OVERVIEW OF THE FY 2016 IPPS FINAL RULE

SUMMARY OF CALCULATION ELEMENTS

Published in the *Federal Register* August 17th
Comments due September 29th
Rule to take effect October 1st

INDEX TO FFY 2016 CHANGES IN IPPS FACTORS

- Payment Updates
- New Technology
- 2-Midnight Rule
- Wage Index
- DSH Payment Adjustment
- Inpatient Quality Reporting Program
- Readmission Reductions
- Hospital Acquired Conditions (HAC)
- Value Based Purchasing
- Bundled Payments for Care Improvement Initiative (BPCI)

SUMMARY OF CHANGES IN IPPS FINAL RULE FY 2016

- Will apply to approximately 3,400 acute care hospitals
- Market basket increase of 2.4%, but 0.9% total impact
- 1% reduction in DSH/uncompensated care payments
- Average payments will increase by 0.4% compared to FY 15
- 63 total IQR measures for FY 18 payment: removes 9 measures, requires 16 eCQMs, and adds 8 measures
- Readmissions program expands pneumonia definition for FY 2017
- New Value-Based Purchasing measures for FYs 18, 19, and 21, and revised domain weights for FY 18
- Modifies HAC Reduction Program domain weighting for FY 17

FY 2016 IPPS FINAL RULE PAYMENT UPDATE: SUMMARY

Change in Medicare operating rates:	
Market Basket Update	2.4%
Less Multi-Factor Productivity	-0.5%
Less ACA Mandated Cuts	-0.2%
Less Documentation and Coding Recoupment (*ATRA*)	-0.8%
TOTAL IMPACT	**0.9%**

Hospitals that report inpatient quality data and are meaningful users of EHRs will experience a 0.9% increase in payments in FY 2016 relative to FY 2015.

SEQUESTER FACTOR

- The 2% Federal sequester factor remains in place for FFY 2016.

- The factor is not applied to payment rate. It is applied to federal payment portion after determining patient responsibility for coinsurance, deductibles, or secondary payment adjustments.

- NHA has **NOT** applied the 2% sequester factor in any portion of the FFY 2016 IPPS MS-DRG Medicare Expected Payment calculations.

FY 2016 PAYMENT UPDATE: WITH AND WITHOUT **QUALITY REPORTING & MEANINGFUL USE**

FY 2016	Submitted quality data & is meaningful EHR user	Submitted quality data but not a meaningful EHR user	Did not submit quality data but is a meaningful EHR user	Did not submit quality data and is not a meaningful EHR user
MFP adjustment under section 1886 (b)(3)(B)(xi)	-0.5	-0.5	-0.5	-0.5
Statutory adjustment under section 1886(b)(3)(B)(xii)	-0.2	-0.2	-0.2	-0.2
Adjustment for failure to submit quality data under section 1886(b)(3)(B)(viii)	0.0	0.0	-0.6	-0.6
Adjustment for failure to be a meaningful EHR user under section 1886(b)(3)(B)(ix)	0.0	-1.2	0.0	-1.2
Final applicable % increase applied to market basket rate of 2.4%	1.7	0.5	1.1	-0.1

25% penalty of Market Basket = -0.6 | 50% penalty of Market Basket = -1.2

NEW TECHNOLOGY: ICD-10 CONVERSION

- Creating new component within ICD-10 PCS codes, labeled Section "X" (analogous to outpatient C codes). Will be available October 1, 2015.
- Will be used to describe, identify and track new technologies, services & drugs that are not specifically identified in the current ICD-10 PCS structure
- More information available at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD9-CM-C-and-M-Meeting-Materials.html

NEW TECHNOLOGY: ADD-ON PAYMENTS

- Continuation of existing add-on technologies:
  - Kcentra (ICD-10 code: 30283B1)
  - Argus II System (ICD-10 code: 09H005Z or 08H105Z)
  - CardioMESH (ICD-10 codes: 02HR30Z, 02HQ30Z)
  - MitraClip System (ICD-10 code: 02UG3JZ)
  - Responsive Neurostimulator System (RNS) (ICD-10 codes: 0NH00NZ, 00H00MZ)

2-MIDNIGHT RULE

- Created in 2014, a patient that is expected to stay across two consecutive nights will be presumed appropriate for Part A payment.
- CMS did not propose any changes to the rule in the FY 16 IPPS Proposed Rule, but did address short stays in the FY 16 OPPS & ASC rules where fewer than two midnights may still justify as a short-stay inpatient admit.
- Final rule does not include extension of the partial enforcement delay of the two-midnight policy. Delay will expire September 30.

