

Fiscal Year 2016 proposed Inpatient and Long-term Care Hospital policy and payment changes (CMS-1632-P)

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Contact go.cms.gov/media

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On April 17, 2015 the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update fiscal year (FY) 2016 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, would affect discharges occurring on or after October 1, 2015.

The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and market conditions to the hospital's geographic area.

The proposed rule proposes policies that continue a commitment to increasingly shift Medicare payments from volume to value. The Administration has set measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The proposed rule includes policies that advance that vision and support building a health care system that delivers better care, spends health care dollars more wisely and results in healthier people.

This fact sheet discusses major provisions of the proposed rule.

Background

CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS generally sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital receives a single payment for the case based on the payment classification – MS-DRGs under the IPPS and MS-LTC-DRGs under the LTCH PPS – assigned at discharge.

By law, CMS is required to update payment rates for IPPS hospitals annually, and to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital “market basket.” LTCHs are paid according to a separate market basket based on LTCH-specific goods and services.

Changes and Updates in FY 2016 Policies

Proposed Changes to Payment Rates under IPPS

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

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 EHR user will be reduced by one-half of the market basket update in FY 2016.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 0.3 percent. CMS projects that total Medicare spending on inpatient hospital services will increase by about \$120 million in FY 2016.

Other payment adjustments will include continued penalties for readmissions, a continued -1% 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. The Medicare Access and CHIP Reauthorization Act of 2015 also contains provisions that would impact certain payment adjustments and policies discussed in this proposed rule, including extensions of additional payments for Medicare-dependent hospitals and low-volume hospitals that were due to expire. Those extensions are not reflected in this proposed rule.

Potential Expansion of Bundled Payments for Care Improvement Initiative

In 2011, CMS launched the Bundled Payments for Care Improvement (BPCI) initiative. The BPCI initiative links payments for multiple services during an episode of care into a bundled payment. BPCI episodes initiate either with an inpatient stay or with post-acute services following a qualifying inpatient stay. CMS is continuing to implement the initiative, which is testing four models of care with hundreds of providers across the country.

In the rule, CMS is seeking comment on policy and operational issues surrounding the potential future expansion of this initiative.

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.

Long-Term Care Hospital Prospective Payment System Changes

Nationwide, most chronically ill patients are treated in acute care hospitals, but some are admitted to LTCHs. The Pathway for SGR Reform Act of 2013 directed CMS to make significant changes to the payments system for LTCHs. The law directs CMS to establish two different types of LTCH PPS payment rates depending on whether or not the patient meets certain clinical criteria: standard LTCH PPS payment rates, and new, lower site neutral LTCH PPS payment rates that are generally based on the IPPS rates. The law transitions the payment reduction for site neutral cases for the first two years of the revised LTCH PPS by requiring payment based on a 50/50 blend of the standard LTCH PPS rate and the site neutral LTCH PPS rate. In the proposed rule, CMS is proposing specifics of the implementation of this statutory requirement.

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

Medicare Disproportionate Share Hospital (DSH) Payments

Beginning in FY 2014, the Affordable Care Act changed the Medicare DSH payment methodology. Hospitals now receive 25 percent of the amount they previously would have received under the statutory DSH formula. The remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, is aggregated nationally, adjusted for decreases in the rate of uninsured individuals and other factors, and then distributed to hospitals based on their relative share of the total amount of uncompensated care. In this rule, CMS is proposing to distribute \$6.4 billion in uncompensated care payments in FY 2016, a decrease of \$1.3 billion from the estimated FY 2015 amount. This decrease is primarily attributable to continued declines in the number of uninsured individuals since the passage of the Affordable Care Act. The estimate of the uncompensated care payments to be distributed in FY 2016 will be updated in the final rule based on more recent data.

Electronic Health Record Incentive Programs and Quality Reporting

This proposed rule also includes the requirements for eligible hospitals and Critical Access Hospitals (CAHs) participating in electronic reporting of clinical quality measures (CQMs) for the Electronic Health Record (EHR) Incentive Programs and the Inpatient Quality Reporting (IQR) program. CMS is proposing modifications to some of the CQM reporting and submission requirements to align the CQM reporting period for electronic reporting for both programs, to specify the options for the Editions of certified EHR technology providers may use, and to establish requirements for the version of electronic specifications (eCQMs) a provider must use for electronic submission of quality reporting data. No changes are proposed for the CQM reporting and submissions requirements for Medicaid eligible hospitals/CAHs. No new CQMs are proposed.

