Issue Brief

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KEY POINTS

- The final rule will increase Medicare inpatient operating payments by 0.4 percent and capital payments by 2.3 percent, amounting to a total increase of $565 million.
- Long term care hospital payments are expected to decrease by $250 million.

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CMS Issues Final FY 2016 Medicare IPPS and LTCH Changes

The Centers for Medicare and Medicaid Services has released a final 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 some 2,149 pages. The proposed version was 1,526 pages and neither includes any tables.

The document is currently on public display at the *Federal Register* office and is scheduled for publication August 17. A copy is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-19049.pdf.

The IPPS tables are available through on CMS' website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending. Click on the link on the left side of the screen titled, "FY 2016 IPPS Final 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-F.

COMMENT

Like most IPPS updates of recent years the shear length of the material continues to grow and makes the rule much more difficult to digest the many issues presented. For example, the table of contents is 32 pages.

Unfortunately, CMS still does not provide a definitive or final action paragraph for its actions. Maybe one solution would be to have CMS state at the start of each section the action(s) it is taking before going into long discussions on history, proposals and responses to comments.

The rule appears to have undergone some format changes that are beneficial, but the material continues to recite much too much history.

As we have previously stated, this is no longer a simple payment rate update. There is extensive material on quality, value-based purchasing, readmission policies, hospital-acquired conditions and other items. The executive summary contains some "snippets" of the changes (see pages 58-73).

To help direct those with a particular subject interest, page numbers corresponding to the display copy are provided in the detailed section of this analysis. 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 (beginning on page 1844) contains helpful information.

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CMS says the "applicable percentage increase to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule, will result in an estimated $378 million increase in FY 2016 operating payments (or 0.4 percent change) and an estimated $187 million increase in FY 2016 capital payments (or 2.3 percent change). These changes are relative to payments made in FY 2015."

However, these cited increases do not reflect a reduction in Disproportionate Share Hospital payments of some $1.2 billion.

LTCHs are expected to experience a decrease in payments by $250 million in FY 2016 relative to FY 2015.

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.

CHANGES TO PAYMENT RATES UNDER IPPS

The 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 demonstrate meaningful use of certified electronic health record technology is 0.9 percent. This reflects the hospital market basket update of 2.4 percent adjusted by -0.5 percentage points for multi-factor productivity and an additional adjustment of -0.2 percentage points in accordance with the Affordable Care Act; the rate is further decreased by 0.8 percentage points for a documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012.

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 market basket update. Also, the law requires that the update for any hospital that is not a meaningful user of EHR will be reduced by one-half of the market basket update in FY 2016. 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.

Documentation and Coding Adjustment

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

Beginning in FY 2014, 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 distributing an estimated $6.4 billion in uncompensated care payments in FY 2016, a decrease of $1.2 billion from the estimated FY 2015 amount. This decrease is primarily attributable to continued declines in the number of uninsured individuals since the passage of the ACA.

Hospital Inpatient Quality Reporting Program

CMS is updating the measures used in the Hospital IQR Program. CMS will add a total of seven new measures: three new claims-based measures and

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one structural measure for the FY 2018 payment determination and subsequent years; and three new claims-based measures for the FY 2019 payment determination and subsequent years.

For the FY 2018 payment determination and subsequent years, CMS will remove nine measures, two of which are suspended, as well as refine two previously adopted measures to expand measure cohorts.

In addition, CMS is finalizing changes in relation to eCQMs. CMS is extending its policy that hospitals are not required to also chart-abstract and submit STK-01 if they submit the STK-02, STK-03, STK-04, STK-05, STK-06, STK-08, and STK-10 as electronic clinical quality measures for the CY 2015/FY 2017 payment determination.

Also, CMS is finalizing modifications of its proposals and will require hospitals to submit four of 28 available eCQMs of their choice beginning in CY 2016 for the FY 2018 payment determination. Additionally, hospitals will be required to submit one quarter (either Q3 or Q4) of electronic data in CY 2016 by February 28, 2017.

Hospital Value-Based Purchasing Program

Established by the ACA, the Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on a set of measures. CMS is finalizing updates to the Hospital VBP Program and expanding the number of measures. Specifically, 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 also remove two measures, effective with the FY 2018 program year. The amount of base operating MS-DRG payment amount reductions for the FY 2016 program year is 1.75 percent. Therefore, the estimated amount available for value-based incentive payments for FY 2016 discharges is approximately $1.5 billion.

Hospital Acquired Conditions Reduction Program

CMS is finalizing: (1) the dates of the time period used to calculate hospital performance, (2) an expanded population for two measures that are already included in the program, (3) an adjustment to the relative contribution of each domain to the Total HAC Score, (4) an adjustment to the relative contribution of each measure within Domain 2, and (5) an extraordinary circumstance exception policy.

Hospital Readmissions Reduction Program

CMS is finalizing a refinement of the pneumonia readmission measure that expands the measure cohort. This finalized measure is a modification from what was proposed. CMS is also finalizing the formal adoption of an extraordinary circumstance exception policy. CMS estimates that the Hospital Readmissions Reduction Program will save approximately $420 million in FY 2016, an increase of $6 million over the estimated FY 2015 savings.

PPS-Exempt Cancer Hospital Quality Reporting Program

CMS is finalizing three new patient safety measures under this program. Specifically, the rule finalizes adding a Clostridium difficile (C. 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 is also finalizing removing six Surgical Care Improvement Project measures

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and publicly displaying six additional PCHQR measures.