Update: Enforcement delay extended to January 2016.

WAGE INDEX

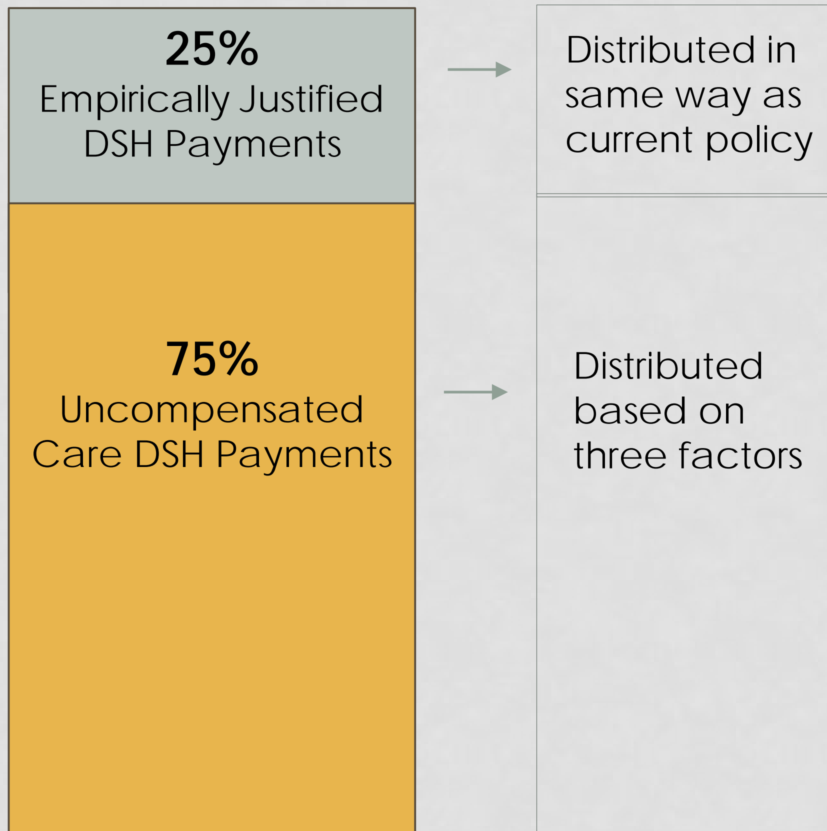
- FY 2016 uses same labor market areas to calculate wage indexes
- Occupational mix- updated based on 2013 Medicare survey.
- National Average Hourly Wage (AHW) adjusted for occupational mix is $40.2555

RURAL WAGE INDEX ADJUSTMENTS

- Second year of transition policies for new OMB delineations of urban to rural.
  - 1 year 50/50 blend wage index through end of FY 2015
  - Keep old urban area wage index for 3 years if not reclassified/redesignated
  - Get 1/3 of the difference between urban/rural DSH for the second year of the transition
- Outmigration- updated using 2008-2012 ACS data. 75 hospitals newly eligible.
  - Hospitals that qualified for adjustment in FYs 2014 or 2015 receive same adjustment for remainder of 3-year period (not updated).
- Frontier floor- applies 1.0 floor in MT, ND, SD, WY
- Imputed rural floor- extended to September 30, 2016 (1 year) for all urban states and alternative method for RI

DSH PAYMENTS

FY 2015



Distributed in same way as current policy

Distributed based on three factors

FY 2016

2016 Final Value of factors for Uncompensated Care DSH Payments:

1. Total DSH payment pool
   - July 2015 estimate was $13.411 billion.
   - 75% of $13.411= **$10.058 billion**
2. Change in the percentage of uninsured
   - FY 2016 percent uninsured estimate 11.5%
   - (1-percent change in uninsured)= available portion of **63.69%** (**$6.406 billion**)
3. Proportion of total uncompensated care each Medicare DSH hospital provides
   - $\frac{\text{Hospital's Medicare SSI Days + Medicaid Days}}{\text{Total DSH Hospitals' Medicare SSI Days + Medicaid Days}}$

DSH PAYMENTS

- No changes in eligibility from FY 2014
- Only affects *operating* DSH, not *capital* DSH

Adjusting for the factors on the previous slide, available pool money for FY 2016 is $6.406 billion. DSH payments will be **cut by $1.24 billion** in FY 2016 compared to the FY 2015 amount.

