Issue Brief

FEDERAL ISSUE BRIEF • APRIL 20, 2015

KEY POINTS

Major updates for acute inpatient PPS include:

- Marketbasket increase of 1.1 percent for those who submit quality data and are EHR meaningful users
- Outlier threshold reduced from $24,626 to $24,485
- Plans for broad discussions of issues related to the 2-midight benchmark

Major updates for long-term care hospital PPS include:

- Base rate increased from $41,043.71 to $41,883.93
- Long-term care hospital quality reporting program updates
- Adjustments to high-cost outlier cases

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MISSOURI HOSPITAL ASSOCIATION

CMS Proposes FY 2016 Medicare IPPS and LTCH Changes

The Centers for Medicare and Medicaid Services has released a proposed rule to update both the Hospital Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2016.

The rule is 1,526 pages and doesn't include any tables. A 60-day comment period is provided.

The document is currently on public display at the *Federal Register* office and is scheduled for publication April 30. A copy is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-09245.pdf.

The IPPS tables for this proposed rule are available on CMS' website at: http://www.cms.hhs.gov/Medicare/medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2016 IPPS Proposed Rule Home Page" or "Acute Inpatient – Files for Download."

The LTCH PPS tables are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1632-P.

COMMENT

Unfortunately, like most IPPS updates of recent years the shear length of the material continues to grow and makes the rule more difficult to digest the many issues presented. The rule appears to have undergone some format changes that are beneficial, but the material continues to recite much too much history of the IPPS rulemaking. CMS should place the history in Addendum as a reference only. The introductory material below is adopted from CMS' fact sheet. Detailed material is from the rule, itself. There are subjects that have not been covered.

As stated in last year's analysis, this is no longer a simple PPS payment rate update. There is extensive material on quality, value-based purchasing, readmission policies, hospital-acquired conditions and other items. The proposal's executive summary contains "snippets" of the changes (see pages 51-88).

To help direct those with a particular subject interest page numbers corresponding to the display copy are provided. Note, these numbers will change upon the rule's publication in the *Federal Register*. It is highly recommended that you download the display version before it is removed. Also, there are instances in which a particular item can be discussed in more than one area. Not all such area page listings are identified.

For many payment issues, the rule's Addendum (page 1247) contains concise and helpful information.

continued

CMS is estimating a $278 million increase in proposed FY 2016 operating payments (or a 0.3 percent change) and an estimated $160 million increase in proposed FY 2016 capital payments (or 2.0 percent change). This is a far lower increase rate than the cited net market-basket update of 1.1 percent.

CHANGES IN POLICIES AFFECTING ACUTE-CARE HOSPITALS

Changes to Payment Rates under IPPS (See Addendum [page 1244] and Appendix B [page 1519])

The proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users is cited as 1.1 percent. This reflects a projected hospital marketbasket update of 2.7 percent adjusted by a -0.6 percentage point for multi-factor productivity and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act; and, like last year, the rate is further decreased by a proposed 0.8 percent for a documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012. (2.7-0.6-0.2-0.8=1.1 percent)

Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the marketbasket update (2.7 x .25 = 0.675 percent). Also, the law requires that the update for any hospital that is not a meaningful EHR user will be reduced by one-half of the market-basket update in FY 2016 (2.7 x .50 = 1.35 percent).

Other payment adjustments will include continued penalties for readmissions, a continued -1.0 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued bonuses and penalties for hospital-valued based purchasing. These items are likely to sharply reduce the 1.1 percent amount referred above.

The Medicare Access and CHIP Reauthorization Act of 2015 also contains provisions that would impact certain payment adjustments and policies discussed in this proposed rule, including extensions of additional payments for Medicare-dependent hospitals and low-volume hospitals that were due to expire. Those extensions are not reflected in this proposed rule.

Documentation and Coding Adjustment (page 89)

Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 billion by 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008. For FY 2016, CMS is proposing to continue the approach begun in FY 2014 by making another -0.8 percent adjustment to continue the recoupment process.

Medicare Disproportionate Share Hospital Payments (page 644)

The ACA changed the Medicare DSH payment methodology. Hospitals now receive 25 percent of the amount they previously would have received under the statutory DSH formula. The remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, is aggregated nationally, adjusted for decreases in the rate of uninsured individuals and other factors, and then distributed to hospitals based on their relative share of the total amount of uncompensated care. In this rule, CMS is proposing to distribute $6.4

continued

billion in uncompensated care payments in FY 2016, a decrease of $1.3 billion from the estimated FY 2015 amount. This decrease is primarily attributable to continued declines in the number of uninsured individuals. The estimate of the uncompensated care payments to be distributed in FY 2016 will be updated in the final rule based on more recent data.

Electronic Health Record Incentive Programs and Quality Reporting (page 1181)

This proposed rule also includes the requirements for eligible hospitals and Critical Access Hospitals participating in electronic reporting of clinical quality measures for the Electronic Health

Record (EHR) Incentive Programs and the Inpatient Quality Reporting program. CMS is proposing modifications to some of the CQM reporting and submission requirements to align the CQM reporting period for electronic reporting for both programs, to specify the options for the editions of certified EHR technology providers may use, and to establish requirements for the version of electronic specifications (eCQMs) a provider must use for electronic submission of quality reporting data. No changes are proposed for the CQM reporting and submissions requirements for Medicaid eligible hospitals/CAHs. No new CQMs are proposed.

Hospital Inpatient Quality Reporting Program (page 954)

CMS is proposing to update the measures used in the Hospital Inpatient Quality Reporting Program. CMS proposes to add a total of eight new measures for the FY 2018 payment determination and subsequent years (five clinical episode-based payment measures, one patient safety measure, and two coordination-of-care measures). CMS also proposes to remove nine measures, two of which are suspended, for the FY 2018 payment determination and subsequent years, as well as refine two previously adopted measures to expand measure cohorts.

In addition, CMS proposes two changes in relation to electronic clinical quality measures. CMS proposes to clarify requirements for the submission of the STK-01 measure for CY 2015/FY 2017 payment determination. Also, CMS proposes to require hospitals to submit sixteen eCQMs covering three National Quality Strategy domains beginning in Calendar Year 2016 for the FY 2018 payment determination, with each hospital choosing which measures to submit, from the 28 available inpatient electronic Clinical Quality Measures.

Hospital Value-Based Purchasing Program (page 716)

The Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. In the proposed rule, CMS proposes to continue updates to the Hospital VBP Program and to expand the number of measures. Specifically, the rule proposes to add a care coordination measure to the FY 2018 program year and a 30-day mortality measure for chronic obstructive pulmonary disease to the FY 2021 program year. CMS also proposes to remove two measures, effective with the FY 2018 program year, and signals future policy changes that will affect certain National Health Safety Network measures beginning with the FY 2019 program year.

continued

Hospital Acquired Conditions Reduction Program (page 759)

CMS is proposing: (1) an expanded population for two measures that are already included in the program, (2) an adjustment to the relative contribution of each domain to the Total HAC Score, and (3) an extraordinary circumstances exception policy.

Hospital Readmissions Reduction Program (page 679)

CMS is proposing: the implementation of a refinement of the pneumonia readmission measure to expand the measure cohort and the formal adoption of an extraordinary circumstance exception policy. CMS also is continuing to conduct research on the issue of risk adjustment for socioeconomic status in its quality programs, and are working with the Office of the Assistant Secretary of Planning and Evaluation, who expects to issue a report to Congress on this issue by October 2016.

PPS-Exempt Cancer Hospital Quality Reporting Program (page 1092)

CMS proposes to collect three new patient safety measures under this program. Specifically, the rule proposes to add a Clostridium difficile infection outcome measure, a Hospital-Onset Methicillin-resistant Staphylococcus aureus bacteremia outcome measure, and a measure of Influenza vaccination coverage among healthcare personnel. CMS also proposes to remove six Surgical Care Improvement Project measures because it will not be operationally feasible to continue collecting data on these measures in the future.

