**CAH Necessary Provider Issue**

Some CMS Regional Offices sent letters to certain CAHs requesting documentation of their compliance with CAH location requirements. This was a follow-up to the 2013 OIG [report on CAH compliance with location requirements](http://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf), which identified approximately 100 CAHs that did not meet the distance requirement *and* were not identified as Necessary Providers.

* Recipients of the CMS letters should have received notice that the letters have been rescinded and do not require a response.
* However, the [State Operations Manual Appendix W for CAHs](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf) states that CMS Regional Offices (RO) and state Survey Agencies (SA) should have documentation of a CAH’s original Necessary Provider designation in their files. If they do not, they should ask the CAH to supply it. CAHs will need to provide this information during their next recertification survey, or upon RO/SA request.
* CAHs that do not meet the distance requirements and are not Necessary Providers are subject to loss of CAH status, which would require conversion to PPS to continue participating in Medicare.

All CAHs must also be located in a rural area (non-metro county) or must complete an urban-to-rural reclassification to be treated as rural ([42 CFR §412.103](http://www.ecfr.gov/cgi-bin/text-idx?SID=53ce343dafa3dd04c61f6d86def52885&node=se42.2.412_1103&rgn=div8)). The rural requirement is separate from the distance requirement and Necessary Provider status does not provide a waiver to the rural requirement. FORHP project officers notified state offices in November about CAHs that may need to complete an urban-to-rural reclassification. (Note: “Lugar county” designation does not affect CAH rural status.)

**CAH/RHC PQRS Participation**

There has been some confusion around [PQRS](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html) payment penalties for CAHs and RHCs due to letters that CMS sent to eligible professionals who practice in these facilities.

* RHC Medicare claims **are not** subject to PQRS penalties.  However, any Part B fee schedule claims for professional service submitted separately by RHC providers are subject to PQRS (e.g., services provided to hospital inpatients).  The CMS letters reference the affected Tax ID # (TIN) and NPI, which should be for the Part B practice, [not the RHC](https://questions.cms.gov/faq.php?id=5005&faqId=11910). CMS used the best available address in PECOS to send the letters, which sometimes was the RHC address.
* Method II CAH eligible professionals (EPs) **are not** subject to 2015 PQRS penalties based on 2013 claims, because their claims couldn’t be processed for PQRS until 2014. However, a small number of Method II CAH clinicians received a letter in error.  CMS has identified them and updated the system.  The Quality Net Help Desk (866-288-8912 or Qnetsupport@hcqis.org) has a corrected list of EPs subject to the 2015 penalty.  The TIN and NPI listed in the letter should refer to a non-CAH Part B practice that will be penalized in 2015.
* Method II CAH eligible professionals **can** participate in PQRS beginning in 2014, according to a recently issued [FAQ](https://questions.cms.gov/faq.php?id=5005&faqId=9952).

If an EP remains concerned about whether the PQRS penalty is being properly applied to them, they can request an informal review by February 28, as indicated in the letter.

Also, the deadline to avoid a 2016 penalty for applicable 2014 Medicare claims for most providers is February 28.  For additional important dates, check out the [PQRS Timeline](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS-Timeline-2014-2016.pdf).

**CMS Issues Final 2016 Essential Community Providers List, Includes RHCs**

On February 6, CMS posted a [final list of Essential Community Providers](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/FINAL-non-exhaustive-HHS-List-of-ECPs-for-PY-2016.xlsx) (ECPs) for 2016 Marketplace Qualified Health Plans (QHPs). Insurers use the ECP list to identify providers for their marketplace/exchange plan networks.

In 2016 and beyond, CMS will include an RHC on the ECP list if it meets the following requirements:

1. Based on attestation, it accepts patients regardless of ability to pay and offers a sliding fee schedule, or is located in a primary care Health Professional Shortage Area (geographic, population, or automatic); and

2. Accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, Marketplace plan, etc.).

More than 3,300 RHCs currently meet the requirements and are included on the 2016 list. The remaining RHCs have the opportunity to be included on the 2017 list if they meet the requirements above and complete this [form](http://bhpr.hrsa.gov/shortage/hpsas/certofeligibility.pdf) (also used for [automatic HPSA designation](http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html)) and submit it, along with a copy of the clinic’s sliding fee schedule, to HRSA via fax at 301-443-2111 or 301-443-0463.

**CMS Updates State Operations Manual for CAHs, RHCs, FQHCs, Other Providers**

On January 16, CMS issued updates to the CAH appendix to the State Operations Manual (SOM). An advance copy of the revised manual was attached to [Survey & Certification Letter 15-19](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-19.html?DLPage=1&DLSort=2&DLSortDir=descending). The full manual is stilling being updated, but the new guidelines are effective immediately. Updates with significantly increased interpretive guidance include:

* Clarification of required MD/DO review of *inpatient* records when care is provided by non-physician practitioners (review not required for outpatient records unless by state law)
* Inpatient services must be commensurate with the level of other services
* Requirements that therapy services (PT, OT, & SLT) are provided by staff qualified under state law
* Requirements to monitor patient access to specialty services not available at the CAH
* Expanded medication administration and safety standards
* Drug oversight and drug compounding
* Infection control, monitoring, and reporting of healthcare acquired infections
* Patient nutrition and dietary assessments

On January 30, CMS issued updates to the SOM appendices impacting several provider types. An advanced copy of the revised manual was attached to [Survey & Certification Letter 15-22](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-22.html). The affected provider types include:

* Appendix A – Hospitals
* Appendix T - Hospital Swing Beds
* Appendix L – ASCs
* Appendix G – RHCs and FQHCs

In addition, the [Medicare Benefit Policy Manual, Chapter 13](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf) (RHC and FQHC Services) has been updated effective January 1.  RHC updates include employment requirements, preventive health services, and other issues related to billing and services. [MedLearn Matters 8981](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8981.pdf) provides a summary of the updates.