Overview and Resources

On August 17, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 final payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. Among the regular updates, this final rule includes:

- Updates to the program rules for the Value-Based Purchasing (VBP), Readmissions Reduction, and Hospital-Acquired Condition (HAC) programs;
- Updates to the payment penalties for non-compliance with the Electronic Health Record (EHR) Incentive Program; and
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, as mandated in the Affordable Care Act of 2010 (ACA).

Program changes are effective for discharges on or after October 1, 2015 unless otherwise noted.

A copy of the final rule Federal Register (FR) and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html.

An online version of the rule is available at https://federalregister.gov/a/2015-19049.

A brief summary of the major hospital IPPS sections of the final rule is provided below.

IPPS Payment Rates

FR pages 49345, 49508-49511, 49597-49598, and 49771-49795

The table below lists the full federal operating and capital rates for FFY 2016 compared to the rates currently in effect for FFY 2015. These rates include all marketbasket increases and reductions as well as the application of an annual Budget Neutrality factor. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2015</th>
<th>Final FFY 2016</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$5,437.85</td>
<td>$5,466.09</td>
<td>+0.5%</td>
</tr>
<tr>
<td></td>
<td>(proposed at $5,479.03)</td>
<td>(proposed at $5,479.03)</td>
<td></td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$434.97</td>
<td>$438.65</td>
<td>+0.8%</td>
</tr>
<tr>
<td></td>
<td>(proposed at $438.40)</td>
<td>(proposed at $438.40)</td>
<td></td>
</tr>
</tbody>
</table>
The table below provides details for the annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2016.

<table>
<thead>
<tr>
<th></th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update/Capital Input Price Index</td>
<td>+2.4%</td>
<td>+2.4%</td>
<td>+1.3%</td>
</tr>
<tr>
<td>ACA-Mandated Reductions</td>
<td>-0.7 percentage points (PPT)</td>
<td>-0.7 PPT</td>
<td>-</td>
</tr>
<tr>
<td>American Taxpayer Relief Act (ATRA)-Mandated Retrospective Documentation and Coding Adjustment</td>
<td>-0.8%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Annual Budget Neutrality Adjustment</td>
<td>-0.4%</td>
<td>-0.4%</td>
<td>-0.5%</td>
</tr>
<tr>
<td><strong>Net Rate Update</strong></td>
<td>+0.5%</td>
<td>+1.3%</td>
<td>+0.8%</td>
</tr>
</tbody>
</table>

- **Effect of the IQR and EHR Incentive Programs (FR pages 49508-49511):** Beginning in FFY 2015, the IQR MB penalty shifted from a set -2.0 percentage points to 25% of the full MB, and the EHR Meaningful Use (MU) penalty began its phase-in over three years, starting at 25% of the full MB. In FFY 2016, the EHR MU penalty will increase to 50% of the MB, then to 75% of the MB in FFY 2017. Hence, by FFY 2017, the full MB update will be at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2016 is below:

<table>
<thead>
<tr>
<th></th>
<th>Neither Penalty</th>
<th>IQR Penalty</th>
<th>EHR MU Penalty</th>
<th>Both Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Rate Federal Rate Update (from above)</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
</tr>
<tr>
<td>Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.4%)</td>
<td>—</td>
<td>-0.6 PPT</td>
<td>—</td>
<td>-0.6 PPT</td>
</tr>
<tr>
<td>Penalty for Failure to be a Meaningful User of EHR (50% of the base MB Update of 2.4%)</td>
<td>—</td>
<td>—</td>
<td>-1.2 PPT</td>
<td>-1.2 PPT</td>
</tr>
<tr>
<td><strong>Adjusted Net Rate Update</strong></td>
<td>+0.5%</td>
<td>-0.1%</td>
<td>-0.7%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

CMS has released an initial list of hospitals to be penalized under the IQR for FFY 2016, with 203 hospitals considered non-compliant. However, a list of hospitals penalized for non-compliance under EHR MU for FFY 2016 has not yet been released. In FFY 2015, 178 hospitals were penalized under the EHR MU Program, while 55 were considered non-compliant under IQR. Generally, successful participation in both programs is based on data collection two years prior to the payment adjustment year.