Long-Term Care Hospital Prospective Payment System Changes (see Addendum page 1332)

The Pathway for SGR Reform Act of 2013 directed CMS to make significant changes to the payments system for LTCHs. The law directs CMS to establish two different types of LTCH PPS payment rates depending on whether or not the patient meets certain clinical criteria: standard LTCH PPS payment rates, and new, lower site neutral LTCH PPS payment rates that are generally based on the IPPS rates. The law transitions the payment reduction for site neutral cases for the first two years of the revised LTCH PPS by requiring payment based on a 50/50 blend of the standard LTCH PPS rate and the site neutral LTCH PPS rate.

CMS projects that LTCH PPS payments would decrease by 4.6 percent, or approximately $250 million, based on the proposed payment rates for FY 2016. This estimated decrease is primarily attributable to the statutory decrease in the payment rates for site neutral LTCH PPS cases that do not meet the clinical criteria to qualify for the higher standard LTCH PPS payment rates. Cases that do qualify for the higher standard LTCH PPS payment rate will see an increase in that payment rate of 1.9 percent (based on a marketbasket update of 2.7 percent adjusted by a multi-factor productivity adjustment of -0.6 percentage point and an additional adjustment of -0.2 percentage point in accordance with the ACA).

Long-Term Care Hospital Quality Reporting Program (page 1113)

CMS is proposing one new functional status quality measure, as well as two previously finalized quality measures (Percent of Residents or Patients with

continued

Pressure Ulcers That Are New or Worsened [Short-Stay] [NQF #0678], and an Application of Percent of Residents Experiencing One or More Falls with Major Injury [Long-Stay] [NQF #0674]), in order to establish their use as cross-setting measures that satisfy the required measurement domains under the Improving Medicare Post-Acute Care Transformation Act of 2014. CMS is additionally proposing the previously finalized All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals (NQF #2512), in order to establish the newly NQF-endorsed status of this measure. Finally, CMS is proposing to begin to publically report quality data by fall 2016, on a CMS website, such as Hospital Compare.

The material that follows is a section-by-section analysis of major components based on the proposed rule. The material does not follow the order in the regulation.

I. STANDARDIZED PAYMENT RATES (PAGE 1249)

(Note: The page numbers of the document skip three pages after page 1247 – i.e., the Addendum says it is page 1247, but the document count under the Adobe program says 1244. The numbers referenced here refer to the document's count.)

The proposed standardized amounts for operating and capital costs appear in Tables 1A, 1B, and 1C that are listed and published in section VI. of the Addendum to this proposed rule and are available on CMS' website.

There are four possible applicable percentage increases that can be applied to the national standardized amount. The table below reflects these four options.

FY 2016	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Marketbasket Rate-of-Increase	2.7	2.7	2.7	2.7
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.675	-0.675
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-1.35	0.0	-1.35
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.6	-0.6	-0.6	-0.6
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act (ACA)	-0.2	-0.2	-0.2	-0.2
Proposed Applicable Percentage Increase Applied to Standardized Amount	1.9	0.55	1.225	-0.125

The labor-related portion for areas with wage indexes greater than 1.0000 would remain at 69.6 percent. Areas with wage index values equal to or less than 1.000 would remain at 62 percent.

continued

Note: CMS corrected the final FY 2015 standardized amounts Oct. 3, 2015. The revised/corrected FY 2015 rates are as follows: The combined labor and non-labor amount for the full update (left column is $5,437.85)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.2 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.475 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update =1.475 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0.75 Percent)	
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
If Wage Index is Greater Than 1.0000:							
$3,784.75	$1,653.10	$3,757.90	$1,641.37	$3,757.90	$1,641.37	$3,731.05	$1,629.65
If Wage Index is less Than or Equal to 1.0000:							
$3,371.47	$2,066.38	$3,347.55	$2,051.72	$3,347.55	$2,051.72	$3,323.63	$2,037.07

The full MB update labor and non-labor amounts (left column) total $5,437.85

The following table (pages 1299-1300) illustrates the changes from the FY 2015 national standardized amount. The unadjusted FY 2015 total rates are $6,078.13 for all columns. Multiplying this amount by the adjustments in red in the left column yields $5,437.85. This is the combined labor and nonlabor amount for the full-corrected marketbasket FY 2015 update in the table above. (left column)

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2015 Base Rate after removing 1. FY 2015 Geographic Reclassification Budget Neutrality **(0.9900429)** 2. FY 2015 Rural Community Hospital Demonstration Program Budget Neutrality **(0.999313)** 3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013 and FY 2014, FY 2015 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012 **(0.9329)** 4. FY 2015 Operating Outlier Offset **(0.948999)** 5. FY 2015 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor **(0.998854)**	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74 *(Combined labor and nonlabor = 6,212.97)* If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93 *(Combined labor and nonlabor = $6,212.97*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74 *(Combined labor and nonlabor = $6,212.97)* If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93 *(Combined labor and nonlabor = $6,212.97*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74 *(Combined labor and nonlabor = 6,212.97)* If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93 *(Combined labor and nonlabor = $6,212.97*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74 *(Combined labor and nonlabor = $6,212.97)* If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93 *(Combined labor and nonlabor = $6,212.97*
Proposed FY 2016 Update Factor (refer table above)	1.019 (1.9 percent = MB of 2.7 minus MFP 0.6 and ACA 0.2)	1.0055 (1.9 percent minus 1.35 = 1.0055)	1.01225 (1.9 percent minus 0.675= 1.01225)	0.99875 1.9 percent minus 1.35 and 0.675 = 0.99875)
Proposed FY 2016 MS-DRG Recalibration and Wage Index Budget Neutrality Factor	0.997018	0.997018	0.997018	0.997018
Proposed FY 2016 Reclassification Budget Neutrality Factor	0.988486	0.988486	0.988486	0.988486

continued

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed FY 2016 Rural Community Demonstration Program Budget Neutrality Factor	0.999808	0.999808	0.999808	0.999808
Proposed FY 2016 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015 and FY 2016 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012	0.9255	0.9255	0.9255	0.9255
Proposed FY 2016 New Labor Market Delineation Wage Index Three Year Hold Harmless Transition Budget Neutrality Factor	0.999995	0.999995	0.999995	0.999995
Proposed National Standardized Amount for FY 2016 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)	Labor: $3,813.40 Nonlabor: $1,665.63	Labor: $3,762.88 Nonlabor: $1,643.56	Labor: $3,788.14 Nonlabor: $1,654.60	Labor: $3,737.62 Nonlabor: $1,632.53
Proposed National Standardized Amount for FY 2016 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	Labor: $3,397.00 Nonlabor: $2,082.03	Labor: $3,351.99 Nonlabor: $2,054.45	Labor: $3,374.50 Nonlabor: $2,068.24	Labor: $3,329.49 Nonlabor: $2,040.66

continued

As shown above, CMS adjusts the standardized payment amounts for several budget neutrality factors. (page 1268)

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2016 (page 1312)

The FY 2016 capital rate is proposed at $438.40. The current amount is $434.97. The update changes are shown in the following table.

Comparison of Factors and Adjustments: FY 2015 Capital Federal Rate and FY 2016 Capital Federal Rate

	FY 2015	Proposed FY 2016	Change	Percent Change
Update Factor[1]	1.0150	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor	0.9993	0.9976	0.9976	-0.24
Outlier Adjustment Factor2	0.9382	0.9357	0.9973	-0.27
Capital Federal Rate	$434.97	$438.40	0.0079	0.79

[1] The proposed update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the proposed incremental change from FY 2015 to FY 2016 resulting from the application of the proposed 0.9976 GAF/DRG budget neutrality adjustment factor for FY 2016 is a proposed net change of 0.9976 (or –0.24 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the proposed net change resulting from the application of the FY 2016 outlier adjustment factor is 0.9357/0.9382, or 0.9973 (or -0.27 percent).

Outlier Payments (page 1282)

CMS is proposing an outlier fixed-loss cost threshold for FY 2016 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $24,485. The current amount is $24,626.

CMS' current estimate, using available FY 2014 claims data, is that actual outlier payments for FY 2014 were approximately 5.34 percent of actual total MS-DRG payments, approximately 0.24 percentage points higher than projected.

CMS currently estimates that, using the latest CCRs from the December 2014 update of the PSF, actual outlier payments for FY 2015 will be approximately 4.88 percent of actual total MS-DRG payments, approximately 0.22 percentage point lower than the 5.1 percent projected when setting the outlier policies for FY 2015. This estimate of 4.88 percent is based on simulations using the FY 2014 MedPAR file (discharge data for FY 2014 claims).

