliminate the simplified method
  - Stating the issue with setting DRGs and APC payment levels.

DSH Audits

- Application process
  - Preliminary calculation
- Audits
  - Uncompensated care cost is cap for DSH payment
  - Includes other supplementary payments (as payment by not subject to payback)
- Hospitals may have paybacks to 2011
  - Payables can and should be estimated to date
  - Care should be taken to report fully uninsured patients as such in your system

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PRRB Reinstatement

- Effective June 1, 2015
- Allows reinstatement
  - Keep all correspondence from MAC
  - Insist on something in writing

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CAH Distance

- Census data changed in 2015
  - CAHs may have changed rural to urban (or vise versa)
  - 2 years to reclass
- 35 mile rule
  - Tribal to tribal
  - Non-tribal to non-tribal
- Island hospitals
  - Surrounded by water (360º)
  - Only hospital
  - Not accessible by a road
- Primary roads clarified
  - If a US highway, regardless of the roads characteristics

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CAH 96-hour Rule

- Condition of ***payment***
  - Physician certifies patient will be discharged or transferred within 96 hours
  - **Certification must occur before bill is submitted to Medicare**
    - Was time of admission
- Condition of ***participation***
  - On average, cannot have more than 96 hour stays

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Cost Report Worksheet S-10

- DSH payments and S-10
- Not used *yet*
  - Obvious errors – Medicare bad debts claimed but no bad debts, not filled out
- Take time to get reports right
- Proposed 2016 IPPS still finds issues with this report

Value-based Purchasing

- Value-based purchasing in 2015
  - Patient experience of care = 30%
  - Outcomes = 30%
  - Clinical processes of care = 20%
  - Efficiencies (cost) = 20%
- **Proposed** for 2016
  - Patient experience of care = 25%
  - Outcomes = 40%
  - Efficiencies (cost) = 25%
  - Clinical processes of care = 10%

Billing Off-campus Locations

- Off-campus provider-based locations
- Bill with PO modifier (elective in 2015)
- Mandatory in 2016 to bill with new POS identifying as off-campus
- Excluded
  - Emergency rooms
  - Satellite facilities

2-Midnight Rule

- Inpatient vs. outpatient status
- 2-midnight rule
  - Physician's assumption
  - Assumptions can change

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2-Midnight Rule (continued)

- 2-midnight rule
- Start time includes outpatient services (excludes triage)
  - Can have one inpatient day stay, but patient was at hospital for 2 midnights
- Should eliminate observation stays greater than 2-midnights
- One-midnight inpatients should be rare occurrence

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2-Midnight Rule (continued)

- Protecting Access to Medicare Act extended “probe and educate” through March 31, 2015
- CMS extended through April 30
- HR2 extends through September 30, 2015
- October 1, 2015 – changes from RAC auditors to Quality Improvement Organization (QIO)
  - Short hospital stays only

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NOTICE ACT

- Passed Senate July 27, 2015, awaiting the President’s signature
- Requires written and oral description of inpatient vs. outpatient status
  - Patient in observation over 24 hours
  - To patient the earlier of 36 hours of start of services or discharge
  - To be defined by CMS

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NOTICE ACT (continued)

- Notice to include
  - Reason for outpatient status
  - Difference in cost to patient
  - Implications for skilled nursing coverage
  - Signature of patient (or representative)
    - If patient refuses to sign, needs two hospital representatives signature and date and time it was presented

2-Midnight Rule (continued)

- 2016 OPPS **proposes** change to “rare and unusual” policy
  - Current: only exceptions are CMS “IP only” cases as published on the CMS website
  - **Proposed**: case by case basis by physician (subject to medical review)
    - Stay under 24 hours will rarely qualify
    - Must be well documented in the medical record
      - Severity of the symptoms
      - Medical predictability of adverse events
      - Need for typical outpatient diagnostic services

2-Midnight Rule (continued)

- 2016 OPPS **proposed** changes
- Short stays will be priority for review
- CMS requesting comments whether specific medical review criteria should be adopted
- QIO will review short stays
  - Will send repeat offends to the RAC auditors
- 2-midnight presumption is not changing

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2-Midnight Rule (continued)

- Billing Inpatient Part B
  - Documentation does not support inpatient status
- Routine charges are forgone
- Outpatient (services before admission) and ancillary charges are billed Part B
  - Subject to timely billing

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2-Midnight Rule (continued)