Long-Term Care Hospital Prospective Payment System Changes

The Pathway for SGR Reform Act of 2013 directed CMS to make significant changes to the payment system for LTCHs. The law directs CMS to establish two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria: the LTCH PPS standard Federal payment rate and a new LTCH PPS site neutral payment rate comparable to the IPPS payment rates. The law provides a two-year transition period for those paid at the site neutral payment rate. During that transition, site neutral payment rate cases are paid based on a 50/50 blend of the LTCH PPS standard Federal payment rate and the LTCH PPS site neutral payment rate. In the final rule, CMS is implementing these statutory requirements.

CMS projects that LTCH PPS payments will decrease by -4.6 percent, or approximately $250 million, based on the final payment rates for FY 2016. This estimated decrease is primarily attributable to the statutory decrease in the payment rates for site neutral payment rate cases that do not meet the clinical criteria to qualify for the standard Federal payment rate. Cases that do qualify for the higher standard Federal payment rate will see an increase in that payment rate of 1.7 percent (based on a market basket update of 2.4 percent adjusted by a multi-factor productivity adjustment of -0.5 percentage point and an additional adjustment of -0.2 percentage point in accordance with the ACA).

Long Term Care Hospital Quality Reporting Program

Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS is subject to a 2.0 percentage point reduction. The IMPACT Act requires the specification of quality measures for the LTCH QRP, including such areas as skin integrity, functional status measures, such as mobility and self-care, as well as incidence of major falls.

In order to satisfy the requirements of the IMPACT Act, CMS is adding one new functional status quality measure (Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); as well as two previously finalized quality measures (Percent of Residents or Patients with 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)).

CMS is additionally adopting the previously finalized All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512). Finally, CMS is finalizing a policy to begin to publically report quality data by fall 2016.

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.

STANDARDIZED PAYMENT RATES

Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2016 (refer pages 758 & 1848)
The 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 and are available on CMS' website.

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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 at 2.7 percent)	2.4	2.4	2.4	2.4
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act (25 percent of MB Update)	0.0	0.0	-0.6	-0.6
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act (50 Percent of MB Update – will increase to 75 percent in 2017)	0.0	-1.2	0.0	-1.2
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act (Proposed at 0.6 percent)	-0.5	-0.5	-0.5	-0.5
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the ACA	-0.2	-0.2	-0.2	-0.2
Applicable Percentage Increase Applied to Standardized Amount	1.7	0.5	1.1	-0.1

The labor-related portion for areas with wage indexes greater than 1.0000 remains at 69.6 percent. Areas with wage index values equal to or less than 1.000 remains at 62.0 percent.

The following are the FY 2015 payment amounts. These amounts are not in the final FY 2016 rule. They are presented for informational purposes only.

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
$3,784.75	$1,653.10	$3,757.90	$1,641.37	$3,757.90	$1,641.37	$3,731.05	$1,629.65

The following table (refer pages 1915-1916) illustrates the changes from the FY 2015 national standardized amount. The unadjusted FY 2015 total rates are $6,212.97 for all columns. Dividing this amount by the adjustments in red in the left column yields $5,437.85. This is the combined labor and non-labor amount for the full-corrected market basket FY 2015 update. (see table above — $3,784.75 + $1,653.10 = $5,437.85).

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	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	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 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 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 Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74 (Combined labor and nonlabor = $6,212.97)
1. FY 2015 Geographic Reclassification Budget Neutrality (0.990429)				
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)	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 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 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 less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93 (Combined labor and nonlabor = $6,212.97
4. FY 2015 Operating Outlier Offset (0.948999)				
5. FY 2015 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.998854)				
FY 2016 Update Factor (refer table above)	1.017	1.005	1.011	0.999
FY 2016 MS-DRG Recalibration and Wage Index Budget Neutrality Factor	0.997150	0.997150	0.997150	0.997150
Proposed FY 2016 Reclassification Budget Neutrality Factor	0.987905	0.987905	0.987905	0.987905
Proposed FY 2016 Rural Community Demonstration Program Budget Neutrality Factor	0.999861	0.999861	0.999861	0.999861
Proposed FY 2016 Operating Outlier Factor	0.949000	0.949000	0.949000	0.949000
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	0.925	0.9255

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	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 New Labor Market Delineation Wage Index Three Year Hold Harmless Transition Budget Neutrality Factor	0.999996	0.999996	0.999996	0.999996
National Standardized Amount for FY 2016 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)	Labor: $3,804.40 Nonlabor: $1,661.69	Labor: $3,759.51 Nonlabor: $1,642.08	Labor: $3,781.96 Nonlabor: $1,651.89	Labor: $3,737.07 Nonlabor: $1,632.28
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: $3,388.98 Nonlabor: $2,077.11	Labor: $3,348.99 Nonlabor: $2,052.60	Labor: $3,368.99 Nonlabor: $2,064.86	Labor: $3,329.00 Nonlabor: $2,040.35

CMS further adjusts these standardized payment amounts for several budget neutrality factors.

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2016 (refer page 1942)

The FY 2016 capital rate is $438.65. The current amount is $434.97. The update changes are shown in the table below.

Comparison of Factors and Adjustments: FY 2015 Capital Federal Rate and FY 2016 Capital Federal Rate				
	FY 2015	FY 2016	Change	Percent Change
Update Factor[1]	1.0150	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor	0.9993	0.9973	0.9973	-0.27
Outlier Adjustment Factor[2]	0.9382	0.9365	0.9982	-0.18
Capital Federal Rate	$434.97	$438.65	1.0085	0.85

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2015 to FY 2016 resulting from the application of the 0.9973 GAF/DRG budget neutrality adjustment factor for FY 2016 is a net change of 0.9973 (or –0.27 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 net change resulting from the application of the FY 2016 outlier adjustment factor is 0.9365/0.9382, or 0.9982 (or -0.18 percent).