COMMENT

CMS' estimate of FY 2014 outliers exceeding 5.1 percent is the first time in many many years that CMS has paid more than the 5.1 percent set aside. However, projections for FY 2015 already suggest that once again, CMS may have overstated the threshold value. And, again, CMS does not make any corrections to this highly visible factor.

continued

Sole Community and Medicare Dependent Hospitals (page 1304)

CMS developed this proposed rule before Congress enacted and the President signed the Medicare Access and CHIP Reauthorization Act of 2015. This law extends the MDH provision from April 1, 2015, through Sept. 30, 2017. CMS will have to address MDH issues in either a correction notice or in the final FY 2016 rulemaking.

The proposed prospective payment rate for SCHs for FY 2016 equals the higher of the applicable Federal rate, or the hospital-specific rate. The hospital-specific rate is based on updated FY 1982 costs per discharge; updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2015 (page 1320)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

The proposed rate of increase update would be 2.7 percent.

II. CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (PAGE 570)

Proposed FY 2016 Wage Index Tables (page 599)

CMS is proposing to streamline and consolidate the wage index tables associated with the IPPS proposed and final rules for FY 2016 and subsequent fiscal years. The wage index tables have consisted of 12 tables (Tables 2, 3A, 3B, 4A, 4B, 4C, 4D, 4E, 4F, 4J, 9A, and 9C) that have been made available via the Internet on the CMS Web site. However, with the exception of Table 4E, CMS is proposing to streamline and consolidate 11 tables into 2 tables.

The revised table 2 contains the following information: CMS Certification Number; Case-mix Indexes for discharges occurring in FY 2014; FY 2016 Wage Index; Average Hourly Wages FY 2014, 2015 and 2016; 3-Year Average Hourly Wage; Geographic CBSA, Reclassified/Redesignated CBSA (if appropriate); Lugar/NECMA; MGCRG Reclass (if appropriate); Hospital Reclassified as Rural Under Section 1886(d)(8)(E) of the Act (412.103); Out-Migration Adjustment; County Name; and, County Code.

The revised table 3 contains the following information: CBSA; Area name; State; State code; FY 2016 Average Hourly Wage; 3-Year Average Hourly Wage (2014, 2015,2016); GAF, Reclassified Wage Index; Reclassified GAF; Pre-Frontier and/or Pre-Rural Floor Wage Index; Eligible for Frontier Wage Index; and, Eligible for Rural Floor Wage Index.

Core-Based Statistical Areas (page 571)

The current statistical areas (which were implemented beginning with FY 2015)

continued

are based on revised OMB delineations issued on Feb. 28, 2013, in OMB Bulletin No. 13-01.

Proposed Occupational Mix Adjustment to the FY 2016 Wage Index (page 578)

For the proposed FY 2016 wage index, CMS is proposing to use the occupational mix data collected using the new 2013 survey.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY 2016 wage index results in a proposed national average hourly wage of $40.0853

The proposed FY 2016 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Proposed Average Hourly Wage
National RN	38.707899140
National LPN and Surgical Technician	22.793680926
National Nurse Aide, Orderly, and Attendant	15.944111418
National Medical Assistant	18.009577806
National Nurse Category	32.783151666

COMMENT

One must question why CMS extends these amounts to so many decimal places.

Transitional Wage Indexes (page 586)

CMS notes that it is in the second year of two, three-year transition periods for the area wage index:

- one for hospitals that, for FY 2014, were located in an urban county that became rural under the new OMB delineations, and had no form of wage index reclassification or redesignation in place for FY 2015 (that is, MGCRB reclassifications under section 1886(d)(10) of the act, redesignations under section 1886(d)(8)(B) of the act, or rural reclassifications under section 1886(d)(8)(E) of the act); and
- one for hospitals deemed urban under section 1886(d)(8)(B) of the act where the urban area became rural under the new OMB delineations.

In addition, the 1-year transition that CMS applied in FY 2015 for hospitals that experienced a decrease in wage index under the new OMB delineations expires at the end of FY 2015 and does not apply in FY 2016.

1. Transition for Hospitals in Urban Areas That Became Rural: CMS adopted a policy to assign these hospitals the urban wage index value of the CBSA in which they were physically located for FY 2014 for a period of 3 fiscal years. CMS is not proposing any changes to this policy.

continued

If a hospital for FY 2014 was located in an urban county that became rural for FY 2015 under the new OMB delineations and such hospital sought and was granted reclassification or redesignation for FY 2015 or such hospital seeks and is granted any reclassification or redesignation for FY 2016 or FY 2017, the hospital will permanently lose its 3-year transitional assigned wage index status, and will not be eligible to reinstate it.

For FY 2016, the wage data of all hospitals receiving this type of 3-year transition adjustment will be included in the statewide rural area in which they are geographically located under the new OMB labor market area delineations. After the 3-year transition period, beginning in FY 2018, these formerly urban hospitals will receive their statewide rural wage index, absent any reclassification or redesignation.

These hospitals' are considered as rural hospitals for other payment considerations.

2. Transition for Hospitals Deemed Urban where the Urban Area Became Rural under the New OMB Delineations: For FY 2016, CMS is not proposing any changes to its policy and will continue to the second year of the implementation to provide a 3-year transition.

Proposed Rural Floor Section

The area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. CMS estimates that 459 hospitals would receive an increase in their FY 2016 proposed wage index due to the application of the rural floor.

Proposed Imputed Floor for FY 2016

Currently, there are three all-urban states (Delaware, New Jersey and Rhode Island), with a range of wage indexes assigned to hospitals in these States, including through reclassification or redesignation.

There are 16 providers in New Jersey, and no providers in Delaware that would receive an increase in their proposed FY 2016 wage index due to the proposed continued application of the imputed floor policy under the original methodology and four hospitals in Rhode Island that would benefit under the alternative methodology.

Proposed State Frontier Floor

Forty-seven hospitals would receive the frontier floor value of 1.0000 for their FY 2016 wage index. These hospitals are located in Montana, North Dakota, South Dakota and Wyoming.

FY 2016 Reclassification Requirements and Approvals

There are 285 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2016. Because MGCRB wage index reclassifications are effective for three years, hospitals reclassified beginning in FY 2014 or FY 2015 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their three-year period. There were 275 hospitals approved for wage index reclassifications in FY 2014 that continue for FY 2016, and 312 hospitals approved for wage index reclassifications in FY 2015 that continue for FY 2016. Of all the hospitals approved for reclassification for FY 2014, FY 2015, and FY 2016, based upon the review at the time of this proposed rule, 872 hospitals are in a reclassification status for FY 2016.

continued

Hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of the proposed rule.

Applications for FY 2017 reclassifications are due to the MGCRB by Sept. 1, 2015 (the first working day of September 2015). Applications and other information about MGCRB reclassifications may be obtained on CMS' website at: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html, or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244.

Lugar Counties

Section 1886(d)(8)(B)(i) of the act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute if certain adjacency and commuting criteria are met.

Hospitals located in these counties are referred to as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. The chart for this FY 2016 proposed rule with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act is available via the Internet on the CMS Web site as part of table 3.

Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees

Table 2 (formerly Table 4J) associated with this proposed rule (which is available on CMS' website) lists the proposed out-migration adjustments for the FY 2016 wage index.

Based on the new out-migration adjustment data used for this proposed rule, 325 hospitals would receive the out-migration adjustment for FY 2016.

Eighty-two hospitals would be newly eligible for the out-migration adjustment in FY 2016 using the new data. A table (page 610) shows the states and territory in which the 82 affected hospitals are located.

Process for Requests for Wage Index Data Corrections

Hospitals should examine Table 2 at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html.

Table 2 contains each hospital's proposed adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2012 data used to construct the proposed FY 2016 wage index. Table 2 only reflects changes made to a hospital's data that were transmitted to CMS by February 27, 2015.

CMS will release the final wage index data public use files on May 1, 2015, at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html. The May 2015 public use files are made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data that resulted from the correction process (revisions submitted to CMS by the MACs by April 8, 2015).

continued

COMMENT

As a result of CMS' change to consolidate many of the wage index related tables, identifying hospitals by category is no longer easy. All such information is now merged together.

III. CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (REFER PAGES 89)

Changes to the MS-DRGs for FY 2015 (page 102)

The following items are those MS-DRG changes that CMS is proposing for FY 2016. CMS address many that are not being adopted. The material that follows does not reflect such items.

Nonstandard Cost Center Codes (page 108)

CMS says it calculated the proposed MS–DRG relative weights for FY 2016 using two data sources: the MedPAR file as the claims data source and the Hospital Cost Report Information System. Further, CMS says that while preparing to calculate the 19 national average CCRs developed from the cost reports, the agency reviewed the HCRIS data and noticed inconsistencies in hospitals' cost reporting and use of nonstandard cost center codes.

Proposed Changes to Specific MS-DRG Classifications

a. Conversion of MS-DRGs to the International Classification of Diseases, 10th Revision (ICD-10) (page 138)

CMS is proposing the ICD-10 MS-DRGs Version 33 as the replacement logic for the ICD-9-CM based MS-DRGs Version 32 for FY 2016.

b. Proposed FY 2016 MS-DRG Updates

- Percutaneous Intracardiac Procedures (page 166)

  CMS is proposing to create two new MS-DRGs to classify percutaneous intracardiac procedures. Specifically, CMS is proposing to create MS-DRG 273, entitled "Percutaneous Intracardiac Procedures with MCC," and MS-DRG 274, entitled "Percutaneous Intracardiac Procedures without MCC," and to assign the procedures performed within the heart chambers using intracardiac techniques to the two proposed new MS-DRGs. CMS is proposing that existing percutaneous intracoronary procedures with and without stents continue to be assigned to the other MS-DRGs to reflect that those procedures are performed within the coronary vessels and require fewer resources.

- Percutaneous Mitral Valve Repair System — Proposed Revision of ICD-10-PCS (page 176)

  CMS is proposing to assign ICD-10-PCS procedure code 02UG3JZ to MS-DRGs 231 and 232 and MS-DRGs 246 through 251.

- Major Cardiovascular Procedures (pages 177)

  CMS is proposing to delete MS-DRGs 237 and 238, and to create the following five new MS-DRGs.
  - MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
  - MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
  - MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)

continued

- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)

CMS is proposing to assign the more complex, more invasive cardiovascular procedures to proposed new MS-DRGs 268 and 269. In addition, CMS is proposing to assign the less complex, less invasive cardiovascular procedures to proposed new MS-DRGs 270, 271 and 272.

- Revision of Hip or Knee Replacements: Proposed Revision of ICD-10-PCS (page 218)

  CMS is proposing to add code combinations which capture the joint revisions to the Version 33 MS-DRG structure for ICD-10 MS-DRGs 466, 467 and 468. The tables reflecting this proposal run from pages 220 to 281.

- Spinal Fusion (page 282)

  CMS is proposing new titles for three MS-DRGs that would change the reference of "9+ Fusions" to "Extensive Fusions." The proposed title revisions to MS-DRGs 456, 457 and 458 are as follows.
  - MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusion with MCC)
  - MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusion with CC)
  - MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusion without CC/MCC)

- MS-DRG 775 (Vaginal Delivery Without Complicating Diagnosis) (page 282)

  CMS is proposing to make ICD-10-PCS procedure code 3E0P7GC a non-O.R. code so that cases reporting this procedure code will group to the appropriate MS-DRG assignment.

- Replaced Devices Offered without Cost or With a Credit (page 336)

  CMS is proposing to add MS-DRGs 266 and 267 to the list of "device dependent" MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit.

  The proposed list of MS-DRGs to be subject to the IPPS policy for replaced devices offered without cost or with a credit is displayed in the table beginning on page 337.

Proposed Add-On Payments for (Existing) New Services and Technologies (page 383)

- Glucarpidase (Voraxaze®) – CMS is proposing to discontinue the new technology add-on.
- Zenith® F. Graft – CMS is proposing to discontinue the new technology add-on.
- Kcentra™ - Because the 3-year anniversary date of the entry of Kcentra™ on the U.S. market will occur in the second half of FY 2016 (April 29, 2016), CMS is proposing to continue new technology add-on payments for this technology for FY 2016. The maximum new technology add-on payment would remain at $1,587.50 for FY 2016.

continued

- Argus® II Retinal Prosthesis System—Because the 3-year anniversary date of the entry of the Argus® II System on the U.S. market will occur in the first half of FY 2017 (Dec. 23, 2016), CMS is proposing to continue new technology add-on payments for this technology for FY 2016. The maximum new technology add-on payment would remain at $72,028.75 for FY 2016.
- Zilver® PTX® Drug Eluting Peripheral Stent — CMS is proposing to discontinue the new technology add-on payment.
- CardioMEMS™ HF (Heart Failure) Monitoring System — CMS is proposing to continue new technology add-on payments for this technology for FY 2016. The maximum new technology add-on payment for a case involving the CardioMEMS™ HF Monitoring System is $8,875.
- MitraClip® System — CMS is proposing to continue new technology add-on payments for this technology for FY 2016. The maximum payment for would remain at $15,000 for FY 2016.
- Responsive Neurostimulator (RNS®) System — CMS is proposing to continue new technology add-on payments for this technology for FY 2016. The maximum new technology add-on payment is $18,475.

FY 2016 Applications for New Technology Add-On Payments (pages 424-569)

CMS received applications for nine new technology add-on payments for FY 2016. They are:

- Angel Medical Guardian® Ischemic Monitoring Device
- Blinatumomab (BLINCYTO™)
- Ceftazidime Avibactam (AVYCAZ)
- DIAMONDBACK 360® Coronary Orbital Atherectomy System
- CRESEMBA® (Isavuconazonium)
- Idarucizumab
- LUTONIX® Drug-Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
- VERASENSE™ Knee Balancer System (VKS)
- WATCHMAN® Left Atrial Appendage (LAA) Closure Technology

To date, none have been approved or adopted.

IV. OTHER DECISIONS AND PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS AND GRADUATE MEDICAL EDUCATION COSTS

Proposed Rural Referral Centers (page 638)

A rural hospital with less than 275 beds may be classified as an RRC if:

- The hospital's case-mix index is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- the hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

CMS is proposing that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting

continued

periods beginning on or after Oct. 1, 2015, they must have a CMI value for FY 2014 that is at least 1.6075, or the median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed CMI values by region are set forth in the following table:

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.3737
2	Middle Atlantic (PA, NJ, NY)	1.4532
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5042
4	East North Central (IL, IN, MI, OH, WI)	1.5109
5	East South Central (AL, KY, MS, TN)	1.4172
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5890
7	West South Central (AR, LA, OK, TX)	1.6294
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7048
9	Pacific (AK, CA, HI, OR, WA)	1.6157

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2015, must also have the number of discharges for its cost reporting period that began during FY 2012 a figure that is at least 5,000 (3,000 for an osteopathic hospital), or the median number of discharges for urban hospitals in the census region in which the hospital is located.

All census proposed regional discharge numbers are greater than 5,000.

Proposed IME Adjustment Factor for FY 2016 (page 643)

For discharges occurring during FY 2016, the formula multiplier is 1.35.

Proposed FY 2016 Payment Adjustment for Medicare Disproportionate Share Hospitals (§ 412.106) (page 644)

Impact on Medicare DSH Payment Adjustment of the Continued Implementation of New OMB Labor Market Area Delineations (page 646)

Hospitals with less than 500 beds that were in urban counties that became rural when CMS adopted the new OMB delineations, and that did not become RRCs, are subject to a maximum DSH payment adjustment of 12 percent.

Payment Adjustment Methodology for Medicare Disproportionate Share Hospitals Under Section 3133 of the Affordable Care Act (page 648)

The three factors proposed to distribute DSH payments for FY 2016 are the same as the ones used for the current fiscal year.

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

continued

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care.

Proposed Calculation of Factor 1 for FY 2016 (page 659)

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for the fiscal year, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the Act. In other words, this factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The Office of the Actuary's estimates for FY 2016 begins with a baseline of $11.632 billion in Medicare DSH expenditures for FY 2012. The following table shows the factors applied to update this baseline through the current estimate for FY 2016.