- Billing Inpatient Part B
  - Charges must be revoked in CMS' system
- Stay denied as part of Medical review
  - Likely outside of timely billing
  - Appeal if appropriate
- Stay reprocessed as part on internal review
  - Revoke in system and bill as part B

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2-Midnight Rule (continued)

- Billing Inpatient Part B
  - PPS –
    - Outpatient on TOB 13x
    - Ancillary on TOB 12x
  - CAH
    - Outpatient will already have been billed as OP
    - Ancillary on TOB 12x

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2-Midnight Rule (continued)

- Billing Inpatient Part B
  - Patient days
    - Day counted in total days
    - Day not counted as a Medicare day
    - Ouch

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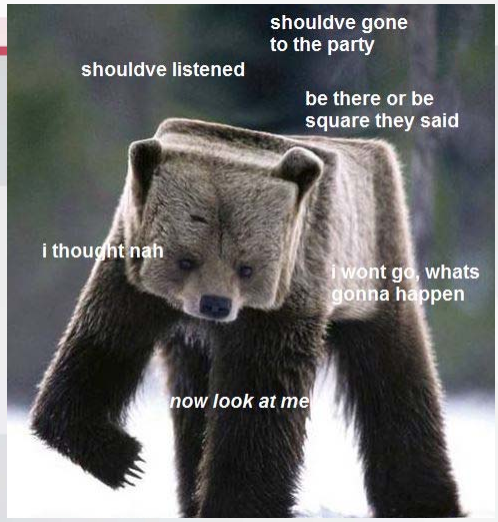

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Telehealth – 2016 Proposed MPFS Rule

- Add new CPT codes
  - 99356 & 99357 – prolonged service in the inpatient or observation setting
  - 90963-90966 – end-stage renal disease (ESRD) for home dialysis
    - Must be at authorized originating site which is not the patient's home
    - Does not include clinical exam of catheter access site
- Add CRNAs as allowed practitioner

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RHCs and Telehealth

- RHCs service as originating site only
  - Originating = where the patient is originating
- Can bill with or without qualifying encounter
  - HCPCS code Q3014

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Incident to – 2016 Proposed MPFS Rule

- Relates to auxiliary personnel providing the incident to service
- To be supervised by the practitioner that bills for the incident to service

Chronic Care Management

- Started January 1, 2015
- CPT 99490 (cannot be billed in conjunction with transitional care management codes 99495-99496)
- Billable once a month

- Must have 2 or more chronic conditions
- Chronic conditions place the patient at significant risk
- Comprehensive care plan established, implemented, revised, or monitored
- At least 20 minutes of time a calendar month
- Certified EHR technology required

Chronic Care Management

- No deductible or coinsurance
- Not face to face
- Other qualifiers
- One provider only can bill
- Not duplicative
- Wellness visit not required
- Alaska
  - Facility - $44.50
  - Non-facility - $55.64

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Chronic Care and RHCs (& FQHCs)

- Currently does not apply to RHCs as there is no face-to-face encounter
- MPFS proposes to add RHCs
  - Cost of CCM services not already captured in the RHC rate
  - One practitioner can bill a month
  - Bill with or without qualifying encounter
  - Minimum 20-minutes per month
  - Must let beneficiary know of service

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Surgery Global Periods

- CHIP Act blocks CMS from removing surgery global periods
  - OIG report states patients receive fewer follow up visits than estimated in payment
  - Surgeons report a fear patients will not come in for as many follow ups if each is billed separately

FQHC/RHC Final Rule

- Contracted mid-levels
  - Must employ a mid-level at all times
  - If above is yes, can contract a mid-level

Changes to RHC Manual

- Location
  - Rural
  - HPSA
  - Manual states CMS does not have method to decertify for these two
- Expect future legislation – if you've lost your HPSA, be proactive

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Changes to RHC Manual (Continued)

- 50% mid-level rule *clarified*
  - Physically present at the RHC
  - Available to see patients
  - Time outside the building (even if billable as RHC is **EX**cluded
    - Think RHC visits at a nursing home
  - Waivers
  - Can be decertified for no mid-level

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Changes to RHC Manual (Continued)

- Waivers to 50% mid-level rule
  - Temporary
  - Demonstrate how clinic has tried to recruit and retain in the 90 days prior to the waiver request
    - Recruitment must start as soon as you know you are losing your mid-level
  - Cannot have a waiver for more than a year
    - Additional waivers cannot be granted for 6-months after the first waiver expires

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Proposed RHC Reporting of HCPCS* Codes

