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Final MOON Released

CMS has released the final version of the Medicare Outpatient Observation Notice. Hospitals and critical access hospitals are required to provide this form to all Medicare patients who have been in observation status for more than 24 hours starting March 8, 2017. Early implementation is allowed.

A copy of the final form can be found on CMS' website: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html

Change in the President of the United States of America

In January, Donald Trump will take over as the President of the United States of America. As part of his platform, he (as well as the Republicans in Congress) has sworn to overturn the affordable care act (ACA). The repeal of the affordable care act will significantly affect many hospitals.

The ACA began as a concept from the Heritage Foundation, a politically conservative think tank. It was thought by conservatives at the time to be a good alternative to a single payor system.

The republican's issue with the law appears to be the individual mandate. The ACA is a robust law with many changes. Below are a few highlights from the ACA.

1. Expanded 340B covered facilities to include critical access hospitals. It also expanded 340B covered facilities to include rural referral centers and sole community hospitals as covered entities at a lower disproportionate share percentage.
2. Removed lifetime limits for insurance coverage. For those with chronic illnesses, the lifetime limit can come rather quickly. Based on family experience, once those limits are hit, the patient is without healthcare until deemed disabled. Once disabled they may qualify for Medicare. Once indigent they will qualify for Medicaid. Removal of lifetime limits helps ensure those that are able to still work and pay into our system can.
3. Allows for parents to keep their children on health insurance up to the age of 26. This provision expanded the number of college age children who have insurance coverage.
4. It allows states to expand Medicaid.

5. Prohibits insurance plans from resending insurance due to a mistake on the application form (fraud is another story).
6. Added wellness visits as covered services for Medicare beneficiaries.
7. Established a PPS payment system for federally qualified health centers (FQHCs).
8. Added non-provider time to allowable resident time for graduate medical education (GME) and indirect medical education (IME). This increased the FTEs that a teaching hospital could report and as long as the FTEs were not greater than the FTE cap, payment is increased.
9. Increased Medicaid prescription drug rebates from 15.1% to 23.1%.
10. Requires health insurance companies to report the percentage of total premium revenue spent on clinical services and the percent spent on administrative costs.
11. Requires health insurance companies to cover preventative health services without cost sharing (no copay).
12. It established the readmissions reduction, value-based purchasing, and hospital acquired conditions programs.
13. It changed how hospitals are paid for disproportionate share by Medicare (added the uncompensated care calculation).
14. It includes the mental health parity act which essentially requires insurers to cover mental health issues on the same level as other outpatient continuing services (like physical therapy).

Please consider writing your congressional leaders to help them understand the effect a full repeal of the ACA will have on your facilities. For you critical access hospitals, this should at a minimum request that you remain a covered entity with regards to the 340B discount drug program.

21st Century Cures Act

President Obama signed into law the 21st Century Cures Act on December 13, 2016. Highlights from the law follow:

Outpatient Supervision in Small Rural Hospitals – Hospitals are required to have physician supervision for all outpatient therapeutic services except for services listed on CMS' website as exemptions.

Small rural hospitals and critical access hospital have been operating under an exception to the enforcement of this rule. The exception for these facilities has been extended through the end of 2016.

The exception to the enforcement rules has been on-going for several years. In this portion of the law, Congress requests that the Medicare Payment Advisory Commission (MedPAC) report on the effect the exception has on "access to health care by Medicare beneficiaries, on the

economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries."

Off-campus Provider-based Locations – the Bipartisan Budget Act of 2015 (the Budget Act) requires site-neutral payments for new off-campus provider-based locations. The reading of the Budget Act states only off-campus locations that were billing as provider-based before November 2, 2015, would be grandfathered and paid under the hospital level payment system.

Section 16001 of the 21st Century Cures Act adds additional language to the existing law –

- Grandfathered off-campus sites now also include those sites that had submitted attestation to their Medicare Administrative Contractor for a location before December 2, 2015. These sites are considered "deemed" to have met the requirement to be billing as provider-based as of November 2, 2015.
- For services provided January 1, 2018, and thereafter, an off-campus provider-based location may be grandfathered in under the hospital level payment system if they comply with each of the following:
    - The hospital sends CMS an attestation by February 11, 2017 (received by CMS date) that the department location met the provider-based requirements
    - The department location is included as a location on the hospital's enrollment form (i.e. included as a location in PECOS).
    - The hospital's CEO or COO certifies to CMS in writing that the hospital had a "binding written agreement with an outside unrelated party for the actual construction" of the off-campus department location. Please note that the certification must be **received** by CMS on or before February 11, 2017, and signed by either the **CEO or COO** of the hospital. The CFO or reimbursement manager cannot certify for this purpose.

Extension of the Rural Community Hospital Demonstration Program – the rural community hospital demonstration program allows for small rural hospitals that do not meet the requirements to be a critical access hospital an alternative payment methodology. Specifically, a potential hospital has fewer than 51 beds and is located in a rural area in one of the 20 states with low population density.

The extension of this program also expands the eligible hospitals to any state, but priority will be given to hospitals in one of the 20 low population density states.

The alternative payment is a cost per discharge for inpatient services based on the cost per discharge from the first cost report while under the program. Subsequent years are paid this cost-per-discharge inflated using the PPS market basket updates.

The program has been extended for five years. Applications for interested hospitals will be available on CMS' website shortly.

If you are a small rural hospital, we recommend contacting your DZA representative to talk about the feasibility of this program.

Telehealth Services – CMS and MedPAC have been charged with providing Congress with information on how telehealth services are utilized. Specifically, MedPAC is to report on the telehealth services that Medicare covers and the telehealth services that other insurers cover. Telehealth services allowed by other insurers but not Medicare will then be analyzed to see if they too should be part of Medicare-covered services.

Congress also indicated they believe the current telehealth originating sites (the location of the patient) should be expanded.

Additional movement on allowable telehealth services will be forthcoming based on these reports. However, the reports do not seem to address adding RHCs as a distant site (site of the physician) location.

Medicare Price Transparency – starting in 2018 Congress has mandated that CMS provide beneficiaries with a website where they can look up services that will be provided in either a hospital outpatient setting or an ambulatory surgical center (ASC). For each service, based on the location, it should tell the patient the approximate Medicare payment and the approximate amount that will be the patient's responsibility.

While providing information to Medicare beneficiaries is certainly a good idea, I worry about the effect this will have on critical access hospitals. Coinsurance at a critical access hospital is based on charge and not fee schedule. Therefore, patients looking up an area may have the wrong idea of what their cost-sharing will be. Additional review of this part of the law will be necessary.

Closing

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