CMS projects this impact to be a **downward payment of ≈1%** as compared to the Medicare DSH and uncompensated payments distributed in FY 2015.

MS-DRG CHANGES

- **Compress** percutaneous intracardiac procedures, MS-DRGs 246-251 into:
  - MS-DRG 273: Percutaneous Intracardiac Procedures with MCC
  - MS-DRG 274: Percutaneous Intracardiac Procedures without MCC

- **Delete** MS-DRGs 237 & 238 and **create 5 new ones:**
  - 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

MS-DRG CHANGES

- **Revise** the titles of the following 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/ICD CHANGES

- **Convert** the following ICD-10 PCS procedure codes to **non-O.R. codes:**
  - 3E0P7GC ***NEW***
  - 3E0P76Z
  - 3E0P77Z
  - 3E0P7SF
  - 3E0P83Z
  - 3E0P86Z
  - 3E0P87Z
  - 3E0P8GC
  - 3E0P8SF

- **Update** procedure code assignment and DRG titles to accurately replicate and better reflect the ICD-10 MS-DRG assignments (*see Table 5 in Appendix*)

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

Seven new measures for the Hospital Inpatient Quality Reporting program:

FY 2018:

- Add **three** claims-based measures
  - Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA (90 days)
  - Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
  - Excess Days in Acute Care after Hospitalization for Heart Failure
- Add **one** structural measure
  - Hospital Survey on Patient Safety Culture

FY 2019:

- Add **three** claims-Based measures
  - Kidney/UTI Clinical Episode-Based Payment Measure
  - Cellulitis Clinical Episode-Based Payment Measure
  - Gastrointestinal Hemorrhage Clinical-Based Payment Measure

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

For FY 2018 and subsequent years:

- Removed the following measures from IQR program, but will retain five as electronic clinical quality measures:

Measure #	Measure Name	Retain as eCQM
STK-01	Venous Thromboembolism (VTE) Prophylaxis	
STK-06	Discharged on Statin Medication	✓
STK-08	Stroke Education	✓
VTE-1	Venous Thromboembolism Prophylaxis	✓
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	✓
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	✓
IMM-1	Pneumococcal Vaccination (NQF #1653)	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival (NQF #0164)	✓
SCIP-Inf-4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300)	

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM: eCQMs

Electronic Clinical Quality Measures (eCQM):

- CMS extended its policy that hospitals are not required to chart-abstract and submit STK-01 if they submit the following for the CY 2015/ FY 2017 payment determination:
  - STK-02
  - STK-03
  - STK-04
  - STK-05
  - STK-06
  - STK-08
  - STK-10

CHANGES IN QUALITY REPORTING

For FY 2016 & 2017:

- Required to submit one quarter (either Q3 or Q4) of electronic data (eCQMs) from CY 16 by Feb. 28, 2017
- Can report using either 2014 or 2015 edition of CEHRT, but must use the most recent measure specifications

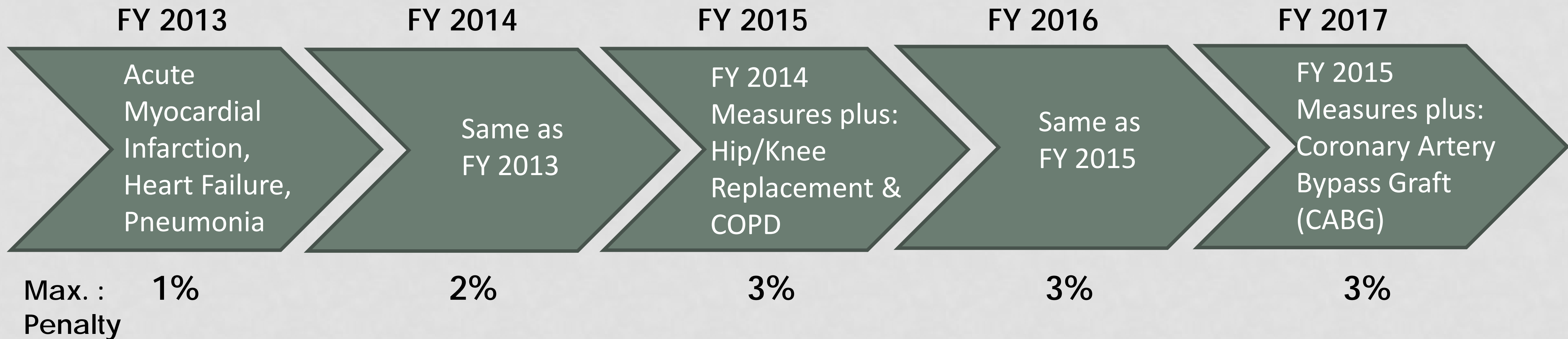
CHANGES IN QUALITY REPORTING

Starting FY 2018:

- Hospitals are required to select & submit 4 (of 28) Electronic Clinical Quality Measures (eCQM) measures
- Only need to submit population and sample size data for measures that are submitted as chart-abstracted measures
- Remove immunization strata from topic area weighting for validation
- Expands Extraordinary Circumstances Extensions/Exemptions policy to include electronic reporting hardships

HOSPITAL READMISSIONS REDUCTION PROGRAM

- Began October 1, 2012 and adjusts payments based on each hospital's ratio of actual versus expected readmissions
- No changes to current or planned measures:



HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS finalized proposal to refine readmission rate following pneumonia hospitalization.

Readmission cohort (not the mortality cohort) **includes patients with**:

- Pneumonia
- Aspiration pneumonia
- Sepsis with a secondary diagnosis of pneumonia present on admission

Does NOT include patients with a principal discharge diagnosis of respiratory failure or severe sepsis. CMS did not refine the mortality cohort.

This change impacts seven of the variables used in the risk adjustment algorithm and is expected to increase the number of discharges included in the measure by 50%.

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

- 1% payment reduction will continue to apply to those hospitals that rank in the lowest performing quartile relative to the national average of all applicable hospitals.
  - *Domain 1*: AHRQ PSI-90 Measure, composite of 8 patient safety measures.
  - *Domain 2*: Measures include CDC Central-Line Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), and Colon and Abdominal Hysterectomy Surgical Site Infection (SSI).
- Finalized the 24-month period from July 1, 2013-June 30, 2015 as the time frame for Domain 1 measure (AHRQ PSI-90 Composite Measure).
- For **FY 2016, weight of Domain 1 is 25% and weight of Domain 2 is 75%.**
- Not adding or removing any HAC measures for **FY 2016**, but is making changes for **FY 2017 & 2018** (next slide).

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

FY 2017:

- Inclusion of two new measures for Domain 2:
  - Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia
  - Clostridium difficile (CDI)
- Decrease the Domain 1 weight from 25% to 15% and increase the Domain 2 weight from 75% to 85%.

FY 2018:

- Finalized expansion of patient population for CLABSI & CAUTI measures.
  1. Expands to include patients in select non-intensive care units. (pediatric & adult medical wards, surgical wards, and med/surg wards locations.
  2. Changes the relative contribution of each measure within domain 2 and the domain weighting of the total HAC score, which could impact the mix of hospitals receiving the HAC penalty.

EXTRAORDINARY CIRCUMSTANCE POLICY

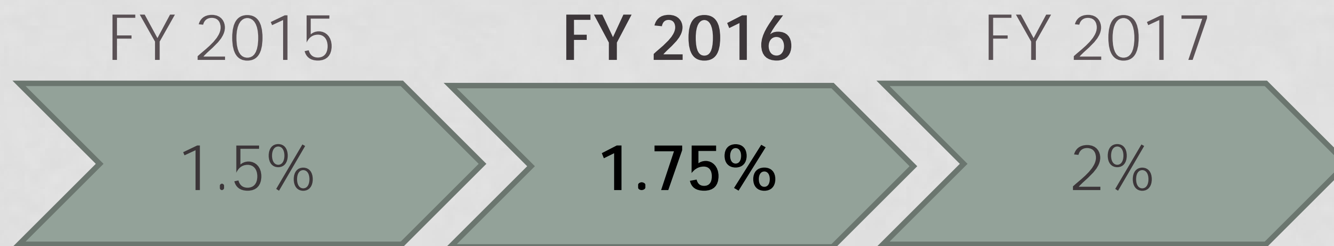
For both the Hospital Readmissions Reduction Program and the HAC Reduction Program, CMS has finalized an extraordinary circumstance exception policy to address hospitals that experience a disaster or other extraordinary circumstance beginning in FY 2016.

Hospitals must submit ECE form within 90 days post event, request form similar to existing VBP and IQR ECE policy.

