Medicare Inpatient Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2016

Overview and Resources

On April 17, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. Due to timing, this proposed rule does not incorporate any of the changes that were implemented as a result of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015; however, those changes will be referenced in this Brief where applicable. Among the regular updates, this proposed 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, if adopted as final, would be effective for discharges on or after October 1, 2015 unless otherwise noted.

A copy of the proposed rule Federal Register (FR) and other resources related to the IPPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html. Comments on all aspects of the proposed rule are due to CMS by June 16 and can be submitted electronically at http://www.Regulations.gov by using the website’s search feature to search for file code “1632-P”.

An online version of the rule is available at https://federalregister.gov/a/2015-09245. Page numbers noted in this summary are from the version of the proposed rule published in the Federal Register.

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

IPPS Payment Rates
FR pages 24,477-24,479, 24,625-24,631, and 24,634-24,641

The table below lists the full federal operating and capital rates for FFY 2016 compared to the rates currently in effect. These rates reflect all marketbasket increases and reductions as well as the application of an annual Budget Neutrality factor. These rates do not reflect any hospital-specific reductions for non-compliance under the Inpatient Quality Reporting (IQR) Program and EHR Incentive Program.

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2015</th>
<th>Proposed FFY 2016</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$5,437.85</td>
<td>$5,479.03</td>
<td>+0.8%</td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$434.97</td>
<td>$438.40</td>
<td>+0.8%</td>
</tr>
</tbody>
</table>
The table below provides details and compares the proposed updates for 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>+2.7%</td>
<td>+2.7%</td>
<td>+1.3%</td>
</tr>
<tr>
<td>ACA-Mandated Reductions 0.6% productivity reduction and 0.2% pre-determined reduction</td>
<td>-0.8%</td>
<td>-0.8%</td>
<td>—</td>
</tr>
<tr>
<td>American Taxpayer Relief Act (ATRA)-Mandated Retrospective Coding Adjustment Reduction</td>
<td>-0.8%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Annual Budget Neutrality Adjustment</td>
<td>-0.3%</td>
<td>-0.3%</td>
<td>—</td>
</tr>
<tr>
<td><strong>Net Rate Update</strong></td>
<td>+0.8%</td>
<td>+1.6%</td>
<td>+1.3%</td>
</tr>
</tbody>
</table>

- **Effect of the IQR and EHR Incentive Programs (FR pages 24,477-24,479 and 24,625-24,626):** As of FFY 2015, the IQR MB penalty shifted from -2.0 percentage points to 25% of the full MB, and the EHR MB penalty began its phase-in over three years, starting at 25% of the full MB. In FFY 2016, the EHR MB penalty will increase to 50% of the MB, then to 75% of the MB in FFY 2017. Hence, the full MB update will be at risk under these two programs by FFY 2017. A CMS table displaying the various update scenarios for FFY 2016 is available on page 24,478 of the FR. CMS has not yet finalized the list of hospitals that will be penalized under the IQR and/or EHR Incentive Programs for FFY 2016, but likely will release that list prior to October 1. For FFY 2015, 238 hospitals were penalized under the EHR Incentive Program, while 67 were not considered 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 24,342):** CMS is proposing to 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 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, 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 anticipated 3.2% positive adjustment, meant to restore the federal base rates, was anticipated in FFY 2018; however, due to MACRA, this adjustment will be phased-in over 6 years (FFYs 2018-2023) in 0.5% increments, resulting in a total restoration of 3.0%, maintaining a prospective reduction of 0.2%.

- **Effect of Sequestration (no FR page reference):** While the proposed rule does not specifically address the 2.0% sequester 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 24,463-24,477*

In FFY 2015, CMS updated the CBSA delineations used in the determination of the wage index. This change resulted in a one year transition for the 611 hospitals that experienced a decrease in wage index due to the new definitions. FFY 2016 is the second year of the three-year hold harmless provision for nine hospitals that are located in a county formerly considered to be either urban or LUGAR. For FFY 2016, CMS proposes several changes that will affect the wage index and wage index-related policies; the most significant those proposals are:
• **Outmigration Adjustment Changes (FR pages 24,471-24,472):** 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 proposes to utilize 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. This change will impact approximately 10% of the hospitals receiving this adjustment. A complete list of the proposed 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-Proposed-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html).