Outlier Payments (refer page 1906)

CMS is adopting 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 $22,544. It was proposed at $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 5.38 percent of actual total MS-DRG payments, approximately 0.28 percentage points higher than projected.

CMS says that for FY 2015 outlier payments will be approximately 4.65 percent of actual total MS-DRG payments, approximately 0.45 percentage point lower than the 5.1 percent projected when setting the outlier policies for FY 2015. This estimate of 4.65 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 has greatly overstated the threshold value. And, again, CMS does not make any corrections to this highly visible factor.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2016 (refer pages 1126 & 1948)

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 rate of increase update will be 2.4 percent.

CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (REFER PAGE 666)

FY 2016 Wage Index Tables

CMS is streamlining and consolidating the wage index tables associated with the IPPS 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 consolidating the 11 tables into two 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.

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Core-Based Statistical Areas (page 667)

The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13-01. A copy of this bulletin may be obtained at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.

Occupational Mix Adjustment to the FY 2016 Wage Index (page 682)

For the FY 2016 wage index, CMS used the occupational mix data collected using the 2013 survey.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2016 wage index results in a national average hourly wage of $40.2555 up from the proposed amount of $40.0853

The final 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	38.823902202
National LPN and Surgical Technician	22.767361175
National Nurse Aide, Orderly, and Attendant	15.955866208
National Medical Assistant	18.006207097
National Nurse Category	32.875956041

COMMENT

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

Transitional Wage Indexes (page 691)

CMS notes that FY 2016 is 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

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making any changes to this policy.

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 making any changes to its policy and will continue to the second year of the implementation to provide a 3-year transition.

Rural Floor Section (page 700)

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 346 hospitals will receive an increase in their FY 2016 wage index due to the application of the rural floor.

Imputed Floor for FY 2016 (page 701)

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 21 hospitals in New Jersey that will receive an increase in their FY 2016 wage index due to the continued application of the imputed floor policy under the original methodology and 4 hospitals in Rhode Island that will benefit under the alternative methodology. No hospitals in Delaware will benefit from the imputed floor under either methodology because all hospitals in the affected labor market areas will receive a higher wage index value due to reclassification.

State Frontier Floor (page 707)

Forty-eight hospitals will 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 (page 708)

There are 282 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2016. Because MGCRB wage index reclassifications are effective for 3 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 3-year period. There were 248 hospitals approved for wage index reclassifications in FY 2014 that continue for FY 2016, and 311 hospitals

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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, there will be 841 hospitals in a reclassification status for FY 2016.

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 (page 715)

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 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.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (page 717)

Table 2 (formerly Table 4J) lists the out-migration adjustments for the FY 2016 wage index.

Based on the new out-migration adjustment data 336 hospitals will receive the out-migration adjustment for FY 2016.

CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (REFER PAGE 90)

Changes to the MS-DRGs (page 102)

The following items are those MS-DRG changes that CMS is adopting for FY 2016. CMS address many that are not being adopted.

Nonstandard Cost Center Codes (page 109)

CMS says it calculated the 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. At this point, however, CMS is not making any changes.

Changes to Specific MS-DRG Classifications

a. Conversion of MS-DRGs to the International Classification of Diseases, 10th Revision (ICD-10) (page 141)

CMS is adopting the ICD-10 MS-DRGs Version 33 for FY 2016.

CMS is designating the following ICD-10-PCS codes as O.R. procedures and assigning them to ICD-10 MS-DRG 264: (page 151)

- 02HQ00Z (Insertion of pressure sensor monitoring device into right pulmonary artery, open approach);
- 02HQ30Z (Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous approach);

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- 02HQ40Z (Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous endoscopic approach);
- 02HR00Z (Insertion of pressure sensor monitoring device into left pulmonary artery, open approach);
- 02HR30Z (Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous approach); and
- 02HR40Z (Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous endoscopic approach).

CMS is assigning ICD-10-PCS procedure codes 0LBT0ZZ (Excision of left ankle tendon, open approach) and 0LBS0ZZ (Excision of right ankle tendon, open approach) to ICD-10 MS-DRGs 579, 580, and 581 (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC, and without CC/MCC, respectively). (page 152)

b. FY 2016 MS-DRG Updates

- Percutaneous Intracardiac Procedures (page 174)
- CMS is finalizing its proposal to create MS-DRGs 273 (Percutaneous Intracardiac Procedures with MCC) and MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC).
- Major Cardiovascular Procedures: (pages 250)
- CMS is deleting MS-DRGs 237 and 238, and is creating 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);
  - MS-DRG 271 (Other Major Cardiovascular Procedures with CC);
  - MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC).

- Revision of Hip or Knee Replacements: (page 252)

  CMS is finalizing code combinations which capture the joint revisions to the Version 33 MS-DRG structure for ICD-10 MS-DRGs 466, 467, 468 628, 629 and 630. The tables reflecting this item run from pages 255 to 324.

- Spinal Fusion (page 317)

  CMS is adopting new titles for three MS-DRGs.

  - 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 321)

  CMS is finalizing its proposal to designate the following ICD-10-PCS procedure codes as non-O.R. for the FY 2016 ICD-10 MS-DRGs Version 33: 3E0P76Z; 3E0P77Z; 3E0P7SF;

continued

3E0P83Z; 3E0P86Z; 3E0P87Z; 3E0P8GC; and 3E0P8SF.

- Replaced Devices Offered without Cost or With a Credit (page 387)

  CMS is adding MS-DRGs 266 and 267 to the list of MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit, and consistent with the applicable finalized MS-DRG changes, also removing existing MS-DRGs 237 and 238 and adding new MS-DRGs 268 through 272.

