WISCONSIN HOSPITAL ASSOCIATION

The Valued Voice

WHA's Member Newsletter

August 7, 2018 Volume 62, Issue 32

Table of Contents [click on title to go directly to story]

CMS Issues Final 2019 IPPS Rule

The Centers for Medicare & Medicaid Services (CMS) issued its final 2019 Inpatient Prospective Payment System (IPPS) rule on August 2. Overall, the rule will increase hospital payments by about 1.35% or around $4.8 billion in FY2019. This reflects a market basket update of 2.9%, a 0.8% productivity reduction, a 0.75% reduction required by the Affordable Care Act, and a 0.5% increase to restore cuts made in the American Taxpayer Relief Act of 2012 relating to documentation and coding changes.

WHA will analyze the final rule in the coming weeks and will hold a webinar for interested members, so stay tuned for more information. In the meantime, an overview of some of the main provisions are below and CMS has a factsheet and text of the final rule on its website.

- **Electronic Health Records (EHR)** – renames the EHR Incentive Program as the Medicare and Medicaid Promoting Interoperability Programs. The new program will have a 90-day reporting period beginning in 2019, with fewer objectives that will be more targeted to streamline the program. This will include finalizing two new e-prescribing measures for opioids and Schedule II controlled substances.

- **Reducing and Deduplicating Quality Measures** – finalizes the removal of 18 measures from the inpatient quality reporting program that are no longer relevant or where the cost of reporting the measures outweighs their value. It also removes redundancy of 21 inpatient quality reporting (IQR) measures. However, CMS did not finalize its proposal to remove the safety measure domain from hospital value-based purchasing programs.

- **Boosting Payments for Medical Innovations** – contains an increase for new technology add-on payments for chimeric antigen receptor t-cell (CAR-T) therapies, as well as 9 of the other 11 applications discussed in the proposed rule.

- **Updating Price Transparency Guidance** – requires hospitals to publicly post their charges in machine-readable format, and update them at least annually, or more often as appropriate. CMS is holding off on additional price transparency initiatives, such as issues related to surprise billing issues commonly associated with out-of-network radiologists and anesthesiologists, until it receives additional feedback. *Note: WHA is analyzing these guidelines to determine if updates are needed in the WHA PricePoint platform which helps hospitals provide standard online charges in a consumer-friendly format.*

- **Long-Term Care Hospital (LTCH) Changes** – updates the LTCH PPS standard federal payment rate by 1.35%, which CMS projects will increase LTCH PPS payments by approximately 0.9%, or $39 million in FY 2019. The rule also finalizes CMS' proposal to eliminate the 25% threshold policy, which limited the share of an LTCH's cases that could be admitted from certain referring acute care hospitals.

One other area of interest to WHA members is related to the Medicare area wage index. CMS notes it has begun the process of making geographic payments more equitable for rural hospitals to the extent permitted under current law by finalizing its proposal to allow the imputed wage index floor to expire for all-urban states (MA, NJ, RI). CMS says it looks forward to continuing work on geographic payment disparities.

Attorneys to Help Navigate NP and PA Regulatory Issues at WHA Event

Register today for WHA APC Conference on September 13

Attorneys from Hall Render, Quarles & Brady, and WHA will present a comprehensive review of key regulations and payment policies impacting organizations that employ advanced practice clinicians and providers during the morning sessions at the upcoming one-day WHA program, "*WHA Advanced Practice Clinician Conference: A Comprehensive Look at APC Practice Challenges and Opportunities for Integrated Care Delivery in Wisconsin"* in Wisconsin Dells on September 13.

The presentations will help answer questions on advanced practice provider and clinician licensure, scope of practice, compliance, billing and reimbursement and other regulatory issues regularly received by WHA.

Sarah Coyne, partner with Quarles & Brady, and Matthew Stanford, WHA general counsel, will team up on the opening session, during which they'll share an overview of the current regulatory landscape that affects NP, PA and other advanced practice provider and clinician practice and will discuss WHA's team-based care regulatory reform initiative.

Lori Wink, attorney for Hall, Render, Killian, Heath & Lyman, will then present a session focusing on understanding and navigating billing compliance complexities and requirements to help organizations receive payment for services provided by advanced practice providers and clinicians and to reduce risk from potential audits and allegations of fraud and abuse.

In addition to legal and regulatory topics, WHA's one-day conference will also include presentations and panels focusing on education and training of advanced practice providers and clinicians, and recruitment, retention and utilization trends of advanced practice providers and clinicians in integrated care organizations.

Register today for this important WHA conference.

A full conference brochure can be viewed here. Registration questions can be directed to Kayla Chatterton or call 608-274-1820.

CMS Changes in Nursing Home Reimbursement Will Impact Post-Acute Care

Significant changes in the methodology for skilled nursing facility reimbursement were finalized in a rule published by the Centers for Medicare and Medicaid Services (CMS) on July 31, 2018.

- The first major change implemented in this rule is the Patient-Driven Payment Model (PDPM). The PDPM, which will take effect October 1, 2019, focuses on the patient's condition and resulting care needs to determine Medicare payment, rather than on the amount of care provided. According to the Centers for Medicare & Medicaid Services (CMS), the PDPM adjusts Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries, such as drugs and medical supplies. The goal is to more accurately address costs associated with medically complex patients. This change could respond to a concern of WHA's Post-Acute Care Work Group, which found that transitions to post-acute care for medically complex patients can be hampered by the difficulty skilled nursing facilities (SNFs) incur in absorbing high costs for these patients. The PDPM model also limits the use of group and concurrent therapy to 25% of all therapy given. The therapy limits have been identified by some SNF providers as an area of concern.

- The SNF Quality Reporting Program (QRP) applies to SNFs affiliated with acute care facilities, freestanding SNFs, and swing-bed rural hospitals (except for critical access hospitals). CMS did not add any new measures to the QRP in the final rule, but will implement one change when evaluating measures for removal from the SNF QRP measure set. The additional factor will consider costs associated with a measure and weigh them against the benefit of its continued use in the program.

- The rule also implements an $820 million increase in Medicare payments to SNFs in fiscal year 2019, resulting from the SNF market basket update required to be 2.4% by the Bipartisan Budget Act of 2018.

WHA will monitor the impact of these proposed changes on Wisconsin SNFS, many of whom are important post-acute care providers for patients who are discharged from Wisconsin hospitals. For further information, contact Laura Rose, WHA Vice President for Policy Development.

CMS.gov Risk Adjustment Payments Will Resume

On July 24, the Centers for Medicare & Medicaid Services (CMS) posted a final rule indicating it will initiate $10.4 billion in risk adjustment transfers in September for benefit year 2017.

The Affordable Care Act (ACA) created the risk adjustment program to transfer funds in the individual and small group health insurance markets with lower-risk enrollees to health plans with higher-risk enrollees to spread the financial risk and help stabilize premiums. Earlier this summer, CMS announced the transfers were on hold due to litigation. Later this year, CMS intends to issue a new proposed rule on the risk adjustment methodology for the 2018 benefit.

Attorneys General File Association Health Plans Lawsuit

On July 26, Attorneys General (AGs) from 11 states and the District of Columbia filed a lawsuit challenging the Trump Administration's final rule pertaining to Association Health Plans. The rule, issued June 19, allows small firms and self-employed individuals to band together to purchase insurance across state lines and across industries.

The AGs cited concerns with the proposal include the potential to draw healthier, younger enrollees from the exchange market (estimates suggested as many as 4.3 million by 2023), and that the policy change could lead to exchange premium increases.

The lawsuit claims the rule "upends a decades-old understanding of a foundational employee benefits law for the purpose of exempting a significant portion of the health insurance market from the Affordable Care Act's consumer protections."

Short Term Limited Duration Plans Approved

On August 1, the Trump administration extended the allowable terms of "Short Term Limited Duration Plans." Instead of the current limit of three months, the policies will be available for 12 months at a time, and customers will be able to renew the policies for additional years. A federal analysis accompanying the new rules estimates that 600,000 extra people will buy such plans next year, increasing to 1.6 million within four years.

The plans can deny consumers coverage for having pre-existing conditions or charge them more based on their health status. The plans also do not have to cover the Affordable Care Act (ACA) 10 essential health benefit categories, such as maternity care or prescription drugs.

Federal health officials have portrayed this expansion of alternative coverage as a way to make insurance more affordable. When the proposal was announced earlier this year, it was met with opposition from the health insurance industry, hospitals, and patient advocacy groups. In comments submitted on the proposed rule in April, WHA highlighted concerns about short-term insurance policies being exempt from aspects of the ACA that are meant to protect consumers, as well as the potential impact on the individual market.

"Today's final rule will reintroduce to an already shaky individual market health plans that do not constitute true 'insurance,'" said AHA President and CEO Rick Pollack on August 1. "While these products may be appealing because of their cheaper price tag, the reality is that they could end up costing a patient far more by covering fewer benefits and ensuring fewer critical protections, like covering pre-existing conditions. Patients could find themselves responsible for their entire medical bill without any help from their 'health plan.' For providers, these products will lead to increased bad debt, with underinsured patients unable to afford the care they need but that is not covered."

The final rule goes into effect 60 days after it is posted, though state regulators still need to approve new plans. The plans are effectively banned in New York, New Jersey and Massachusetts, and several other states, such as California and Minnesota, impose restrictions on the policies.

WHA Member Forum:
Using Video Monitoring to Reduce Readmissions

On August 22, plan to attend the WHA Member Forum, ***"My Care, My Home: Using Video Monitoring to Reduce Readmissions."***

This complimentary webinar will focus on the use of video-monitoring devices in long-term care and patient home settings to reduce avoidable emergency room visits and inpatient stays. Registration is available online.

During the webinar, Lois Van Abel, Bellin Health's Director of Care Coordination, will describe how Bellin Health Partners, a CMS Next Generation Accountable Care Organization (ACO), uses video monitoring in long-term care settings and at the patient's home to prevent high-cost care utilization for certain patients suffering from chronic conditions. Van Abel will also share available data about the ACO's strategic use of telehealth, as well as any lessons learned.

This webinar has been designed for telemedicine program managers, chief operating officers, chief nursing officers, chief medical officers, emergency room directors, chief information officers, discharge planners, and compliance officers.

WHA members are encouraged to pass registration information for this webinar along to other appropriate persons in their organizations.

The webinar is scheduled for
Wednesday, August 22,
from ***10:00 -11:15 am.***

This WHA Member Forum is complimentary and open only to WHA hospital and corporate members.

Register online today!

Contact Kayla Chatterton with registration questions.