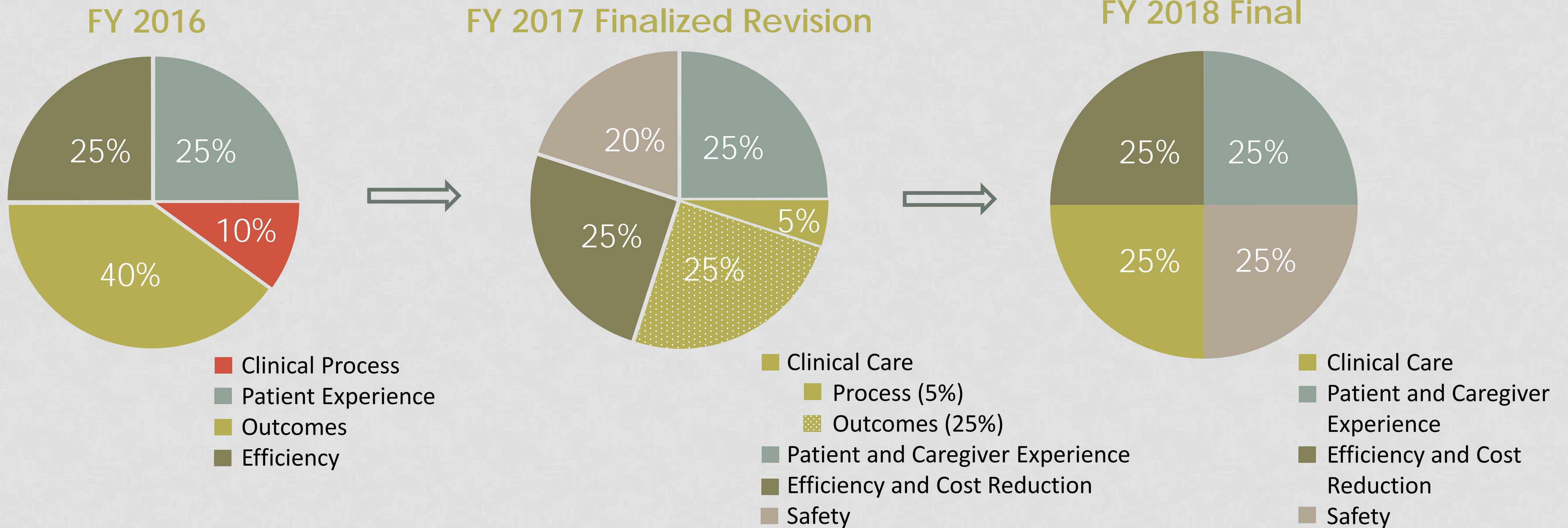
VALUE-BASED PURCHASING PROGRAM (VBP)

- Expansion of program to fund incentive payments to high-performing hospitals through a coefficient reduction in base operating DRG payments for hospital discharges. These base payment reductions will be reallocated within the IPPS system as incentive payments & the size of the reallocation will increase until maxing out in FY 2017.

- Reduction coefficients:



VALUE-BASED PURCHASING PROGRAM (VBP)

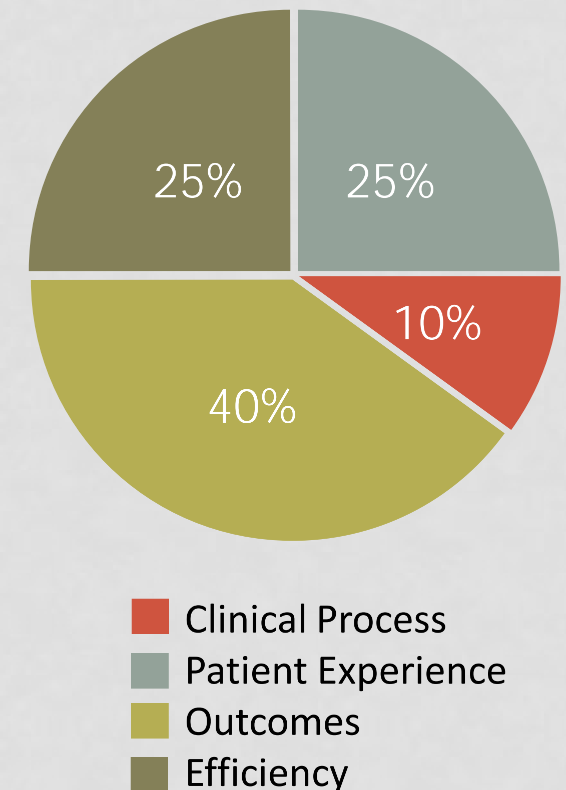


Source: Premier, Inc., Advisor Live, "IPPS FY 2016 Final Rule"