• **Labor-Related Share (FR pages 24,474-24,475):** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2016, CMS is proposing to continue applying a labor-related share of 69.6% for hospitals with a wage index greater than 1.0. 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 24,475-24,477):** Currently, CMS calculates the pension cost component of the wage index as the three-year average of pension contributions from using cost report data for the base wage index year, the year prior, and the year post the base year. In light of the recent changes made to the timetable for development of the wage index, CMS is proposing to 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.

• **Updated Wage Index Development Timetable for FFY 2017 (FR pages 24,475-24,477):** 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 proposed changes to the pension data, CMS is proposing to revise the wage index development timetable for FFY 2017 to allow more time for hospitals to review and correct the data. The proposed FFY 2017 wage index development timeline is available on page 24,476 of the rule.

A complete list of the proposed 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-Proposed-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html).

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**Quality-Based Payment Adjustments**

**FR pages 24,498-24,514**

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

• **VBP Adjustment (FR pages 24,498-24,509):** The FFY 2016 program will include hospital quality data for 18 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 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 for FFY 2016, changes to domain weights, updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors published with the proposed rule are available in Table 16 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html. CMS anticipates making actual FFY 2016 VBP adjustment factors available in October 2015. 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 (RRP) (FR pages 24,488-24,498):** The FFY 2016 Readmissions program 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 no material impact change from the FFY 2015 program, which was estimated to cut about $422 million from IPPS payments (up from about $227 million in FFY 2014).

While the data applicable to the FFY 2016 program is still being finalized, CMS has calculated and published proxy adjustment factors. Unlike the VBP proxy factors, the Readmissions Reduction Program proxy factors take into consideration performance on all FFY 2016 program measures and provide a good assessment of relative performance and potential exposure. It is anticipated that CMS will make actual FFY 2016 adjustment factors available in October 2015 with the final rule.

The proxy factors published with the proposed rule are available in Table 15 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html. 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 Adjustment (FR pages 24,509-24,514):** 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. In FFY 2015, the HAC Reduction Program resulted in a $330 million reduction to IPPS payments. Because the 1.0% reduction factor is not scheduled to increase in future years, the IPPS cut should remain around $300-$400 million each year going forward. CMS did not release a list of hospitals subject to the program penalty for FFY 2016 in order to give them more experience with the review and corrections process. It is anticipated that CMS will make actual FFY 2016 HAC flags available in October 2015.

- **Extraordinary Circumstances (FR pages 24,497-24,498):** CMS is proposing 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.
The ACA mandates the implementation of new Medicare DSH payment policies to reduce and redistribute DSH payments over time, as the law will reduce the amount of uncompensated care. Under the 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 and will be redistributed to hospitals as a new and separate uncompensated care (UCC) payment based on each hospital’s ratio of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2016 (FR pages 24,480-24,488)**: CMS did not propose any major changes to the DSH payment policies for FFY 2016; it is proposing to continue to use the most recent of the 2011 or 2012 cost report data (the same years used in FFY 2015) to calculate the Medicaid days component of the UCC.

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 DSH-eligible hospitals using traditional DSH formula (15% disproportionate patient percentage or more) and project total DSH payments for the nation using traditional per-discharge formula.**
   - $13.338 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 traditional DSH at 25% of current DSH adjustment value**
   - $3.334 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)** Take 75% of total DSH payments to fund UCC payments
   - $10.003 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
   - 36.3% cut (FFY 2016); 23.8% cut (FFY 2015); 5.7% cut (FFY 2014)
   - $1.277 B reduction compared to FFY 2015 UCC pool; $3.632 B reduction compared to the prior DSH methodology
   - Based on latest CBO projections of insurance expansion

3c. **(FACTOR 3)** Distribute UCC payments to DSH-eligible hospitals based on ratio of UCC relative to the total for all DSH-eligible hospitals
   \[
   \text{UCC Factor} = \frac{\text{Medicaid Days} + \text{Medicare SSI Days}}{\text{Medicaid Days} + \text{Medicare SSI Days}}_{\text{Nation}} \quad \text{(same as FFY 2015)}
   \]
   - Based on 2011/2012 data (same as FFY 2015)
   - Pay on per-discharge basis (same as FFY 2015) as an add-on factor to the federal amount