Factors Applied for FY 2013 Through FY 2016 to Estimate Medicare DSH Expenditures Using FY 2012 Baseline

FY	Update	Discharge	Case-Mix	Other	Total	Estimated DSH Payments (in Billions)
2013	1.028	0.9844	1.014	1.0139	1.040394	$12.102
2014	1.009	0.9595	1.015	0.9993	0.98197	$11.884
2015	1.014	0.9885	1.005	1.0485	1.056207	$12.552
2016	1.011	1.0012	1.005	1.0446	1.062645	$13.338

Therefore CMS is proposing that Factor 1 for FY 2016 is $10,003,425,327.39 ($13,337,900,436.52 * 75 percent).

Proposed Calculation of Factor 2 for FY 2015 (page 664)

Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment. Specifically, section 1886(r)(2)(B)(i) of the Act provides that for each of FYs 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act.

CMS is using the CBO's January 2015 estimates of the effects of the ACA on health insurance coverage (which are available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf) to calculate the percent of individuals without insurance. The CBO's January 2015 estimate of individuals under the age of 65 with insurance in CY 2015 is 87 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2015 is 13 percent (that is, 100 percent minus 87 percent.) Similarly, the CBO's January 2015 estimate of individuals under the age of 65 with insurance in CY 2016 is 89 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2016 available for this proposed rule is 11 percent (that is, 100 percent minus 89 percent.)
The calculation of the proposed Factor 2 for FY 2016, employing a weighted average of the CBO projections for CY 2015 and CY 2016, is as follows.

continued

- CY 2015 rate of insurance coverage (January 2015 CBO estimate): 87 percent
- CY 2016 rate of insurance coverage (January 2015 CBO estimate): 89 percent
- FY 2016 rate of insurance coverage: (87 percent * .25) + (89 percent * .75) = 88.5 percent
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent
- Percent of individuals without insurance for FY 2016 (weighted average): 11.5 percent

  1-/((0.115-0.18)/0.18)|= 1-0.3611=0.6389 (63.89 percent)

  0.6389 (63.89 percent) - .002 (0.2 percentage points for FY 2016 under section 1886(r)(2)(B)(i) of the Act) = 0.6369 or 63.69 percent

0.6369 = Factor 2

The FY 2016 Proposed Uncompensated Care Amount is: $10,003,425,327.39 x 0.6369 = $6,371,181,591.01.

(The FY 2015 Final Uncompensated Care Amount is: $10,037,596,646.78 * 0.7619 = $7,647,644,885.18.)

COMMENT

It would appear that the continued reduction in DSH payments would increase by nearly $1.3 billion.

Proposed Calculation of Factor 3 for FY 2016 (page 668)

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2016 and subsequent fiscal years; i.e., the pool amount of $6.3712 billion.

CMS believes it would be premature to propose the use of Worksheet S-10 data for purposes of determining Factor 3 for FY 2016. CMS is proposing to continue to employ the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients, as defined in § 412.106(b)(4) and § 412.106(b)(2)(i), respectively, to determine Factor 3 for FY 2016.

Hospital Readmissions Reduction Program: Proposed Changes for FY 2016 Through FY 2017 (§§ 412.150 through 412.154) (page 679)

ACA Section added a new section 1886(q) to the act. Section 1886(q) of the Act establishes the "Hospital Readmissions Reduction Program," effective for discharges from an "applicable hospital" beginning on or after Oct. 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions.

CMS is proposing to:

- Make a refinement to the pneumonia readmissions measure, which would expand the measure cohort, for the FY 2017 payment determination and subsequent years; and
- adopt an extraordinary circumstance exception policy to address hospitals that experience a disaster or other extraordinary circumstance beginning in FY 2016 and for subsequent years.

CMS is proposing the following methodology for FY 2016 as displayed below.

continued

Formulas To Calculate The Readmissions Adjustment Factor for FY 2016

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF * (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN * (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) * (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA * (Excess Readmissions Ratio for THA/TKA-1)].

*CMS notes that if a hospital's excess readmissions ratio for a condition is less than/equal to one, there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = 1-(Aggregate payments for excess readmissions/Aggregate payments for all discharges).

Proposed Readmissions Adjustment Factor for FY 2016 is the higher of the ratio or 0.9700.
*Based on claims data from July 1, 2011, to June 30, 2014, for FY 2016.

Hospital Value-Based Purchasing Program: Proposed Policy Changes for the FY 2018 Program Year and Subsequent Years (page 716)

Section 1886(o) of the act, as added by ACA section 3001(a)(1), requires the Secretary to establish a hospital value-based purchasing program (the Hospital VBP Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. Both the performance standards and the performance period for a fiscal year are to be established by the Secretary.

Section 1886(o)(7)(B) of the act instructs the Secretary to reduce the base operating DRG payment amount for a hospital for each discharge in a fiscal year by an applicable percent. The applicable percent for the FY 2016 program year is 1.75 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2016 is $1,489,397,095,

CMS is proposing to remove the IMM-2 Influenza Immunization and AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival measures, effective for the FY 2018 program year.

CMS is proposing a new measure for the FY 2018 program year: 3-Item Care Transition Measure (CTM-3) (NQF #0228).

The CTM-3 measure adds three questions to the HCAHPS Survey, as follows:

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. (Answer options strongly disagree, disagree, agree or strongly agree.)
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. (Answer options strongly disagree, disagree, agree or strongly agree.)
- When I left the hospital, I clearly understood the purpose for taking each of my medications. (Answer options strongly disagree, disagree, agree, strongly agree, or I was not given any medication when I left the hospital.)

continued

In summary, for the FY 2018 program, CMS is proposing the following measure set:

FY 2018 Previously Adopted and Newly Proposed Measures	
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
CTM-3*	3-Item Care Transitions Measure
Clinical Care Domain	
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization
Safety Domain	
CAUTI	National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure
CLABSI	National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure
Colon and Abdominal Hysterectomy SSI	Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure Colon Abdominal Hysterectomy
MRSA bacteremia	National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus Bacteremia Outcome Measure
CDI	National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection Outcome Measure
PSI-90	Patient Safety for Selected Indicators (Composite)
PC-01**	Elective Delivery
Efficiency and Cost Reduction Domain	
MSPB-1	Payment-Standardized Medicare Spending Per Beneficiary

**Proposed new measure.*
***Proposed to be moved from the Clinical Care — Process subdomain to the Safety domain.*

Previously Adopted and Newly Proposed Measures for the FY 2019, FY 2021, and Subsequent Program Years (page 730)

CMS plans to adopt the following:

a. Intent to Propose in Future Rulemaking to Include Selected Ward (Non-Intensive Care Unit (ICU)) Locations in Certain NHSN Measures Beginning with the FY 2019 Program Year

b. Proposed New Measure for the FY 2021 Program Year: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893)

continued

Previously Adopted and Proposed Performance Standards for the FY 2018 Program Year: Safety, Clinical Care, and Efficiency and Cost Reduction Measures			
Safety Measures			
Measure ID	**Description**	**Achievement Threshold**	**Benchmark**
CAUTI*	National Healthcare Safety Network Catheter-associated Urinary Tract Infection Outcome Measure	0.916	0.000
CLABSI*	National Healthcare Safety Network Central line-associated Bloodstream Infection Outcome Measure	0.401	0.000
CDI*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset Clostridium difficile Infection Outcome Measure	0.776	0.000
MRSA bacteremia*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset Methicillin-resistant Staphylococcus aureus Bacteremia Outcome Measure	0.766	0.000
PSI-90±*	Patient safety for selected indicators (composite)	0.577321	0.397051
Colon and Abdominal Hysterectomy SSI*	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure • Colon • Abdominal Hysterectomy	• 0.801 • 0.745	• 0.000 • 0.000
PC-01	Elective Delivery	0.022989	0.000
Clinical Care Measures			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization *	0.851458*	0.871669*
MORT-30-HF*	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure *	0.881794*	0.903985*
MORT-30-PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization *	0.882986*	0.908124*
Efficiency and Cost Reduction Measure			
MSPB-1*	Payment-Standardized Medicare Spending Per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

** Lower values represent better performance.*

± Previously adopted performance standards.

continued

Proposed Performance Standards for the FY 2018 Patient and Caregiver-Centered Experience of Care/Care Coordination Domain			
HCAHPS Survey Dimension	Floor (Percent)	Achievement Threshold (Percent)	Benchmark (Percent)
Communication with Nurses	52.85	78.45	86.70
Communication with Doctors	59.48	80.56	88.59
Responsiveness of Hospital Staff	37.91	65.22	80.35
Pain Management	50.17	70.26	78.44
Communication about Medicines	45.50	63.38	73.61
Hospital Cleanliness & Quietness	43.43	65.58	79.25
Discharge Information	62.00	86.50	91.58
3-Item Care Transition	27.28	51.33	62.18
Overall Rating of Hospital	36.94	70.15	84.72

COMMENT

This is another section with extensive and complex material. The proposal contains additional tables regarding standards beyond FY 2018 as well as scoring information.

