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The 2018 Budget Act: Several Changes Affecting Hospitals

Hospital Changes

Low Volume: Prospectively paid hospitals meeting low-volume criteria are eligible for a percentage add-on to their prospective payments. The Affordable Care Act (ACA) extended this program to temporarily increase the number of hospitals qualifying for the add-on payment, and had repeatedly been extended through September 30, 2017.

The Budget Act extends the program, as delineated in the ACA, through federal fiscal year 2018. However, for federal fiscal years 2019 through 2022, the definition of low-volume hospitals is temporarily changed from both the statutory and the ACA's definition, most notably in the fact that the number of discharges to qualify shifts from Medicare discharges to total discharges, as detailed below

- 2018: A PPS hospital qualifies as a low-volume hospital if there are fewer than 1,600 Medicare discharges and the hospital is located 15 or more miles from the next nearest PPS hospital. The payment add-on is on a linear scale, from 25 percent at 200 or fewer Medicare discharges to 0 percent for greater than 1,600. Medicare discharges
- 2019 through 2022: A PPS hospital qualifies as a low-volume hospital if there are fewer than 3,800 total discharges and the hospital is located 15 or more miles from the next nearest PPS hospital. Payment add-on is on a linear scale from 25 percent for 500 or fewer total discharges to 0 percent for greater than 3,800 total discharges.

DZA will reach out to our clients who qualify. If you think you qualify and would like assistance, please call us at 509.321.9485.

Medicare Dependent Hospitals: The Medicare dependent hospital (MDH) payment program has been extended through federal fiscal year 2022.To qualify, the hospital must meet all of the following:

- be located in a rural area,
- have 100 or fewer beds,
- not be a sole community hospital
- Medicare must account for at least 60 percent of their IP days or discharges, based on two out of the three most recently audited cost reports

If a hospital qualifies, they must request to be part of the program. Inpatient services would be paid on a cost-basis that is converted to a target amount per discharge.

Physician Geographic Floor: Physician payments are geographically adjusted, based on the amount of physician work, practice expense, and malpractice insurance expense estimated in various locations.

These geographic differences lead to differences in operating expenses from region to region. The average operating expenses are used to derive an index of average operating costs. Those states or regions with expenses lower than the average are given a geographic adjustment of less than one based on where they lie within the geographic index, and those whose operating expenses are higher than the average are given a geographic adjustment greater than one.

The current floor geographic adjustment expired December 31, 2017. However, the Budget Act extends a temporary provision through December 31, 2019, which sets a minimum (floor) adjustment of one. Those areas with lower geographic operating expenses benefit from the geographic floor.

Ambulance Add-on: The Act extends ambulance add-on payments through December 31, 2022. Ambulances transporting patients originating in the following areas receive the following add-ons:

- urban area: 2 percent add-on
- rural area: 3 percent add-on.
- super rural: 22.6 percent add-on, based on originating zip code. For a complete listing, go to http://www.cms.gov/M. edicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html?redirect=/AmbulanceFeeSchedule/. The super rural indicator is "B." Choose "End of Year Zip Code File" under downloads.

Rural Home Health Add-on: The home health rural add-on has been extended and revised in the following ways:

1. CMS will calculate rural counties home health episodes furnished per 100 Medicare eligible individuals. For counties landing in the highest quartile:
    a. For calendar year 2019: 1.5 percent increase
    b. For calendar year 2020: .5 percent increase
2. Rural counties with six or fewer individuals per square mile:
    a. For calendar year 2019: 4 percent increase
    b. For calendar year 2020: 3 percent increase
    c. For calendar year 2021: 2 percent increase
    d. For calendar year 2022: 1 percent increase
3. For all other rural counties
    a. For calendar year 2019: 3 percent increase
    b. For calendar year 2020: 2 percent increase
    c. For calendar year 2019: 1 percent increase

CMS will use 2015 paid claims data and the 2010 census to calculate the population of rural Counties and the home health utilization. There is no administrative review of the calculation. Once CMS has determined which type of rural county your home health falls into, you will remain with those percentage increases through 2022.

Therapy Caps: Physical, occupational, and speech therapy caps have been removed for services on or after January 1, 2018.

The threshold for medical review was decreased to $3,000 through 2028, after which that amount will increase yearly based on the Medicare Economic Index.

