PUBLICATION

CMS Issues FY 2016 Final Inpatient and Long-Term Care Hospital Rule [Ober|Kaler]

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On July 21, 2015, CMS issued a final rule updating the fiscal year (FY) 2016 Medicare payment polices and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS), which was published in the Federal Register [PDF] on August 17, 2015.

The final rule will affect discharges occurring on or after October 1, 2015. It includes policies that continue CMS's commitment to shift Medicare payments from the volume of patient care to the value and quality of care. Among other things, the final rule makes the following changes

Changes to IPPS Payment Rates

- Hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and demonstrate meaningful use of electronic health record (EHR) technology will receive a .9% increase in operating payment rates.
- This reflects a market basket update of 2.4% adjusted by -0.5 percentage points for multifactor productivity and -0.2 percentage points as required by the Affordable Care Act (ACA).
- The rate continues to be decreased by 0.8 percentage points for a documentation and coding recoupment adjustment as mandated by the American Taxpayer Relief Act of 2012. CMS must recover $11 billion for documentation and coding overpayments by 2017.
- Hospitals that do not successfully participate in the Hospital IQR Program and do not submit required quality data are subject to a one-quarter reduction of the market basket update.
- The update for hospitals that do not meaningfully use EHR will be reduced by one-half of the market basket update in FY 2016. CMS is also finalizing modifications to proposed policies for clinical quality measures for the EHR and Hospital IQR Programs and specifying certain editions of acceptable technology that providers may use.
- There is a -1% penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program.

Potential Expansion of Bundled Payments for Care Improvement Initiative (BCPI)

- CMS continues to test four models for bundled payments with hundreds of providers across the country, and thanks commenters in the rule for their feedback on the policy and operation issues surrounding future expansion of this initiative.

Changes to LTCH PPS Payment Rates

- The Pathway for SGR Reform Act of 2013 requires CMS to establish the LTCH PPS standard federal payment rate as well as a new LTCH PPS site neutral rate comparable to the IPPS rates, for those cases that do not meet the clinical criteria to qualify for the standard rate. This final rule implements these changes. There is a two year transition period.

- During the transition period, site neutral rate cases are paid on a 50/50 blend of the standard rate and the site neutral rate.
- CMS projects that LTCH PPS payments will decrease by 4.6% based on payment decreases for the site neutral rate cases. However, cases that do meet the criteria for the higher standard federal rate will see an increase in the payment rate of 1.7% (based on the aforementioned market basket update as adjusted).

Medicare Disproportionate Share Hospital (DSH) Payments

- Pursuant to ACA adjustments to the DHS payment methodology that began in 2014, hospitals receive 25% less than under the previous DSH formula. Now, a lower national aggregate payment is adjusted to account for uninsured individuals and distributed to hospitals based on their share of uncompensated care. Under this methodology, CMS is distributing $6.4 billion in FY 2016, a decrease from FY 2015, attributed to a declining number of uninsured individuals since the passage of ACA.

Hospital Inpatient Quality Reporting (IQR) Program

- CMS will add seven new measures to the IQR Program, as well as make the additional changes listed below:

  - CMS will add three new claims-based measures and one structural measure for FY 2018 payment determinations and subsequent years,
  - CMS proposes to remove nine measures from the 2018 payment determination and subsequent years, two of which are suspended,
  - CMS also proposes to refine two previously adopted measures to expand measure cohorts,
  - The Rule adds three new claims-based measures for FY 2019 payment determinations and subsequent years,
  - CMS is extending its policy that hospitals are not required to chart-abstract and submit STK-01 if they submit STK-02, -03, -04, -05, -06, -08, and -10 as clinical quality measures for the calendar year 2015/FY 2017 payment determination,
  - CMS is finalizing modifications of its proposals and will require hospitals to submit four of 28 available electronic clinical quality measures of their choice beginning in calendar year 2016 for the FY 2018 payment determination, and
  - Hospitals will be required to submit one quarter (Q3 or Q4) of electronic data in calendar year 2016 by February 28, 2017.

Hospital Value-Based Purchasing (VBP) Program

- CMS updates and expands the measures under the VBP Program. The rule adds a care coordination measure beginning with the FY 2018 program year and a 30-day mortality measure for chronic obstructive pulmonary disease beginning with the FY 2021 program year.
- CMS will remove two measures effective with the FY 2018 program year.
- The rule signals future policy changes affecting certain National Health Safety Network measures beginning with the FY 2019 program year.

Hospital-Acquired Conditions (HAC) Reduction Program

- CMS is finalizing:

- The dates of the time period used to calculate hospital performance,
- An expanded population for two measures that are already included in the program,
- An adjustment to the relative contribution of each domain to the Total HAC score,
- An adjustment of each measure within Domain 2, and
- And extraordinary circumstance exception policy.

Hospital Readmission Reduction Program

- CMS is finalizing a refinement of the pneumonia readmission measure that expands the measure cohort (which modifies the proposed rule) and a formal adoption of the extraordinary circumstance exception policy.
- CMS continues to study and monitor the impact of socioeconomic status on provider results.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- Pursuant to the IMPACT Act, CMS is adding a new function status quality measure, two previously finalized quality measures (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)) and an application of Percent of Residents Experiencing One or More Falls with Major Injury (long stay).
- CMS is adopting the previously finalized All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs.
- CMS is finalizing a policy to begin to publically report quality data by fall 2016 on a CMS website.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

- CMS is finalizing the addition of a *Clostridium difficile* infection outcome measure, a hospital-onset MRSA outcome measure, and a measure of influenza vaccination coverage among healthcare personnel.
- CMS is finalizing the removal of six Surgical Care Improvement Project measures and publically displaying six additional PCHQR measures.