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2016

- Removes 5 Clinical Process Measures:
  - **AMI-8a**: Heart Attack Patients given PCI l
  - **HF-1:** Heart Failure patients given discharge instructions
  - **PN-3b**: Pneumonia patients with ER blood culture prior to first hospital dose of antibiotics
  - **SCIP-Inf-1:** Surgery patients given antibiotic at the right time to prevent infection
  - **SCIP-Inf-4:** Heart surgery patients whose blood glucose is controlled in the days after surgery
- Adds 1 Clinical Process Measure:
  - **IMM-2**: Influenza Immunization
- Adds 2 Outcome Measures:
  - **CAUTI:** Catheter-Associated Urinary Tract Infection
  - **SSI:** Surgical Site Infection

Measure ID	NQS-Based Domain
AMI-7a	Clinical Process
IMM-2 *NEW*	Clinical Process
PN-6	Clinical Process
SCIP-Inf-2	Clinical Process
SCIP-Inf-3	Clinical Process
SCIP-Inf-9	Clinical Process
SCIP-Card-2	Clinical Process
SCIP-VTE-2	Clinical Process
HCAHPS	Patient Experience
CAUTI *NEW*	Outcomes
CLABSI	Outcomes
MORT-30-AMI	Outcomes
MORT-30-HF	Outcomes
MORT-30-PN	Outcomes
PSI-90	Outcomes
SSI *NEW*	Outcomes
MSPB-1	Efficiency

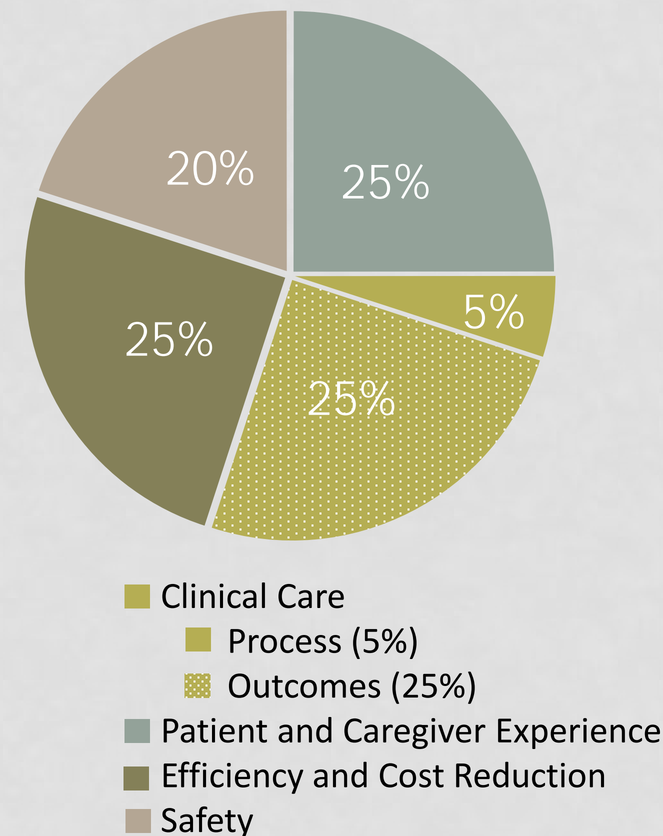


Source: Premier, Inc., Advisor Live, "IPPS FY 2016 Final Rule"

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2017

- Combines Clinical Process and Outcomes categories into "Clinical Care"
- Removes 6 Clinical Process Measures:
  - **PN-6**: Initial Antibiotic selection for CAP
  - **SCIP-Inf-2:** Prophylactic antibiotic surgical pts
  - **SCIP-Inf-3:** Prophylactic antibiotics discontinued within 24 hours after surgery
  - **SCIP-Inf-9:** Urinary catheter removed on postoperative days 1 or 2
  - **SCIP-Card-2:** Beta-blocker prior to arrival
  - **SCIP-VTE-2:** Appropriate venous thromboembolism prophylaxis
- Adds 1 Clinical Process Measure:
  - **PC-01**: Elective Delivery
- Adds "Safety" Category with 2 new measures:
  - **MRSA:** Methicillin-Resistant Staphylococcus Aureus
  - **C. Diff:** Clostridium difficile colitis