Proposed Changes to the Hospital-Acquired Condition Reduction Program (pages 759-778)

For hospitals with HAC scores in the top quartile relative to other applicable hospitals for a given fiscal year, the amount of Medicare payment is reduced to 99 percent of the amount of payment that would otherwise apply to discharges under section 1886(d) or 1814(b)(3) of the Act, as applicable. Section 1886(p)(1) of the Act specifies that the amount of payment shall be equal to 99 percent.

CMS is not proposing any changes to the policies for the implementation of the HAC Reduction Program for FY 2016.

For FY 2017, CMS is proposing three changes to existing program policies: (1) the dates of the time period used to calculate hospital performance; (2) the addition of a narrative rule used in the methodology to calculate the Domain 2 score; and (3) the relative contribution of Domain 1 (patient safety) and Domain 2 (infection) to the total HAC score.

COMMENT

This is another complex discussion. While CMS says it is not proposing changes for FY 2016. Changes are being proposed for years beyond 2016.

Proposed Elimination of the Simplified Cost Allocation Methodology for Hospitals (§412.302) (page 779)

CMS is proposing to eliminate the simplified cost allocation methodology because the allocation of the costs of capital-related movable equipment using this methodology yields less precise calculated CCRs.

continued

Rural Community Hospital Demonstration Program (page 782)

For FY 2016, the total budget neutrality offset amount that CMS is proposing to apply is $17,738,497.

Proposed Changes to MS-DRGs Subject to the Post-Acute Care Transfer Policy (§ 412.4 (page 809)

CMS is proposing to update the list of MS-DRGs that are subject to the post-acute care transfer policy to include the proposed new MS-DRGs 273 and 274. Existing MS-DRGs 246 through 251 do not currently qualify for the post-acute care transfer policy and would not meet the review criteria for FY 2016. Proposed new MS-DRGs 268 through 272 also would not qualify for post-acute care transfer policy status.

Short Inpatient Hospital Stays (2-Midnight Benchmark) (page 815)

CMS says it expects to include a further discussion of the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the CY 2016 hospital outpatient prospective payment system proposed rule that will be published this summer.

V. PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR FY 2016 (PAGE 827)

Proposed Application of the Site Neutral Payment Rate (Proposed New § 412.522)

Section 1206 of the Pathway for SGR Reform Act of 2013 requires the establishment of an alternate "site neutral" payment rate for Medicare inpatient discharges from a LTCH that fail to meet certain statutorily defined criteria.

Section 1886(m)(6)(A)(ii)(II) of the Act specifies that in order for a LTCH discharge to be excluded from payment under the site neutral payment rate, the LTCH discharge cannot have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

CMS is proposing that a LTCH discharge assigned to one of the following proposed ICD-10 MS-LTC-DRGs Version 33 would identify a case with a principal diagnosis relating to a psychiatric diagnosis:

- MS-LTC-DRG 876 (O.R. Procedure with Principal Diagnosis of Mental Illness);
- MS-LTC-DRG 880 (Acute Adjustment Reaction & Psychosocial Dysfunction);
- MS-LTC-DRG 881 (Depressive Neuroses);
- MS-LTC-DRG 882 (Neuroses except Depressive);
- MS-LTC-DRG 883 (Disorders of Personality & Impulse Control);
- MS-LTC-DRG 884 (Organic Disturbances & Mental Retardation);
- MS-LTC-DRG 885 (Psychoses);
- MS-LTC-DRG 886 (Behavioral & Developmental Disorders);
- MS-LTC-DRG 887 (Other Mental Disorder Diagnoses);
- MS-LTC-DRG 894 (Alcohol/Drug Abuse or Dependence, Left Ama);
- MS-LTC-DRG 895 (Alcohol/Drug Abuse or Dependence, with Rehabilitation Therapy);
- MS-LTC-DRG 896 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy with MCC); and
- MS-LTC-DRG 897 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy without MCC).

continued

CMS is proposing that, for FY 2016, a LTCH discharge assigned to one of the following proposed ICD-10 MS-LTC-DRGs Version 33 would identify a LTCH discharge with a principal diagnosis relating to rehabilitation:

- MS-LTC-DRG 945 (Rehabilitation with CC/MCC); and
- MS-LTC-DRG 946 (Rehabilitation without CC/MCC).

Section 1886(m)(6)(A)(ii)(II) of the Act specifies that, in order to be excluded from payment under the site neutral payment rate, the LTCH discharge must meet ICU criterion. To implement the ICU criterion CMS is proposing under proposed new § 412.522(b)(2) that the discharge from the subsection (d) hospital that immediately preceded the admission to the LTCH includes at least three days in an ICU (as defined in § 413.53(d) of the regulations).

CMS is proposing that, for the purposes of a discharge being excluded from the site neutral payment rate, the discharge must use the applicable procedure code to indicate that at least 96 hours of ventilator services were received during the LTCH stay. CMS is proposing to require LTCHs to report ICD-10-PCS procedure code 5A1955Z on their claims to indicate that the beneficiary received at least 96 hours of ventilator services.

CMS is proposing under proposed new § 412.522(c)(1) that the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case determined under § 412.529(d)(2).

COMMENT

The material in this section consists of nearly 125 pages. Unfortunately, the material is difficult to follow. There is too much redundancy, history and a lack of concise summaries of what is being proposed.

Proposed Updates to the Payment Rates for the LTCH PPS for FY 2016 (page 1332)

CMS is proposing to establish an annual update to the standard LTCH federal rate of 1.9 percent, which is based on the full estimated increase in the LTCH PPS marketbasket of 2.7 percent, less the proposed MFP adjustment of 0.6 percentage point, and less the 0.2 percentage point required by the ACA. For LTCHs that fail to submit required quality reporting data for FY 2016, the proposed update is reduced further by 2.0 percentage points.

CMS is proposing to apply an area wage level adjustment budget neutrality factor of 1.001444.

CMS is proposing to establish a LTCH PPS standard Federal payment rate of $41,883.93 (calculated as $41,043.71[the FY 2015 amount] * 1.019 [MB Update] * 1.001444 [area wage index budget neutrality) for FY 2016.

CMS is proposing to continue to use the CBSA-based labor market area delineations currently used under the LTCH PPS (as adopted in the FY 2015 IPPS/LTCH PPS final rule). The labor-related share would be 62.2 percent.

The proposed FY 2016 LTCH PPS standard federal payment rate wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on CMS' website.

continued

Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

CMS is proposing to establish two separate HCO targets — one for LTCH PPS standard federal payment rate cases and one for site neutral payment rate cases.

CMS is proposing to establish a total CCR ceiling of 1.345 under the LTCH PPS for FY 2016 for HCOs, for SSOs, and proposed site neutral payment rate cases.

CMS is proposing a fixed-loss HCO amount of $18,768.

