REGULATORY REVIEW — MAY 2016

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The following is a summary of recent regulatory changes from Jan. 1 to May 31, 2016.

CMS

CMS Issues New Survey And Certification Guideline
The Centers for Medicare & Medicaid Services has released a new survey and certification memo for solid transplant programs. Medicare Conditions of Participation require that each solid organ transplant program maintain patient and graft survival rates that are within certain CMS tolerance limits. Outcomes between 150 and 185 percent of the risk-adjusted expected number would constitute a "standard level" deficiency, which requires improvement efforts, but by itself, does not put a program's Medicare participation at risk. One-year, post-transplant patient deaths or graft failures that exceed 185 percent of the expected number generally will be classified at the more serious "condition-level" if such a finding occurs in more than one report.

CMS Releases Physician And Other Supplier Utilization And Payment Data
As the seventh annual Health Datapalooza conference begins, the Centers for Medicare & Medicaid Services announced the release of the physician and other supplier utilization and payment public use data. This is the third annual release of the data, which includes payment and submitted charges for services and procedures provided by each physician or supplier. CMS Chief Data Officer Niall Brennan stated, "This week's announcements underscore CMS' ongoing commitment to releasing data and information to promote a vibrant health information economy."

CMS Clarifies Care For Justice-Involved Individuals
On May 4, the Centers for Medicare & Medicaid Services released a new survey and certification letter, Ref: S&C: 16-21-ALL. The guidance to surveyors clarifies requirements for providing services to justice-involved individuals in numerous health care settings, including skilled nursing facilities, nursing facilities, hospitals, psychiatric hospitals, critical access hospitals and intermediate care facilities for individuals with intellectual disabilities. Specifically, the guidance seeks to guarantee high quality care that is consistent with essential patient rights and safety for all individuals.

CMS Updates RAC ADR Limits
The Centers for Medicare & Medicaid Services announced a change to the additional documentation request limits for Medicare institutional providers under the Recovery Audit Contractor Program. The new ADR limits are two-pronged. The first will include a limit of .5 percent of the provider's total number of paid claims from the previous 12 months, then divided by eight to serve as a 45-day cycle limit. After three 45-day cycles have been completed, the facility denial rate will be calculated. The ADR limit would then be set based on the denial rate table as follows.

Denial Rate (Range)	Adjusted ADR Limit (Percent of Total Paid

	Claims)
91-100%	5.0%
71-90%	4.0%
51-70%	3.0%
36-50%	1.5%
21-35%	1.0%
10-20%	0.5%
4-9%	0.25%
0-3%	No reviews for three (45-day) review cycles

CMS Publishes Fire Safety Requirements Final Rule
The Centers for Medicare & Medicaid Services published a final rule to update health care facilities' fire protection guidelines. The rule adopts the National Fire Protection Association's 2012 edition of the Life Safety Code and the Health Care Facilities Code. The provisions, applicable to hospitals, critical access hospitals, long-term care facilities, inpatient hospice facilities, ambulatory surgical centers and other affiliated health care providers, cover construction, protection and operational features designed to provide safety for Medicare beneficiaries. Health care providers affected by the rule must comply with all regulations within 60 days of the publication date (Wednesday, May 4) unless otherwise specified in the final rule.

CMS Publishes Medicare Part B Drug Payment Model Proposed Rule
The Centers for Medicare & Medicaid Services published a proposed payment model for how Medicare Part B pays for prescription drugs provided in physician offices, hospital outpatient departments and by durable medical equipment suppliers. CMS proposed a two-phase model to test whether alternative payment approaches for Part B drugs will improve value, improve outcomes and/or reduce expenditures for Part B drugs.

MHA received the files for distribution on April 29. Because of the short turnaround time imposed by CMS, MHA has prepared an analysis of the estimated impact of the proposal on hospitals' outpatient drug claims only, and provided a breakout by clinical categories. Under the Part B Drug Model, only providers in selected geographic areas will receive the alternate payment amount. The affected areas have not yet been identified by CMS; therefore, this analysis illustrates the impact of the new payment formula on all providers. Hospitals have until Monday, May 9, to review their hospital-specific data and electronically submit comments to CMS.

CMS Releases MACRA Proposed Rule
The Centers for Medicare & Medicaid Services released a proposed rule which would implement provisions of the Medicare Access and Children's Health Insurance Program Reauthorization Act related to the physician payment system. The new regulation establishes a two-track physician payment system, offering the choice of aligning with an alternative payment model or being subject to a quality performance scoring system. Comments must be received by 4 p.m. Monday, June 27. Notable points about the two tracks include the following.

- Merit-based Incentive Payment System
    - 2017 performance will be used to set payment adjustments for 2019.
    - Quality measures include four performance categories: quality, advancing care information, clinical practice improvement activities and cost. Measures and activities vary by category and include outcome measures, performance measures and global and population measures.
    - Meaningful use will be replaced by the term "advancing care information."
- Alternative Payment Models
    - Initially, Medicare Advantage would not qualify as an APM.

