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# Regulatory Recap: 2015 Medicare Update

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In this update, we cover changes to regulations and emerging issues covered in the final inpatient prospective payment systems (IPPS) and proposed hospital outpatient prospective payment system (OPPS) rules.

The Centers for Medicare & Medicaid Services (CMS) continues to focus on tightening payments while enhancing the compliance, quality, and safety requirements of facilities nationwide. While the issues listed below are specific to acute care hospitals, CMS has implemented similar changes for post-acute providers as well, especially in skilled nursing facilities.

While CMS continues to transition providers to the new world of low cost and high quality, the administrative burden of keeping up is increasing at an exponential rate. This article doesn't cover everything providers will be faced with, but here are the key issues to be aware of in the coming months as well as insight on what your health care organization can do to stay ahead.

**Reporting Quality Data Pays**

Acute care hospitals that report quality data and function as meaningful users of electronic health records (EHRs) will receive a 0.90 percent increase in their operating diagnosis-related grouping (DRG) payments for discharges on or after October 1, 2015, according to the IPPS rule. Acute care hospitals that don't report quality data will lose a quarter of the market basket update, or -0.60 percent, and they stand to lose half of the market basket update, or -1.20 percent, if they aren't meaningful users of EHRs. Hospitals, meanwhile, would lose three-quarters of the market basket update, or -1.80 percent.

The CMS describes market baskets as a fixed-weight index because it gives you input as to how much more or less it would cost, at a later time, to buy the same goods and services purchased in a base period. Within CMS payments systems, market baskets are used to update payments and cost limits and reflect input price inflation facing providers in the provision of medical services.

CMS updates the DRG base payment rate each year to account for the changes in market basket pricing. The market basket update is then reduced by various factors that incorporate CMS's methodology of keeping the overall IPPS spending budget neutral year over year. Sole

community hospitals will receive a market basket increase to their hospital-specific payment rates consistent with hospitals receiving traditional DRG reimbursement, and rural sole community hospitals will continue to receive a 7.1 percent add-on for outpatient services paid under OPPS.

**EHR Reporting Periods**

EHR reporting periods are now a calendar year. If a hospital is demonstrating meaningful use for the first time in 2016, the period will be any continuous 90-day period within 2016 or one full year. If a hospital met meaningful use prior to 2016, the period will be one full calendar reporting period for 2016. Attestations are due February 28, 2017.

**Uninsured Levels Drop**

The disproportionate share and uncompensated care pool continues to decline from prior years due to the Congressional Budget Office's estimate that the overall rate of uninsured Americans has declined with the expansion of Medicaid coverage and the existence of health insurance exchanges. For 2016, the Congressional Budget Office estimates the uninsured level dropped to 11.5 percent from 18 percent in 2013. This accounts for a $1.3 billion decrease to the disproportionate share-uncompensated care pool from the prior year, which now totals $6.4 billion that's distributable to hospitals in the final IPPS rule.

**Modifications for Purchasing, Readmission Reduction**

In the final rule, CMS continues to modify the value-based purchasing and readmission reduction programs. For the value-based purchasing program, CMS is adding a care coordination measure beginning with the fiscal 2018 program year and a 30-day mortality measure for chronic obstructive pulmonary disease beginning with the fiscal 2021 program year. For the readmission reduction program, CMS is adding a readmission measure for coronary artery bypass grafting with the fiscal 2017 program year. In continually adding measures, CMS is demonstrating a continued commitment of its transition from volume-based to quality, value-based care.

**Lower Outlier Threshold**

The final IPPS outlier threshold for federal fiscal year 2016 will be $22,544 compared with the proposed threshold of $24,485. CMS estimates the threshold will result in outlier payments of 5.1 percent of total operating DRG payments. CMS continually revisits the outlier threshold each fiscal year to account for costing changes. Outlier payments continue to attract scrutiny from CMS due to the calculations sensitivity to charging practices on the part of the provider. Organizations must continually revisit their charging practices to ensure their prices reflect both the marketplace and the acuity of their patient population.