- **Retrospective Coding Adjustment (FR page 49345):** CMS will apply a retrospective coding adjustment of -0.8% to the federal operating rate in FFY 2016. This rate reduction was authorized as part of the American Taxpayer Relief Act of 2012 (ATRA) and requires inpatient payments to be reduced by $11 billion (or -9.3%) over a 4-year period. To meet the ATRA requirements, CMS applied -0.8% coding adjustments in FFYs 2014 and 2015, is applying this 0.8% reduction in FFY 2016, and is expected to apply a similar reduction in FFY 2017. Each of these -0.8% reductions has been layered on top of the prior year’s, thereby compounding the reductions in order to achieve the full recoupment over four years. Once the full recoupment has been accomplished, the base amount must be restored.

The 3.2% positive adjustment, meant to restore the federal base rates, was anticipated to take effect in FFY 2018; however, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), delays and phases in this adjustment over 6 years (FFY 2018-2023) in 0.5% increments, resulting in a total restoration of 3.0% and maintaining a prospective reduction of 0.2%.
Effect of Sequestration (no FR page reference): While the final rule does not specifically address the 2.0% sequestration reductions to all Medicare payments authorized by Congress and currently in effect through FFY 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and EHR incentives are also affected by the sequester reductions. Payments from Medicare Advantage plans should not be automatically impacted by sequester.

Wage Index
FR pages 49488-49508

In FFY 2015, CMS updated the CBSA delineations used in the determination of the wage index. This change caused some shifts in the CBSA assignments for providers. CMS provided a one year transition for 611 hospitals that experienced decreased wage index values due to the new definitions. That transition adjustment no longer applies in FFY 2016. For the nine hospitals that are located in counties that were formerly considered to be either urban or LUGAR, FFY 2016 is the second year of the three-year hold harmless provision.

For FFY 2016, CMS adopted several changes that will affect the wage index and wage index-related policies; the most significant changes are:

- **Outmigration Adjustment Changes (FR pages 49500-49502):** Currently, CMS uses the journey-to-work data from the 2000 Census for all industries to determine the outmigration adjustment to the wage index. The 2010 Census did not include the long-form that would have collected the data necessary for updating these adjustments. CMS adopted the use of a subset (specific to hospital employees) of the 2008-2012 data taken from the American Community Survey (ACS), which compiles responses on workers’ counties of residence and to where they commute. For FFY 2016, hospitals that qualified in FFY 2014 and FFY 2015 to receive the outmigration adjustment, based on the commuting data and CBSA delineations used in FFY 2014, will continue to receive the same outmigration adjustment for the remainder of their 3-year qualification period. This change will impact approximately 10% of the hospitals receiving this adjustment. A complete list of the adopted outmigration adjustments may be found on Table 2 on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html.

- **Labor-Related Share (FR pages 49503-49505):** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2016, CMS will continue to apply a labor-related share of 69.6% for hospitals with a wage index of 1.0 or more. By law, the labor-related share for hospitals with a wage index less than 1.0 will remain at 62%.

- **Changes to the Three-Year Average Pension Policy (FR pages 49505-49507):** Currently, CMS calculates the pension cost component of the wage index as the three-year average of pension contributions using cost report data for the base wage index year, the year prior, and the year post the base year. Beginning in FFY 2017, CMS will instead calculate the three-year average pension contribution using the base cost report year and the two preceding years. Hence, for FFY 2017 (the first year of this change) the pension component of the wage index would use the same three years of data that will be used for FFY 2016.

- **Updated Wage Index Development Timetable for FFY 2017 (FR pages 49505-49507):** Each year, CMS develops the upcoming year’s Medicare wage indexes using a three-step process. This process allows hospitals to ensure accurate data is included in the wage index. Given the adopted changes to the pension data, CMS will revise the wage index development timetable for FFY 2017 to allow more time for hospitals to review and correct the data. The adopted FFY 2017 wage index development timeline is available on page 49506 of the rule.