CMS provides a listing of what is considered an APM in Table 32 of the proposed rule. Nominal risk standard must be met to be considered an APM (marginal risk set at 30 percent, minimum loss rate set at 4 percent, total risk set at 4 percent).

CMS Releases Proposed FY 2017 SNF PPS Rule
The Centers for Medicare & Medicaid Services released a proposed rule to update the payment rates for skilled nursing facilities for federal fiscal year 2017. The payment update includes a 2.1 percent or $800 million increase over the 2016 payments. The proposed rule also includes information about the new

SNF value-based purchasing program scheduled to begin in FFY 2019 and other quality program updates. Comments about the proposed rule are due by 4 p.m. Monday, June 20. MHA has published an issue brief with additional details.

CMS Releases Proposed FY 2017 IRF PPS Rule
The Centers for Medicare & Medicaid Services released a proposed rule to update the payment rates for inpatient rehabilitation facilities for federal fiscal year 2017. The payment update includes a 1.45 percent increase. CMS also increased the payment rate to 1.6 percent because of revisions to the outlier threshold. The total amount of increase over 2016 payments are projected to be $125 million. The proposed rule includes updates to the IRF quality reporting program and small revisions to the wage index information used under the IRF program. Comments about the proposed rule are due by 4 p.m. Monday, June 20. MHA has published an issue brief with additional details.

CMS Releases Proposed FY 2017 Hospice Payment And Policy Updates
The Centers for Medicare & Medicaid Services released a proposed rule to update the payment rates for hospice providers for federal fiscal year 2017. The payment update includes a 2.0 percent or $330 million increase over the 2016 payments. The proposed rule also includes a 2.0 percent update for the FY 2017 hospice cap, description for the Hospice CAHPS survey, and annual payment update requirements for FY's 2019 and 2020. Comments about the proposed rule are due by 4 p.m. Monday, June 20. MHA has published an issue brief with additional details.

CMS Issues Final Rule On Medicaid Managed Care
The Centers for Medicare & Medicaid Services has issued a display copy of its final rules governing managed care in the Medicaid and CHIP programs. The agency published various fact sheets, available under the "Final Rule" tab on the website, as well as a table of implementation dates. The rules officially will be published in the May 6 *Federal Register*.

CMS Clarifies Computed Tomography Compliance
Radiologists, hospital administrators, medical physicists and individual institutions have raised concern regarding the uncertainty of determination and documentation of compliance to the NEMA XR-29 "Standard Attributes on CT Equipment Related to Dose Optimization and Management" (MITA SmartDose) Standard. In response, the Centers for Medicare & Medicaid Services has compiled an FAQ document to clarify reimbursement changes for noncompliant systems and information regarding billing, coding and payment rates. The FAQs clarify stakeholder uncertainty and include aspects of payment reductions if computed tomography systems are found noncompliant.

CMS Releases Policy Clarification On Acceptable Control Materials
The Centers for Medicare & Medicaid Services has released a survey and certification memo, titled "Policy Clarification on Acceptable Control Materials Used When Quality Control is Performed in Laboratories." The memo provides clarification regarding acceptable control materials, function checks and procedural controls, and guidance for surveyors.

MHA Distributes Analysis Of Medicare's HAC Reduction Program
MHA has released a projection of the effect of Medicare's federal fiscal year 2017 hospital-acquired conditions reduction program based on the fourth quarter 2015 data update from Hospital Compare. The analysis, which is posted on HIDI Analytic Advantage®, evaluates performance scores for hospitals included in the Centers for Medicare & Medicaid Services' Hospital Compare database. The latest release indicates that the projected effect on hospitals' finances is estimated to decrease operating payments to Missouri hospitals by $7.9 million. Seventeen of Missouri's 74 (23 percent) participating hospitals are projected to receive the payment reduction. As mandated by the HAC program, 25 percent of participating hospitals in the nation receive a penalty.

CMS Publishes Final Rule On Home And Community-Based Services
The Centers for Medicare & Medicaid Services published a final rule to enhance the quality of home and community-based services and provide protections for participants. The rule ensures that individuals who receive HCBS have full access to the benefits of community living and have the opportunity to receive services in the most integrated and appropriate type of setting. Missouri's Medicaid Audit and Compliance Unit is participating in the state's transition plan and transition activities.

CMS Issues Guidance For Labs And Radiology
The Centers for Medicare & Medicaid Services has issued two documents clarifying requirements for computed tomography imaging services and clinical laboratory services. Survey and certification memo 16-19 ALL provides FAQs for complying with XR-29 standards and survey and certification memo 16-20 CLIA provides direction on complying with quality control standards.