  The 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 388.

COMMENT

The discussion of changes to the MS-DRGs is both extensive excessive consuming some 300+ pages. The material contains many useful tables.

Add-On Payments for (Existing) New Services and Technologies (page 429)

- Glucarpidase (Voraxaze®) — CMS is discontinuing the new technology add-on.
- Zenith® F. Graft — CMS is discontinuing the new technology add-on.
- Zilver® PTX® Drug Eluting Peripheral Stent — CMS is discontinuing this new technology add-on payment.
- Kcentra™ — CMS will continue new technology add-on payments for the Kcentra™ technology for FY 2016. CMS will identify and make new technology add-on payments for cases involving Kcentra™ with the presence of ICD-10-PCS procedure code 30283B1 (Transfusion of nonautologous 4-factor prothrombin complex concentrate into vein, percutaneous approach).The maximum new technology add-on payment will remain at $1,587.50.
- 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 will continue new technology add-on payments for this technology. The maximum new technology add-on payment will remain at $72,028.75 for FY 2016.
- CardioMEMS™ HF (Heart Failure) Monitoring System — CMS will continue new technology add-on payments for this technology for FY 2016. CMS will use either ICD-10-PCS procedure code 02HQ30Z (Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous approach) or ICD-10-PCS procedure code 02HR30Z (Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous approach) to identify the item. The maximum new technology add-on payment for a case involving the CardioMEMS™ HF Monitoring System is $8,875.
- MitraClip® System — CMS will continue new technology add-on payments for this technology for FY 2016. Beginning Oct. 1, 2015, CMS will identify and make new technology add-on payments for cases involving the MitraClip® System using ICD-10-PCS procedure code 02UG3JZ (Supplement mitral valve with synthetic substitute, percutaneous approach). The maximum payment will remain at $15,000 for FY 2016.
- Responsive Neurostimulator (RNS®) System—CMS will continue new technology add-on payments for this technology for FY 2016. CMS will identify and make new technology add-on payments for cases involving

continued

the RNS® System using the following ICD-10-PCS procedure code combination: 0NH00NZ (Insertion of neurostimulator generator into skull, open approach) in combination with 00H00MZ (Insertion of neurostimulator lead into brain, open approach). The maximum new technology add-on payment is $18,475.

FY 2016 Applications for New Technology Add-On Payments (pages 478-665)

CMS received nine applications for new technology add-on payments for FY 2016. Two applications, the Angel Medical Guardian® Ischemia Monitoring Device and Ceftazidime Avibactam, were withdrawn from consideration prior to the publication of this final rule.

One applicant did not receive FDA approval for its technology, Idarucizumab, by July 1, 2015, and, therefore, is ineligible for consideration for new technology add-on payments for FY 2016.

Of the remaining, CMS has approved two and has not approved four.

- Blinatumomab (BLINCYTO™) — CMS is approving new technology add-on payments for the BLINCYTO™ technology for FY 2016. Cases involving the BLINCYTO™ technology that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure codes XW03351 or XW04351. The maximum new technology add-on payment amount for a case involving the use of the BLINCYTO™ is $27,017.85.
- LUTONIX® Drug-Coated Balloon Percutaneous Transluminal Angioplasty Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty Balloon Catheter — CMS is approving the LUTONIX® and IN.PACT™ Admiral™ technologies for new technology add-on payments for FY 2016. The maximum payment for a case involving the LUTONIX® or IN.PACT™ Admiral™ DCBs is $1,035.72 for FY 2016.
- VERASENSE™ Knee Balancer System — CMS finds that the VKS does not represents a substantial clinical improvement over existing technologies, and is not approving new technology add-on payments for the VKS for FY 2016.
- WATCHMAN® Left Atrial Appendage Closure Technology — CMS is not approving the WATCHMAN® System for new technology add-on payment for FY 2016.
- DIAMONDBACK 360® Coronary Orbital Atherectomy System — CMS has determined that the DIAMONDBACK® Coronary OAS does not meet the criteria for approval of a new technology add-on payment.
- CRESEMBA® (Isavuconazonium) — CMS is not approving the CRESEMBA® for new technology add-on payments for FY 2016.

COMMENT

CMS spends some 236 pages — more than 10 percent of the rule itself — addressing some 17 new technology items. Most of the comments and CMS' responses are with the technology applicant seeking additional payments. CMS should be congratulated for the thoroughness of its material.

Nonetheless, one could argue that CMS could find a better way to address these applications than in this rulemaking. As is, the rule is too long already. Here is a place CMS could reduce material that is applicable to only some providers. Just knowing a new technology is being approved; the amount of payment and ICD-10 codes should suffice.

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

Rural Referral Centers (page 763)

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.)

If rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after Oct. 1, 2015, they must have a CMI value for FY 2014 that is at least:

- 1.6082; 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 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)	1.4500
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5035
4	East North Central (IL, IN, MI, OH, WI)	1.5104
5	East South Central (AL, KY, MS, TN)	1.4184
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5855
7	West South Central (AR, LA, OK, TX)	1.6276
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7074
9	Pacific (AK, CA, HI, OR, WA)	1.6168

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after Oct. 1, 2015, must also have the number of discharges for its cost reporting period that began during FY 2013 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.

IME Adjustment Factor for FY 2016 (page 768)

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

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FY 2016 Payment Adjustment for Medicare Disproportionate Share Hospitals (§ 412.106) (page 770)

Impact on Medicare DSH Payment Adjustment of the Continued Implementation of New OMB Labor Market Area Delineations (page 771)
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 773)
The 3 factors 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.

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.

