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CMS Final Rule on 2014 OPPS and Quality Reporting

In December, CMS issued a Final Rule for the 2014 Outpatient Prospective Payment System (OPPS). Changes to the OQR were effective January 1, 2014.The final rule did not differ significantly from the proposed rule and includes only minor changes to quality reporting requirements.

The 25 quality measures for **CY 2014 and CY 2015** payment determination remain unchanged from those adopted in the final rules for CY 2012 and 2013. Based on the prior rulemaking, data collection on two new measures begins January 1, 2014. The measures include:

1. OP-25: Safe Surgery Checklist
2. OP-26: Hospital Outpatient Volume Data on Select Outpatient Procedures

For **2016** payment determination, CMS adopted its proposal to remove two OQR measures:

1. OP-19 Transition Record with Specified Elements Received by Discharged ED Patients
2. OP-24 Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting

CMS adopted four of the five new measures proposed for **2016** payment determination:

1. Influenza Vaccination Coverage Among Healthcare Personnel (reported through the NHSN by May 15th)
2. Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
3. Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps
4. Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

For **CY 2016** and beyond, CMS adopted its proposal to revise OQR reporting periods. Hospitals will be asked to report between July 1 and November 1 of the year prior to the payment determination year on data from the previous year (i.e. report July 1, 2015 on data from January 1, 2014 to December 31, 2014 for 2016 payment determination). To reduce the reporting burden on hospitals, a sampling scheme will be applied to the new data measures (2, 3, and 4 above). Hospitals should use the same sampling and reporting methods used for ED throughput measures currently.

This issue includes information about:

Hospitals that don't successfully meet OQR requirements will receive a two percentage point reduction to their marketbasket update.

In the rule, CMS identified CY 2012 as the baseline period and CY 2014 as the performance period for CLABSI, CAUTI, and SSI measures for 2016 Value Based Purchasing payment determination (time periods were inadvertently omitted from the final inpatient rule).

The State Fiscal Year 2014-2015 Budget Proposal

Earlier this month, Governor Cuomo released his $142 billion Executive Budget Proposal for SFY 2014-2015. The healthcare initiatives included in the budget continue to be largely driven by the recent and ongoing efforts of the Medicaid Redesign Team in achieving the Triple Aim: better care, better health, lower costs. The New York State Division of the Budget summarizes healthcare initiatives included in the budget as those that:

"support more effective models of care, sustain the State's health benefit exchange, encourage regional collaborations among providers and communities, and make investments in the healthcare infrastructure and health information technology to transform the healthcare delivery system."

According to the Executive Budget Summary, MRT initiatives will have saved $17 billion in federal dollars, $10 billion of which they hope to reinvest in the healthcare system in New York State through the Medicaid 1115 Waiver. The recently amended waiver request would provide almost $7.4 million to pay for the Delivery System Reform Incentive Payment Plan. The DSRIP program would give hospitals and health systems performance-based funding for achieving the NYSDOH's goal of reducing potentially preventable hospitalizations by 25 percent over five years.

Through waiver funding and other investments, the proposed budget aims to expand access to capital for healthcare restructuring projects, establish and support Regional Healthcare Improvement Collaboratives and continue work in HIT infrastructure. To this end, a $1.2 billion capital program has been included to fund projects that make healthcare in New York State more efficient and affordable including facility integration, mergers and consolidation, expansion of primary care and implementation of care management models. Regional Health Improvement Collaboratives have been written into the budget for $7 million in 2015 and $16 million in 2017 to act as regional facilitators and conveners with the goal of improving healthcare quality, health outcomes and population health and reducing health disparities. Finally, the State will continue to support implementation of the SHINY (Statewide Health Information Network for New York) through $65 million in SFY 2014-2015 made possible by covered lives assessment revenues. An additional $30 million will go towards ongoing efforts to create an all payer database that will allow for future research and analysis of how patients are using the healthcare system and where future improvements and savings can be made.

Other MRT recommendations included in the proposed budget were support for the integration of behavioral and medical services through Behavioral Health Organizations, increased funding for social services including affordable housing and community providers as well as continuation of the Health Home initiative.

The budget proposes the continuation of the Medicaid Global Spending Cap, enacted in 2011, through March 31, 2016. If Medicaid spending continues to fall below the cap, a portion of savings (no less than 50%) will be returned to providers proportionally and no more than 50% will be made available to "critically needed providers" experiencing financial difficulty. The budget also proposes the elimination of the 2 percent across-the-board Medicaid cut that, if approved, would take effect March 31, 2014.

Other programs and changes included in the proposed budget are:

- Increased state oversight of urgent care centers, limited services clinics and office based surgery centers
- CON (Certificate of Need) reform
- A Basic Health Plan to insure those who may not qualify for Medicaid programs based on income or immigration status
- Out-of-network billing protections for patients
- Vital Access Provider Funding
- Modified HIV informed consent processes
- Nurse Practitioner Modernization Act

Members are encouraged to participate in local and state advocacy efforts on matters important to them during this election year.

Hepatitis C Testing Requirements

On October 23, 2013 Governor Cuomo signed into law a policy that will require healthcare providers to offer Hepatitis C tests to any patient receiving hospital inpatient or primary care born between the years 1945 and 1965. The NYSDOH estimates that there are 200,000 cases of HCV and that 75% of those infected are unaware of their status. The CDC estimates that three quarters of those infected with HCV are between the ages of 49 and 69 years old. The policy aims to identify Hepatitis C infection earlier so that treatment can be provided to stop the progression of the disease and to reduce related morbidity and mortality.

Certain patients will be exempt from this requirement including those that:

- Are receiving life saving care
- Have already been offered a test or have been tested
- Are unable to consent to the test

Emergency departments will not be under the jurisdiction of this law, however any hospital outpatient department or freestanding diagnostic and treatment center in which the patient is receiving primary care will be. Any physician, NP or PA providing primary care services to a patient regardless of setting is required to offer the test. This law could also apply to nursing homes, retail clinics, urgent care centers, STD clinics, employee health services and family planning sites if primary care is being provided by a physician, PA or NP. The law does not require that patients in observation care be offered the test.

Hospitals will be required to provide follow up care or a referral for patients that have been tested and returned positive results.

The law does not explicitly require insurance companies to pay for HCV testing and Medicare currently does not cover it. A NYSDOH FAQ document indicates that if patients are offered the HCV test but their insurance will not pay for it that providers should follow the "normal protocol for any other test that is ordered".

The HCV testing law is very similar to the HIV testing law but differs in a few key ways. The HIV test must be offered to patients in the 13-64 age bracket as well as those for whom risk factors have been identified. HCV testing only needs to be offered to patients within the above-mentioned age brackets. HIV laws require that the hospital or physician help the patient obtain follow-up care including help with making an appointment; the HCV requires only a referral for follow up care. There is no partner notification requirement for patients who test positive for HCV. The law went into effect January 1, 2014 but does not yet include any additional reporting requirements.

New Pediatric Regulations

On December 31, 2013 new regulations for hospitals providing inpatient or emergency care to pediatric patients were published in the New York State Register. Among the new policies are staffing and training requirements for Emergency Departments (EDs) and Pediatric Intensive Care Units (PICUs), new protocols for the review and communication of critical value test results and a requirement to provide caregivers with a Parent's Bill of Rights. The new regulations will apply to children as well as patients lacking decision making capacity.

Emergency Departments with more than 15,000 visits per year will be required to have at least on clinician with the skills needed to diagnose and treat critically ill or injured children on every shift. Hospitals with fewer visits must be able to have a skilled physician on site within 30 minutes. Clinicians staffing the ED will need to be trained in infant and child resuscitation. PICUs will be subject o a new volume requirement of 200 patients per year under the policy, and will be required to appoint a director who is a board-certified pediatric, medical, surgical or anesthesiology critical care physician and staff trained in pediatric advanced life support.

Hospitals may only admit patients for whom they have the staff training and resources to care for (including appropriately sized medical devices). Under the new regulations, all critical value test results must be reviewed by a physician, NP or PA familiar with the patient's condition once they become available. Hospital staff must ask patients and/or caregivers if they have a primary care physician and test results must be forwarded to the PCP if one has been identified.

Patients cannot be discharged until all critical value tests results have been received, reviewed by a clinician and communicated to the patient or caregiver in a way that they can understand and use to make subsequent medical decisions. Discharge plans must include a summary of the diagnostic tests completed, their status and results, medications, diagnosis and follow up care required for the patient. Patient caregivers must be given a written and verbal explanation of the summary of care and discharge instructions.

Hospitals will have to provide a Parent's Bill of Rights notifying parents of the previously described regulations relating to review and communication of critical test results and explanation of discharge instructions. The Bill of Rights must also explain the caregiver's right to access the patient's medical information as well as their right to accompany the patient at all times. The regulations were created to ensure that hospitals are only providing care to pediatric patients they have the resources and expertise to treat and will go into effect March 1, 2014.

Notice of Observation Care

On October 21, 2013 Governor Cuomo signed a new law that will require hospitals to notify patients both verbally and in writing that they are under observation care within 24 hours of placement. Patients or their representatives must sign a written notice of observation care to acknowledge that they have received it. Within the notice, the hospital must state that observation status may affect insurance coverage for services including medications and other pharmaceutical supplies as well as post-discharge services in a nursing home or through home care. Patients should be advised that if they have questions regarding their coverage, they should follow up with their insurance provider.

This law was scaled back from its proposed version which included a requirement that hospital staff explain the patient's coverage and possible out-of-pocket expenses.

The NYSDOH has released guidance on delivering both the written and verbal communication with patients. The law went into effect January 19, 2014.

Delay of Two Midnight Full Enforcement

CMS announced on Friday January 31st, that it would delay the full enforcement of the "two midnight" rule until October 1, 2014, giving hospitals an additional 6 months to prepare. Medicare Administrative Contractors (MACs) have been advised to continue the current "probe and educate" campaign through the six-month extension. Under the campaign, the MACS — including this region's MACS, National Government Services — select 10-25 short-stay claims based on the size of the hospital for review. They will deny claims that are found not to be compliant with the rule. They will then revisit providers where there were concerns for additional educational outreach. Hospitals with "moderate to significant" concerns will have to submit 10 or 25 more claims, depending on size. Hospitals with "major concerns" will have to submit 100 or 250 claims. Recovery Audit Contractors will be advised not to not to review claims with admission dates that fall within the probe/education campaign for compliance with the new regulation.

CMS also released a document further clarifying the requirements for the physician certification and the inpatient order in greater detail than any other documents released up to this point. To access the CMS "two midnight" clarification document, please click here.

HANYS and the allied associations will continue to advocate for payment reform that would adequately reimburse for services provided under observation care.