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Official CMS news from the Medicare Learning Network

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News & Announcements

CMS Updates Medicare Payment Rates, Quality Reporting Requirements

CMS issued three final rules outlining 2018 Medicare payment rates for skilled nursing facilities, hospice, and inpatient rehabilitation facilities. The final rules are effective for FY 2018 and reflect a broader Administration strategy to streamline administrative requirements for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

“These announcements take important steps to support innovation in the delivery of care in order to promote a Medicare program that is responsive to patients’ unique needs and ensure that patients have access to high-quality skilled nursing, hospice, and inpatient rehabilitative care,” said CMS Administrator Seema Verma. “These rules update quality reporting requirements and allow providers to spend less time and fewer resources on cumbersome paperwork, so they can increase their focus on the needs of Medicare patients.”

Final Rules:

- Hospice: Fact Sheet and Final Rule
- IRF: Fact Sheet and Final Rule
- SNF: Fact Sheet and Final Rule

See the full text of this excerpted Press Release (issued August 1).

Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates

On August 1, CMS issued a final rule that updates FY 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries, and also updates the hospice quality reporting requirements. Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 amends section 1814(i) of the Social Security Act to set the market basket percentage increase at 1 percent for hospices in FY 2018. Hospices will generally see a 1.0 percent ($180 million aggregate) increase in their payments for FY 2018. As mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014, the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025, must be updated by the hospice payment update percentage, rather than the Consumer Price Index. The cap amount for FY 2018 will be $28,689.04 (2017 cap amount of $28,404.99 increased by 1 percent).

The final rule also includes:

- Hospice Quality Reporting Program, including submission exemption and extension requirements for the FY 2019 payment determination and subsequent years
- Hospice CAHPS® Experience of Care Survey
- Public reporting
- Quality measure concepts under consideration for future years
- New data collection mechanisms under consideration: Hospice Evaluation & Assessment Reporting Tool

For More Information:

- Final Rule (CMS-1675-F)
- Hospice Center website

See the full text of this excerpted Fact Sheet (issued August 1).

IRFs: Final FY 2018 Payment and Policy Changes

On July 31, CMS issued a final rule outlining FY 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program:

- CMS is finalizing an update to the IRF PPS payments to reflect a 1.0 percent increase factor, in accordance with section 1886(j)(3)(C)(iii) of the Social Security Act, as added by section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015
- An additional approximate 0.1 percent decrease to aggregate payments due to updating the outlier threshold results in an overall estimated update for FY 2018 of approximately 0.9 percent (or $75 million), relative to payments in FY 2017
- CMS will continue to maintain the facility-level adjustment factors at current levels as we continue to monitor the most current IRF claims data available to assess the effects of the FY 2014 changes
- FY 2018 is the third and final year of the phase-out of the 14.9 percent rural adjustment for the 20 IRF providers that were designated as rural in FY 2015 and changed to urban under the new Office of Management and Budget delineations in FY 2016

The final rule also includes:

- Removal of 25 percent payment penalty for late transmissions of the IRF Patient Assessment Instrument (IRF-PAI)
- Refinements to the 60 percent rule presumptive methodology
- Removal of voluntary item for swallowing status from IRF-PAI
- Sub-regulatory process for certain updates to presumptive methodology diagnosis code lists
- Use of IRF-PAI data to determine patient body mass index greater than 50 for cases of lower extremity single joint replacement

For more information, view the Final Rule (CMS-1671-F). See the full text of this excerpted Fact Sheet (issued July 31).

SNFs: Final FY 2018 Payment and Policy Changes

On July 31, CMS issued a final rule outlining FY 2018 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). Policies in the final rule continue to build on our commitment to shift Medicare payments from volume to value, with continued implementation of the SNF Value-based Purchasing (VBP) Program.

Based on changes contained within this final rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by $370 million or 1.0 percent, from payments in FY 2017. This estimated increase is attributable to a 1.0 percent market basket increase required by section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015.

The final rule also includes:

- SNF Quality Reporting Program (QRP)
- End-Stage Renal Disease Quality Incentive Program, including updated PY 2020 performance period
- National Healthcare Safety Network Healthcare Personnel Influenza Vaccination Reporting Measure
- Survey team composition

For More Information:

- Final Rule (CMS-1679-F)
- SNF PPS website
- SNF VBP webpage
- Proposed Specifications for SNF QRP Quality Measures and Standardized Data Elements

See the full text of this excerpted Fact Sheet (issued July 31).

SNF Quality Reporting Program: Reconsideration Period Ends August 13

CMS notified Skilled Nursing Facility (SNFs) that are non-compliant with SNF Quality Reporting Program (QRP) requirements for Quarter 4 of CY 2016, which will affect their FY 2018 annual payment update. CMS mailed non-compliance letters and placed them in the Quality Improvement and Evaluation System (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 14.

Providers that received a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 pm PST, August 13. See the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

Antipsychotic Drug use in Nursing Homes: Trend Update

CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease, or Tourette’s syndrome.

In the fourth quarter of 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication; since then there has been a decrease of 34.1 percent to a national prevalence of 15.7 percent in the first quarter of 2017. Success varies by state and CMS region; some states and regions have a reduction greater than 35 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website.