A complete list of the wage indexes for payment in FFY 2016 is available on Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html.
Quality-Based Payment Adjustments
FR pages 49530-49581

For FFY 2016, IPPS payments to hospitals will be adjusted for quality performance under the Value Based Purchasing (VBP) Program, Readmissions Reduction Program (RRP), and the Hospital-Acquired Conditions (HAC) Reduction Program. The following provides detail on the FFY 2016 programs and payment adjustment factors (future program year changes are addressed at the end of this Brief):

- **VBP Adjustment (FR pages 49544-49570):** The FFY 2016 program will include hospital quality data for 25 measures in 4 domains: process of care; patient experience of care; patient outcomes; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2016 program will be funded by a 1.75% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.5 billion) compared to a 1.5% in FFY 2015. Because the program is budget neutral, hospitals can earn back some, all, or more than their 1.75% reduction.

  While the data applicable to the FFY 2016 VBP program is still being finalized, CMS has calculated and published proxy factors based on the current year’s (FFY 2015) program. Hospitals should use caution in reviewing these factors as they do not reflect performance on the new measures for FFY 2016, changes to domain weights, updated performance periods/standards, nor changes to hospital eligibility.

  The proxy factors published with the rule are available in Table 16 on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html).


- **Readmissions Reduction Program (RRP) (FR pages 49530-49543):** The FFY 2016 RRP will evaluate hospitals on the same 5 conditions/procedures as the FFY 2015 program: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD) and elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%. CMS estimates that the FFY 2016 program results in a cut of about $420 million to IPPS payments.

  The final FFY 2016 RRP factors are published with the final rule in Table 15 and on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html).

  Details and information on the RRP currently are available on CMS’ QualityNet website at [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458).

- **HAC Reduction Program (FR pages 49570-49581):** The FFY 2016 HAC program will evaluate hospital performance on 4 measures: the AHRQ Patient Safety Indicator (PSI)-90—a composite of 8 individual HAC measures, Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, and the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio (New in FFY 2016). The Surgical Site Infection pooled measure combines performance on the SSI-Abdominal Hysterectomy and SSI-Colon Surgery measures. The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. CMS has not yet released the list of hospitals subject to the HAC program penalty for FFY 2016; this delay is purposeful, in order to give hospitals’ QualityNet administrators more time to review and correct the new SSI measure. CMS is expected to release the FFY 2016 HAC flags in October 2015.
• **Extraordinary Circumstances (FR pages 49542-49543 and 49580-49581):** CMS has adopted an extraordinary circumstance exception policy for the FFY 2016 RRP and HAC programs. A similar policy is already in place for the VBP program. Hospitals experiencing an extraordinary event that limits their ability to submit quality data in a timely and accurate fashion would be exempted for the time period when the event occurs only. Any data submissions required during the event timeframe would be excluded from the programs.

**DSH Payments**

*FR pages 49512-49530*

The ACA mandates the implementation of new Medicare DSH calculation and payment in order to address the reductions to uncompensated care as the law takes effect. By law, 25% of estimated DSH funds, using the traditional formula, will continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds are subject to reduction to reflect the impact of insurance expansion under the ACA. This new Uncompensated Care (UCC) pool will be redistributed to hospitals based on each hospital’s proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

• **DSH Payment Methodology for FFY 2016 (FR pages 49512-49530):**

The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2015 to FFY 2016:

1. Project list of DSH-eligible hospitals (15% DSH percentage or more) and project total DSH payments for the nation using traditional per-discharge formula
   - $13.411 B (FFY 2016); [$13.384 B (FFY 2015); $12.791 B (FFY 2014)]
   - Includes adjustments for inflation, utilization, and case mix changes

2. Continue to pay 25% at traditional DSH value
   - $3.353 B (FFY 2016); [$3.346 B (FFY 2015); $3.198 B (FFY 2014)]
   - Paid on per-discharge basis as an add-on factor to the federal amount

3a. FACTOR 1: Calculate 75% of total projected DSH payments to fund UCC pool
   - $10.058 B (FFY 2016); [$10.038 B (FFY 2015); $9.593 B (FFY 2014)]

3b. FACTOR 2: Adjust Factor 1 to reflect impact of ACA insurance expansion
   - Based on latest CBO projections of insurance expansion
   - 36.3% reduction (FFY 2016); [23.8% (FFY 2015); 5.7% (FFY 2014)]
   - $6.406 B to be distributed.