Hospital EHR: Currently, the electronic health records program (EHR) requires CMS to calculate more difficult reporting measures. From the beginning of the program CMS has proposed three stages of meaningful use (stages 1, 2, and 3), and if a hospital is unable to meet the required EHR stage, a hardship exception is in place for which they could potentially apply for.

The Budget Act removes the language in the Social Security Act that requires "more stringent measures of meaningful use."

The intent is that with less stringent measures, fewer hospitals will need hardship exceptions to meeting the meaningful use criteria.

Outpatient Physician Supervision of Therapeutic Services: In a startling move I like to call "Congress has no idea what CMS is doing," Congress extended non-enforcement of outpatient physician supervision rules for small rural hospitals through 2017. CMS previously extended the non-enforcement of outpatient physician supervision for small rural hospitals through 2019.

Medicaid DSH Allotments: As partial payment for the ACA (which, as signed into law, was budget neutral), state disproportionate share payments are set to decrease. The thinking was that if more people are insured theoretically hospitals would have less need to cover the cost of uninsured patients. Since implementation of the ACA, the amount of the Medicaid DSH decreases has been pushed out several times.

The Budget Act pushes the decrease in Medicaid DSH payments to 2020. In 2020, Medicaid DSH will decrease by $400,000,000 (this amount is the same amount that was scheduled for 2020). For each year in 2021 through 2025, Medicaid DSH will decrease by $8,000,000,000 (this is an increase of the prior decrease amount). .

Physician Payments Changes

Dialysis Telehealth: Patients with end stage renal dialysis receiving home dialysis can do monthly clinical assessments via telehealth starting January 1, 2019.

To qualify, the patient must first have a face-to-face encounter with a practitioner monthly the first three months of home dialysis and at least every three months after that.

A facility fee cannot be billed for the telehealth provided in the patient's home.

Telehealth for Stroke Victims: Some physician services are allowable via telehealth as long as the patient is at an approved originating site. Telehealth service provided at an originating site can bill Medicare a facility fee.

For services on or after January 1, 2019, CMS has been tasked with defining additional originating locations for acute stroke victims. A Medicare beneficiary can receive physician services via telehealth to "diagnosis, evaluation, or treatment of symptoms of an acute stroke" outside of the current originating site list, including a mobile stroke unit or other location deemed appropriate by CMS. However, for these new originating sites (as defined by CMS), facility fees cannot be billed for telehealth services provided.

Merit-based Incentive Payment System (MIPS): MIPS reporting began in 2017 and payments based on this data begins for service on or after January 1, 2019. For each physician, their Medicare payment is

based on a composite score based on their performance in four categories: quality, improvement activities, advancing care information, and cost. The weighting of each category is statutorily set.

Congress is allowing CMS flexibility in the weighting of resource use or the cost of services for five years (three additional years), allowing for a more gradual transition to the MIPS program.

We anticipate CMS will continue to calculate the cost portion for the physicians, but the weighting of that category will stay at zero or at least below its final calculation of 30 percent.

Base Physician Fee Schedule: Under the MIPS program, the base physician fee schedule was set to increase at .5 percent in 2019. However, with the Budget Act, 2019 will see .25 percent increase instead.

Remember that years 2020 through 2025 will have no increase to the base physician fee schedule. The only increase a physician can receive from Medicare is through performing better under the MIPS program.

Physicians Assistants to Provide Services to Hospice Patients: For services performed on or after January 1, 2019, physician assistants can be the attending physician for hospice patients; however, initial certification must still be performed by a medical doctor and the hospice's medical director.

Mid-level Supervision of Cardiac Rehabilitation: Currently, outpatient physician supervision rules require physician supervision of cardiac, intensive cardiac, and pulmonary rehabilitation services. Services on or after January 1, 2024 can be supervised by a medical doctor, nurse practitioner, physicians assistant, or clinical nurse specialist.

Miscellaneous Changes

Dialysis Facility Accreditation –Dialysis accreditation can now come from other organizations approved by CMS.

Home Health Payment Reform – CMS has been tasked with coming up with a 30-day episode for home health, beginning with services provided in 2020. The current unit of payment is a 60-day episode of care.

Statutorily, this change must be budget neutral.

Closing

CMS will issue rules to comply with the new law for each of the above items. We will update you as those regulations are proposed.

If you have questions or require additional information, please call me at 509.321.9485.