Majority Of U.S. House And Senate Support CMS Star Rating Delay
Sixty U.S. Senators wrote the Centers for Medicare & Medicaid Services asking the agency to delay the

April 21 release of its Star Ratings of overall hospital quality on Hospital Compare. Two hundred and twenty-five members of the U.S. House of Representatives signed a similar letter. The Senate letter was signed by Sens. Roy Blunt and Claire McCaskill. The House letter was signed by Reps. William "Lacy" Clay, Jason Smith, Ann Wagner, Billy Long and Blaine Luetkemeyer. MHA thanks the legislators for their leadership on this issue.

MHA Distributes Analysis Of Proposed Medicare Inpatient PPS For FFY 2017
MHA has made available a summary and analysis of the federal fiscal year 2017 inpatient PPS proposed payment and policy updates. Hospitals have until Friday, June 17, to review their hospital-specific data and submit comments to the Centers for Medicare & Medicaid Services.

The analysis includes the financial effects of marketbasket updates, the budget neutrality adjustment, reductions mandated by the Affordable Care Act, prospective coding adjustment as mandated by the American Taxpayer Relief Act of 2012 and two-midnight rule adjustments. The analysis also includes results from the proposed transition to S-10 for Medicare disproportionate share hospital uncompensated care payments and the transition to a Z-score methodology to assign hospital-acquired condition payment cuts. Results are illustrated in national, state, health system and individual hospital groupings. Policy and analytic studies, prepared for distribution by the Hospital Industry Data Institute, are made available for download to authorized users of HIDI Analytic Advantage®.

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CMS Releases FY 2017 IPPS And LTCH Proposed Rule
The Centers for Medicare & Medicaid Services released the proposed payment and policy rules for fiscal year 2017 inpatient and long-term care hospital prospective payment systems. CMS projects that IPPS payments will increase by $539 million, while LTCH PPS payments will decrease by $355 million. CMS has proposed the following.

- permanently remove the 0.2 percent payment reduction because of the 2-midnight rule implementation
- transition the distribution of Medicare disproportionate share hospital uncompensated payments from Medicaid and Medicare surgical site infection days to using the Medicare cost report, form S-10
- pay-for-performance and quality reporting revisions
- implementation of the Notice of Observation Treatment and Implications for Care Eligibility Act and introduction of the Medicare Outpatient Observation Notice
- temporary exception for certain severe wound discharges from the LTCH site-neutral payment adjustment

Comments are due by 4 p.m. Friday, June 17.

CMS Accepts Primary Source Verification For Laboratories
The Centers for Medicare & Medicaid Services has had many requests from laboratories, accreditation organizations and other health care facilities to accept primary source verification of education, training, experience and licensure in laboratory services to demonstrate compliance with regulatory requirements. Effective immediately, CMS surveyors will accept PSV documentation as evidence of laboratory compliance with the personnel requirements stated in 42 CFR, Part 493, Subpart M. It should be noted that the PSV company is not responsible for determining whether a given individual meets the personnel requirements under clinical laboratory improvement amendments. Learn more in CMS' survey and certification memo 16-18-CLIA.

CMS Releases New Survey And Certification Memo On Exit Conferences
The Centers for Medicare & Medicaid Services has received questions on what degree of specificity

surveyors should give during the exit conference to Medicare/Medicaid providers and suppliers regarding deficiencies found during federal surveys. The policy memo is relevant to all surveyors conducting all types of federal surveys. To address questions, provide additional clarity and ensure uniformity in the survey procedures, CMS has revised chapters two and five, and Appendix P in the State Operations Manual. MHA will update the survey manual guide to reflect these changes.

CMS Provides Additional RHC Billing Guidance
The Centers for Medicare & Medicaid Services previously announced that beginning Friday, April 1, rural health clinics will be required to detail bill for services provided. CMS now has released a slide deck with additional details and contact information about the new requirements.

CMS Proposes Testing New Medicare Part B Prescription Drug Models
The Centers for Medicare & Medicaid Services announced a proposed rule that focuses on testing new models to improve how Medicare pays for prescription drugs. The proposed Medicare Part B Model would test new ways to support physicians and other clinicians as they choose the right drug for their patients. The proposed rule is designed to drive the prescribing of the most effective drugs and test new payment approaches to reward positive patient outcomes. CMS outlined six new payment approaches, including the following. Comments about the proposed model are due no later than 4 p.m. Monday, May 9.

- improving incentives for best clinical care
- discounting or eliminating patient cost-sharing
- feedback on prescribing patterns and online decision support tools
- indications-based pricing
- reference pricing
- risk-sharing agreements based on outcomes

MHA Releases Issue Brief: Medicare Part B Prescription Drug Model Proposal
The Centers for Medicare & Medicaid Services recently announced a proposed rule that focuses on testing new models to improve how Medicare pays for prescription drugs. The proposed model is designed to test different physician and patient incentives to drive the prescribing of effective drugs and test new payment approaches to reward positive patient outcomes. MHA has published an issue brief with additional details.