4. **Cost report settlement**
   - Determine actual DSH eligibility at cost report settlement
   - Reconcile 25% traditional DSH per-discharge payment based on actual program year cost report data; reconcile UCC per-discharge payment to ensure value paid out = hospital-specific value identified by CMS during rulemaking process
   - Do not update nationwide value of UCC payment amount or hospital-specific UCC factors (unless merger occurs) – these data are fixed once finalized by CMS
   - Recoup both 25% traditional DSH payment and UCC payment if projected by CMS to be DSH-eligible, but ultimately determined to be ineligible at settlement; pay both 25% traditional DSH payment and UCC payment if not determined to be DSH-eligible until cost report
DSH dollars available to hospitals under the ACA’s payment formula will decline in FFY 2016. The decline is the result of three factors: updated traditional DSH dollar projections, updated insurance expansion estimates from the CBO, and mandated DSH payment reductions. The UCC pool will continue to be reduced in the coming years as insurance coverage rates are expected to increase. Based on the proposed rule, 53 hospitals are projected to receive DSH payments in FFY 2016 that were not eligible in FFY 2015; while 48 are projected to lose eligibility due to changes in their Medicare and Medicaid days.

- **Eligibility for FFY 2016 DSH Payments (FR pages 24,482-24,483):** CMS is projecting that 2,375 hospitals will be eligible for DSH payments in FFY 2016. This projection is significant because only hospitals identified as DSH-eligible will be paid as such during FFY 2016. CMS has made a file available that includes DSH eligibility status. The file also includes the UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html).

- **Impact of the New CBSA Delineations on DSH Payments (FR page 24,481):** 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 24,486-24,488):** CMS indicates its desire eventually to determine the UCC payment factor (Factor 3) using UCC data from Worksheet S-10 of the Medicare cost report. CMS has been using a low-income patient days proxy for Factor 3 in FFYs 2014 and 2015 and is proposing to do so again for FFY 2016, due to concerns regarding data variability and lack of reporting experience with this relatively new cost report Worksheet. In the proposed 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 24,480*

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 24,339-24,463 and 24,521-24,523*

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 proposed for the DRGs for FFY 2016 will increase the number payable DRGs from 751 to 758. The majority of the DRG weights (80%) will change by less than +/- 5%. CMS also proposes that the IPPS transition to ICD-10 effective October 1, 2015. In the rule, CMS solicits comments on the MS-DRG logic used for payment that is currently in ICD-9-CM and will be in ICD-10-CM for FY 2016.

Related to the general updates to the DRGs, CMS is proposing to update 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 proposed new MS-DRGs 273 and 274. The post-acute transfer DRG changes are listed on pages 24,522-24,523.

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 [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html).
Outlier Payments  
*FR pages 24,631-24,634*

To maintain outlier payments at 5.1% of total IPPS payments, CMS is proposing an outlier threshold of $24,485 for FFY 2016. The new threshold is 0.57% 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 24,346-24,349*

CMS is not proposing to expand or remove any categories/conditions for the HAC MS-DRG payment policy. CMS is proposing that, when implemented, the ICD-10-CM/PCS Version 33 HAC list replace the ICD-9-CM Version 32 HAC list and is seeking public comments on this proposal.

Updates to the IQR Program and Electronic Reporting Under the Program  
*FR pages 24,534-24,590*

CMS proposes to update the measures used in the Hospital Inpatient Quality Reporting (IQR) Program by adding eight new measures (five 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 two that have been suspended) beginning in FY 2018, as well as refining two previously adopted measures.

CMS also proposes two changes to the electronic clinical quality measures (eCQMs). CMS proposes to clarify requirements for the submission of the STK-01 measure for CY 2015/FY 2017 payment determination. CMS proposes to require hospitals to submit sixteen 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 proposes to require two quarters (Q3 and Q4) of reporting in CY 2016 within 2 months following the last discharge date of the quarter.

See the “Effect of the IQR and EHR Incentive Programs” section above regarding the penalty for those hospitals that do not participate in the IQR Program and do not submit the required quality data, or are not meaningful EHR users.

A table on pages 24,579-24,581 of the proposed rule outlines the Hospital IQR Program measure set for the FY 2018 payment determination and subsequent years and includes both previously adopted and proposed measures.

Two-Midnight Policy  
*FR page 24,523*

CMS acknowledges that MACRA extended the prohibition of Recovery Auditor review of patient status on hospital admissions until September 30, 2015. When this prohibition expires, Congress has limited Recovery Auditors to a six month window within which to review a claim for patient status, when the hospital bills within three months of the date of service, to allow hospitals to bill for all medically necessary services under Medicare Part B within the statutory timely filing limits.
CMS is carefully considering feedback from hospitals and physicians on the two-midnight rule policy, as well as recent MedPAC recommendations, and expects to include a further discussion of the broader issues (i.e. short inpatient hospital stays, long outpatient stays with observation services, and the prospective -0.2 percent IPPS payment adjustment) in the CY 2016 hospital outpatient prospective payment system proposed rule that will be published this summer.