Calculation of Factor 1 for FY 2016 (page 783)

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 July 2015 Medicare DSH estimate for FY 2016, without regard to the application of section 1886(r)(1) of the Act, is $13,411,096,528.05.

Therefore, for this final rule, Factor 1 for FY 2016 is $10,058,322,396.04 ($13,411,096,528.05 minus $3,352,774,132.01). The Office of the Actuary's estimates for FY 2016 begins with a baseline of $11.637 billion in Medicare DSH expenditures for FY 2012.

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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	1.0137	1.040189	$12.105
2014	1.009	0.9634	1.015	0.9993	0.985961	$11.935
2015	1.014	0.9893	1.005	1.0512	1.059784	$12.648
2016	1.009	1.0006	1.005	1.0450	1.060313	$13.411

Calculation of Factor 2 for FY 2015 (page 799)

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 Factor 2 for FY 2016, employing a weighted average of the CBO projections for CY 2015 and CY 2016, is as follows:

- CY 2015 rate of insurance coverage (March 2015 CBO estimate): 87 percent.
- CY 2016 rate of insurance coverage (March 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 2013 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

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- The FY 2016 Estimated Uncompensated Care Amount is: $10,058,322,396.04 x 0.6369 = $6,406,145,534.04.
- (The FY 2015 Final Uncompensated Care Amount is: $10,037,596,646.78 x 0.7619 = $7,647,644,885.18.)

COMMENT

It would appear that the continued reduction in DSH payments would increase by nearly $1.2 billion.

Calculation of Factor 3 for FY 2016 (page 812)

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 $6.406 billion.

CMS says it 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 continuing 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: Changes for FY 2016 Through FY 2017 (§§ 412.150 through 412.154) (page 845)

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:

- Making a refinement to the pneumonia readmissions measure, which will expand the measure cohort, for the FY 2017 payment determination and subsequent years; and
- Adopting 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 provides the following methodology for FY 2016.

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 x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (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 1, 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).

continued

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: Policy Changes for the FY 2018 Program Year and Subsequent Years (pages 901-1007)

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 $ $1,499,107,502.

The applicable percentage for FY 2017 and subsequent years is capped at 2.0 percent.

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

CMS will move PC-01 to the Safety domain, remove the Clinical Care—Process subdomain, and rename the Clinical Care—Outcomes subdomain as the Clinical Care domain for the FY 2018 program year and subsequent years.

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

FY 2018 Previously Adopted and Newly Adopted 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

continued

FY 2018 Previously Adopted and Newly Adopted Measures	
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	
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

**Finalized new measure.*

***Finalized to be moved from the Clinical Care— Process subdomain to the Safety domain.*

Previously Adopted and Newly Adopted Measures for the FY 2019, FY 2021, and Subsequent Program Years

CMS says it will adopt the following:

- Selected Ward (Non-Intensive Care Unit) Locations in Certain NHSN Measures Beginning with the FY 2019 Program Year.
- New Measure for the FY 2021 Program Year: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease Hospitalization (NQF #1893).

Performance Standards for the FY 2018 Program Year (page 988)

Previously Adopted and Newly Finalized 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	0.906	0.000
CLABSI*	National Healthcare Safety Network Central line-associated Bloodstream Infection Outcome Measure	0.369	0.000
CDI*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset Clostridium difficile Infection Outcome Measure	0.794	0.000
MRSA bacteremia*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset Methicillin-resistant Staphylococcus aureus Bacteremia Outcome Measure	0.767	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	• 0.824 • 0.710	• 0.000 • 0.000
PC-01	Elective Delivery	0.020408	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.

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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	55.27	78.52	86.68
Communication with Doctors	57.39	80.44	88.51
Responsiveness of Hospital Staff	38.40	65.08	80.35
Pain Management	52.19	70.20	78.46
Communication about Medicines	43.43	63.37	73.66
Hospital Cleanliness & Quietness	40.05	65.60	79.00
Discharge Information	62.25	86.60	91.63
3-Item Care Transition	25.21	51.45	62.44
Overall Rating of Hospital	37.67	70.23	84.58

COMMENT

This is another section with extensive and complex material. The material contains additional tables regarding standards beyond FY 2018 as well as vital scoring information. Based on the number of comments, the issue of quality is at the forefront of many providers.

Changes to the Hospital-Acquired Condition Reduction Program (pages 1008-1054)

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 did not propose any changes to the policies for the implementation of the HAC Reduction Program for FY 2016.

CMS is reminding readers that it finalized the following measures for use in the FY 2016 program: AHRQ PSI-90 Composite and CDC Central Line-Associated Bloodstream Infection, Catheter-Associated Urinary Tract Infection, and Colon and Abdominal Hysterectomy Surgical Site Infection in previous rulemaking.

For FY 2017, CMS proposed 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. CMS is finalizing the proposed applicable time periods without modification.

COMMENT

Again, this is another complex discussion. While CMS says it is not proposing changes for FY 2016. Changes are being adopted for years beyond 2016.

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Simplified Cost Allocation Methodology for Hospitals (§412.302) (Page 1055)

CMS proposed 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.

CMS is not finalizing its proposal. Instead, CMS is modifying the simplified cost allocation methodology set forth at CMS Pub. 15-2, Chapter 40, Section 4020, to provide additional flexibility to hospitals that use the simplified cost allocation methodology by allowing them to obtain approval from their MACs to use an alternative statistical basis of dollar value for capital-related moveable equipment.

Rural Community Hospital Demonstration Program (page 1067)

For FY 2016, the total budget neutrality offset amount that CMS is applying is $12,835,618.