VI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (PAGE 950)

Hospital IQR (page 954)

CMS is proposing to remove the following nine measures, either in their entirety or just the chart-abstracted form, from the Hospital IQR Program measure set for the FY 2018 payment determination and subsequent years:

- STK-01: Venous Thromboembolism (VTE) Prophylaxis (NQF #0434)
- STK-06: Discharged on Statin Medication (NQF #0439)
- STK-08: Stroke Education (NQF endorsement removed)
- VTE-1: Venous Thromboembolism Prophylaxis (NQF #0371)
- VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis (NQF #0372)
- VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)
- IMM-1: Pneumococcal Immunization (NQF #1653)
- AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival (NQF #0164)
- SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300)

The proposal contains a table showing measures previously adopted for the Hospital IQR Program FY 2017 payment determination. (page 973)

CMS is proposing refinements to the measure cohorts for: (1) the Hospital 30-day, All-cause, Risk-Standardized Mortality Rate following Pneumonia Hospitalization (NQF #0468) measure; and (2) the Hospital 30-day, All-cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization (NQF #0506) measure.

CMS is proposing to add eight new measures to the Hospital IQR Program for the FY 2018 payment determination and subsequent years; seven new claims-based measures and one new structural measure:

- Hospital Survey on Patient Safety Culture (structural);
- Kidney/UTI Clinical Episode-Based Payment Measure (claims-based);
- Cellulitis Clinical Episode-Based Payment Measure (claims-based);
- Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure (claims-based);
- Lumbar Spine Fusion/Re-Fusion Clinical Episode-Based Payment Measure (claims-based);
- Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA (claims-based);
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (claims-based); and (8) Excess Days in Acute Care after Hospitalization for Heart Failure (claims-based).

continued

The following table outlines the Hospital IQR Program measure set for the FY 2018 payment determination and subsequent years and includes both previously adopted and proposed measures.

Hospital IQR Program Measures for the FY 2018 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
NHSN		
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure Colon Procedures Hysterectomy Procedures	0753
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin- resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
Chart-Abstracted		
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Imm-2	Influenza Immunization	1659
PC-01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
STK-04*	Thrombolytic Therapy	0437
VTE-5*	Venous Thromboembolism Discharge Instructions	N/A
VTE-6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A
Claims		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
STK Mortality	Stroke 30-day Mortality Rate	N/A
CABG Mortality	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	2558

continued

Hospital IQR Program Measures for the FY 2018 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
READM-30-AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	0505
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	0330
READM-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	0506
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1551
READM-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
COPD READMIT	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1891
STK READMIT	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	N/A
CABG READMIT	Hospital 30-Day, All-Cause, Unplanned, Risk- Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	2515
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia	2579
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
PSI 4 (PSI/NSI)	Death among Surgical Inpatients with Serious, Treatable Complications	0351
PSI 90	Patient Safety for Selected Indicators (Composite Measure)	0531
THA/TKA Payment**	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	N/A
Kidney/UTI Payment**	Kidney/Urinary Tract Infection Clinical Episode- Based Payment Measure	N/A
Spine Fusion/ Refusion Payment**	Spine Fusion/Refusion Clinical Episode-Based Payment Measure	N/A
Cellulitis Payment**	Cellulitis Clinical Episode-Based Payment Measure	N/A
GI Payment**	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	N/A
AMI Excess Days**	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	N/A
HF Excess Days**	Excess Days in Acute Care after Hospitalization for Heart Failure	N/A
Electronic Clinical Quality Measure		
AMI-2	Aspirin Prescribed at Discharge for AMI	0142
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0164
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
AMI-10	Statin Prescribed at Discharge	N/A

continued

Hospital IQR Program Measures for the FY 2018 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
CAC-3	Home Management Plan of Care Document Given to Patient/ Caregiver	N/A
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI-1a	Hearing Screening Prior to Hospital Discharge	1354
HTN	Healthy Term Newborn	0716
PC-01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
PC-05	Exclusive Breast Milk Feeding and the Subset Measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice	0480
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	0147
SCIP-Inf-1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0527
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients	0528
SCIP-Inf-9	Urinary catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero	N/A
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-04*	Thrombolytic Therapy	0437
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
STK-08	Stroke Education	N/A
STK-10	Assessed for Rehabilitation	0441
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	0373
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	N/A
VTE-5*	Venous Thromboembolism Discharge Instructions	N/A
VTE-6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A
Patient Survey		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM-3)	0166 0228
Structural		
Patient Safety Culture**	Hospital Survey on Patient Safety Culture	N/A
Registry for Nursing Sensitive Care	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	N/A
Registry for General Surgery	Participation in a Systematic Clinical Database Registry for Registry for General Surgery	N/A
Safe Surgery Checklist	Safe Surgery Checklist Use	N/A

** Measure is listed twice, as both chart-abstracted and electronic clinical quality measure.*

***Measures we are proposing beginning with FY 2018 and for subsequent years.*

continued

CMS is proposing to expand its electronic clinical quality measure policy in order to make reporting of electronic clinical quality measures required, rather than voluntary, under the Hospital IQR Program. Specifically, beginning in CY 2016/FY 2018 payment determination and subsequent years, hospitals would be required to select and submit 16 electronic clinical quality measures covering three NQS domains from the 28 available electronic clinical quality measures.

COMMENT

The section on the Inpatient Quality Reporting extends some 137 pages. The material is very well written. It's easy to follow and understand. It's just long, too long to summarize.

Those individuals responsible for quality adoption need to pay careful attention to the changes being proposed. Failure to do so could result in reduced payments for not providing required quality measures.

PPS-Exempt Cancer Hospital Quality Reporting Program (page 1092)

CMS is proposing to remove six SCIP measures from the PCHQR Program beginning with fourth quarter 2015 discharges and for subsequent years. Under this proposal, PCHs will meet reporting requirements for the FY 2016 and FY 2017 programs by submitting first quarter through third quarter 2015 data for the following measures:

- Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)
- Urinary Catheter Removed on Post-Operative Day One (POD1) or Post-Operative Day Two (POD2) with Day of Surgery Being Day Zero (NQF #0453)
- Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (NQF #0527)
- Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
- Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time (NQF #0529)
- Surgery Patients on Beta-Blocker Therapy Prior to Admission who Received a Beta-Blocker During the Perioperative Period (NQF #0284)

For the FY 2018 PCHQR Program, CMS is proposing to adopt three new quality measures.

- Centers for Disease Control and Prevention National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection Outcome Measure (NQF #1717) (CDC NHSN CDI Measure)
- CDC NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus Bacteremia Outcome Measure (NQF #1716) (CDC NHSN MRSA Measure)
- CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel Measure (NQF #0431) (CDC NHSN HCP Measure)

Long-Term Care Hospital Quality Reporting Program (page 1113)

CMS is proposing four quality measures to reflect the NQF endorsement of one measure and to meet the requirements of the IMPACT Act of 2014. These proposed measures are: (a) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512) to reflect NQF endorsement; (b) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) to meet the requirements of the

continued

IMPACT Act of 2014; (c) an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) to meet the requirements of the IMPACT Act of 2014; and (d) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under NQF review) to meet the requirements of the IMPACT Act of 2014.

COMMENT

Like the LTCH material regarding updates and other changes, this section dealing with quality is complex, difficult to follow and redundant.

Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals Participating in the EHR Incentive Programs in 2016 (page 1181)

CMS is proposing to align the reporting period in CY 2016 for eligible hospitals and CAHs that report CQMs electronically for the Medicare EHR Incentive Program with that of the Hospital IQR Program and require quarterly reporting and submission periods for eCQMs in the 3rd and 4th CY quarters. In addition, in this proposed rule, the Hospital IQR Program is proposing to change its submission period for eCQMs from annual to quarterly submission, and proposing to change the submission deadline from November 30, 2015 to ending two calendar months after the close of the reporting CY quarter (for CY 2016/FY 2018 payment determination, the proposed deadlines are Nov. 30, 2016, for Q3 and Feb. 28, 2017 for Q4).

CMS is proposing the following CQM reporting periods and submission deadlines for eligible hospitals and CAHs participating in the Medicare EHR Incentive Program in CY 2016:

- Eligible hospitals and CAHs Reporting CQMs by Attestation
  - for eligible hospitals and CAHs demonstrating meaningful use for the first time in 2016, any continuous 90-day reporting period within CY 2016; or one full calendar year reporting period for CY 2016. Attestation by Feb. 28, 2017
  - for eligible hospitals and CAHs that demonstrated meaningful use in any year prior to 2016, one full calendar year reporting period for CY 2016. Attestation by Feb. 28, 2017
- Eligible hospitals and CAHs Reporting CQMs Electronically — Two full quarters of data (Q3 and Q4 of CY 2016) submitted via electronic reporting within two months after the close of each quarter (Q3 by Nov. 30, 2016; Q4 by Feb. 28, 2017).

