The FY 2016 Annual Medicare Update

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October 6, 2015
Comment

- Display versus Published Copies
- Display out several days/weeks sooner than published
- Once display copy is superseded by published copy it is no longer available
- Bottom line – get the display copy
The Federal Government

- Open or shut??
- Budget when??
- Status of Sequester
- Other
Agenda

- IPPS
- SNF
- IPF
- IRF
- Hospice
- Comprehensive Care for Joint Replacement (CCJR)
Agenda

- Proposed OPPS
- Notice Act
- Proposed ESRD
- Proposed MPFS
- Proposed HHA
Comment

- Another overly difficult to read and follow rule:
- It’s too long – 2,149 pages up from the proposed at 1,526 pages
- Lacks many clear concise actions/decisions
- Problem is CMS is trying to defend itself against potential litigation
- A suggestion – next time you respond to comments offer CMS the concept of placing final actions at the beginning of each section followed by the long back and forth on comments
FY 2016 IPPS

- Posted on 7/31/15
- Published in 8/17/15 Federal Register
- Tables for IPPS at: http://www.cms.hhs.gov/Medicare/medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- Tables for LTCH at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html
Corrected notice issued 9/30

- Impacts standardized amounts
- Capital rate
- Other
- Changes are small, but widespread
- To be published October 5th
IPPS Update Market Basket Increase

- MB is 2.4 percent – proposed at 2.7
- Offsets:
  - (0.5%) for productivity -- proposed at 0.6
  - (0.2%) for ACA mandate
  - (0.8%) for documentation & coding (per ATRA)
- Increase in total payments of $272 million
  - Operating $ 85 million
  - Capital $187 million
- Don’t believe CMS’ numbers
IPPS Update

- Beware of offsets that will further reduce
  - Value-based purchasing
  - Readmissions
  - HAC
  - DSH
- ACA law said updates could be less than current
- Impact of sequester still in play and not addressed
IPPS Budget Neutrality

- **Budget neutrality adjustments for:**
  - DRG recalibration
  - Wage index changes
  - Geographic reclassification
  - Rural community hospital demonstration program
  - Removing the FY 2015 outlier offset
IPPS Update Labor Share

- No changes to labor share
  - "Large" Urban areas – those with wage index greater than 1.000 – at **69.6** percent
  - "Other" areas with wage index values equal to or less than 1.000 remain at **62.0** percent by law
FY 2016 regarding failures to report quality and be a meaningful EHR user

- No Quality –
  - ¼ of market basket \((2.4 \times 0.25 = 0.6)\)

- No EHR
  - For FY 2016
  - ¾ of market basket reduced by 66 2/3 percent
    - \((2.4 \times 0.75 \times 0.667 = 0.5) = 1.2\)
  - For FY 2017
  - ¾ of market basket reduced by 100%
# Current FY 2015 IPPS Rates

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Large Urban Areas</strong></td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>$3,784.75</td>
</tr>
<tr>
<td>Non-Labor</td>
<td>$1,653.10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,437.85</td>
</tr>
<tr>
<td><strong>All Others</strong></td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>$3,371.47</td>
</tr>
<tr>
<td>Non-Labor</td>
<td>$2,066.38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,437.85</td>
</tr>
</tbody>
</table>
## IPPS Rate Changes

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Rate-of-Increase</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Adjustment for Failure to Submit Quality Data</td>
<td>0.0</td>
<td>0.00</td>
<td>-0.6</td>
<td>-0.6</td>
</tr>
<tr>
<td>Adjustment for Failure to be a Meaningful EHR User</td>
<td>0.0</td>
<td>-1.2</td>
<td>0.0</td>
<td>-1.2</td>
</tr>
</tbody>
</table>
## IPPS Rate Quality Changes

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi Factor Productivity (MFP) Adj</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>Statutory ACA Adjustment</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
</tr>
<tr>
<td>Applicable Percentage Increase Applied to Standardized Amount</td>
<td>1.7</td>
<td>0.5</td>
<td>1.1</td>
<td>-0.1</td>
</tr>
</tbody>
</table>
## FY 2016 Rate Factors

<table>
<thead>
<tr>
<th>FY 2015 Base Rate after removing:</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FY 2015 Geographic Reclassification Budget Neutrality (0.990429)</td>
<td>If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23</td>
<td>If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23</td>
<td>If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23</td>
<td>If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23</td>
</tr>
<tr>
<td>2. FY 2015 Rural Community Hospital Demonstration Program Budget Neutrality (0.999313)</td>
<td>Non-labor (30.4%): $1,888.74</td>
<td>Non-labor (30.4%): $1,888.74</td>
<td>Non-labor (30.4%): $1,888.74</td>
<td>Non-labor (30.4%): $1,888.74</td>
</tr>
<tr>
<td></td>
<td>(Combined labor and non-labor = $6,212.97)</td>
<td>(Combined labor and non-labor = $6,212.97)</td>
<td>(Combined labor and non-labor = $6,212.97)</td>
<td>(Combined labor and non-labor = $6,212.97)</td>
</tr>
<tr>
<td>3. Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, and FY 2015 Documentation and Coding Adjustment and Coding Recoupment Section 631 of the American Taxpayer Relief Act of 2012 (0.9329)</td>
<td>Hospital Submitted Quality Data and is a Meaningful EHR User</td>
<td>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</td>
<td>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</td>
<td>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>If Wage Index is less Than or Equal to 1.0000:</td>
<td>If Wage Index is less Than or Equal to 1.0000:</td>
<td>If Wage Index is less Than or Equal to 1.0000:</td>
<td>If Wage Index is less Than or Equal to 1.0000:</td>
<td></td>
</tr>
<tr>
<td>Labor (62%): $3,852.04</td>
<td>Labor (62%): $3,852.04</td>
<td>Labor (62%): $3,852.04</td>
<td>Labor (62%): $3,852.04</td>
<td></td>
</tr>
<tr>
<td>Non-labor (38%): $2,360.93</td>
<td>Non-labor (38%): $2,360.93</td>
<td>Non-labor (38%): $2,360.93</td>
<td>Non-labor (38%): $2,360.93</td>
<td></td>
</tr>
<tr>
<td><em>(Combined labor and non-labor = $6,212.97)</em></td>
<td><em>(Combined labor and non-labor = $6,212.97)</em></td>
<td><em>(Combined labor and non-labor = $6,212.97)</em></td>
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<table>
<thead>
<tr>
<th></th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
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<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. FY 2015 Operating Outlier Offset</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0.948999)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. FY 2015 Wage Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0.998854)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FY 2015 Current Rates</strong></td>
<td>$5,437.85</td>
<td>$5,437.85</td>
<td>$5,437.85</td>
<td>$5,437.85</td>
</tr>
<tr>
<td>FY 2016 MB Update Factor</td>
<td>Hospital Submitted Quality Data and is a Meaningful EHR User</td>
<td>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</td>
<td>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</td>
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<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>1.017 (1.7)</td>
<td>1.005 (1.7-1.2 =0.5)</td>
<td>1.011 (1.7-0.6=1.1)</td>
<td>0.999 (1.7-1.2-0.6=-0.1)</td>
</tr>
</tbody>
</table>
## FY 2016 Rate Factors