- RHCs only required to report HCPCS code for preventative services only
- **Proposal** to report ALL RHC services with HCPCS codes starting January 1, 2016
  - Exempt RHCs:
    - Fewer than 10 full time equivalent employees
    - Unable to submit electronic claims
    - RHCs should submit comments on the viability of this proposal

*Healthcare Common Procedure Coding System (HCPC)

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RHC Initial Applications

- Change required approval of CMS-29 sooner in the process
  - To ensure the clinic meets the rural and shortage requirements
- CMS will use the following two websites
  - http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
  - http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx
- I prefer: http://www.raconline.org/amirural/tool

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Physician Quality Reporting System

- Proposed 2% of physician fee schedule payment
  - Reporting in calendar year 2016
  - Payment adjustment in calendar year 2018

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PQRS, CAHs, and RHCs

- RHC services **are not** reported
- RHC providers in hospital, hospital services reported
- Method II services **are** reported
  - 2015 reporting affects 2017 payment
  - 2016 reporting affects 2018 payment
  - 2017 reporting will change to MIPS

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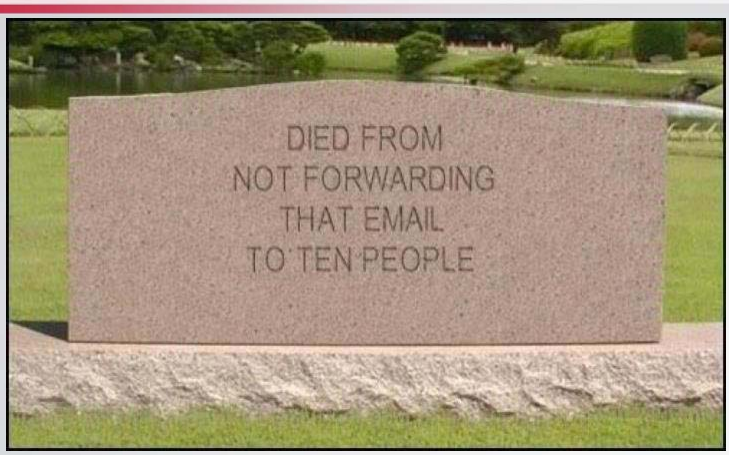

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EHR Reporting Periods

- **Proposed** calendar year reporting starting in 2015
- **Proposed** 90-day reporting period for 2015
  - EPs – any continuous 90-day period in calendar year
  - EHs – any continuous 90-day period from October 1, 2014 through December 31, 2015
- 2016 reporting for full calendar year (EPs and EHs)
- Stage 3 delayed through 2017

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MU Tables

CURRENT

First Payment Year	Stage of Meaningful Use								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
2011	1	1	1	1 or 2*	2	2	3	3	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD
2013			1	1 *	2	2	3	3	TBD
2014				1 *	1	2	2	3	3
2015					1	1	2	2	3
2016						1	1	2	2
2017							1	1	2

PROPOSED

First Year as a Meaningful User	2011	2012	2013	2014	2015	2016	2017	2018
2011	1	1	1	1 or 2*	Modified Stage 2	Modified Stage 2	Modified 2 or 3	3
2012		1	1	1 or 2*	Modified Stage 2	Modified Stage 2	Modified 2 or 3	3
2013			1	1 *	Modified Stage 2	Modified Stage 2	Modified 2 or 3	3
2014				1 *	Modified Stage 2	Modified Stage 2	Modified 2 or 3	3
2015					Modified Stage 2*	Modified Stage 2	Modified 2 or 3	3
2016					Modified Stage 2*	Modified Stage 2	Modified 2 or 3	3

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EHR Penalties

- Two year lag
  - PPS
  - EP
  - ONLY
- CAH in year of noncompliance
  - Settlement

Penalties PPS Hospitals

- Ex: hospital meets MU in 2014, 2015, not in 2016, and then again in 2017
- For October 1, 2017 through September 30, 2018, they receive a 0% market basket update
- No penalties in federal fiscal year 2016, 2017, or 2019

Penalties EPs

- Ex: EP meets MU in 2014, 2015, not in 2016, and then again in 2017
- Penalties in calendar year 2018 equal 97% of Medicare physician fee schedule
- No penalties in calendar years 2016, 2017, or 2019

Penalties CAH

- Ex: CAH meets MU in 2014, 2015, not in 2016, and then again in 2017
- Based on MU for cost report periods ***beginning*** in year of noncompliance
  - December 31 year end = penalties on 2016 cost report (100.33% of cost)
  - September 30 year end = penalties on 2016 cost report (100.33% of cost)
  - June 30 year end = penalties on 2017 cost report (100.33% of cost)
- No penalties in cost report years 2014, 2015, or 2017
  - June 30 hospital: 2015, 2016, 2018

Asset Cost Audit (CAHs)

- When first submitted
- Again at audit
  - REED (doing them on behalf of Noridian) required to view 100% of invoices and contracts
  - Likely your MAC will require 100% of the invoices

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Charity Care Audit

- Charity care by patient name
  - Sample including application and bank statements required
  - Is it worth it?