3c. FACTOR 3: Distribute UCC payments based on hospital’s ratio of UCC relative to the total UCC for DSH-eligible hospitals
   - Based on 2011/2012 Cost Report data (same as FFY 2015) and 2013 SSI ratios
   - Paid on per-discharge basis as an add-on factor to the federal amount

4. Determine actual DSH eligibility at cost report settlement
   - No update to national UCC pool amount or hospital-specific UCC factors (unless merger occurs)
   - Recoup both 25% traditional DSH payment and UCC payment if determined to be ineligible at settlement
   - Pay both 25% traditional DSH payment and UCC payment determined to be DSH-eligible at settlement, but not prior
The DSH dollars available to hospitals under the ACA's payment formula will decline in FFY 2016 and will continue to be reduced in the coming years as insurance coverage rates are expected to increase.

- **Eligibility for FFY 2016 DSH Payments** (*FR pages 49514-49515*): CMS is projecting that 2,396 hospitals will be eligible for DSH payments in FFY 2016. Only hospitals identified in the rule as DSH-eligible will be paid as such during FFY 2016. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html).

  According to the tables provided in this final rule, 99 hospitals that were not eligible for DSH in FFY 2015 are projected to receive DSH payments in FFY 2016; while 72 are projected to lose eligibility due to changes in their Medicare and Medicaid days.

- **Impact of the New CBSA Delineations on DSH Payments** (*FR page 49513*): Under the new CBSA delineations adopted in FFY 2015, a hospital’s DSH payments may be impacted if it loses urban status, because there is a 12% cap on traditional DSH payments to rural hospitals. To address this, CMS adopted a three-year transition from the urban DSH payment amount to the rural DSH amount for six hospitals that changed status due to the new CBSAs. FFY 2016 is the second year of this transition and impacted hospitals will receive 1/3 of the difference between current DSH payments and what would have been paid without the 12% cap.

- **Future Use of Data from Cost Report Worksheet S-10 for Determining Factor 3** (*FR pages 49522-49530*): CMS indicates its desire to determine the UCC payment factor (Factor 3) using data reported on Worksheet S-10 of the Medicare cost report. CMS has been using a proxy for Factor 3 in FFYs 2014 and 2015 and will do so again for FFY 2016, due to concerns regarding data variability and lack of reporting experience with S-10 Worksheet. In the final rule, CMS again states its commitment to making the necessary revisions and clarifications to the S-10 instructions to ensure accurate and consistent reporting across hospitals.

**GME Payments**  
*FR page 49512*

CMS did not make any proposals related to the Indirect Medical Education (IME) and direct GME payment policies; the IME adjustment factor will remain at 1.35 for FFY 2016.

**Updates to the MS-DRGs**  
*FR pages 49345-49350, 49354-49488 and 49592-49593*

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes adopted to the MS-DRGs for FFY 2016 will increase the number of payable DRGs from 751 to 758. The majority of the DRG weights (79%) will change by less than +/- 5%. CMS also adopted an IPPS transition to ICD-10 effective October 1, 2015.

CMS has updated the list of DRGs subject to the post-acute care transfer policy, reassigning the heart chamber procedures using intracardiac techniques from their current assignment in MS-DRGs 246 through 251 to the two new MS-DRGs 273 and 274. The post-acute transfer DRG changes are listed on pages 49592-49593.

The full list of FFY 2016 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html).
For comparison purposes, the FFY 2015 DRGs are available in Table 5 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html.

**Outlier Payments**

*FR pages 49779-49786*

To maintain outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of $22,544 for FFY 2016. The new threshold is 8.45% lower than the current (FFY 2015) outlier threshold of $24,626. CMS cites a decrease in hospital charges as the reason for the threshold decrease.

**HAC MS-DRG Payment Policy**

*FR pages 49350-49354*

CMS is not expanding or removing any categories/conditions for the HAC MS-DRG payment policy. CMS has also adopted its proposal to replace the ICD-9-CM Version 32 HAC list with the ICD-10-CM/PCS Version 33 HAC list.

**Updates to the IQR Program and Electronic Reporting Under the Program**

*FR pages 49639-49713 and 49757-49761*

CMS is adding four new measures (one clinical episode-based payment measures, one patient safety measure, and two coordination-of-care measures) and removing nine measures (six of which are topped-out and three that have been suspended) to the HIQR program beginning in FFY 2018. CMS is also refining two previously adopted measures for FFY 2018 and is adopting three clinical episode-based payment measures beginning in FFY 2019.

CMS also adopted two changes to the electronic clinical quality measures (eCQMs). CMS will clarify requirements for the submission of the STK-01 measure for CY 2015/FY 2017 payment determination. CMS will also require hospitals to submit four of the available twenty-eight eCQMs covering three National Quality Strategy (NQS) domains beginning in Calendar Year 2016 for the FY 2018 payment determination. These align the CQM reporting period for electronic reporting for both the EHR and IQR programs for eligible hospitals and critical access hospitals, specify the options for the editions of certified EHR technology providers may use, and establish requirements for the version of electronic specifications (eCQMs) a provider must use for electronic submission of quality reporting data. CMS adopted the requirement of using one of the two quarters (Q3 and Q4) of reporting in CY 2016, with a reporting deadline of February 28, 2017.

A table on pages 49690-49692 of the final rule outlines the Hospital IQR Program measure set for the FY 2018 payment determination and subsequent years and includes both previously adopted and new measures.

**New Technology**

*FR pages 49431-49488*

In the final rule, CMS responded to feedback on numerous new medical services or technologies for potential add-on payments outside the PPS. There are three medical services/technologies for which CMS will discontinue add-on payments, five for which CMS will continue new technology add-on payments, and two for which CMS adopted new add-on payments.
Expiration of the More Inclusive Low-Volume Adjustment Criteria  
*FR pages 49594-49597*

Legislative action by Congress over the past several years had mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. MACRA extended the relaxed low volume adjustment criteria (15-mile/1,600 discharge) by an additional 30 months, through the end of FFY 2017. Generally, hospitals that qualified for the low-volume adjustment for FFY 2015 should continue to qualify; however, hospitals must notify their MAC in writing, by September 1, that the 15-mile distance criterion continues to be met. Hospitals newly seeking the adjustment are required to make a request in writing to their MAC by September 1, 2015 in order to achieve the adjustment beginning October 1. Hospitals that request the status after September 1 and qualify will be eligible for the adjustment, prospectively, within 30 days of the MACs determination. CMS estimates that this adjustment results in increased IPPS payments of $322 million for FFY 2016.

Expiration of MDH Status  
*FR pages 49594-49597*

The Medicare-Dependent Hospital (MDH) program has been extended several times by Congressional legislative action. Most recently, MACRA, extended this program by an additional 30 months, through the end of FFY 2017. CMS estimates that this program will apply to 90 facilities for a total, positive, impact of $96 million in FFY 2016.

RRC Status  
*FR pages 49511-49512*

Hospitals that meet certain criteria can be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and special treatment with respect to geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The FFY 2016 minimum case-mix and discharge values by region are available on page 49512.

Bundled Payment for Care Improvement Initiative  
*FR page 49432*

In 2011, CMS announced the Bundled Payment for Care Improvement Initiative (BPCI) where organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Episodes of care under the BPCI initiative begin with an inpatient hospital stay or a post-acute care encounter following a qualifying inpatient hospital stay. CMS is currently testing four models of care for determining and paying for episodes of care. CMS received public comments on a number of policy and operational issues regarding a potential expansion of the BPCI initiative including: breadth and scope of an expansion, episode definitions, models for expansion, roles of organizations and the relationships necessary or beneficial to care transformation, setting bundled payment amounts, mitigating risk of high-cost cases, administering bundled payments, data needs, use of health information technology, quality measurement and payment for value, and how to transition from Medicare FFS payments to bundled payments. CMS will consider these comments if the BPCI initiative is expanded through future rulemaking.
CAH Payment Policies

CBSA Delineation Changes: Critical Access Hospital (CAH) status may be at risk for facilities that are no longer situated in a rural area under the new CBSA delineations. CMS has provided a two-year grace period for CAHs to retain their current status, providing an opportunity for them to achieve rural status under a reclassification or other mechanism. FFY 2016 is the second year of the grace period.

Quality-Based Payment Policies—FFYs 2017 and Beyond

For FFYs 2017 and beyond, CMS is adopting new quality-based payment policies and measures for the VBP Program, Readmissions Reduction Program, and HAC Reduction Program, as follows:

- **VBP Program—FFYs 2018-2021 (FR pages 49544-49570):** CMS has already adopted VBP program rules through FFY 2017 and some program policies and rules beyond FFY 2017. CMS is adopting further program updates/changes for FFYs 2018-2021. These changes include:
  - Measure additions/deletions for FFYs 2018 and 2021 (the adopted measure changes would continue the shift of the program’s focus from process to patient outcomes/safety measures);
  - New data collection time periods (baseline/performance periods) for the FFY 2018-2021 program years (some periods were previously adopted);
  - National performance standards for a subset of the FFY 2018, 2019, 2020 and 2021 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking);
  - Removal of the Clinical Care – Process subdomain for FFY 2018 and future program years;
  - New measure weighting formulas for FFY 2018 used for calculating each hospital’s VBP Total Performance Score (TPS) and resulting payment adjustment (the adopted weighting formula would continue the shift toward a greater emphasis on patient outcomes, safety, and efficiency); and
  - Updates to the minimum measure/case counts and domain count requirements hospitals must meet in order to be included in the program.

CMS also addresses two potential changes to the subset of program measures that are reported to the Centers for Disease Control (CAUTI, CLABSI, SSI – Abdominal Hysterectomy, SSI – Colon, C. difficile and MRSA). For the CAUTI and CLABSI measures, CMS will be expanding data set to cover medical and surgical wards in addition to the Intensive Care Units (ICUs) they currently cover. For the infection measures, CMS notes that the CDC will be updating the reference population used to calculate measure ratios for the Hospital Acquired Infection (HAI) measures. Both changes would affect VBP-eligible hospitals beginning with the FFY 2019 program and will be addressed in future rulemaking.

Details and tables on the newly adopted measures, collection time periods, performance standards, and measure weighting are available on the pages listed above. Other details and information on the program currently in place for FFY 2015 and FFY 2016 program are available on CMS’ QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

- **Readmissions Reduction Program—FFY 2017 (FR pages 49530-49543):** CMS did not add any new readmissions measures to the RRP for FFY 2017; however, it is adopting a significant refinement to the pneumonia measure for FFY 2017 and future years that will expand the number of patients evaluated by the measure. Currently, the pneumonia measure evaluates hospital readmissions for patients with a principal diagnosis of viral or bacterial pneumonia only. The refined measure includes patients with a principal diagnosis of pneumonia or
aspiration pneumonia; and patients with a principle diagnosis of sepsis who also have a secondary diagnosis of pneumonia coded as present on admission. Under the RRP program, the refinement would have an effect on hospital readmission rates, national readmission rates, excess readmission ratios, and total revenue for the condition and will likely increase impacts under the program. CMS believes the change will better reflect the full population of pneumonia patients and would reduce variation between hospitals that results from differences in coding practices. CMS states that the modified refinements to the pneumonia measure adopted in this final rule will result in an increase in patients evaluated under the measure, approximately 15% smaller than the 65% estimated in the proposed rule.

Details and information on the program currently in place is available on CMS’ QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.

- **HAC Reduction Program—FFYs 2017 and 2018 (FR pages 49570-49581):** CMS is not adopting any additional measures for FFY 2017; however, it will shift the domain weighting used to calculate the Total HAC Score for determining penalty applicability for FFY 2017. CMS will increase the Domain 2 weight (CDC/NHSN measures) from 75% to 85% in FFY 2017, to reflect the increased number of measures in the domain as well as MedPAC recommendations. CMS also adopted a change that will provide hospitals with a score of 10 (worst possible) for any measures that a hospital does not submit, unless they have also been provided with a waiver.

For FFY 2018, CMS will expand the CAUTI and CLABSI measures to non-ICU locations such as adult/pediatric medical, surgical, and medical/surgical wards to reflect NQF recommendations. The change is consistent with finalized policies for the IQR.

CMS notes that the measures included under the Quality-Based Payment program are currently under review. The National Quality Forum (NQF) is considering adding three PSI component measures to the PSI-90 composite calculation (PSI-9, PSI-10, and PSI-11). Additionally, CDC is updating the reference population used to evaluate hospitals under the Domain 2 measures. The updated reference population would not take effect until FFY 2016 reporting and FFY 2018 payment adjustments.

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