CMS Releases New Survey And Certification Memo
The Centers for Medicare & Medicaid Services released a new survey and certification memo, "Certification Number (CCN) State Codes — State Operations Manual Section 2779A Revisions," which provides guidance regarding the numbering system for CCNs for Medicare-participating providers and suppliers. The revisions reflect the addition of new state codes.

CMS Issues New Guidance For Organ Transplant Centers
The Centers for Medicare & Medicaid Services has released survey and certification memo S&C 16-10-Transplant, which provides interpretive guidelines for organ transplant centers. The memo updates the organ transplant interpretive guidelines to incorporate previously published changes, clarify certain areas and address feedback received based on previously released drafts. The guidelines will be published in a new Appendix X of the State Operations Manual.

CMS Announces DMEPOS Competitive Bidding
The Centers for Medicare & Medicaid Services announced the new single payment amounts and began sending contract offers to successful bidders for Medicare's Round 2 Recompete and the national mail-order recompete Durable Medical Equipment, Prosthetics, Orthotics And Supplies Competitive Bidding Program. The new contracts will go into effect Friday, July 1. According to Medicare, $3.6 billion has been saved because of the program.

Region 7 Releases "*The Pulse* of CMS" Winter Edition
The Centers for Medicare & Medicaid Services' Region 7 released its winter edition of *The Pulse* of CMS. The newsletter highlights the following.

- Affordable Care Act results in premium rebates
- transforming clinical practice initiative
- durable medical equipment, prosthetics, orthotics and supplies update
- comprehensive care for joint replacement update

CMS Issues 2017 MA And Part D Advance Notice And Draft Call Letter
The Centers for Medicare & Medicaid Services released proposed updates to the Medicare Advantage

and Part D programs though the 2017 Advance Notice and Draft Call Letter. CMS is proposing to increase MA payment rates by 1.35 percent. Percent increases can be seen by downloading "Applicable Percentages for CY 2017." When factoring in risk-coding tendencies, the average change in MA insurers' revenue is expected to increase by 3.55 percent. MHA has published an issue brief with additional details.

CMS Publishes Medicare Fee-For-Service Provider And Supplier List
The Centers for Medicare & Medicaid Services released two public datasets used to prevent fraud, waste and abuse; one on ground ambulance suppliers and the other on home health agencies. The datasets are in response to a recently published Federal Register notice, extending the temporary enrollment moratoria on new ground ambulance suppliers and home health agencies for an additional six months. CMS also has released the information through an interactive Web page.

MHA Posts MACRA Resources
The Medicare Access and CHIP Reauthorization Act of 2015 makes sweeping changes to how Medicare will pay for physician services. The legislation repeals the flawed Medicare physician sustainable growth rate formula and provides predictable payment increases. The law also calls for the Centers for Medicare & Medicaid Services to implement a new two-track payment system for physicians and other eligible professionals. Visit MHAnet for additional information and resources.

CMS Issues Program Integrity Enhancements Proposed Rule For Provider Enrollment Process
The Centers for Medicare & Medicaid Services released a proposed rule that would implement additional provider enrollment provisions to ensure that entities and individuals who pose risks to the Medicare program are kept out of or removed from Medicare for extended periods of time. The rule would grant CMS the authority to do the following.

- deny or revoke a provider's or supplier's Medicare enrollment if currently revoked under a different name
- revoke a physician's or eligible professional's enrollment if a pattern of practice of ordering services which represent a threat to the health of Medicare beneficiaries is established
- increase the maximum reenrollment bar from 3 to 10 years
- prohibit a provider or supplier from enrolling in the Medicare program for up to 3 years if its enrollment application is denied due to false or misleading information

MHA has published an issue brief with additional details. Comments will be due 60 days after the date of publication in the *Federal Register*.

WPS Denying Claims In Error Due To LCD Edits
The Centers for Medicare & Medicaid Services' Medicare Administrative Contractor, Wisconsin Physicians Service Insurance Company, is denying claims and making payments in error due to local coverage determination edits. WPS states that they will be issuing an eNews message soon. Until that time, WPS has asked MHA to share the following message.

Coverage for services under Medicare is based on medical necessity. Title XVIII of the Social Security Act, Section 1862(a)(1)(A) excludes services that are not "reasonable and necessary" unless otherwise specifically noted. WPS Medicare has implemented automated system editing for Part A Local Coverage Determination (LCD) coverage criteria to prevent improper payments. Medicare claims associated with LCD coverage criteria that do not have a payable diagnosis will be denied. WPS Medicare will be performing mass adjustments to identify two types of claims; 1) claims denied in error with payable diagnosis and 2) claims paid in error with non-payable diagnosis. We will be publishing information on the mass adjustments via the website. During this time we ask that you review the website for periodic updates. Providers may correct a diagnosis by submitting an adjustment or written correspondence. Actual changes to coverage criteria will be identified in the LCD history. Reconsideration requests of an LCD should follow the appropriate protocol.