	With CC	W/O CC
Medicare (including HMO days)	355	355
Total inpatient days	500	500
Total hospital charges	24,000,000	24,000,000
Total charity care charges	500,000	-
EHR cost	400,000	400,000
HIT incentive payment	370,043	364,000
Difference of		6,043

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MU Criteria Audit

- Will require support for **all** measures
- Will request additional support if something is not sufficient
- Be tenacious and follow up
- Pass or fail
- Can appeal
  - Must show why you meet the measure
  - Include support only if not given to auditor
    - With explanation of why it wasn't given to auditor

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Medicaid Reporting

- MU feeds off of Medicare
- REGISTRATION AND REQUEST FOR PAYMENT DOES NOT

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OIG EHR Audits

- On-site audits (2-3 weeks)
- Will cover numerous years and stages
- Intended to see how well the program is functioning
- No word on paybacks
- Auditing states payments as well
- 15 days to respond to letter (22 questions)

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CAH Distance Requirement

- Why? CAHs are paid 101% of cost
- 2/3 of CAHs are necessary providers
- CMS does not have authority to decertify
  - Estimated 449 million in 2011 (based on 15 or more miles)

CAH Distance Requirement

- OIG recommendation: CMS seek legislation that removes the grandfathered NP exemption to the distance requirement
- CMS concurred with NP grandfathering, but pointed to the President's budget (10 miles limitation)
- OIG does not think that is enough

OIG Activity

- CAHs – distance requirement
- RHCs – distance requirements
- CAH – swing beds
- CAHs – coinsurance
- Provider-based locations
- PPS look-back period

RHC Location Requirements

- RHCs have two distance requirements
  - Rural
  - HPSA/MUA
- OIG noted over 500 RHCs did not meet one of these requirements
- BBA allowed for CMS to define “essential providers”
- CMS cannot decertify RHCs without first defining “essential providers”
- CMS has issued two proposed rules
- CMS did not concur or nonconcur
  - “Thanks!”
  - Funny?

CAH Coinsurance

- PPS hospital coinsurance is 20% of fee schedule
- CAH coinsurance is 20% of ***charge***
- OIG estimates patients are paying for "nearly half" of the cost

CAH Coinsurance

	Amounts	Calc. %
Charges	25,000,000	
Laboratory charges	3,500,000	
Charges net of laboratory	21,500,000	
Costs	12,000,000	
101% of cost	12,120,000	
Patient's portion*	4,300,000	36.77%
Patient's deductible (from PS&R)	100,000	
Medicare's portion is the remainder	7,720,000	63.23%
Less sequestration	(154,400)	
Total payment	11,965,600	100.00%
** 20% of charges, less laboratory*		

CAH Coinsurance

- OIG recommends: CMS seek legislative authority to modify CAH OP coinsurance
- CMS response: “we look forward to working with you in the future”

CAH Swing Beds

- Swing bed services paid cost at CAHs
  - Same care as skilled nursing home stays
  - Skilled nursing home stays paid based on RUGs
- OIG estimates 4.1 billion in savings over a 6-year period
- OIG does not account for the capacity at a CAH and the cost CMS is already reimbursing
- CMS finds issue with the calculation method, the difference in acuity, and cost to transfer to a different facility
  - Agrees payment is high

PPS DRG Window

- Currently 3-days
- Study done on 14-day
- OIG recommendations:
  - Seek legislation to increase DRG window
  - Seek legislation to include other affiliates in the look back such as
    - Affiliated hospital groups
  - Notes they have done this study repeatedly and CMS has not sought legislation
  - Estimates $24 million per day savings for the first four days and $15.9 for additional days after
- CMS does not concur and points out there is not a specific days requested and it is not in the President's budget

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OIG Work Plan

- IP vs. OP under the 2-midnight rule
- Cost savings if there were salary caps on the cost report
- Review of provider-based locations (review to see if they meet or do not meet CMS' criteria)
- Comparison of provider-based to free-standing clinics
- Review for duplicate graduate medical education payments

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QUESTIONS?

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