

## **Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions**

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

Please note that this summary does not include all of the Medicare provisions in the new law. For provisions not included below, more information will be forthcoming. In addition, if further implementation information and guidance for some of the provisions described below [including those that may involve provider action] is needed, it will be forthcoming.

**For Sections 50201 “Extension of Work Geographic Practice Cost Index (GPCI) Floor”, 50202 “Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy”, and 50203 “Medicare Ambulance Services” provision changes, Medicare Administrative Contractors (MAC) will implement these changes no later than February 26, 2018, and will provide additional details on timelines for reprocessing or release of held claims impacted by these changes. The following are brief descriptions of these provisions:**

*Section 50201 - Extension of Work Geographic Practice Cost Index (GPCI) 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 (MPFS) for those localities. The Work GPCI floor is extended through December 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* - The new law requires for services after December 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, 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 MACs 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 December 31, 2022; and (2) the increase 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 December 31, 2022. No new provider action is necessary for implementation.

**For the following Medicare provisions in the new law, Medicare claims processing system changes are under development but are anticipated to be included in systems changes effective in the Spring. More information related to these changes will be forthcoming. As system changes are implemented, we will share information related to any necessary claims reprocessing.**

*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 fiscal year 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 year 2018 through fiscal year 2022. For fiscal year 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 fiscal year 2023 and subsequent fiscal years, the qualifying criteria and payment adjustment revert to the preexisting requirements.

Hospitals that believe they meet the mileage criterion should review, once publically available in Table 14, the Medicare discharges and potential FY 2018 low-volume hospital payment adjustment based on the March 2017 update of the FY 2016 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2018 payment rates and factors established in the FY 2018 IPPS/LTCH PPS final rule, which will be used to determine qualifying low-volume hospitals and their fiscal year 2018 low-volume adjustment, and consistent with past practice should submit to its MAC a written request to continue to receive a low-volume payment adjustment. This written request must state that the hospital meets the mileage and discharge criteria applicable for fiscal year 2018 under the amendments provided by the Bipartisan Budget Act of 2018, and must provide sufficient evidence to document that it meets the discharge and mileage requirements. For hospitals that

qualified for the low-volume adjustment in fiscal year 2017, this written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. A hospital that is seeking to newly qualify to receive a low-volume hospital payment adjustment based on the mileage and discharge criteria applicable for fiscal year 2018 under the amendments provided by the Bipartisan Budget Act of 2018 must submit to its MAC a written request for low-volume hospital status, including documentation that the hospital meets the fiscal year 2018 discharge and mileage criteria. For example, the use of a Web-based mapping tool as part of documenting that the hospital meets the mileage criterion for the low-volume hospital adjustment is acceptable.

CMS will issue further instruction to hospitals for requesting the low-volume hospital adjustment for FY 2018, including the deadline for receipt of written requests to apply the low-volume percentage increase to payments for discharges beginning on or after October 1, 2017 (that is, the beginning of FY 2018). If the request for low-volume hospital status for FY 2018 is received after this deadline, and the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume adjustment in determining payments for the hospital's FY 2018 discharges prospectively effective within 30 days of the date of the MAC's low-volume status determination..

*Section 50205 - Extension of the Medicare-Dependent Hospital (MDH) 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 October 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 January 1, 2018), or (III) to be reclassified as rural. Hospitals that qualified as Medicare-dependent hospitals in fiscal year 2017 and did not reclassify as a Sole Community Hospital (SCH) or cancel their rural classification do not need to take further action. Their claims will be reprocessed retroactive to October 1, 2017.

However, former MDHs that classified as an SCH on or after October 1, 2017 would not be automatically reinstated as MDHs. In order to be classified as an MDH, a former MDH that is currently 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 October 1, 2017 would also 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 must also reapply for MDH status under § 412.108(b). Under § 412.108(b)(3), the Medicare contractor (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 December 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 (LTCH) 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.

**For the following Medicare provisions in the new law with future effective dates, Medicare claims processing system changes are under development for implementation of these provisions on their effective dates. More information related to these changes will be forthcoming.**

*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 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 6 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 ESRD 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 October 1, 2018. The reduction is being increased from 10% to 23%.

**In addition, with regard to *Section 53111 – Medicare Payment Update for Skilled Nursing Facilities*, CMS has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility (SNF) update due to section 53111 of the BBA of 2018.**

To help answer these questions, we are 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 (PPS).

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 a 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.