Measure ID	NQS-Based Domain
AMI-7a	Clinical Care- Process
IMM-2	Clinical Care- Process
PC-01 *NEW*	Clinical Care- Process
MORT-30-AMI	Clinical Care-Outcomes
MORT-30-HF	Clinical Care-Outcomes
MORT-30-PN	Clinical Care-Outcomes
HCAHPS	Patient and Caregiver Centered Experience of Care/ Care Coordination
CAUTI	Safety
CLABSI	Safety
MRSA *NEW*	Safety
C. Diff *NEW*	Safety
PSI-90	Safety
SSI	Safety
MSPB-1	Efficiency and Cost Reduction

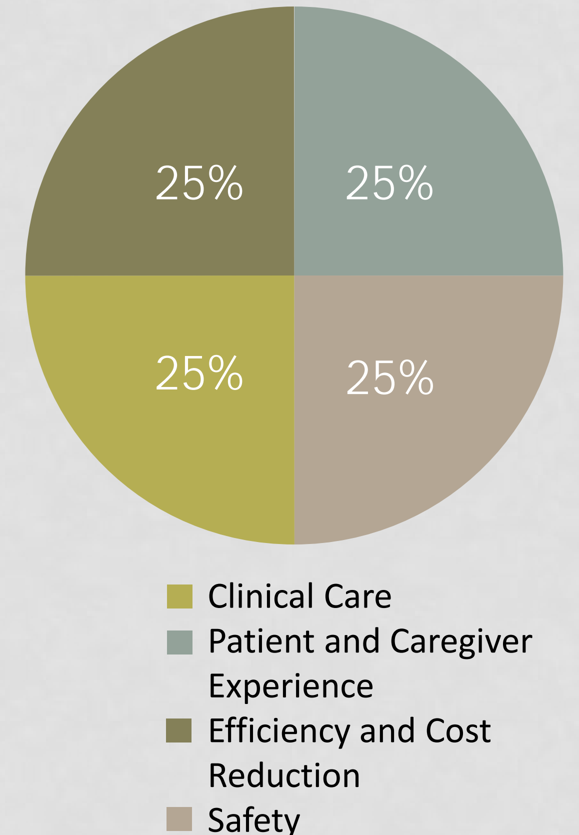


Source: Premier, Inc., Advisor Live, "IPPS FY 2016 Final Rule"

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2018

- Creates overall "Clinical Care" category, removing 2 clinical process measures:
  - **AMI-7a**: Fibrinolytic Therapy received within 30 minutes of arrival
  - **IMM-2:** Influenza Immunization
- Moves 1 Clinical Process Measure to Safety category:
  - **PC-01:** Elective Delivery
- Adds 1 Patient and Caregiver Experience measure:
  - **CTM-3:** Three-Item Care Transition Measure

Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
HCAHPS CTM-3 *NEW*	Patient and Caregiver Centered Experience of Care/ Care Coordination
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	Safety
SSI	Safety
PC-01	Safety
MSPB-1	Efficiency and Cost Reduction



Source: Premier, Inc., Advisor Live, "IPPS FY 2016 Final Rule"

BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE (BPCI)

Composed of four related payment models to link payments with episodes of care. Organizations that participate in the initiative receive a discounted bundled payment for a single episode of care.

CMS requested comments in proposed rule. They received over 75 public comments considering the potential future expansion of the BCPI (evaluation of BCPI models, further testing of the BCPI initiative, target pricing methodologies, etc.).

UPDATE: CMS announced in August that 2,100 acute care hospitals, skilled nursing facilities, physician group practices, long-term care hospitals, inpatient rehabilitation facilities, and home health agencies transitioned to a risk-bearing implementation period in which they will assume financial risk for episodes of care. 360 of those organizations are participating in BCPI, while the other 1,755 are partnering with those organizations.

ADDITIONAL CMS COMMENTS

- No review yet of the Patient Safety Indicator 90 measure (PSI 90)—NHQ is considering expanding it from 8 PSIs to 11 PSIs. Prior version remains adopted.
- Acknowledged the overlapping measures in the HVBP Program and the HAC Reduction program stating that they "cover topics of critical importance to quality improvement in the inpatient hospital setting and to patient safety."
- CMS is committed to increasingly shifting Medicare payments from volume to value.