Changes to MS-DRGs Subject to the Post-acute Care Transfer Policy (§ 412.40) (page 1097)

CMS proposed to update the list of MS-DRGs that are subject to the post-acute care transfer policy to include new MS-DRGs 273 and 274.

CMS is adopting this proposal.

Interim Final Rule with Comment Period Implementing Legislative Extensions Relating to the Payment Adjustment for Low-Volume Hospitals and the Medicare-Dependent, Small Rural Hospital Program (1106)

The Medicare Access and CHIP Reauthorization Act of 2015 enacted on April 16, 2015, extended the Medicare-dependent, small rural hospital program as well as certain provisions relating to payment to low-volume hospitals under the IPPS for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017).

Low Volume Hospitals

Table 14 listed in the Addendum of the FY 2016 IPPS/LTCH PPS final rule lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the claims data from the FY 2014 MedPAR file and their potential low-volume payment adjustment for FY 2016. CMS notes that this list of hospitals with fewer than 1,600 Medicare discharges does not reflect whether or not the hospital meets the mileage criterion.

A hospital that qualified for the low-volume payment adjustment in FY 2015 may continue to receive a low-volume payment adjustment for FY 2016 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2016 and the mileage criterion. However, the hospital must send written verification that is received by its MAC no later than September 1, 2015, stating that it continues to be more than 15 miles from any other "subsection (d)" hospital.

If a hospital's written request for low-volume hospital status for FY 2016 is received after September 1, 2015, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2016 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination, consistent with past practice.

CMS estimates that approximately 593 hospitals will qualify as a low-volume

continued

hospital in FY 2016 with an increase in payments of approximately $322 million.

MDHs

As explained in Change Request 9197, consistent with the previous extensions of the MDH program and the regulations at § 412.108, generally, a provider that was classified as an MDH as of March 31, 2015, was reinstated as an MDH effective April 1, 2015, with no need to reapply for MDH classification. However, if the MDH had classified as an SCH or cancelled its rural classification under § 412.103(g) effective on or after April 1, 2015, the effective date of MDH status may not be retroactive to April 1, 2015.

CMS projects that 90 MDHs will be eligible for FY 2016 with an overall increase in payments of approximately $96 million.

CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2016 (PAGE 1130)

Application of the Site Neutral Payment Rate (§ 412.522) (page 1138)

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 adopting, as proposed, that a LTCH discharge assigned to one of the following 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).

CMS is adopting, as proposed, 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:

continued

- 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 proposed under new § 412.522(b)(2) that the discharge from the subsection (d) hospital that immediately preceded the admission to the LTCH includes at least 3 days in an ICU (as defined in § 413.53(d) of the regulations).

CMS is finalizing without modification its proposal that at least 3 days of ICU services must be reported on the preceding subsection (d) hospital claim using revenue center codes 020X or 021X, and that such coding must be consistent with policies governing ICU services under § 413.53(d) in order for an LTCH discharge to fulfill the requirements of the ICU criterion for exclusion from the site neutral payment rate.

CMS is adopting 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 will 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 finalizing, without modification, its proposal to establish that the site neutral payment rate is the lesser of the IPPS comparable per diem amount, or 100 percent of the estimated cost of the case.

Section 1886(m)(6)(B) of the Act establishes a transitional payment method for cases that will be paid the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. Section 1886(m)(6)(B)(iii) of the Act specifies that the blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge under section 1886(m)(6)(B)(ii) of the Act and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if paragraph (6) of section 1886(m) of the Act had not been enacted.

CMS is, without modification, adopting its proposals to apply the interrupted stay policy and the 25-percent threshold policy to site neutral payment rate cases, and not to apply the SSO policy to site neutral payment rate cases at this time.

CMS is adopting its proposal that, beginning with FY 2016, the annual recalibration of the MS-LTC-DRG relative payment weighting factors would be determined using only data from LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases).

Updates to the Payment Rates for the LTCH PPS for FY 2016 (pages 1285 & 1950)

CMS is establishing an annual update to the standard LTCH Federal rate of 1.7 percent, which is based on the full estimated increase in the LTCH PPS market basket of 2.4 percent, less the MFP adjustment of 0.5 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 update is reduced by 2.0 percentage points to 0.997 (1.7 minus 2.0)

continued

CMS is applying an area wage level adjustment budget neutrality factor of 1.000513.

The FY 2016 LTCH PPS standard Federal payment rate will be $41,726.85 (calculated as $41,043.71[the FY 2015 amount] X 1.017 [MB Update] X 1.000513 [area wage index budget neutrality).

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 will be 62.0 percent.

The FY 2016 LTCH PPS standard Federal payment rate wage index values that are applicable for LTCH PPS standard Federal payment rate discharges occurring on or after Oct. 1, 2015, through September 30, 2016, are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available via the Internet on the CMS Web site.

Adjustment for LTCH PPS High-Cost Outlier Cases

CMS is adopting two separate HCO targets — one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases.

CMS is establishing a fixed-loss amount of $16,423 for LTCH PPS standard Federal payment rate cases. The applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount of $22,544 under the IPPS.

CMS is adopting an approach under which the budget neutrality adjustment for estimated HCO payments to site neutral payment rate cases will be applied to the site neutral payment rate portion of the transitional blended rate payment in FY 2016 (and will not be applied to the LTCH PPS standard Federal payment rate portion of the transitional blended rate payment).

QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (PAGE 1301)

Hospital IQR (page 1305)

CMS proposed 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), and
- SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300).

CMS will remove the chart-abstracted versions of STK-01, STK-06, STK-08, VTE-1, VTE-2, and VTE-3, but also retain STK-06, STK-08, VTE-1, VTE-2, and VTE-3 as electronic clinical quality measures for the FY 2018 payment

continued

determination and subsequent years as proposed.