CMS Releases 2017 Marketplace Notice Of Benefit And Payment Parameters
The Centers for Medicare & Medicaid Services announced the release of the final annual Notice of Benefit and Payment Parameters for the 2017 coverage year. The rule finalizes provisions to help consumers with out-of-network costs at in-network facilities, provides consumers with notifications when a provider network changes, allows insurance companies to offer plans with standardized cost-sharing structures, provides a rating on each qualified health plan on HealthCare.gov, and improves the risk adjustment formula. CMS has released the following supplemental documents.

- fact sheet
- annual letter to issuers
- rate filing justifications for the 2016 filing year for single risk pool compliant coverage

- FAQs related to the moratorium on the health insurance provider fee
- transitional policy for plans that have been continuously renewed since 2014

MHA Releases Issue Brief
The Centers for Medicare & Medicaid Services released a final rule requiring Medicare Parts A and B health care providers to report and return overpayments by the later of the date that is 60 days after the date of overpayment, or the due date of any corresponding cost report. MHA has published an issue brief with additional details. Major provisions include the following.

- overpayments must be reported and returned if identified within six years of the date of overpayment
- defining "identification" of an overpayment
- clarification and definition of an overpayment
- how to report and return overpayments

CMS Issues Guidance On CAH Necessary Provider Status
The Centers for Medicare & Medicaid Services has issued survey and certification memo S&C 16-08-CAH. The memo provides state survey agencies with a checklist and guidance for performing surveys and determining critical access hospital compliance with location and distance requirements. Included in the guidance is a procedure for CAHs lacking documentation of the designation of necessary provider status before Jan. 1, 2006. MHA is working with the Department of Health and Senior Services' Office of Primary Care and Rural Health to obtain necessary documents to comply with CMS' requirements to maintain CAH status.

MHA Distributes Wage Index, Occupational Mix Data For Review
The Centers for Medicare & Medicaid Services released revised public-use files that will be used to develop the federal fiscal year 2017 Medicare wage index. Hospitals can review their hospital-specific data and request any revisions until Tuesday, Feb. 16. Requests and supporting documentation for revisions should be directed to the Medicare Administrative Contractor. Requests for revisions are limited to error corrections in the Jan. 29 public-use file or for revisions of desk review adjustments to wage index data. MHA has posted these files to HIDI Analytic Advantage® for your review.

CMS Issues Survey And Certification Letter
The Centers for Medicare & Medicaid Services released a survey and certification group letter (S&C: 16-07-AO) to state survey agency directors. The 2015 annual report to Congress details the review, validation and oversight of the fiscal year 2014 activities of approved accrediting organization's Medicare accreditation programs, as well as the Clinical Laboratory Improvement Amendment Validation Program.

Medicare Learning Network Offers Infection Control Courses For Surveyors
The Centers for Medicare & Medicaid Services issued survey and certification memo S&C: 16-06-ALL. Effective Jan. 22, the Medicare Learning Network sent the memo to survey and certification groups noting that surveyors have the opportunity to improve their knowledge of infection control standards through the many courses offered by the network. Any health care provider that creates an account also can access the modules. Instructions to register for an account are included in the memo.

CMS Proposes Update To ACO Benchmark Methodology
The Centers for Medicare & Medicaid Services issued a proposed rule that will update the methodology used to calculate accountable care organization benchmarks. The proposed rule focuses on incorporating regional fee-for-service expenditures into the methodology for establishing, adjusting and updating an ACO's historical benchmark for its second or subsequent agreement period. CMS also has released a fact sheet with additional details. The comment period will be due 60 days after publication in the *Federal Register*.

CMS Proposes Rule To Give Providers And Employers Access To Quality Information
The Centers for Medicare & Medicaid Services issued a proposed rule that will expand access to information that will help providers, employers and others make more informed decisions about care delivery. The rule also includes strict privacy and security requirements for all entities receiving the data. CMS Acting Administrator Andy Slavitt stated, "Increasing access to analyses and data that include Medicare data will make it easier for stakeholders throughout the health care system to make smarter and more informed health care decisions." Comments may be submitted until Tuesday, March 29.

CMS To Reprocess Medicare Claims Because Of Consolidated Appropriations Act, 2016
Late last year, Congress passed and the president signed into law the Consolidated Appropriations Act, 2016. In section 601 of the act, modifications to the Medicare inpatient hospital payment rate for Puerto Rico hospitals are required, which affects the federal fiscal year 2016 inpatient PPS FY 2016 Pricer. The change will affect IPPS discharges on or after Jan. 1. The revised pricer will be implemented on

Monday, April 4. The Medicare administrative contractors have been ordered to reprocess IPPS claims from Puerto Rico and all other IPPS hospitals with discharge dates on or after Jan. 1. The reprocessing of claims should be completed no later than Thursday, June 30.

CMS Announces Direction For EHR Incentive Programs
The Centers for Medicare & Medicaid Services announced that the administration is working to transition the Electronic Health Record Incentive Program from "measuring clicks to focusing on care." The transition is in line with the overarching goal of the "better care, smarter spending, healthier people" initiative and the recent passage of the Medicare Access and CHIP Reauthorization Act of 2015. CMS published several guiding principles which will be used to draft the proposed regulations through the MACRA, including rewarding providers for the outcomes that technology helps them to achieve, allowing providers the flexibility to customize health information technology to their individual practice needs and making efforts to level the technology playing field.

CMS Provides Update On LTC PBJ Requirements
The Centers for Medicare & Medicaid Services released a memo with additional instructions about the payroll-based journal requirements for long-term care facilities in 2016. CMS states that "electronic submission of staffing data through the PBJ is required on all Long Term Care Facilities in 2016." All nursing homes will need to register to submit data. CMS also provides training and instructions about registration, and has published a dedicated website with additional details about the PBJ requirement.

CMS Issues Final Rule On Medicaid Outpatient Drugs
The Centers for Medicare & Medicaid Services issued a final rule with comment period to revise its standards for Medicaid outpatient drugs. The agency also released a fact sheet. MHA published an issue brief on the new final rule.

CMS Releases Explanation Of FY 2004 Outlier Fixed-Loss Threshold
The Centers for Medicare & Medicaid Services released an explanation of the fiscal year 2004 outlier fixed-loss threshold. This is in response to a case which challenged the outlier fixed-loss threshold rulemaking for FY 2004. The explanation centers on why the secretary corrected for only 50 turbocharging hospitals in the 2004 rulemaking rather than for the 123 that were identified. Turbocharging is being used as a term to describe improper manipulation of charges by hospitals.

CMS Releases Guide To Prevent Readmissions Among Diverse Medicare Beneficiaries
The Centers for Medicare & Medicaid services released a new guide to preventing readmissions among racially and ethnically diverse Medicare beneficiaries. The guide provides action-oriented guidance for addressing avoidable readmissions in this population, a set of seven key recommendations that hospital leaders can take to prevent avoidable readmissions and concrete examples of initiatives and strategies that may be applied to reduce readmissions in diverse populations.

GOP Members Of U.S. House Subcommittee Press For CMS Response
The Republican members of the Subcommittee on Health of the U.S. House of Representatives' Committee on Energy and Commerce have sent a letter to the Centers for Medicare & Medicaid Services pressing for responses to questions raised at a July 2015 hearing. Missouri congressman Billy Long is among the signatories.

MHA Releases Report On Final Rule For Comprehensive Care For Joint Replacement
The Centers for Medicare & Medicaid Services previously announced the final rule for comprehensive care for joint replacement for selected acute care hospitals. To assist hospitals affected by the rule, MHA is releasing an analytic analysis that includes a bundled cost overview of joint replacement episodes. The report is an update to the August 2015 analysis, which was based on the specifications initially proposed by CMS. The final rule specifications include three full years of data (2012-2014) that CMS will use to measure baseline performance. Policy and analytic studies, prepared for distribution by the Hospital Industry Data Institute, are available for download to authorized users of HIDI Analytic Advantage®.

CDC

CDC Responds To Increased Hepatitis C In Dialysis Patients
A Centers for Disease Control and Prevention Health Advisory was released urging dialysis providers to assess and improve infection control practices to stop Hepatitis C virus transmission. The advisory is in response to the increased identification of HCV transmission in dialysis clinics.

MHA Responds With Site Resources Dedicated to Emerging Infectious Diseases

Infectious diseases — most of which are preventable — disrupt the lives of millions of Americans each year. New threats can arise quickly and lapse in preparedness can leave communities unnecessarily vulnerable. Below are resources to help hospitals, health care coalitions and other organizations to prepare for and respond to the diseases that are currently a threat to our world. MHA's website has a special resource area dedicated to Zika, Flu and Ebola.

Missouri

MHA Publishes Summary Of The 2016 State Legislative Session
MHA has published an issue brief with the outcomes of the 2016 Missouri legislative session. The session ended Friday, May 13. MHA deeply appreciates all of the support its membership provided to advance advocacy efforts.

MO HealthNet Division Requires DiagnosticSite Certification
On Jan. 15, the MO HealthNet Division released a radiology bulletin outlining the change in the radiology benefit management vendor from EviCore/MedSolutions to HealthHelp. Effective February 2016, each facility was given a 90-day grace period in which to certify. Providers that intend to perform high-tech and/or cardiac imaging procedures for MO HealthNet participants must receive DiagnosticSite certification from HealthHelp by Tuesday, May 31.