For More Information:

- Visit the National Partnership webpage
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

Vaccines are Not Just for Kids

National Immunization Awareness Month (NIAM) is an annual observance to highlight the importance of vaccinations. All adults should get vaccines to protect their health. Even healthy adults can become seriously ill and can pass certain illnesses on to others. Talk to your Medicare patients about vaccines they may need, including influenza, pneumococcal, and hepatitis B.

For More Information:

- Medicare Preventive Services Educational Tool
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool
- Mass Immunizers and Roster Billing: Simplified Billing for Influenza Virus and Pneumococcal Vaccinations Fact Sheet
- Vaccine and Vaccine Administration Payments Under Medicare Part D Fact Sheet
- Centers for Disease Control and Prevention NIAM website
- NIAM Toolkit

Visit the Preventive Services website to learn more about Medicare-covered services.

Provider Compliance

Reporting Changes in Ownership

A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges.

Resources:

- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article
- 42 CFR 424.516
- Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure OIG Report
- PECOS Enrollment Tutorial - Change of Information for an Individual Provider
- PECOS Enrollment Tutorial - Change of Information for an Organization/Supplier

Claims, Pricers & Codes

ICD-10 GEMS for 2018 Available

The 2018 General Equivalence Mappings (GEMs) are available:

- Diagnosis: 2018 ICD-10-CM and GEMs webpage
- Procedures: 2018 ICD-10-PCS and GEMs webpage

This is the last year that the GEMs will be produced. The 2018 ICD-10-CM Guidelines and Conversion Table will be posted once the Centers for Disease Control and Prevention finalizes them.

Upcoming Events

SNF Quality Reporting Program: Review and Correct Reports Refresher Training Webinar — August 7
Monday, August 7 from 2 to 3 pm ET

CMS is hosting a webinar for Skilled Nursing Facility (SNF) providers. Visit the August 7 Webinar webpage for more information and to register.

Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
Wednesday, August 16 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

The CY 2018 Medicare Physician Fee Schedule proposed rule makes additional proposals to implement the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018, including the payment structure, as well as additional supplier enrollment requirements and supplier compliance standards to ensure program integrity. During this call, CMS experts provide a high-level overview of the proposed policies; participants should review the proposed rule prior to the call. Visit the MDPP webpage for more information.

If time allows, we will open the lines for feedback. Note: feedback received during the listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the comment period on September 11.

Target Audience: Current Centers for Disease Control and Prevention recognized Diabetes Prevention Program organizations; organizations interested in becoming MDPP suppliers, including existing Medicare providers/suppliers, community organizations, not-for-profits; associations, and advocacy groups focused on seniors or diabetes; and other interested stakeholders, including health plans, primary care/internal medicine specialties.

IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
Thursday, August 17 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals for specified domains. During this call, CMS and measure developers will present the Drug Regimen Review (DRR) quality measure for the home health Quality Reporting Program (QRP), which was adopted to fulfill the medication reconciliation domain requirement. A question and answer session follows the presentation.

Agenda:

- Review the goals of the DRR measure
- Review guidance and walk through scenarios for coding the Outcome and Assessment Information Set (OASIS) items used to calculate the measure

You may email questions in advance of the call to PACQualityInitiative@cms.hhs.gov. Questions received in advance of the call may be addressed during the call or used for other materials following the call.

Target Audience: PAC providers, healthcare industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

CMS National Provider Enrollment Conference — September 6 and 7

North Charleston, South Carolina
Wednesday, September 6 from 8 am to 5 pm ET
Thursday, September 7 from 8 am to 4 pm ET

CMS will hold a National Provider Enrollment Conference on September 6 and 7 at the Charleston Area Convention Center in South Carolina. Take advantage of this opportunity to interact directly with CMS and Medicare Administrative Contractor provider enrollment experts. Register and learn more about this conference.

Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Thursday, September 7 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn about the new Facility Assessment Tool to help identify and develop the specific assessment of your facility. Also, find out about frequently asked questions related to revision of the State Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities final rule. A question and answer session follows the presentation.

Speakers:

- Kelly O'Neill, Stratis Health
- CMS Experts

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

Comparative Billing Report on IPPE/AWV Webinar — September 13

Wednesday, September 13 from 3 to 4 pm ET

Join us for a discussion of the comparative billing report on Initial Preventive Physical Examinations (IPPEs) and Annual Wellness Visits (AWVs) (CBR201707), an educational tool for providers who submit claims for these services using Healthcare Common Procedure Coding System (HCPCS) codes G0402, G0438, and G0439. During the webinar, providers interact directly with content specialists and submit questions about the report. See the announcement for more information and find out how to participate.

Medicare Learning Network Publications & Multimedia

Medicare Part B Immunization Billing Educational Tool — Revised

A revised Medicare Part B Immunization Billing Educational Tool is available. Learn about:

- Administration and diagnosis codes
- Vaccine codes and descriptors
- FAQs

The ABCs of the Annual Wellness Visit Educational Tool — Reminder

The ABCs of the Annual Wellness Visit (AWV) Educational Tool is available. Learn about:

- Minimum elements of the Health Risk Assessment
- How to acquire beneficiary information
- How to begin assessment
- How to counsel beneficiary

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