CMS will remove Immunization 1 (IMM-1) Pneumococcal Immunization (NQF #1653) for the FY 2018 payment determination and subsequent years as proposed.

CMS will remove the chart-abstracted version of AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival Measure (NQF #0164), but retain the electronic version for the CY 2016/ FY 2018 payment determination and subsequent years as proposed.

CMS will remove SCIP-Inf-4 Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300) for the FY 2018 payment determination and subsequent years as proposed.

The final rule contains a table showing measures previously adopted for the Hospital IQR Program FY 2017 payment determination. (refer page 1341)

CMS proposed refinements to the measure cohorts for: (1) the Hospital 30-day, All-cause, Risk-Standardized Mortality Rate (RSMR) 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 finalizing a modified version of the measure refinements (expanded pneumonia cohort) proposed for the FY 2017 payment determination and subsequent years for both the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization (NQF #0506) measure and the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following Pneumonia Hospitalization (NQF #0468) measure. Instead of including all five proposed diagnosis categories, CMS is finalizing only three: (1) patients with a principal discharge diagnosis of pneumonia (the current reported cohort); (2) patients with a principal discharge diagnosis of aspiration pneumonia; and (3) patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission. CMS is not including patients with the most severe illness, which are represented in the 2 diagnosis categories it is not finalizing: (1) patients with a principal discharge diagnosis of respiratory failure with a secondary diagnosis of pneumonia present on admission; and (2) patients with a principal discharge diagnosis of sepsis (including septic shock) with a secondary diagnosis of pneumonia present on admission.

CMS proposed 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);

continued

- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (claims-based); and
- Excess Days in Acute Care after Hospitalization for Heart Failure (claims-based).

CMS is adopting the Hospital Survey on Patient Safety Culture measure for the FY 2018 payment determination and subsequent years as proposed.

CMS is finalizing three of the four proposed measures (the Kidney/Urinary Tract Infection Clinical Episode-Based Payment measure, the Cellulitis Clinical Episode-Based Payment measure, and the Gastrointestinal Hemorrhage Clinical Episode-Based Payment measure). CMS is not finalizing the Lumbar Spine Fusion/Refusion Clinical Episode-Based Payment measure. In addition, CMS is postponing implementation of these three measures for the FY 2019 payment determination and subsequent years (CY 2017 performance period and subsequent years), instead of the FY 2018 payment determination and subsequent years (CY 2016 performance period and subsequent years) as proposed.

CMS is finalizing the Hospital Level, Risk-Standardized Payment Associated with a 90-Day Episode-of-Care for Elective Primary THA and/or TKA measure for the FY 2018 payment determination and subsequent years as proposed.

CMS is finalizing both the Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction and Excess Days in Acute Care after Hospitalization for Heart Failure measures for the FY 2018 payment determination and subsequent years as proposed.

The table below outlines the Hospital IQR Program measure set for the FY 2018 and FY 2019 payment determinations and subsequent years and includes both previously adopted measures and measures adopted in this final rule. CMS notes that in past rules, it has included separate charts for each FY; however, CMS is combining the chart for the FY 2018 payment determination and subsequent years with that of the FY 2019 payment determination and subsequent years. CMS identifies those measures that begin to be included in the program starting with the FY 2019 payment determination with a ±. In addition, all measures finalized for removal in this rule are not included in this chart.

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

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Hospital IQR Program Measures for the FY 2018 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
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
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
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

continued

Hospital IQR Program Measures for the FY 2018 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
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
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 CMS is adopting with FY 2018 and for subsequent years.*

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continued

Hospital IQR Program Measures for the FY 2019 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
Claims		
Kidney/UTI Payment**	Kidney/Urinary Tract Infection 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

COMMENT

The section on the Inpatient Quality Reporting extends some 500 pages. The material is very well written. It's basically easy to follow and understand. It's just long, too long to summarize. CMS goes into much detail about the various reporting elements. There are also discussions regarding the LTCH and Excluded cancer hospital quality programs. Those individuals responsible for quality adoption need to pay careful attention to the changes being made. Failure to do so could result in reduced payments for not providing required quality measures.

TABLES

The following IPPS tables 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 Final Rule Home Page" or "Acute Inpatient--Files for Download."

Table 1A-1E: This excel spreadsheet contains the final rule FY 2016 Operating and Capital National and Puerto Rico Specific Standardized Amounts.

Tables 2 and 3 (Wage Index Tables): Table 2- Final Case-Mix Index and Wage Index Table by CCN; Table 3- Final Wage Index Table by CBSA. Note: Table 2 contains information by CCN and information 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).

Table 5: List of final MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay.

Tables 6B-6M and Tables 6P.1a-6P.2a: Table 6B-New Procedure Codes; Table 6I- Complete Major CC List; Table 6J- Complete CC List; Table 6K- Complete List of CC Exclusions; Table 6L- Principal Diagnosis Is Its Own MCC List; Table 6M- Principal Diagnosis Is Its Own CC List; Table 6M.1- Additions to the Principal Diagnosis Is Its Own CC List.

Tables 6P.1a-6P.2a (ICD-10-PCS Code Translations for MS-DRG Changes): See summary tab in excel spreadsheet and/or summary file in zip file called "CMS-1632-F TABLE 6P.1a-6P.2a.zip" for complete description of all tables.

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.

continued

Tables 8A, 8B, and 8C: Tables 8A and 8B contain the final FY 2016 IPPS operating and capital statewide average cost-to-charge-ratios as published in the Federal Register. Table 8C contains the final FY 2016 LTCH statewide average cost-to-charge-ratios as published in the Federal Register.