**New Technology**  
*FR pages 24,419-24,463*

CMS is soliciting 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 proposes to discontinue add-on payments, two for which CMS proposes continuing new technology add-on payments, three for which CMS proposes new add-on payments, and nine medical services/technologies for which CMS cannot yet determine whether they meet the criterion.

**Expiration of the More Inclusive Low-Volume Adjustment Criteria**  
*FR page 24,521*

Legislative action by Congress over the past several years has mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. Absent additional legislation, beginning mid-FFY 2015 (April 1, 2015), the low-volume adjustment criteria was set to revert to the more restrictive requirements previously in effect (25-mile/800 discharge criteria and 25% payment adjustment). This change would have reduced the number of hospitals eligible for the adjustment from about 600 to 5.

*MACRA extends these criteria by an additional 30 months, through the end of FFY 2017. Based on prior experience with extensions to this policy, it can be assumed that hospitals that qualified for the low-volume adjustment in the first half of FFY 2015 will not need to reapply to receive the adjustment for the remainder of the FFY. Hospitals would need to notify their MAC in writing that the 15-mile distance criterion continues to be met. It is likely that hospitals newly seeking the adjustment would be 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 would be eligible for the adjustment, effective prospectively, within 30 days of the MACs determination.*

**Expiration of MDH Status**  
*FR page 24,483*

Legislative action by Congress over the past several years has extended the Medicare-Dependent Hospital (MDH) program through mid-FFY 2015 (March 31, 2015). *MACRA extends this program by an additional 30 months, through the end of FFY 2017.*

**RRC Status**  
*FR pages 24,479-24,480*

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 24,480.
Bundled Payment for Care Improvement Initiative
FR pages 24,414-24,418

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 is seeking 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.

CAH Payment Policies
No FR page reference

- **CBSA Delineation Changes:** Critical Access Hospital (CAH) status may be at risk for CAHs 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 proposing 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 24,498-24,509):** CMS has already adopted VBP program rules through FFY 2017 and some program policies and rules beyond FFY 2017. CMS is proposing program updates/changes for FFYs 2018-2021. These proposals include:
  o Measure additions/deletions for FFYs 2018 and 2021 (the proposed measure changes would continue the shift of the program’s focus from process to patient outcomes/safety measures);
  o New data collection time periods (baseline/performance periods) for the FFY 2018-2021 program years (some periods were previously adopted and some are newly proposed);
  o 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);
  o Removal of the Clinical Care – Process subdomain for FFY 2018 and future program years;
  o New measure weighting formulas for FFY 2018 used for calculating each hospital’s VBP Total Performance Score (TPS) and resulting payment adjustment (the proposed weighting formula would continue the shift toward a greater emphasis on patient outcomes, safety, and efficiency); and
  o 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 a subset of program measures (CAUTI, CLABSI, SSI – Abdominal Hysterectomy, SSI – Colon, C. difficile and MRSA). For the CAUTI and CLABSI measures, CMS is soliciting comments on its intention to expand the measures to cover medical or surgical wards in addition to the Intensive Care Units (ICUs) they currently cover. 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 would be addressed in future rulemaking.

Details and tables on the newly proposed measures, collection time periods, performance standards, and measure weighting are available on the FR 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](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937).

- **Readmissions Reduction Program—FFYs 2016 and 2017 (FR pages 24,488-24,498):** CMS is not proposing to add any additional readmissions measures to the program; however, it is proposing a significant refinement to the Pneumonia measure for FFY 2017 and future years that would 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 would include patients with a principal diagnosis of sepsis or respiratory failure who also have a secondary diagnosis of Pneumonia. 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 estimates the refinement would result in a 65% increase in patients evaluated under the measure. CMS is not proposing any changes to the payment adjustment factor calculation. The maximum adjustment applicable for FFY 2015 and beyond is -3.0% (0.9700 adjustment factor). 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](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458).

- **HAC Reduction Program—FFYs 2017 and 2018 (FR pages 24,509-24,514):** CMS is not proposing any additional measure expansion for FFY 2017; however, it is proposing to shift the domain weighting used to calculate the Total HAC Score for determining penalty applicability for FFY 2017. CMS would increase the Domain 2 weight (CDC/NHSN measures) from 75% to 85% to reflect the increased number of measures in the domain as well as MedPAC recommendations. For FFY 2018, CMS is proposing to 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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