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Official CMS news from the Medicare Learning Network

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- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised

News & Announcements

CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing

On November 30, CMS announced actions that will bolster nursing home oversight and improve transparency in order to ensure that facilities are staffed adequately to provide high-quality care. These actions include

sharing data with states when potential issues arise regarding staffing levels and the availability of onsite registered nurses; clarifying how facilities should report hours and deduct time for staff meal breaks; and providing facilities with new tools to help ensure their resident census is accurate.

“CMS takes very seriously our responsibility to protect the safety and quality of care for our beneficiaries,” said CMS Administrator Seema Verma. “Today CMS is taking important steps to protect nursing home residents based on potential risks revealed by new payroll-based staffing data that our Administration released. We’re deeply concerned about potential inadequacies in staffing, such as low weekend staffing levels or times when registered nurses are not onsite, and the impact that this can have on patient care. The actions announced today strengthen our oversight of resident health and safety, and help ensure accurate public reporting.”

Research shows the ratio of nurses to residents impacts quality of care and health outcomes. For example, facilities with higher nurse staffing levels tend to have fewer resident hospitalizations. In general, the new payroll-based staffing data shows most facilities have somewhat fewer staff on weekends, but some facilities have significantly lower weekend staffing. Additionally, some facilities have reported days with no registered nurse onsite, although nursing homes are generally required by law to have a registered nurse onsite eight hours a day, seven days a week.

To help address these risks, CMS will use frequently-updated payroll-based data to identify and provide state survey agencies with a list of nursing homes that have a significant drop in staffing levels on weekends or that have several days in a quarter without a registered nurse onsite. State survey agencies will then be required to conduct surveys on some weekends based on this list. If surveyors identify insufficient nurse staffing levels, the facility will be cited for noncompliance and required to implement a plan of correction.

See the full text of this excerpted CMS Press Release (issued November 30).

Hospital Value-Based Purchasing Program Results for FY 2019

The Hospital Value-Based Purchasing (VBP) Program adjusts what Medicare pays hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of inpatient care the hospitals provide to patients. CMS estimates that the total amount available for value-based incentive payments in FY 2019 will be approximately $1.9 billion.

This is the seventh year of the Hospital VBP Program, affecting payment for inpatient stays to approximately 2,800 hospitals across the country. Hospitals’ IPPS payments will depend on the following:

- How well they performed—compared to their peers—on important health care quality and cost measures during a performance period
- How much they have improved the quality of care provided to patients over time

For FY 2019, more hospitals will have an increase in their Medicare payments than will have a decrease. In total, more than 1,550 hospitals (over 55 percent) will receive higher Medicare payments.

For FY 2019, almost 60 percent of hospitals will see a small change (between -0.5 and 0.5 percent) in their IPPS payments. The average net payment adjustment is 0.17 percent. The average net increase in payment adjustments is 0.61 percent, and the average net decrease in payment adjustments is -0.39 percent. Due to the Hospital VBP Program, the highest performing hospital in FY 2019 will receive a net increase in IPPS payments of 3.67 percent, and the lowest performing hospital will incur a net decrease in IPPS payments of 1.59 percent.

For More Information:

- Hospital VBP Program website
- QualityNet website

See the full text of this excerpted CMS Fact Sheet (issued December 3), including how the Hospital VBP Program Score is computed.

Physician Compare Preview Period Open through December 31

The Physician Compare preview period is open through December 31 at 8 pm ET. Preview your 2017 Quality Payment Program performance information before it will appear on Physician Compare profile pages and in the downloadable database. Access the secured preview through the Quality Payment Program website.

For More Information:
- Physician Compare Preview Period User Guide
- Medicare Learning Network Webcast
- Clinician Performance Information on Physician Compare: Performance Year 2017 Preview Period
- Group Performance Information on Physician Compare: Performance Year 2017 Preview Period
- For assistance accessing the Quality Payment Program website or obtaining your Enterprise Identity Management (EIDM) user role, contact QPP@cms.hhs.gov
- For questions about Physician Compare, public reporting, or the 30-day preview period, contact PhysicianCompare@Westat.com.

QRURs and PQRS Feedback Reports: Access Ends December 31

The final performance period for the Value Modifier and Physician Quality Reporting System (PQRS) programs was 2016 and the final payment adjustment year is 2018. Quality and Resource Use Reports (QRURs) and PQRS Feedback Reports will no longer be available after the end of 2018. If you need these reports, download them through December 31, 2018, from the CMS Enterprise Portal using an Enterprise Identity Management (EIDM) system account with the correct role. Visit the How to Obtain a QRUR webpage for more information.

For access to PQRS Taxpayer Identification Number or National Provider Identifier reports from program year 2013 or earlier, contact the QualityNet Help Desk. They are no longer available from the QualityNet Secure Portal.

The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Value Modifier and PQRS programs. Visit the Quality Payment Program website to learn more. Note: QRURs and PQRS Feedback Reports are not same as the MIPS Performance Feedback.

For More Information:
- PQRS Analysis and Payment webpage: Information on PQRS Feedback Reports
- Value-Based Payment Modifier webpage: Information on QRURs
- For assistance with EIDM or PQRS Feedback Reports , contact the QualityNet Help Desk
- For assistance with the QRURs or Value Modifier, contact the Physician Value Help Desk at pvhelpdesk@cms.hhs.gov or 888-734-6433 (select option 4)

Quality Payment Program: Check Your Final 2018 MIPS Eligibility Status

You can now check the Quality Payment Program (QPP) Participation Status Tool to view your final 2018 eligibility status for the Merit-based Incentive Payment System (MIPS). Your initial 2018 MIPS eligibility status was based on CMS review of Medicare Part B claims and PECOS data from September 1, 2016, to August 31, 2017. Now, CMS updated your eligibility status based on our second review of Medicare Part B claims and Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data, from September 1, 2017, to August 31, 2018. Your status may have changed, so we encourage you to confirm your final 2018 MIPS eligibility.

For More Information:
- About MIPS Participation webpage
- Participating in the Quality Payment Program in 2018 Infographic

- Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Quality Payment Program: MIPS Resources

CMS posted new Merit-based Incentive Payment System (MIPS) resources:

- 2018 MIPS Cost User Guide: Overview of the MIPS Cost performance category, including measures, reporting requirements, and scoring
- 2018 MIPS Improvement Activities User Guide: Overview of the MIPS Improvement Activities performance category, including participation requirements, reporting methods, and scoring
- 2018 MIPS Specialty Measures Guides for Emergency Medicine, Ophthalmologists, Optometrists, Orthopedists, Pathologists, Podiatrists, and Primary Care: Overview of MIPS and provides a list of measures and activities that may apply to these specialty clinicians
- 2019 MIPS Quick Start Guide: High-level overview of who is eligible for MIPS in 2019 and how to participate
- 2018 CMS Web Interface Sampling Methodology: Outlines the sampling methodology for the 15 clinical quality measures and provides information on the number of beneficiaries each organization is expected to report on and how those beneficiaries are selected
- QP Methodology Fact Sheet: Overview of how CMS determines who is eligible to be a Qualifying Alternative Payment Model Participant (QP) and Partial QP

For More Information:

- Resource Library webpage
- Quality Payment Program website

Questions?

- Reach out to your local technical assistance organization
- Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Nursing Home Staff Competency Assessment Toolkit

The Civil Money Penalty Reinvestment Program (CMPRP) competency assessment poses questions about behavioral, technical, and resident-based competencies. Use the assessment to identify areas where your nursing home is doing well, versus where your facility might need support.

Toolkit 1 includes:

- Competency assessments
- Instruction Manual with resources
- Answer sheets

Once you know where you need support, CMPRP can provide funding, technical assistance, and learning opportunities to help address some of your facility’s toughest challenges. Visit the CMPRP webpage for more information. Toolkit 1 is available in the Downloads section.

PEPPERs for Short-term Acute Care Hospitals

Third quarter FY 2018 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for short-term acute care hospitals. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. The PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

For More Information:

- Visit the PEPPER Resources website for guides, recorded training sessions, QualityNet account information, FAQs, and examples of how other hospitals are using the report
- Visit the Help Desk if you have questions or need help obtaining your report
- Send us your feedback or suggestions

eCQM Resources for the 2019 Performance Period

An updated list of Electronic Clinical Quality Measures (eCQMs) and supporting documents for eligible clinicians and eligible professionals are available on the eCQI Resource Center website for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System and Advanced Alternative Payment Models (Advanced APMs)
- Advanced APM: Comprehensive Primary Care Plus
- Medicaid Promoting Interoperability Program for Eligible Professionals

Updated QRDA I Conformance Statement Resource for Hospital Submissions

CMS updated the Quality Reporting Document Architecture (QRDA) Category I Conformance Statement Resource to support CY 2018 electronic clinical quality measure reporting for the Hospital Inpatient Quality Reporting and the Promoting Interoperability programs. Use the resource to troubleshoot the most common conformance errors.

For More Information:

- Visit the eCQI Resource Center website
- Visit QRDA Issue Tracker website for questions about QRDA and schematrons
- Contact the he QualityNet Help Desk at 866-288-8912

National Influenza Vaccination Week: December 2 through 8

National Influenza Vaccination Week is a national observance that highlights the importance of continuing influenza vaccination efforts through the holiday season and beyond. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. It's not too late to vaccinate – to help protect your patients, your staff, and yourself.

Medicare Part B covers the influenza virus vaccine once per influenza season. Medicare covers additional influenza vaccines if medically necessary.

For More Information:

- Preventive Services Educational Tool
- Influenza Resources for Health Care Professionals MLN Matters® Article
- Influenza Vaccine Payment Allowances MLN Matters Article
- CDC Influenza website
- CDC Information for Health Professionals webpage
- CDC Tools to Prepare Your Practice for Flu Season webpage
- CDC Make a Strong Flu Vaccine Recommendation webpage

National Handwashing Awareness Week: December 2 through 8

Practicing hand hygiene is a simple and effective way to prevent infections. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics. Create a safe environment for your patients and staff.

Medicare Learning Network resources:

- Infection Control: Hand Hygiene Video: Learn when to wash your hands and techniques to wash visibly and non-visibly dirty hands — run time 1:58
- Infection Control: Hand Hygiene Web-Based Training Course: Learn about hand hygiene in patient care zones and nearby administrative areas; appropriate methods for maintaining good hand hygiene; and how to recognize opportunities for hand hygiene in a health care setting — with continuing education credit

Provider Compliance

Cardiac Device Credits: Medicare Billing — Reminder

A 2018 Office of the Inspector General (OIG) Report noted that payments reviewed for recalled cardiac medical devices did not comply with Medicare requirements for reporting manufacturer credits. Medicare incorrectly paid hospitals $7.7 million for cardiac device replacement claims, resulting in potential overpayments of $4.4 million. Manufacturers issued reportable credits to hospitals for recalled cardiac medical devices, but the hospitals did not adjust the claims with the proper condition codes, value codes, or modifiers to reduce payment as required.

CMS developed the Medicare Billing for Cardiac Device Credits Fact Sheet to ensure that hospitals properly report manufacturer credits for cardiac devices and avoid overpayment recoveries. Additional resources:

- Hospitals Did Not Comply With Medicare Requirements For Reporting Certain Cardiac Device Credits OIG Report, March 2018
- Medicare Quarterly Provider Compliance Newsletter Volume 5, Issue 2, January 2015
- Medicare Claims Processing Manual, Chapter 3, Section 100.8: Replaced Devices Offered Without Cost or With a Credit
- Medicare Claims Processing Manual, Chapter 4, Section 61.3.5: Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014

Claims, Pricers & Codes

HETS to Release MSP Diagnosis Codes Starting December 8

Starting December 8, the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) will return Medicare Secondary Payer (MSP) diagnosis codes when applicable. MSP diagnosis codes primarily relate to those situations where your patient gets treatment for an injury or illness that resulted from an automobile accident or other incident for which:

- Liability or no-fault insurance may pay
- Another party is responsible for payment

The same will apply if your patient gets workers' compensation benefits for a given condition. In these situations, another party is responsible for payment for services related to the MSP diagnosis codes for the MSP period the patient eligibility inquiry transaction returns, while Medicare is responsible for payment for other services.

This new information will help you determine primary and secondary billing for patient services, especially for automobile accidents or other incidents. Talk with your patient eligibility transaction service provider if you do not get the automobile accident or other incident MSP diagnosis codes after December 8.

January 2019 Average Sales Price Files

CMS posted the January 2019 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the 2019 ASP Drug Pricing Files webpage.

Upcoming Events

SNF PPS: New Patient Driven Payment Model Call — December 11

Tuesday, December 11 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

On October 1, 2019, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). Topics:

- Overview of PDPM, a new case-mix classification system for SNF Part A beneficiaries
- Changeover from RUG-IV to PDPM

For more information, review the FY 2019 SNF PPS final rule, and visit the PDPM webpage. A question and answer session follows the presentation; however, attendees may email questions in advance to PDPM@cms.hhs.gov with “December 11 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: SNF facilities, administrators, and clinicians.

Hospice Public Reporting Webinar — December 13

Thursday, December 13 from 1 to 2:30 pm ET

Register for this webinar.

This webinar on Updates to Public Reporting in FY 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines covers two different topics:

- Part one focuses on the hospice and palliative care composite process measure: Comprehensive Assessment at Admission (NQF #3235), including background, how this measure is calculated, and using your Quality Measure (QM) report to understand your performance
- Part two reviews the 4.5 month data correction deadline for public reporting policy update finalized in the FY 2019 final rule, including how this change will be implemented and the implications

Review these fact sheets prior to the training:

- Hospice Comprehensive Assessment QM Background Methodology
- 4.5 Month Data Correction Deadline for Public Reporting

For more information, visit the Spotlight & Announcements webpage.

Medicare Learning Network® Publications & Multimedia

New Medicare Webpage on Patient Driven Payment Model MLN Matters Article — New

A new MLN Matters Special Edition Article SE18026 on New Medicare Webpage on Patient Driven Payment Model is available. Learn about educational and training resources.

Ambulance Inflation Factor for CY 2019 and Productivity Adjustment MLN Matters Article — New

A new MLN Matters Article MM11031 on the Ambulance Inflation Factor for Calendar Year 2019 and Productivity Adjustment is available. Learn how to determine the payment limit for ambulance services.

ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New

A new MLN Matters Article MM11005 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) is available. Learn about coding changes.

Implementation of Bundled Payment for Multi-Component DME MLN Matters Article — New

A new MLN Matters Article MM10854 on Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME) is available. Learn about a new HCPCS code and special payment rule.

NCD 20.4 Implantable Cardiac Defibrillators MLN Matters Article — New

A new MLN Matters Article MM10865 on NCD 20.4 Implantable Cardiac Defibrillators (ICD) is available. Learn about the final decision for this National Coverage Determination (NCD).

New Telehealth Modifier for Individuals with Stroke MLN Matters Article — New

A new MLN Matters Article MM10883 on New Modifier for Expanding the Use of Telehealth for Individuals with Stroke is available. Learn about a new HCPCS modifier.

New Waived Tests MLN Matters Article — New

A new MLN Matters Article MM10958 on New Waived Tests is available. Learn about the latest tests approved by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments.

NCCI Procedure-to-Procedure Edits, Version 25.0: Quarterly Update MLN Matters Article — New

A new MLN Matters Article MM11044 on Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.0, Effective January 1, 2019 is available. Learn the Chapter 23, Section 20.9 edits of the Medicare Claims Processing Manual.

IRF PPS Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the November 15 call on the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). Learn about changes finalized in the FY 2019 final rule.

Physician Fee Schedule Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the November 19 call on the Physician Fee Schedule Final Rule. During this call, CMS experts cover three provisions:

- Streamlining Evaluation and Management (E/M) payment and reducing clinician burden
- Advancing virtual care
- Continuing to improve the Quality Payment Program to reduce burden and offer flexibilities to help clinicians successfully participate

NGACO Model Post Discharge Home Visit HCPCS MLN Matters Article — Revised

A revised MLN Matters Article MM10907 on Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS is available. Learn about the HCPCS codes G2001 – G2009 and G2013 – G2015.

HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised

A revised HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet is available. Learn:

- Who must comply with HIPAA rules
- Covered entities
- Enforcement

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