Table 10: Contains the final cost thresholds by MS-DRG for the cost criteria for new technology add on payment applications for applications for FY 2017.

Table 14: List of Hospitals with Fewer than 1,600 Medicare Discharges Based on the March 2015 Update of the FY 2014 MedPAR File and Potentially Eligible Hospitals' FY 2016 Low-Volume Hospital Payment Adjustment. (Eligibility for the low-volume hospital payment adjustment is also dependent upon meeting the mileage criteria specified at § 412.101(b)(2)(ii) of the regulations).

Table 15: FY 2016 Readmissions Adjustment Factors under the Hospital Readmissions Reduction Program, which are based on excess readmission ratios from the performance period of July 1, 20011 to June 30, 2014.

Table 16A: Contains updated proxy adjustment factors under the Hospital Value Based Purchasing (VBP) Program that were calculated using historical baseline and performance periods. These proxies for the FY 2016 Hospital VBP payment adjustment factors will not be used to adjust hospital payments. This file includes the proxy adjustment factors published for the FY 2016 Final Rule (CMS-1632-F).

Table 18: FY 2016 Medicare DSH Uncompensated Care Payment Factor 3 and Projected DSH Eligibility

FINAL COMMENTS

Over the past few years, there continues to be 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.

State	Number of Hospitals	Number of Hospitals That Will Receive the Rural Floor or Imputed Floor	Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality	Difference (in millions)
Alabama	86	3	-0.4	$-6.72
Alaska	6	1	-0.3	$-0.51
Arizona	55	5	-0.3	$-5.65
Arkansas	46	0	-0.4	$-4.43
California	303	203	2.2	$220.65
Colorado	47	5	0.4	$4.51
Connecticut	31	7	-0.5	$-8.06
Delaware	6	0	-0.5	$-2.41
Washington, D.C.	7	0	-0.5	$-2.37

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State	Number of Hospitals	Number of Hospitals That Will Receive the Rural Floor or Imputed Floor	Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality	Difference (in millions)
Florida	170	14	-0.3	$-18.34
Georgia	105	0	-0.5	$-11.96
Hawaii	12	1	-0.4	$-1.11
Idaho	14	0	-0.4	$-1.15
Illinois	127	2	-0.5	$-24.07
Indiana	91	0	-0.5	$-11.65
Iowa	35	0	-0.4	$-4.15
Kansas	53	0	-0.4	$-3.5
Kentucky	65	1	-0.4	$-6.76
Louisiana	99	3	-0.5	$-6.39
Maine	20	0	-0.5	$-2.22
Massachusetts	61	39	3.1	$97.64
Michigan	96	0	-0.5	$-21.43
Minnesota	50	0	-0.3	$-5.99
Mississippi	64	0	-0.5	$-4.75
Missouri	78	0	-0.4	$-9.54
Montana	12	2	0.1	$0.19
Nebraska	26	0	-0.4	$-2.43
Nevada	24	3	0.2	$1.8
New Hampshire	13	3	-0.1	$-0.53
New Jersey	64	21	0.2	$8.95
New Mexico	25	0	-0.3	$-1.35
New York	156	2	-0.6	$-43.23
North Carolina	84	0	-0.4	$-13.95
North Dakota	6	0	-0.3	$-0.8
Ohio	132	6	-0.4	$-16.71
Oklahoma	86	4	-0.3	$-4.21
Oregon	34	0	-0.5	$-4.65
Pennsylvania	153	3	-0.5	$-21.99
Puerto Rico	51	10	0.1	$0.17
Rhode Island	11	4	0.7	$2.57
South Carolina	56	5	-0.2	$-2.73
South Dakota	19	0	-0.3	$-0.97
Tennessee	99	10	-0.4	$-9.69
Texas	318	3	-0.5	$-29.15
Utah	34	2	-0.4	$-1.91
Vermont	6	0	-0.3	$-0.57
Virginia	78	1	-0.4	$-11.13
Washington	49	6	0.1	$1.47
West Virginia	29	2	0.1	$1.04
Wisconsin	66	0	-0.5	$-7.85
Wyoming	11	0	-0.2	$-0.22

continued

The rule addresses reduced payments for providers that fail to report quality and/or are not EHR meaningful users. At the time CMS prepared its impact analysis it believed that 24 hospitals would not receive the full market basket rate-of-increase for FY 2016 because they are identified as not meaningful EHR users that do not submit quality data. Further, CMS estimated that 153 hospitals are not meaningful EHR users. (pages 2019 - 2021)

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 Final Rule				
MS-DRG	**MS-DRG Title**	**Final FY 2016 Weights**	**Final FY 2015 Weights**	**Percentage Change**
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0593	1.0643	-0.47%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2265	1.2136	1.06%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1578	1.1743	-1.41%
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9321	0.937	-0.52%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4261	1.4491	-1.59%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9695	0.9688	0.07%
291	HEART FAILURE & SHOCK W MCC	1.4809	1.5097	-1.91%
292	HEART FAILURE & SHOCK W CC	0.9707	0.9824	-1.19%
378	G.I. HEMORRHAGE W CC	0.9949	1.0021	-0.72%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7400	0.7388	0.16%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0816	2.1137	-1.52%
603	CELLULITIS W/O MCC	0.8429	0.8447	-0.21%
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ ELECTROLYTES W/O MCC	0.7221	0.7051	2.41%
682	RENAL FAILURE W MCC	1.5085	1.5194	-0.72%
683	RENAL FAILURE W CC	0.9406	0.9512	-1.11%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7828	0.7794	0.44%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.7926	1.8072	-0.81%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0427	1.0582	-1.46%

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
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