Hospital Inpatient Quality Reporting (IQR) Program

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

In addition, CMS proposes two changes in relation to electronic clinical quality measures (eCQMs). CMS proposes to clarify requirements for the submission of the STK-01 measure for CY 2015/FY 2017 payment determination. Also, CMS proposes to require hospitals to submit sixteen eCQMs covering three National Quality Strategy (NQS) domains beginning in Calendar Year 2016 for the FY 2018 payment determination, with

each hospital choosing which measures to submit, from the 28 available inpatient electronic Clinical Quality Measures. This will align the Hospital IQR Program with the Medicare Electronic Health Record Incentive Program for eligible hospitals and critical access hospitals. CMS proposes to require two quarters (Q3 and Q4) of reporting in CY 2016.

Hospital Value-Based Purchasing (VBP) Program

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

Hospital Acquired Conditions (HAC) Reduction Program

In the FY 2016 IPPS/LTCH PPS Proposed Rule, CMS is proposing: (1) an expanded population for two measures that are already included in the program, (2) an adjustment to the relative contribution of each domain to the Total HAC Score, and (3) an extraordinary circumstances exception (ECE) policy.

Hospital Readmissions Reduction Program

In the FY 2016 IPPS/LTCH PPS Proposed Rule, CMS is proposing: the implementation of a refinement of the pneumonia (PN) readmission measure to expand the measure cohort and the formal adoption of an extraordinary circumstance exception (ECE) policy. CMS is also continuing to conduct research on the issue of risk adjustment for socioeconomic status in our quality programs, and are working with the Office of the Assistant Secretary of Planning and Evaluation, who expects to issue a report to Congress on this issue by October 2016.

Long Term Care Hospital Quality Reporting Program (LTCH QRP)

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

In order to satisfy the cross-setting requirements of the IMPACT Act, CMS is proposing one new functional status quality measure, 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)), in order to establish their use as cross-setting measures that satisfy the required measurement domains under the IMPACT Act. CMS is additionally proposing the previously finalized All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals (NQF #2512), in order to establish the newly NQF-endorsed status of this measure. Finally, CMS is proposing to begin to publically report quality data by fall 2016, on a CMS website, such as Hospital Compare.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Established by the Affordable Care Act, the PPS-Exempt Cancer Hospital Quality Reporting Program collects and publishes data on an announced set of quality measures. In the proposed rule, CMS proposes to collect three new patient safety measures under this program. Specifically, the rule proposes to add a *Clostridium difficile* (*C. difficile*) infection outcome measure, a Hospital-Onset Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia outcome measure, and a measure of Influenza vaccination coverage among healthcare personnel. CMS also proposes to remove six Surgical Care Improvement Project (SCIP) measures because it will not be operationally feasible to continue collecting data on these measures in the future.

Two Midnight Rule

Over the past few years, hospitals have expressed concerns related to Medicare policies surrounding short inpatient hospital stays, long outpatient stays that include observation services, and when payment for short hospital stays is appropriate under Medicare Part A. CMS has worked to clarify when hospital stays would be considered inpatient or outpatient for purposes of payment. As part of those efforts, CMS included a provision in the FY 2014 hospital payment rule establishing a benchmark that stays expected to last two or more midnights would generally be considered appropriate for inpatient payment, while stays expected to last less than two midnights would generally be considered appropriate for outpatient payment (commonly known as the “Two Midnight Rule”).

In addition, in response to hospital concerns about medical review, CMS and Congress have prohibited Recovery Auditor review of patient status on hospital admissions between October 1 2013, and April 30, 2015 while CMS continues to educate hospitals on billing under the new rules. The Medicare Access and CHIP Reauthorization Act of 2015 further extends this prohibition to September 30, 2015 but was not enacted in time for this information to be reflected in the IPPS proposed rule. When this prohibition expires, CMS has limited Recovery Auditors to six months to review a claim for patient status when the hospital bills within three months

of the date of service to allow hospitals to bill for all medically necessary services under Medicare Part B within the statutory timely filing limits. CMS is considering feedback, as well as recent MedPAC recommendations, carefully and expects to include a further discussion of the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the proposed calendar year 2016 Hospital Outpatient Prospective Payment system rule.

CMS will accept comments on the proposed rule until June 16, 2015, and will respond to all comments in a final rule to be issued by August 1, 2015. The proposed rule can be downloaded from the *Federal Register* at: <https://www.federalregister.gov/public-inspection>.