NEW HEALTH ANALYTICS

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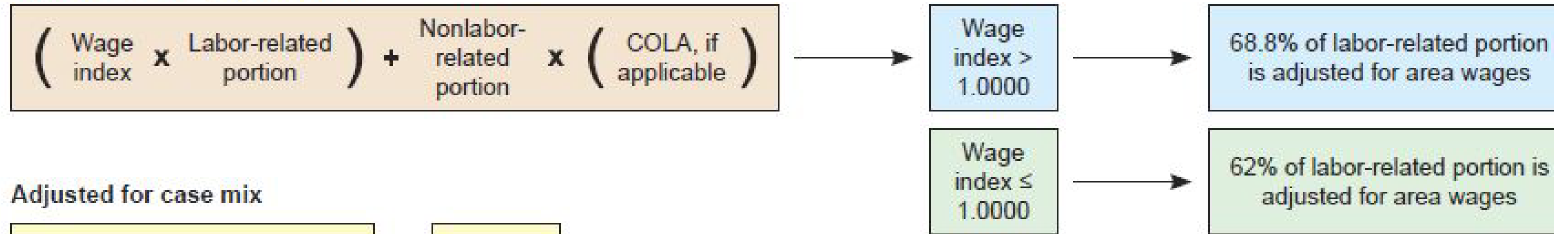
PERFORMANCE INSIGHT

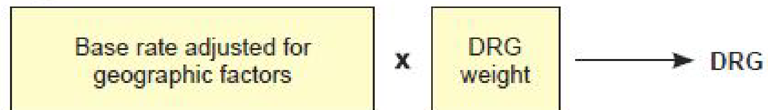
APPENDICES

IPPS OPERATING BASE PAYMENT FORMULA

Adjusted for geographic factors

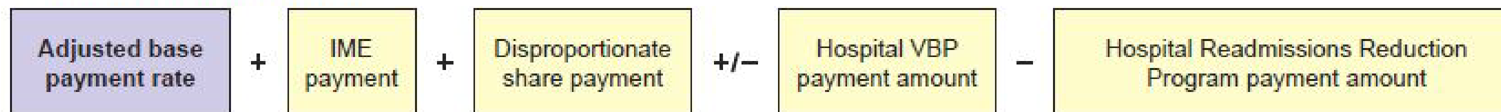


Adjusted for case mix

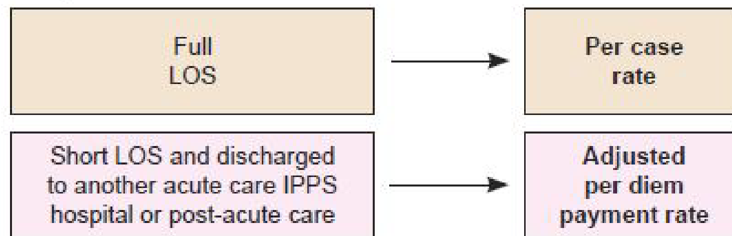


Policy adjustments for qualifying hospitals:

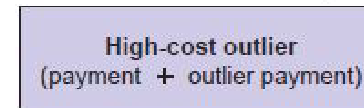
I. Additional operating amounts



II. Adjustments for transfers



III. If case is extraordinarily costly



IV. If case qualifies for new technology add-on

CMS FY 2016 FINAL RULE TABLE 5

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

Click on image below to open full Excel document.

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2016 Final Rule								
MS-DRG	FY 2016 Final Post-Acute DRG	FY 2016 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
001	No	No	PRE	P	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W M	26.2466	29.4	38.8
002	No	No	PRE	P	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/C	14.6448	16.6	20.0
003	Yes	No	PRE	P	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NE	17.6569	25.5	31.7
004	Yes	No	PRE	P	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O M	10.9458	20.0	24.1
005	No	No	PRE	P	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.7263	15.3	21.0
006	No	No	PRE	P	LIVER TRANSPLANT W/O MCC	4.8330	7.9	8.8
007	No	No	PRE	P	LUNG TRANSPLANT	9.7007	15.8	18.8
008	No	No	PRE	P	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.4338	9.8	11.4
010	No	No	PRE	P	PANCREAS TRANSPLANT	4.3039	8.1	9.5
011	No	No	PRE	P	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7501	11.3	13.8
012	No	No	PRE	P	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.4047	8.4	9.8
013	No	No	PRE	P	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC,	2.1906	5.8	6.6
014	No	No	PRE	P	ALLOGENEIC BONE MARROW TRANSPLANT	11.5928	22.7	27.5
016	No	No	PRE	P	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	6.1746	17.8	19.2
017	No	No	PRE	P	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3721	10.0	12.8
020	No	No	01	P	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W	9.7571	13.6	16.8