**Low-Volume Adjustment Extended**

The low-volume adjustment for hospitals with less than 1,600 Medicare discharges that are more than 15 road miles from the nearest IPPS hospital will continue to receive the add-on to inpatient reimbursement through September 30, 2017. The adjustment was extended through the Medicare Access and CHIP Reauthorization Act of 2015. Applications for the low-volume add-on were due to your Medicare administrative contractor (MAC) on September 1, 2015. While the add-on is approved by the Medicare Part A MAC, the provider's payer contracting department should ensure they're also receiving the add-on from the Medicare Part C (Advantage) plans.

**ICD-10 Live as of October 1**

With the transition to International Classification of Diseases—version 10 (ICD-10), CMS has agreed to allow Medicare Part B physician claims submitted to the Part B Medicare carrier to be paid for one year after the October 1, 2015, ICD-10 go-live date—even if coding is wrong. To qualify for payment, the ICD-10 code must be within the same family of codes. If a carrier can't resolve administrative claim issues, CMS may advance payment to the applicable physicians. The grace period doesn't apply to inpatient hospital services.

**Two-Night Stay or Less**

CMS will allow hospitals to admit and bill as Medicare Part A patients who are expected to stay less than two midnights on a case-by-case basis. The medical record documentation must support the admitting physician's determination and will need to demonstrate that the patient may experience an adverse event if discharged or is displaying

severe signs or symptoms. CMS will also begin using quality integrity organizations as first-line reviewers of short-stay cases. If a hospital demonstrates a continued error rate, the cases will be referred to a recovery audit contractor for follow-up.

**Natural Disasters**

The CMS is adding an "extraordinary circumstances exception" for hospitals in areas with a history of natural disasters.

**Reinstatement, Withdrawal of Appeals**

Beginning July 1, 2015, new rules are effective regarding reinstatement and withdrawal of appeals before the Provider Reimbursement Review Board. Hospitals now have potential recourse should the MAC agree to reopen a cost report upon the termination of an appeal. Should the MAC go back on its written word, providers have the ability to file a motion to reinstate their prior appeal.

**Reduction for Ambulatory Payment Classification**

In the proposed rule for OPPS, CMS included a 2 percent reduction in the updated ambulatory payment classification (APC) conversion factor. CMS says the reduction is needed to equalize excess packaged OPPS laboratory test payments that were paid separately in calendar year 2014. Along with the 0.6 percent reduction for multifactor productivity and a 0.2 percent statutory reduction mandated by the Affordable Care Act (ACA), the offsets bring the 2.7 percent market basket update to a 0.1 percent decrease for calendar year 2016.

**Point of Service Codes Established**

Modifiers were established to report all services in provider-based, off-campus departments. Effective January 1, 2016, CMS proposes new point of service (POS) codes for hospital outpatient departments:

- POS 19 is to be used for an outpatient hospital—off campus
- POS 22 was renamed to outpatient hospital—on campus
- POS for teleradiology services are based on where the facility portion of the visit occurred

CMS also proposed to expand the comprehensive APC system (C-APC). The comprehensive service is a primary service, which will be identified with "J1" on the claim form. All adjunctive services are provided to support primary delivery, and payment will be packaged for the adjunctive services. CMS established 25 C-APCs in calendar year 2015, and nine C-APCs are proposed for calendar year 2016. A C-APC is also proposed for observation services.

**Chronic Care Management Expansion**

CMS discussed the continued expansion of the chronic care management (CCM) program. CCMs are comprehensive care plans established and billed as current procedural terminology code 99490 for two or more chronic conditions that are expected to last more than 12 months and place the patient at significant risk. In calendar year 2016 and subsequent years, CCMs may be billed when services are provided to either an inpatient or registered outpatient within the past 12 months.

**We're Here to Help**

Moss Adams continuously reviews the regulatory and tax landscape for the health care industry as it relates to ancillary health care services, health plans, hospitals, long-term care, and medical groups and physicians. For more information about any of the issues discussed above, or for insight on how they may impact your organization, contact your Moss Adams professional.

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