Tables (1382)

The following IPPS tables for this FY 2016 proposed rule are available only on CMS' website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2016 IPPS Proposed Rule Home Page" or "Acute Inpatient — Files for Download."

1. Table 1A-1E: This excel spreadsheet contains the proposed FY 2016 Operating and Capital National and Puerto Rico Specific Standardized Amounts.
2. FY 2016 Proposed Rule Tables 2 and 3 (Wage Index Tables): Table 2- Proposed Case-Mix Index and Wage Index Table by CCN; Table 3- Proposed Wage Index Table by CBSA. Note: Table 2 contains information by CCN and information

continued

from the following tables that have been provided in previous fiscal years: Tables 2, 4J, 9A, and 9C. Table 3 contains information by CBSA and information from the following tables that have been provided in previous fiscal years: Tables 3A, 3B, 4A, 4B, 4C, 4D, and 4F. See the data files page for the Constituent Counties for Acute Care Hospitals File (formerly table 4E).

3. Table 5: List of proposed MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay.
4. Tables 6B-6M and Tables 6P.1a-6P.2a: Table 6B-New Procedure Codes; Table 6I-Proposed Complete Major CC List; Table 6J-Proposed Complete CC List; Table 6K-Proposed Complete List of CC Exclusions; Table 6L-Proposed Principal Diagnosis Is Its Own MCC List; Table 6M-Proposed Principal Diagnosis Is Its Own CC List; Table 6M.1-Proposed Additions to the Principal Diagnosis Is Its Own CC List;
5. Tables 6P.1a-6P.2a (ICD-10-PCS Code Translations for Proposed MS-DRG Changes): See summary tab in excel spreadsheet and/or summary file in zip file called "CMS-1632-P TABLE 6P.1a-6P.2a.zip" for complete description of all tables
6. Tables 7A and 7B: Tables 7A and 7B contain the number of discharges, and selected percentile lengths of stay for both MS-DRGs, version 32 and MS-DRGs, version 33
7. Tables 8A, 8B, and 8C: Tables 8A and 8B contain the proposed FY 2016 IPPS operating and capital statewide average cost-to-charge-ratios as published in the Federal Register. Table 8C contains the proposed FY 2016 LTCH statewide average cost-to-charge-ratios as published in the Federal Register.
8. Table 10: Contains the proposed cost thresholds by MS-DRG for the cost criteria for new technology add on payment applications for applications for FY 2017.
9. Table 15: Proposed FY 2016 Proxy Readmissions Adjustment Factors
10. Table 16: Proposed Proxy Hospital Inpatient Value-Based Purchasing Program Adjustment Factors for FY 2016
11. Table 18: Proposed FY 2016 Medicare DSH Uncompensated Care Payment Factor 3

FINAL COMMENTS

1. Over the past few years, there has been both consternation and dismay by many states over an ACA amendment that reversed a CMS rule that would have set budget neutrality on a statewide basis when urban areas in a state have a lower wage index value than the statewide rural amount. The ACA requirement imposes such budget neutrality on a national basis. The reversal has been extremely beneficial in New England and California.

The following is CMS' FY 2016 estimate of the national budget neutrality calculations.

continued

State	Number of Hospitals (1)	Number of Hospitals That Would Receive the Proposed Rural Floor or Imputed Floor (2)	Proposed Percent Change in Payments due to Application of Proposed Rural Floor and Imputed Floor with Budget Neutrality (3)	Proposed Difference (in millions) (4)
Alabama	86	3	-0.4	$-7.28
Alaska	6	1	-0.3	$-0.53
Arizona	55	4	-0.5	$-8.36
Arkansas	46	2	-0.3	$-3.08
California	303	207	2.4	$233.75
Colorado	47	5	0.3	$3.78
Connecticut	31	7	-0.5	$-7.46
Delaware	6	0	-0.6	$-2.53
Washington, D.C.	7	0	-0.5	$-2.4
Florida	170	14	-0.3	$-16.98
Georgia	105	0	-0.5	$-12.17
Hawaii	12	1	-0.4	$-1.11
Idaho	14	0	-0.4	$-1.17
Illinois	127	2	-0.5	$-24.84
Indiana	91	0	-0.5	$-11.83
Iowa	35	0	-0.5	$-4.3
Kansas	53	0	-0.4	$-3.7
Kentucky	65	1	-0.4	$-7.09
Louisiana	98	1	-0.5	$-6.53
Maine	20	0	-0.5	$-2.4
Massachusetts	61	39	3.1	$98.3
Michigan	96	0	-0.5	$-21.72
Minnesota	50	0	-0.3	$-6.2
Mississippi	64	0	-0.5	$-4.86
Missouri	78	2	-0.4	$-8.38
Montana	12	2	0.2	$0.45
Nebraska	25	0	-0.4	$-2.44
Nevada	24	4	0.3	$2.35
New Hampshire	13	2	-0.2	$-1.19
New Jersey	64	16	0	$0.43
New Mexico	25	0	-0.3	$-1.37
New York	156	2	-0.6	$-43.7
North Carolina	84	0	-0.4	$-14.21
North Dakota	6	0	-0.3	$-0.81
Ohio	132	6	-0.5	$-17.27

continued

State	Number of Hospitals (1)	Number of Hospitals That Would Receive the Proposed Rural Floor or Imputed Floor (2)	Proposed Percent Change in Payments due to Application of Proposed Rural Floor and Imputed Floor with Budget Neutrality (3)	Proposed Difference (in millions) (4)
Oklahoma	86	4	-0.4	$-4.94
Oregon	34	0	-0.5	$-4.67
Pennsylvania	153	5	-0.5	$-21.49
Puerto Rico	51	10	0.1	$0.15
Rhode Island	11	4	0.7	$2.59
South Carolina	56	5	-0.2	$-2.38
South Dakota	19	0	-0.3	$-0.97
Tennessee	99	19	-0.4	$-9.65
Texas	317	3	-0.5	$-30.36
Utah	34	2	-0.4	$-1.95
Vermont	6	0	-0.3	$-0.61
Virginia	78	1	-0.4	$-11.47
Washington	49	6	0.1	$1.49
West Virginia	29	3	-0.2	$-1.24
Wisconsin	66	0	-0.5	$-7.58
Wyoming	11	0	-0.2	$-0.24

2. The proposal addresses reduced payments for providers that fail to report quality and/or are not EHR meaningful users.

CMS says that only 26 hospitals have failed to submit quality information and 153 hospitals are not meaningful EHR users.

The following table identifies those MS-DRGs with 100,000 or more discharges (from table 7B). There are 4 fewer MS-DRGs in this year's list than last year.

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS — FY 2016 Proposed Rule				
MS-DRG	MS-DRG Title	Proposed FY 2016 Weights	Final FY 2015 Weights	Percentage Change
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0588	1.0643	-0.52%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2257	1.2136	1.00%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1577	1.1743	-1.41%
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9315	0.9370	-0.59%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4256	1.4491	-1.62%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9684	0.9688	-0.04%
291	HEART FAILURE & SHOCK W MCC	1.4822	1.5097	-1.82%

continued

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS — FY 2016 Proposed Rule				
MS-DRG	MS-DRG Title	Proposed FY 2016 Weights	Final FY 2015 Weights	Percentage Change
292	HEART FAILURE & SHOCK W CC	0.9884	0.9824	0.61%
378	G.I. HEMORRHAGE W CC	0.9946	1.0021	-0.75%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7388	0.7388	0.00%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0899	2.1137	-1.13%
603	CELLULITIS W/O MCC	0.8413	0.8447	-0.40%
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7202	0.7051	2.14%
682	RENAL FAILURE W MCC	1.5091	1.5194	-0.68%
683	RENAL FAILURE W CC	0.9403	0.9512	-1.15%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7823	0.7794	0.37%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.7934	1.8072	-0.76%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0426	1.0582	-1.47%

These 18 MS-DRGs account for approximately 33.0 percent of the nearly 10 million MS-DRG discharges. Most are declining and would negatively impact case-mix and therefore payment.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting