Issue Brief

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CMS Releases Brief Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions

Via a Medicare ***MLN Connects*** Special Letter, the Centers for Medicare & Medicaid Services is addressing several Medicare expired legislative provisions that were extended in the ***Bipartisan Budget Act of 2018*** (the Continuing Budget Resolution) Provisions, enacted on Friday, Feb. 9.

These items, which do address all items in the Act, are as follows.

Section 50201 - Extension of (the Physician) Work Geographic Practice Cost Index Floor

The new law extends a provision raising the Work GPCI to 1.000 for all localities that currently have a Work GPCI of less than 1.000. The Work GPCI Floor impacts the fees for all codes paid under the Medicare Physician Fee Schedule for those localities. The Work GPCI floor is extended through Dec. 31, 2019. **No new provider action is necessary for implementation.**

Section 50202 - Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy – For services after Dec. 31, 2017:

- Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined);
- Claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps, **must include the KX modifier** indicating that such services are medically necessary as justified by appropriate medical record documentation; and
- Claims for therapy services above certain threshold levels of incurred expenses will be subject to targeted medical review. **The medical review thresholds for therapy services in a year before 2028 are $3,000.**
- CMS will begin the process of releasing claims that had been held briefly after expiration of the therapy caps exceptions process. CMS will release for processing the held claims based on the date the claim was received,

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i.e., on a first-in, first-out basis, until no claims are being held. This process will be accomplished as quickly as possible while staying within the requirements for the volume of claims that Medicare Administrative Contractors can release on a given day.

Section 50203 - Medicare Ambulance Services - The new law extends the following two expiring ambulance payment provisions:

(1) the 3 percent increase in the ambulance fee schedule rates for covered ground ambulance transports that originate in rural areas, and the 2 percent increase in the ambulance fee schedule rates for covered ground ambulance transports that originate in urban areas, are extended through Dec. 31, 2022; and

(2) the increases in the base rate of the fee schedule for covered ground ambulance transports originating in a rural area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" add-on) is extended through Dec. 31, 2022. **No new provider action is necessary for implementation.**

Section 50204 - Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

The new law extends changes to a provision that allows qualifying low-volume hospitals to receive add-on payments based on their number of discharges and their distance from the nearest hospital for fiscal years 2018 through 2022 and makes additional changes to the provision for fiscal years 2019 through 2022.

For FY 2018, a hospital must have less than 1,600 Medicare discharges, consistent with the discharge criterion that applied for fiscal years 2011 through 2017.

For fiscal years 2019 through 2022, a hospital must have less than 3,800 total discharges.

The new law also extends the mileage criterion that applied for fiscal years 2011 through 2017, that the hospital be located more than 15 road miles from the nearest subsection (d) hospital, for fiscal years 2018 through 2022. For FY 2018, a qualifying hospital's add-on payment is calculated using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer Medicare discharges to 0 percent for low-volume hospitals with greater than 1,600 Medicare discharges.

For fiscal years 2019 through 2022, the add-on payment is calculated using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 500 or fewer discharges to 0 percent for low-volume hospitals with greater than 3,800 discharges. For FY 2023 and subsequent fiscal years, the qualifying criteria and payment adjustment revert to the preexisting requirements.

Section 50205 - Extension of the Medicare-Dependent Hospital Program

The MDH program provides enhanced payment to qualifying small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. **This provision extends the MDH program until Oct. 1, 2022.** It also provides for an

eligible hospital that is located in a state with no rural area to qualify for MDH status under an expanded definition if, in general, the hospital satisfies any of the statutory criteria at section 1886(d)(8)(E)(ii)(I), (II) (as of Jan. 1, 2018) or (III) to be reclassified as rural.

Hospitals that qualified as Medicare-dependent hospitals in FY 2017 and did not reclassify as a Sole Community Hospital or cancel their rural classification do not need to take further action. Their claims will be reprocessed retroactive to Oct. 1, 2017.

However, former MDHs that classified as an SCH on or after Oct. 1, 2017, would not be automatically reinstated as MDHs. In order to be classified as an MDH, a former MDH that currently is classified as an SCH must first cancel its SCH status according to § 412.92(b)(4), since a hospital cannot be both an SCH and an MDH, and then reapply and be approved for MDH status under § 412.108(b). Additionally, since one of the criteria to be classified as an MDH is that the hospital must be located in a rural area, a former MDH that canceled its rural status on or after Oct. 1, 2017, also would not be automatically reinstated as an MDH. In order to qualify for MDH status, the hospital must again request to be reclassified as rural under § 412.103(b) and also must reapply for MDH status under § 412.108(b). Under § 412.108(b)(3), the MAC will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the MAC is effective 30 days after the date the MAC provides written notification to the hospital.

Hospitals seeking to newly qualify for MDH status under the amendments made by the Bipartisan Budget Act of 2018 (including the expanded MDH definition for hospitals in all-urban states), must submit a written request along with qualifying documentation to their MAC as outlined in the current regulations at §412.108(b), as described above.

Section 50208 – Extension of Home Health Rural Add-On (for 2018)

The new law extends a provision **through Dec. 31, 2018**, allowing a 3 percent payment add-on for home health services provided in rural areas. **No new provider action is necessary for implementation.**

Section 51005 – Extension of Blended Site Neutral Payment Rate for Certain Long-Term Care Hospital Discharges; Temporary Adjustment to Site-Neutral Payment Rates

This new law extends the blended payment rate for site-neutral payment rate long-term care hospital discharges for cost reporting periods beginning in an additional two years (fiscal years 2018 and 2019). **In addition, the policy reduces the LTCH IPPS comparable per diem amount used in the site neutral payment rate for fiscal years 2018 through 2026, by 4.6 percent.**

Section 50208 – Extension of Home Health Rural Add-On (beginning in 2019)

Beginning in 2019 and subsequent years, the new law puts in place a home health rural add-on payment that varies by year across three different tiers of rural counties in which home health services are furnished: (1) rural counties in the highest quartile of all counties with

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respect to the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under Part A or Part B (but not enrolled in a plan under part C); (2) rural counties with a population density of six or fewer individuals that are not in the above highest quartile of home health utilization; and (3) all other rural counties. **Implementation of this provision will require notice and comment rulemaking.**

Section 53108 – Reduction for Non-Emergency End-Stage Renal Disease Ambulance Transports

The new law mandates an increased reduction applied to the ambulance fee schedule payment rates for ambulance services consisting of non-emergency basic life support services involving transports of beneficiaries with ESRD for renal dialysis services furnished, other than on an emergency basis by a provider of services or a renal dialysis facility, beginning with dates of service on and after Oct. 1, 2018. **The reduction is being increased from 10 percent to 23 percent.**

Section 53111 – Medicare Payment Update for Skilled Nursing Facilities.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

CMS has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility update due to section 53111 of the BBA of 2018.

To help answer these questions, CMS is providing information about the estimated market basket update for FY 2019, based on currently available data. This estimate may be updated in the Notice of Proposed Rulemaking for the FY 2019 SNF Prospective Payment System.

Section 53111 of the BBA of 2018 specified that the FY 2019 update for the SNF PPS be 2.4 percent. Based on data currently available, CMS is projecting that the FY 2019 SNF PPS update would have been 1.8 percent if section 53111 of the BBA of 2018 had not been enacted. This 1.8 percent is a result of the projected SNF market basket increase factor of 2.6 percent, reduced by a 0.8 percent multifactor productivity adjustment. This means that, based on data currently available, SNFs would receive an FY 2019 update of 2.4 percent rather than the currently projected update of 1.8 percent because of the provision in the BBA of 2018.

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