Governor Orders State Agencies To "Ban The Box"
Gov. Jay Nixon issued an Executive Order directing Missouri state agencies to revise their first-level employment applications to remove questions about the applicant's criminal history. Those questions can be asked later in the application review process. Also, the standard won't apply to jobs in which a criminal history would render the applicant ineligible for employment. The so-called "Ban the Box" policy will take effect in 90 days.

Department Of Social Services Engages Contractor To Conduct Audits
HMS will soon conduct credit balance audits on behalf of the Missouri Department of Social Services, MO HealthNet Division and Missouri Medicaid Audit and Compliance. Before receiving correspondence from HMS, MMAC will send a letter notifying a hospital or nursing home when an audit is scheduled. MMAC also will notify MHA, the Missouri Health Care Association and LeadingAge Missouri.

MO HealthNet Issues 2016 Outpatient Radiology Fee Schedule
The MO HealthNet Division has posted its outpatient radiology fee schedule for 2016 on its website under the "General Information" heading. MHD notes that the "revised fee schedule contains rates effective Jan. 1, 2014, through 2016 dates of service."

HB 618 Expands Authorization To Complete Death Certificates
The Missouri Department of Health & Senior Services' Bureau of Vital Records released a notification of Revised Statutes of the State of Missouri through the passage of HB 618 (2015). The amended state statute allows physician assistants, assistant physicians and advanced practice registered nurses in a collaborative practice agreement to complete and sign the medical certification portion of a Missouri death certificate using the electronic vital records system. Additional training is available online.

Federal

FDA Issues New Tobacco Regulation Standardsstrong
The U.S. Food and Drug Administration has issued a set of final regulations expanding its authority to regulate tobacco products, including e-cigarettes. The agency also issued a fact sheet.

Congressional Subcommittee Approves Opioid Bills
The Health Subcommittee of the U.S. House of Representatives' Energy and Commerce Committee has approved twelve bills related to the use and misuse of opioids. The subcommittee has posted bill texts, amendments and background material. Missouri Congressman Billy Long is a member of the subcommittee and the full committee.

Departments Announce New Summary Of Benefits And Coverage
The Affordable Care Act requires issuers of health plans to provide consumers with a summary of what the plan covers and the consumers' cost of sharing responsibility. The U.S. Department of Health & Human Services, the Department of Labor and the Department of Treasury announced key enhancements to the Summary of Benefits and Coverage template. The improvements include

additional examples, and language and terms to improve consumers' understanding of their health coverage.

FDA Proposes Ban On Powdered Gloves
The U.S. Food and Drug Administration is proposing a regulatory ban on powdered surgery and patient examination gloves, as well as absorbable powder for lubricating medical gloves. The agency has determined that products are "dangerous and present an unreasonable and substantial risk." The proposed regulation will be open for public comment through Monday, June 20.

HHS Announces Proposed Rule To Support Certified Health IT
The U.S. Department of Health & Human Services and the Office of the National Coordinator For Health Information Technology proposed a rule that would modify the health IT certification program to reflect the adoption of certified electronic health records and the fast pace of innovation in the health IT market. The proposed rule further enhances the safety, reliability, transparency and accountability of certified health IT for users. The rule focuses on enabling the ONC to directly review certified health IT products, increasing ONC oversight of health IT testing and providing results of surveillance of certified health IT programs to the public. Comments are due by 4 p.m. 60 days after publication in the *Federal Register*.

U.S. Senators Query CMS On Opioid Use And Patient Satisfaction Surveys
Three U.S. senators have written the Centers for Medicare & Medicaid Services regarding the effect of the agency's HCAHPS patient satisfaction survey on pain management practices and the use of opioids for pain control. The letter asks for an update on CMS actions taken in response to an agency review of the issue. A press release includes links to past correspondence between the legislators and CMS.

U.S. Senate Committee Issues Report On Infections From Medical Devices
The Democratic minority staff of the U.S. Senate Committee on Health, Education, Labor & Pensions has issued a report, titled "Preventable Tragedies: Superbugs and How Ineffective Monitoring of Medical Device Safety Fails Patients." The committee's senior Democratic legislator issued an accompanying statement. The report focuses on incidents related to duodenoscopes.

Obama Administration Proposes Incentive To Non-Expansion States
The Obama administration is proposing a new financial incentive for states to authorize an expansion of Medicaid eligibility as permitted by the Affordable Care Act. The administration's federal fiscal year 2017 budget proposal would allow states that expand Medicaid eligibility to have the same federal funding rubric that was given to states that expanded eligibility in 2014. There would be three years of full federal funding for the costs of the Medicaid expansion, followed by a multi-year decline in federal financing levels to a final level of 90 percent. Like many components of the President's proposed budget, the proposal is unlikely to be enacted by Congress.

CBO Marks Legislation To Repeal ACA Mandates And Taxes
The Restoring Americans' Healthcare Freedom Reconciliation Act was introduced to repeal most of the Affordable Care Act's mandates and taxes. The Congressional Budget Office released the fiscal implications of the bill, which would reduce the deficit by $516 billion throughout 10 years. Some of the proposed items include repeal of the following.

- limitations on contributions to flexible spending accounts tax on health savings accounts
- tax on certain employee health insurance premiums and health plan benefits medical device excise tax
- Medicare tax increase and more

President Obama has said he would veto the bill if passed by Congress.

Joint Commission

TJC Releases Standards Clarification
Recently, The Joint Commission updated its primary source verification requirements. Organizations are required to verify and document education and experience only when specific minimum requirements are written into the job description. Organizations determine how verification and documentation of education and experience will be managed. TJC has provided PSV clarification for hospitals and hospital clinics, ambulatory health care, critical access hospitals and home care.

TJC Releases New Fire Protection Standard Module
The Joint Commission's new fire protection standard module identifies 25 life safety and environment of

care elements of performance from eight standards that have been frequently cited during survey activities throughout the past four years. TJC's physical environment portal, in partnership with the American Society for Healthcare Engineering, aims to provide helpful information to improve compliance.

TJC To Delete 131 Accreditation Standards
The Joint Commission has announced major changes to its hospital accreditation standards and elements of performance. TJC released a prepublication list of the 131 requirements, along with the rationale behind deletion. The changes will take effect Friday, July 1. The deletions are part of an effort to improve the accreditation process.

TJC Revises Deemed Program Requirement For Psychiatric Hospitals
The Joint Commission has approved a revision to the deemed program requirement for psychiatric hospitals, which will be published in the next semiannual update to print manuals, as well as in the online E-dition. Effective today, the Provision of Care, Treatment and Services Standard PC.01.03.01 will read as follows, "Elements of Performance for PC.01.03.01 (C6) for psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The written plan of care includes the following: 1) A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis, or it may differ, based on new information and assessment.); 2) Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; 3) Documentation that demonstrates all active therapeutic efforts are included; and 4) The specific treatment modalities used to treat the patient."

TJC Releases 2015 Most Cited Standards List
The Joint Commission's latest list of most-cited standards was dominated by safety issues. Following a multiyear trend, eight of the top 10 cited standards came from the environment of care, life safety or infection control chapters, with most of them changing places within the top 10.

TJC Announces Updates To The Physical Environment Portal
The Joint Commission has identified 25 life safety and environment of care elements of performance that have been frequently cited during survey activity throughout the last four years. The Physical Environment Portal, in partnership with the American Society for Healthcare Engineering, is available on TJC's website and will provide information to reduce findings of non-compliance.

TJC Announces New Requirements For Diagnostic Imaging Services
The Joint Commission has recently approved and released new prepublication standards for accredited hospitals, critical access hospitals and ambulatory care organizations (including those that have achieved Advanced Diagnostic Imaging certification) that provide diagnostic imaging services. The new requirements specify minimum qualifications for technologists who perform diagnostic computed tomography exams.

TJC Releases New Prepublication Standards For Substance Abuse, Palliative Care
The Joint Commission has approved two new prepublication standards. The revisions for publication regarding opioid treatment programs will take effect Friday, July 1. The Substance Abuse and Mental Health Services Administration issued an update to its 2007 Guidelines for the Accreditation of Opioid Treatment Programs. TJC reviewed and incorporated the guidelines for continued accreditation. In addition, home health and hospice facilities already accredited by TJC can receive community-based palliative care certification for providing a CBPC program.

TJC Announces New Requirements
The Joint Commission recently posted the requirements for its new Advanced Certification for Total Hip and Total Knee Replacement Program. TJC also has updated its Sentinel Event Policy and Procedures for various accreditation or certification programs.

TJC Awards First Integrated Care Certification
The Joint Commission has awarded Parish Medical Center, a public not-for-profit facility in Titusville, Fla., with the first Integrated Care Certification award in the U.S. The new certification began in July 2015. The purpose of the award is to recognize hospital and ambulatory centers that excel at integrating information-sharing, transitions of care, hand-off communications and other vital activities which help ensure continuity of care as the patient moves between various settings.

Hospitals and ambulatory care settings that would like to pursue Integrated Care Certification can find additional information by visiting TJC's website or emailing integratedcare@jointcommission.org.

Establish an Effective QAPI Program

The Acute Care and Critical Access QAPI Improvement Guide supports organizations' quality improvement efforts and helps key hospital leaders recognize and understand the major components of the QAPI initiative.

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