<table>
<thead>
<tr>
<th>FY 2016 MS-DRG Recalibration Budget Neutrality Factor</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
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</thead>
<tbody>
<tr>
<td>FY 2016</td>
<td>0.997150 0.997145</td>
<td>0.997150 0.997145</td>
<td>0.997150 0.997145</td>
<td>0.997150 0.997145</td>
</tr>
<tr>
<td>Reclassification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget Neutrality Factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2016</td>
<td>0.987905 0.988168</td>
<td>0.987905 0.988168</td>
<td>0.987905 0.988168</td>
<td>0.987905 0.988168</td>
</tr>
<tr>
<td>Reclassification</td>
<td></td>
<td></td>
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<tbody>
<tr>
<td><strong>FY 2016 Rural Community Budget Neutral</strong></td>
<td>0.999861 0.999837</td>
<td>0.999861 0.999837</td>
<td>0.999861 0.999837</td>
<td>0.999861 0.999837</td>
</tr>
<tr>
<td><strong>FY 2016 Documentation &amp; Coding</strong></td>
<td>0.925500</td>
<td>0.925500</td>
<td>0.925500</td>
<td>0.925500</td>
</tr>
</tbody>
</table>
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<tr>
<td><strong>FY 2016</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Outlier Factor</td>
<td>0.949000 0.948999</td>
<td>0.949000 0.948999</td>
<td>0.949000 0.948999</td>
<td>0.949000 0.948999</td>
</tr>
<tr>
<td>Wage Index Budget Neutral</td>
<td>0.999996 0.999997</td>
<td>0.999996 0.999997</td>
<td>0.999996 0.999997</td>
<td>0.999996 0.999997</td>
</tr>
</tbody>
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<tr>
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<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totals</strong></td>
<td>$5,466.09</td>
<td>$5,401.59</td>
<td>$5,433.85</td>
<td>$5,369.35</td>
</tr>
<tr>
<td></td>
<td>$5,467.39</td>
<td>$5,402.88</td>
<td>$5,435.13</td>
<td>$5,370.92</td>
</tr>
</tbody>
</table>
## FY 2016 Rate Factors

<table>
<thead>
<tr>
<th>National Standardized Amount for FY 2016 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Labor: $3,804.40</td>
<td>Labor: $3,759.51</td>
<td>Labor: $3,781.96</td>
<td>Labor: $3,737.07</td>
</tr>
<tr>
<td></td>
<td>$3,805.30</td>
<td>$3,760.40</td>
<td>$3,782.85</td>
<td>$3,737.95</td>
</tr>
<tr>
<td>Non-labor: $1,661.69</td>
<td>Non-labor: $1,642.08</td>
<td>Non-labor: $1,651.89</td>
<td>Non-labor: $1,632.28</td>
<td></td>
</tr>
<tr>
<td>$1,662.09</td>
<td>$1,642.48</td>
<td>$1,652.28</td>
<td>$1,632.97</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Standardized Amount for FY 2015 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)</td>
<td>Labor: $3,388.98 $3,389.78</td>
<td>Labor: $3,348.99 $3,349.79</td>
<td>Labor: $3,368.99 $3,369.78</td>
</tr>
<tr>
<td>Non-labor: $2,077.11 $2,077.61</td>
<td>Non-labor: $2,052.60 $2,053.09</td>
<td>Non-labor: $2,064.86 $2,065.35</td>
<td>Non-labor: $2,040.35 $2,040.84</td>
</tr>
</tbody>
</table>
### IPPS Rate Comparison (w/Quality & MU)

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>Final FY 2016</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Large</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$3,784.75</td>
<td>$3,805.30</td>
</tr>
<tr>
<td></td>
<td>1,653.10</td>
<td>1,662.09</td>
</tr>
<tr>
<td></td>
<td>$5,437.85</td>
<td>$5,467.39</td>
</tr>
<tr>
<td></td>
<td>$5,437.85</td>
<td>$5,467.39</td>
</tr>
<tr>
<td></td>
<td>$29.54/ 0.54%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$3,371.47</td>
<td>$3,389.78</td>
</tr>
<tr>
<td></td>
<td>2,066.38</td>
<td>2,077.61</td>
</tr>
<tr>
<td></td>
<td>$5,437.85</td>
<td>$5,467.39</td>
</tr>
<tr>
<td></td>
<td>$29.54/ 0.54%</td>
<td></td>
</tr>
</tbody>
</table>

- CMS says update is 0.4 percent
IPPS Rate Quality Changes

- CMS says that only 24 hospitals are not expected to report quality measures for FY 2015
- CMS says that 153 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2015 because they are identified as not meaningful EHR users
IPPS Documentation & Coding

- ATRA mandates $11 billion reduction from 2014 – 2017
- Took $1 billion in 2014
- Will take $2 billion in 2015
- Will take $3 billion in 2016
- Need $5 billion more
- Look out – expect $4 billion next if no change
- Issue not going away
- Now ICD 10 may play a factor
- Go ahead a code “better”
Rate will increase from $434.97 to $438.75 ($438.65)
Excluded Hospitals

- Rate will increase 2.4 percent – full market basket
- Affects
  - Children’s Hospital
  - 11 Cancer Hospitals
  - Hospitals outside 50 states & DC
Outliers

- 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
  - Was proposed at $24,485
  - The current amount is $24,626
Outliers

- CMS currently estimates that actual outlier payments for FY 2015 will be approximately 4.65 percent of actual total MS-DRG payments.
- For FY 2014 5.38 percent – 0.28 more.
- CMS continues to fail to recognize the amount it underestimates for outlier payments.
  - *No one seems to object*” Why???
Wage Index

- Combining tables 2, 3A, 3B, 4A, 4B, 4C, 4D, 4J, 9A, 9C into Table 2

- Table 3 would contain 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
Wage Index

- No new/ additional changes to CBSAs
- Some FY 2015 Transitions would continue
  - Urban to Rural
    - Stay in urban for 3 years
    - Time to seek reclassification
    - Their wage index goes to rural
    - CMS says there are very few
  - Hospitals having decrease index values
    - Transition ends
Wage Index

- No change to the statewide budget neutrality adjustment factor – federal versus state specific
- Massachusetts and California continue to be “big” winners
## FY 2016 IPPS Estimated Payments Due to Rural Floor and Imputed Floor with National Budget Neutrality

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Hospitals</th>
<th>Number of Hospitals Receiving Rural Floor or Imputed Floor</th>
<th>Percent Change in Payments</th>
<th>Difference (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>303</td>
<td>203</td>
<td>2.2</td>
<td>$218.44</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>61</td>
<td>39</td>
<td>3.6</td>
<td>$114.58</td>
</tr>
<tr>
<td>New York</td>
<td>156</td>
<td>2</td>
<td>-0.6</td>
<td>$-45.17</td>
</tr>
<tr>
<td>North Carolina</td>
<td>84</td>
<td>0</td>
<td>-0.4</td>
<td>$-14.60</td>
</tr>
<tr>
<td>Florida</td>
<td>170</td>
<td>14</td>
<td>-0.3</td>
<td>$-19.90</td>
</tr>
<tr>
<td>Georgia</td>
<td>105</td>
<td>0</td>
<td>-0.5</td>
<td>$-12.47</td>
</tr>
<tr>
<td>Illinois</td>
<td>127</td>
<td>2</td>
<td>-0.6</td>
<td>$-25.22</td>
</tr>
<tr>
<td>Michigan</td>
<td>96</td>
<td>0</td>
<td>-0.5</td>
<td>$-22.38</td>
</tr>
<tr>
<td>Missouri</td>
<td>78</td>
<td>2</td>
<td>-0.4</td>
<td>$-9.98</td>
</tr>
<tr>
<td>Ohio</td>
<td>132</td>
<td>6</td>
<td>-0.5</td>
<td>$-17.56</td>
</tr>
</tbody>
</table>
More on Floors

- **Frontier Floor**
  - Montana, North Dakota, South Dakota, and Wyoming, covering 48 providers, will receive a frontier floor value of 1.0000

- **Imputed Floor**
  - Extended till September 30, 2016
  - Benefits
    - 25 providers in New Jersey
    - 4 providers in Rhode Island
    - 0 providers in Delaware
Occupational Mix

- Using FY 2013 survey
- FY 2016 occupational mix adjusted national average hourly wage is $40.2555

<table>
<thead>
<tr>
<th>Occupational Mix Nursing Subcategory</th>
<th>Average Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National RN</td>
<td>38.823902202</td>
</tr>
<tr>
<td>National LPN and Surgical Technician</td>
<td>22.767361175</td>
</tr>
<tr>
<td>National Nurse Aide, Orderly, and Attendant</td>
<td>15.955866208</td>
</tr>
<tr>
<td>National Medical Assistant</td>
<td>18.006207097</td>
</tr>
<tr>
<td>National Nurse Category</td>
<td>32.875956041</td>
</tr>
</tbody>
</table>
Reclassifications

- FY 2016 – 282 approved
- FY 2015 – 311 approved
- FY 2014 – 248 approved
- CMS says there are 841 hospitals reclassified for FY 2016

- Applications to MGCRB were due by September 1st
New FY 2016 – Case-Mix

- National CMI 1.6082 for FY 2014 cost reporting periods or regional, if lower

  - New England (CT, ME, MA, NH, RI, VT) 1.3737
  - Middle Atlantic (PA, NJ, NY) 1.4500
  - South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) 1.5035
  - East North Central (IL, IN, MI, OH, WI) 1.5104
  - East South Central (AL, KY, MS, TN) 1.4184
  - West North Central (IA, KS, MN, MO, NE, ND, SD) 1.5855
  - West South Central (AR, LA, OK, TX) 1.6276
  - Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) 1.7074
  - Pacific (AK, CA, HI, OR, WA) 1.6168
RRCs

- New FY 2016 – Discharges – 5,000
  - National or regional, if lower
  - None Lower
Redesignations

- “Lugar” Hospitals – by statute
  - List available on the CMS Web site
  - Now part of table 3

- Waiving Lugar for the Out-Migration Adjustment
  - Becomes rural for all purposes
  - 336 Hospitals would receive
  - Now part of table 2
MDH/ Low-Volume

- MDH and Low-Volume Hospital programs extended till 9/30/2017
- MDH – depends on status on April 1st
  - If converted from MDH to SCH, must reapply with prospective application
- Low Volume – automatic but must tell MAC it still meets the 15 mile criteria
CAH Hospitals

- Have 3 year transition if made urban under new OMB delineations from 2015
IME / GME

- IME multiplier unchanged at 1.35 – by law
MS-DRGs

- Adopting ICD-10-CM effective 10/1/2015 version 33

- Percutaneous Intracardiac Procedures- 2 New MS-DRGs
  - MS-DRG 273-”Percutaneous Intracardiac with MCC”
  - MS-DRG 274-”Percutaneous Intracardiac w/o MCC”
**MS-DRGs**

- Major Cardiovascular Procedures
- Deleting MS-DRGs 237 and 238
- Replacing with 5 New
  - 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-DRGs

- Revising ICD-CM-PCS code combinations for Hip or Knee Replacements
- Spinal Fusion – New Titles for MS-DRGs 456, 457 and 458
  - 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)
Replaced Devices Offered without Cost or with a Credit

- Will add MS-DRGs 266 and 267 to list of device dependent MS-DRGs
<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>MS-DRG Title</th>
<th>FY 2016 Weights</th>
<th>FY 2015 Weights</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>065</td>
<td>INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS</td>
<td>1.0593</td>
<td>1.0643</td>
<td>-0.47%</td>
</tr>
<tr>
<td>189</td>
<td>PULMONARY EDEMA &amp; RESPIRATORY FAILURE</td>
<td>1.2265</td>
<td>1.2136</td>
<td>1.06%</td>
</tr>
<tr>
<td>190</td>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC</td>
<td>1.1578</td>
<td>1.1743</td>
<td>-1.41%</td>
</tr>
<tr>
<td>191</td>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC</td>
<td>0.9321</td>
<td>0.9370</td>
<td>-0.52%</td>
</tr>
<tr>
<td>193</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W MCC</td>
<td>1.4261</td>
<td>1.4491</td>
<td>-1.59%</td>
</tr>
<tr>
<td>194</td>
<td>SIMPLE PNEUMONIA &amp; PLEURISY W CC</td>
<td>0.9695</td>
<td>0.9688</td>
<td>-0.07%</td>
</tr>
<tr>
<td>291</td>
<td>HEART FAILURE &amp; SHOCK W MCC</td>
<td>1.4809</td>
<td>1.5097</td>
<td>-1.91%</td>
</tr>
<tr>
<td>292</td>
<td>HEART FAILURE &amp; SHOCK W CC</td>
<td>0.9707</td>
<td>0.9824</td>
<td>-1.19%</td>
</tr>
<tr>
<td>378</td>
<td>G.I. HEMORRHAGE W CC</td>
<td>0.9949</td>
<td>1.0021</td>
<td>-0.72%</td>
</tr>
<tr>
<td>392</td>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
<td>0.7400</td>
<td>0.7388</td>
<td>0.16%</td>
</tr>
<tr>
<td>MS-DRG</td>
<td>MS-DRG Title</td>
<td>Final FY 2015 Weights</td>
<td>FY 2014 Weights</td>
<td>Percentage Change</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>470</td>
<td>MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC</td>
<td>2.0816</td>
<td>2.1137</td>
<td>-1.52%</td>
</tr>
<tr>
<td>603</td>
<td>CELLULITIS W/O MCC</td>
<td>0.8429</td>
<td>0.8447</td>
<td>-0.21%</td>
</tr>
<tr>
<td>641</td>
<td>MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W/O MCC</td>
<td>0.7221</td>
<td>0.7051</td>
<td>2.41%</td>
</tr>
<tr>
<td>682</td>
<td>RENAL FAILURE W MCC</td>
<td>1.5085</td>
<td>1.5194</td>
<td>-0.72%</td>
</tr>
<tr>
<td>683</td>
<td>RENAL FAILURE W CC</td>
<td>0.9406</td>
<td>0.9512</td>
<td>-1.11%</td>
</tr>
<tr>
<td>690</td>
<td>KIDNEY &amp; URINARY TRACT INFECTIONS W/O MCC</td>
<td>0.7828</td>
<td>0.7794</td>
<td>0.44%</td>
</tr>
<tr>
<td>871</td>
<td>SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC</td>
<td>1.7926</td>
<td>1.8072</td>
<td>-0.81%</td>
</tr>
<tr>
<td>872</td>
<td>SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC</td>
<td>1.0427</td>
<td>1.0582</td>
<td>-1.46%</td>
</tr>
</tbody>
</table>
New Technology Add-ons

➢ For FY 2016 discontinuing:
  ▪ Voraxaze®
  ▪ Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft
  ▪ Zilver® PTX® Drug Eluting Peripheral Stent
New Technology Add-ons

For FY 2016 continuing:

- Kcentra™ -- $1,587.50
- Argus® II Retinal Prosthesis System -- $72,028.75
- CardioMEMS™ HF (Heart Failure) Monitoring MitraClip® -- $8,875
- Responsive Neurostimulator (RNS®) System -- $18,475
New Technology Add-ons

- For FY 2016 9 new applications received
- Two adopted
  - Blinatumomab (BLINCYTO™) -- $27,017.85
  - LUTONIX® Drug-Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter – $1,035.72
IPPS DSH Formula

- Mandated by Section 3133 of ACA
- Splits system
  - 25 percent remains as old formula
  - Re-scrambles 75 percent
  - Uses 3 factors
DSH Factor One

- Determines 75 percent of what would have been paid under the old methodology
- Excluded hospitals
  - MD Waiver
  - SCHs paid on a hospital-specific basis
  - Hospitals in Rural Community Demo
- Using CMS actuary estimates
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 updated as below:

<table>
<thead>
<tr>
<th>FY</th>
<th>Update</th>
<th>Discharge</th>
<th>Case-Mix</th>
<th>Other</th>
<th>Total</th>
<th>Estimated DSH Payments (in Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1.028</td>
<td>0.9844</td>
<td>1.014</td>
<td>1.0139</td>
<td>1.040394</td>
<td>$12.102</td>
</tr>
<tr>
<td>2014</td>
<td>1.009</td>
<td>0.9595</td>
<td>1.015</td>
<td>0.9993</td>
<td>0.98197</td>
<td>$11.884</td>
</tr>
<tr>
<td>2015</td>
<td>1.014</td>
<td>0.9885</td>
<td>1.005</td>
<td>1.0485</td>
<td>1.056207</td>
<td>$12.552</td>
</tr>
<tr>
<td>2016</td>
<td>1.009</td>
<td>1.0006</td>
<td>1.005</td>
<td>1.0450</td>
<td>1.060313</td>
<td>$13.441</td>
</tr>
</tbody>
</table>
DSH Factor One

- Current DSH estimate is $13,411,096,528.05
  - Was proposed at $13,337,900,436.52
- Current 25% estimate is $3,352,774,132 billion
- Current 75% estimate – Factor 1 is $10,058,322,396 billion
  - [$13,411 - $3,353 = $10,058]
DSH Factor Two

- Reduces Factor One amount by percentage reduction in uninsured
- Using CBO “projections”
  - CY 2015 rate of insurance coverage: 87 percent
  - CY 2016 rate of insurance coverage: 89 percent
  - FY 2016 rate of insurance coverage: (87 percent * .25) + (89 percent * .75) = 88.5 percent
  - The 25/75 ratio is to account for the FY overlapping the CY
DSH Factor Two

- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 Percent

- Formula;
  - \( 1 - \left[ \frac{(0.115 - 0.18)}{0.18} \right] \) = 1 - 0.3611 = 0.6389 (63.89 percent)
  - 0.6389 - 0.002 (0.2 percentage points) = 0.6369
  - **0.6369 = Factor 2**
  - 0.7619 = was Factor 2 for FY 2015
The amount available for uncompensated care payments for FY 2016 will be approximately $6.406 billion (0.6369 times Factor 1 estimate of $10.03 billion)

The FY 2014 “pool” was $9.033 billion

The FY 2015 “pool” was $7.648 billion

The FY 2016 “pool” is $6.406 billion
DSH Factor Two

- If the FY 2015 “pool” was $7.648 billion and the FY 2016 “pool” is $6.406 billion, this suggests a further DSH reduction of $1.242 billion
- CMS says DSH changes decrease of $106 million compared to FY 2015
- ???
DSH Factor Three

- Factor 3 is “equal to the percent, for each subsection (d) hospital, that
  represents the quotient of (i) the amount of uncompensated care for
  such hospital for a period selected by the Secretary (as estimated by
  the Secretary, based on appropriate data (including, in the case where
  the Secretary determines alternative data is available which is a better
  proxy for the costs of subsection (d) hospitals for treating the uninsured,
  the use of such alternative data)); and (ii) the aggregate amount of
  uncompensated care for all subsection (d) hospitals that receive a
  payment under this subsection for such period (as so estimated, based
  on such data)”

- Based on each hospital’s share of total uncompensated care costs
  across all PPS hospitals that received DSH payments
  - So the numerator is all PPS hospitals, but denominator is just DSH
    hospitals
DSH Factor Three

- CMS is using the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3
Readmissions

- Will use 5 measures
  - Risk adjusted rates
    - AMI, HF, and PN in FY 2013 & 2014
    - Addition of COPD & TKA/THA in 2015+
  - Improvement is not recognized
  - Certain planned readmissions are not counted
- Will add CABG in 2017
- Would revise pneumonia cohort for FY 2017 and future
- Adding extraordinary circumstance measure for FY 2016
- Is not budget neutral
Readmissions

- **Aggregate payments for excess readmissions** = [sum of base operating DRG payments for AMI \( \times \) (Excess Readmission Ratio for AMI - 1)] + [sum of base operating DRG payments for HF \( \times \) (Excess Readmission Ratio for HF - 1)] + [sum of base operating DRG payments for PN \( \times \) (Excess Readmission Ratio for PN - 1)].

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

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

- Readmissions Adjustment Factor for FY 2016 is the higher of the ratio or 0.9700
Readmissions

- Impact expected to be $420 million
- Table 15 contains ratios
Value Based Purchasing

- Program became effective FY 2013 (October 1, 2012)
- The only Medicare quality program that provides rewards and penalties (redistributive)
- The only Medicare quality program to recognize improvement as well as achievement
- Funded by IPPS payment “contribution” (1.75% in FY 2016)
- 2% in FY 2017
- $1.5 Billion program (for FY 2016)
Value Based Purchasing

- **Removing**
  - For 2018
    - IMM-2 Influenza Immunization
    - AMI-7a Fibrinolytic Therapy

- **Adding**
  - For 2018
    - 3-Item Care Transition Measure (NQF# 0028)
Value Based Purchasing

Measures for FY 2018

- HCAHPS
- CTM-3
- MORT-30 AMI; MORT-30-HF; MORT-30 PN
- CAUTI
- CLABSI
- Colon & Abdominal Hysterectomy SSI
- MRSA bacteremia
- CDI
- PSI-90
- PC-01
- MSPB-1
Value Based Purchasing

- Benchmarks & Thresholds
  - Refer final rule
HAC Reduction

- Affects payment in FY 2016
- Lowest-performing quartile get 1.0 percent reduction
- No changes for 2016
- For 2017
  - 3 changes
    - Dates, times of period to calculate
    - Addition of a narrative
    - Relative contribution of Domains
Proposed, but is not eliminating the simplified cost allocation methodology for hospitals

But, is modifying to require MAC approval
Quality Reporting

- Consumes 500 pages -- Complex – need to review rule!
- Proposed to remove 9 chart abstracted measures for FY 2018
  - 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).
Will remove chart abstracted measures for
- 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)

But retain
- STK-06, STK-08, VTE-1, VTE-2, and VTE-3 as electronic

Will Remove
- IMM-1, AMI-7a (but retain electronic), and SCIP-INF-4
For FY 2017 is finalizing three “refinement” changes involving:

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 (POA)
Proposed to add measures for FY 2018

- Hospital Survey on Patient Safety Culture (structural); [adopting]
- Kidney/UTI Clinical Episode-Based Payment Measure (claims-based); [adopting]*
- Cellulitis Clinical Episode-Based Payment Measure (claims-based); [adopting]*
- Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure (claims-based); [adopting]*
- Lumbar Spine Fusion/Re-Fusion Clinical Episode-Based Payment Measure (claims-based); [NOT adopting]
- Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA (claims-based); [adopting]
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (claims-based); and
- (8) Excess Days in Acute Care after Hospitalization for Heart Failure (claims-based) [adopting]
- * postponing effective date from 2018 to 2019
LTCHs

- Net Update of 1.7 percent
  - MB of 2.7 percent
  - MFP of -0.6
  - ACA of -0.2
- Area wage factor of 1.000513
- Results in Federal rate of **$41,726.85**
  - (calculated as $41,043.71 (FY 2015 rate) \( \times 1.017 \times 1.000513 \))
LTCHs

- Adopting application of **site neutral provision**
  - Will impact many
  - To be excluded from “site neutral” cannot have a principle diagnosis of psych or rehab
  - Will it end LTCHs as we have known them??

- Updates QR measures
SNF PPS

- Posted on 7/30/15
- Published in 8/4/15 Federal Register
  - Corrected notice issued 9/30 to be published 10/5
    - Modifies wage index amounts
SNF PPS

- SNF market basket is 2.3 percent (was 2.6)
  - Reduced by the ACA’s multifactor productivity adjustment (MFP) adjustment of 0.5 percent.
  - Reduced by error correction of 0.6 percent
  - Net update = 1.2 percent
  - Labor share will be 62.1 percent
    - It’s currently 69.513
  - CMS says increase will be $430 million down from a proposed amount of $500
SNF PPS

- Error correction measure
  - SNF **only** PPS to contain such
  - Original was set at 0.25 percent
  - Increased to 0.5 percent
  - Great Idea, but accruing only to CMS
SNF PPS

Wage Index

- The budget neutrality factor for FY 2016 will be **0.9992**
- SNF PPS wage index for FY 2016 is fully based on the revised OMB delineations adopted in FY 2015
- The wage index applicable to FY 2016 is set forth in Table A on the CMS website at:
  - [http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html](http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html)
Quality

- The *Improving Medicare Post-Acute Care Transformation Act of 2014* (IMPACT Act), enacted October 6, 2014, requires the implementation of a quality reporting program for SNFs beginning in FY 2018.
- Adopting 3 measures
SNF PPS

- **Measures Skin Integrity and Changes in Skin Integrity**  
  **Outcome Measure:** Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) *(NQF #0678; Measure Steward: CMS)*

- **Incidence of Major Falls**  
  **Outcome Measure:** Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) *(NQF #0674; Measure Steward: CMS)*

- **Functional Status, Cognitive Function, and Changes in Function and Cognitive Function**  
  **Process Measure:** Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function *(NQF#2631)*  
  *(Under NQF review Measure Steward: CMS)*
SNF PPS

- Value-Based Purchasing to commence FY 2019
  - May adopt the **Skilled Nursing Facility 30-Day All-Cause Readmission Measure, (SNFRM) (NQF #2510)**, as the all-cause, all-condition readmission measure that will be used in of the SNF VBP Program
  - The Skilled Nursing Facility 30-Day All-Cause Readmission Measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for SNF Medicare beneficiaries within 30 days of their prior proximal short-stay acute hospital discharge
Staffing Data Collection

- ACA Section 6106 added an additional subsection 1128I(g) pertaining to the collection of staffing data for LTC facilities.
- The timeframe to implement is tight, CMS intends to commence this requirement July 1, 2016.
IRF PPS

- Posted on 7/31/15
- Published in 8/6/15 *Federal Register*
- Copy at: https://www.federalregister.gov/articles/2015/08/06/2015-18973/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal
IRF PPS

- IRF market basket is 2.4 percent (proposed at 2.7)
  - Reduced by the ACA’s multifactor productivity adjustment (MFP) adjustment of 0.5 percent
  - Reduced by ACA requirement of 0.2 percent
  - Net update = 1.7 percent
  - CMS says increase will be $135 million
Comment

- CMS proposed a MB update of 2.7 percent.
- The Final is 2.4 percent
- The net increase is now 1.7 percent while the proposed was 1.9
- How does CMS now say the overall increase will be $135 million compared to the proposed at $130 million??????
- Place no faith in CMS numbers!!!!!
<table>
<thead>
<tr>
<th>Explanation for Adjustment</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Payment Conversion Factor for FY 2015</td>
<td>$15,198</td>
</tr>
<tr>
<td>Market Basket Increase Factor for FY 2016 (2.4 percent), reduced by a 0.5 percentage point</td>
<td>x 1.017</td>
</tr>
<tr>
<td>reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of</td>
<td></td>
</tr>
<tr>
<td>the Act, and reduced by 0.2 percentage points in accordance with paragraphs 1886(j)(3)(C)</td>
<td></td>
</tr>
<tr>
<td>and (D) of the Act</td>
<td></td>
</tr>
<tr>
<td>Budget Neutrality Factor for the Wage Index and Labor-Related Share</td>
<td>x 1.0033</td>
</tr>
<tr>
<td>Budget Neutrality Factor for the Revisions to the CMG Relative Weights</td>
<td>x 1.0000</td>
</tr>
<tr>
<td>FY 2016 Standard Payment Conversion Factor</td>
<td>= $15,478</td>
</tr>
</tbody>
</table>
The FY 2016 labor-related share (LRS) will be 71.0 percent.

It is currently forecasted to be 69.6 percent.
Wage Index

- Adopting for FY 2016
- The FY 2016 wage index would consist of a one year blend of 50 percent of the FY 2015 wage and 50 percent of the FY 2016 wage index
- 19 IRF providers that will transition from rural to urban status will be provided with a gradual phase out of their rural adjustment over a three-year period
IRF PPS

- **No changes to the facility-level adjustments**
  - CMS will continue to hold the facility-level adjustment factors at FY 2014 levels as CMS continues to monitor the most current IRF claims data available to assess the effects of its FY 2014 changes

- **ICD-10-CM Conversion**
  - CMS reminds providers that the implementation date for ICD-10-CM is October 1, 2015
Update to Payments for High-Cost Outliers Under the IRF PPS

- CMS estimates that IRF outlier payments as a percentage of total estimated payments will be approximately **2.9 percent** in FY 2015

- Therefore, CMS will update the outlier threshold amount to **$8,658** to maintain estimated outlier payments at approximately **3.0 percent** of total estimated aggregate IRF payments for FY 2016.

- The current amount is **$9,149**

- **Again, no adjustments for underpaying!!!**
Summary of IRF QRP Measures Affecting the FY 2017 Adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors

- NQF #0138: National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure+
- NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel+
- NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
- NQF #1716: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure+
- NQF #1717: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure+
- NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs*
- NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)
IRF PPS

New and Re-Proposed IRF QRP Measures Affecting FY 2018 Adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors

- **NQF #2502**: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs

- **NQF #0678**: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)* (data element source: pressure ulcer items from the LTCH CARE Data Set)

- **NQF #0674**: An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (data element source: Falls items from the Minimum Data Set 3.0)

- **NQF #2631**, under review: An application of Percent of LTCH Patients with a Admission and Discharge Functional Assessment and a Care Plan that Addressed Function (data element source: selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration)

- **NQF #2633**, under review: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients** (data element source: selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration)
IRF PPS

New and Re-Proposed IRF QRP Measures Affecting FY 2018 Adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors

- **NQF #2634;** under review: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (data element source: selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) \(^6,^3\)

- **NQF #2635;** under review: IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (data element source: selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) \(^6,^3\)

- **NQF #2636;** under review: IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (data element source: selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) \(^3\)
Footnotes

1. Using CDC/NHSN
2. Medicare Fee-for-Service claims data
3. New or modified IRF-PAI items
4. Previously adopted quality measure that was re-adopted for FY2018 and subsequent years
5. Not NQF-endorsed for the IRF setting.
6. Not NQF-endorsed, CMS submitted the measure for NQF review in November 2014
IPF PPS

- Posted on 7/31/15
- Published in 8/5/15 Federal Register
IPF PPS

- **IPF market basket 2.4 percent (proposed 2.7 percent)**
  - Reduced by the ACA’s multifactor productivity adjustment (MFP) adjustment of 0.5 percent
  - Reduced by ACA requirement of 0.2 percent
  - Net update = 1.7 percent
  - However, reduced another 0.3 percent for outliers
  - Net, net would be 1.4 percent
  - CMS says increase will be $75 million
IPF PPS

- IPF market basket
  - Labor share increases to **75.2 percent**, from 69.294 percent
  - New stand alone market basket
IPF PPS

- **Wage Index**
  - Wage index budget-neutrality factor for FY 2016 of 1.0041
  - Adopting OMB delineations for the FY 2016 IPF PPS
  - Using a 1-year transition with a 50/50 blended wage index for all providers
  - 37 IPF providers will have their status changed from rural to urban, and therefore will lose their 17 percent rural adjustment
  - CMS adopting 3 year transition for these
Rates

- CMS updating the current IPF per-diem rate of $728.31 to $743.73. ($728.31 \times 1.017 \times (2.4-0.6-0.2) \times 1.0041 \text{ (area wage index budget neutrality)} = $743.73)

- Providers that fail to report quality data for FY 2016 payment would receive FY 2016 per diem rate of $729.10
ECT

- Electroconvulsive therapy (ECT) payment from $313.55 to $320.19
- Providers that fail to report quality data for FY 2016 payment ECT rate of $313.89
Outliers

- CMS updating; i.e., set the fixed dollar loss threshold amount from $8,755 to $9,580 in order to maintain outlier payments that are 2.0 percent of total IPF PPS payments
IPF PPS

- **Facility Adjustments**
  - IPF PPS patient-level and facility-level adjustments remain the same as in FY 2015
IPF PPS

- Quality Measures for FY 2017 –
  - **Removing** HBIPS-4 Patients Discharged on Multiple Antipsychotic Medications
### Quality Measures -- 5 new measures for FY 2018

<table>
<thead>
<tr>
<th>National Strategy Priority</th>
<th>NQF #</th>
<th>Measure ID</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Prevention and Treatment</td>
<td>1656</td>
<td>TOB-3 and TOB-3a</td>
<td>Tobacco Use Treatment Provided or Offered at Discharge and the subset measure Tobacco Use Treatment at Discharge</td>
</tr>
<tr>
<td>Effective Prevention and Treatment</td>
<td>1663</td>
<td>SUB-2 and SUB-2a</td>
<td>Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention</td>
</tr>
<tr>
<td>Communication and Care Coordination; Person and Family Engagement</td>
<td>0647</td>
<td>N/A</td>
<td>Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>0648</td>
<td>N/A</td>
<td>Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)</td>
</tr>
<tr>
<td>Making Care Safer</td>
<td>N/A</td>
<td>N/A</td>
<td>Screening for Metabolic Disorders</td>
</tr>
</tbody>
</table>
Hospice PPS
For CHC, IRC, and GIP For Hospices That Do Not Submit The Required Quality Data,” for Code 652, in the “Description” column, the figure “38.67” is corrected to read “38.59”.

Hospice PPS
Hospice PPS

- Hospice market basket will be 2.4 percent
  - Reduced by the ACA’s multifactor productivity adjustment (MFP) adjustment of 0.5 percent
  - Reduced by ACA requirement of 0.3 percent
  - Update = 1.6 percent
  - Reduced by another 0.7 percent for AWI/BNAF
  - Increased by 0.2 percent for AWI transition
  - Net = 1.1 percent
1.1 percent hospice payment update

- MB of 1.6 = approximately $250 million
- Updated wage data and the phase-out of the BNAF (-$120 million), and the adoption of the new OMB CBSA delineations with a 1-year transition for the FY 2016 hospice wage index ($30 million)
- Bottom line payments estimated to **increase by $160 million** ($250 million - $120 million + $30 million = $160 million)
Hospice PPS

**Hospice stats**

- Medicare beneficiaries -- from 513,000 in FY 2000 to over 1.3 million in FY 2013
- Costs from $2.8 billion in FY 2000 to an estimated $15.3 billion in FY 2013
Hospice PPS

- Splitting Routine Home Care
  - Days 1-60
  - Days 61 +
- Effective 1/1/2016
- Single rate 10/1-12/31/2015
Hospice PPS

- Service Intensity Add-on (SIA) Payment
  - Adopts a Service Intensity Add-On (SIA) Payment adjustment
  - SIA payment is a payment that would be made for the last seven days of life in addition to the per diem rate for the Routine Home Care (RHC) level of care if certain criteria were met
Hospice PPS

- Labor Share
  - Routine Home Care 68.71 percent
  - Continuous Home Care 68.71
  - General Inpatient 64.01
  - Respite Care 54.13
## FY 2016 Hospice RHC Payment Rates 10/1 – 12/31/2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2015 Rate</th>
<th>FY 2016 hospice payment update percentage</th>
<th>FY 2016 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$159.34</td>
<td>X 1.016</td>
<td>$161.89</td>
</tr>
</tbody>
</table>
## FY 2016 Hospice RHC Payment Rates 1/1 – 9/30/2016

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rates</th>
<th>SIA budget neutrality factor adjustment (1-0.0081)</th>
<th>FY 2016 hospice payment update percentage</th>
<th>FY 2016 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$187.54</td>
<td>X 0.9806</td>
<td>X 1.016</td>
<td>$186.84</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$145.14</td>
<td>X 0.9957</td>
<td>X 1.016</td>
<td>$146.83</td>
</tr>
</tbody>
</table>
### FY 2016 Hospice CHC, IRC GIP Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2015 Payment Rates</th>
<th>FY 2016 hospice payment update of 1.6 percent</th>
<th>FY 2016 Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$929.91</td>
<td>$944.79</td>
<td>$944.79</td>
</tr>
<tr>
<td></td>
<td>Full Rate= 24 hours of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$=39.44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>hourly rate FY 2016</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>hourly rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$164.81</td>
<td>$167.45</td>
<td>$167.45</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$708.77</td>
<td>$721.11</td>
<td>$721.11</td>
</tr>
</tbody>
</table>
FY 2016 Hospice

- **Hospice Cap**
  - FY 2016 cap amount will be $27,820.75 ($27,382.63 \* 1.016 = $27,820.75)

- **Alignment of the Inpatient and Aggregate Cap**
  Accounting Year with the Federal Fiscal Year from November to October 1 over 3 years
FY 2016 Hospice

Update to the Hospice Quality Reporting Program

- CMS not adding any new measures at this time
Knee & Hip
Knee & Hip

- Published July 14th Federal Register
Knee & Hip

- Proper name -- Comprehensive Care for Joint Replacement (CCJR)
- 90 day post acute care bundling proposal
- Not voluntary
- Mandatory in 75 MSAs
- To be effective January 1, 2016
- 5 year demo
Knee & Hip

- Would hold **only the participant hospitals** financially responsible for the episode of care
- Would apply to
  - MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) or
  - MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC)
Knee & Hip

- Includes hospitals *not* participating in Model 1 or Phase II of Models 2 or 4 of the Bundled Payment for Care Improvement (BPCI) model for the lower extremity joint replacement clinical episode
Knee & Hip

Services Included

- Physicians' services
- Inpatient hospital services (including readmissions), with certain exceptions
- Inpatient psychiatric facility (IPF) services
- LTCH services
- IRF services
- SNF services
- HHA services
- Hospital outpatient services
- Independent outpatient therapy services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs
- Hospice
Knee & Hip

- Services Excluded
  - Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery
  - Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care
Knee & Hip

- **Retrospective, two-sided risk** model with **hospitals bearing** financial responsibility

- Providers and suppliers continue to be paid via Medicare FFS
  - After a performance year, actual episode spending would be compared to the episode target prices. If in aggregate target prices are greater than actual episode spending, hospital may receive reconciliation payment.
  - If in aggregate target prices are less than actual episode spending, hospitals would be responsible for making a payment to Medicare.

- Responsibility for repaying Medicare begins in Year 2, with **no downside responsibility in Year 1**.
Knee & Hip

- MSAs
  - Akron
  - Cincinnati
  - Toledo
Proposed PPS Updates

- OPPS
- ESRD
- MPFS
- HHA
OPPS & ASC

- Published July 8th
- 60-day comment period ending August 31st
- Forget OPPS proposed MB and MFP updates – will follow IPPS final
- Would decrease overall payments by approximately $43 million
OPPS & ASC

- **Proposes to** reduce the OPPS update by a 2.0 percent reduction to “redress an inflation in payment rates resulting from excess packaged payment under the OPPS for laboratory tests that are excepted from the final CY 2014 laboratory packaging policy”
  - Estimated amount is $1 billion

- **Comment**
  - This proposed reduction could/should open the door to all types of errors in forecasting. Why is CMS doing this?
Outliers

Outlier payments would be triggered when a hospital’s cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus $3,650.
Proposed CY 2016 PHP APC Geometric Mean Per Diem Costs For CMHC PHP Services

<table>
<thead>
<tr>
<th>Proposed Renumbered CY 2016 APC</th>
<th>Group Title</th>
<th>Proposed PHP APC Geometric Mean Per Diem Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5851</td>
<td>Level 1 Partial Hospitalization (3 services) for CMHCs</td>
<td>$105.82</td>
</tr>
<tr>
<td>5852</td>
<td>Level 2 Partial Hospitalization (4 or more services) for CMHCs</td>
<td>$147.51</td>
</tr>
</tbody>
</table>
## Proposed Payment For Partial Hospitalization Program Services (PHP)

<table>
<thead>
<tr>
<th>Proposed Renumbered CY 2016 APC</th>
<th>Group Title</th>
<th>Proposed PHP APC Geometric Mean Per Diem Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5861</td>
<td>Level 1 Partial Hospitalization (3 services) for hospital-based PHPs</td>
<td>$195.73</td>
</tr>
<tr>
<td>5862</td>
<td>Level 2 Partial Hospitalization (4 or more services) for hospital-based PHPs</td>
<td>$218.93</td>
</tr>
</tbody>
</table>
OPPS & ASC

- Talks about 2-midnight rule, but does little to change
- Comprehensive APCs
  - CMS implemented comprehensive APCs (C-APCs) for CY 2015 with a total of 25 C-APCs
  - CMS is proposing to create nine new C-APCs
OPPS & ASC

- Ambulatory Surgical Center Payment Update
- Would increase payment rates under the ASC payment system by 1.1 percent (CPI–U update of 1.7 percent minus a multifactor productivity adjustment required by the ACA that is projected to be 0.6 percentage points)
Hospital Outpatient Quality Reporting (OQR) Program

- For CY 2017 and subsequent years,
  - (1) remove OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache measure, effective January 1, 2016 (no data for this measure will be used for any payment determination);
  - (2) change the deadline for withdrawing from the Hospital OQR Program from November 1 to August 31;
  - (3) shift the quarters on which it bases payment determinations;
  - "
OPPS & ASC

Hospital Outpatient Quality Reporting (OQR) Program

- For CY 2017 and subsequent years,
  - (4) change the data submission timeframe for measures submitted via the CMS Web-based tool (QualityNet Web site) from July 1 through November 1 to January 1 through May 15;
  - (5) rename the extension and exception policy to extension and exemption policy;
  - (6) change the deadline for submitting a reconsideration request from the first business day of the month of February of the affected payment year to the first business day on or after March 17 of the affected payment year; and
  - (7) amend 42 CFR 419.46(f)(1) and 42 CFR 419.46(e)(2) to replace the term “fiscal year” with the term “calendar year.”
Hospital Outpatient Quality Reporting (OQR) Program

- For CY 2018 and subsequent years, CMS is proposing a new measure: OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822).

- For CY 2019 and subsequent years, CMS is proposing a new measure: OP-34: Emergency Department Transfer Communication (EDTC) (NQF #0291).
Ambulatory Surgical Center Quality Reporting (ASCQR) Program

- Proposing to align data submission end dates for data submitted using a Web-based tool,
- to align policies regarding paid claims to be included in the calculation for all claims-based measures,
- to modify the submission date for reconsideration requests,
- to modify the policy for the facility identifier for public reporting of ASCQR Program data, and
- to not consider Indian Health Service hospital outpatient departments that bill as ASCs to be ASCs for purposes of the ASCQR Program
Notice Act
Notice Act

‘Notice of Observation Treatment and Implication for Care Eligibility Act’

- Enacted 8/6/15
  - PL 114-42
- Effective 8/6/16
- Applicable to all hospitals
  - Including IRFs, IPFs and LTACs
  - Includes CAHs
Notice Act

‘Notice of Observation Treatment and Implication for Care Eligibility Act’

- Enacted 8/6/15
  - PL 114-42
  - Effective 8/6/16
  - Applicable to all hospitals
    - Includes CAHs
New Paragraph Y

- beginning 12 months after the date of the enactment -- in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

“(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;
Notice Act
‘Notice of Observation Treatment and Implication for Care Eligibility Act”

New Paragraph Y

“(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

• “(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

• “(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility
ESRD
ESRD

- Published July 1st
- CMS estimates an increase of approximately $20 million
  - $10 million increase from the payment rate update
  - $10 million increase due to the updates to the outlier threshold amounts
  - Hospital-based ESRD facilities would have an estimated 0.5 percent increase
  - Compared with freestanding facilities with an estimated 0.2 percent increase
Update to the ESRD PPS base rate for CY 2016

ESRD PPS base rate of **$230.20** down $9.23 from the current rate of $239.43 – a 3.9 percent payment reduction

CY 2016 ESRD bundled market basket increase factor is 2.0 percent

- Reduced by 1.25 percent, resulting in a proposed CY 2016 ESRDB market basket percentage increase factor of 0.75 percent.
- Multifactor Productivity (MFP) adjustment projected to be 0.6 percent
- Reduces the overall increase to 0.15 percent. (ESRDB market basket of 2.0 percent, less the statutory mandate reduction of 1.25 percent, less the MFP amount of 0.6 percent – (2.0-1.25=0.75 - 0.6=0.15 percent).
ESRD

- Update to the ESRD PPS base rate for CY 2016
- CMS proposes two more adjustments – application of a wage index budget-neutrality adjustment factor (1.000332), and a refinement budget-neutrality adjustment factor (0.959703), so that total projected PPS payments in CY 2016 are equal to what the payments would have been if CMS had not implemented the refinement.
ESRD

- Labor share would stay at 50.673
- Wage indexes at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html
Outliers

- Pediatric beneficiaries would decrease from $54.35 to $49.99 and Medicare Allowable Payments amount would decrease from $43.57 to $37.82
- For adult beneficiaries, would decrease from $86.19 to $85.66 and the MAP amount would decrease from $51.29 to $48.15.
- In CY 2014, outlier payments were 0.9 percent of total ESRD PPS payment
- CMS not paying Outlier set aside
Proposed Revisions of the Payment Adjustments

Changing all

- Patient age
- Body Surface Area (BSA)
- Low-Body Mass Index (BMI)
- Onset of Dialysis
- Acute Comorbidity Categories
- Chronic Comorbidity Categories
Proposed Refinement of Facility-Level Adjustments

- Low-Volume Payment Adjustment (LVPA)
- Elimination of the Grandfathering Provision
- Geographic Payment Adjustment for ESRD Facilities Located in Rural Areas
- Proposed Refinement of the Case-Mix Adjustments for Pediatric Patient
ESRD

- There is much more material
- ESRD QIP
MPFS
MPFS

- Published July 15th
- Provides 60-day comment period ending Sep 8th
Provisions of the Proposed Rule for PFS

- A. Determination of Practice Expense (PE) Relative Value Units (RVUs)
- B. Determination of Malpractice Relative Value Units (RVUs)
- C. Potentially Misvalued Services Under the Physician Fee Schedule
- D. Refinement Panel
- E. Improving Payment Accuracy for Primary Care and Care Management Services
- F. Target for Relative Value Adjustments for Misvalued Services
- G. Phase-in of Significant RVU Reductions
Provisions of the Proposed Rule for PFS

- H. Changes for Computed Tomography (CT) under the Protecting Access to Medicare Act of 2014 (PAMA)
- I. Valuation of Specific Codes
- J. Medicare Telehealth Services
- K. Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements
- L. Portable X-ray: Billing of the Transportation Fee
- M. Technical Correction: Waiver of Deductible for Anesthesia Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test
Other Provisions of the Proposed Regulations

- A. Proposed Provisions associated with the Ambulance Fee Schedule
- B. Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- C. Healthcare Common Procedure Coding System (HCPCS) Coding for Rural Health Clinics (RHCs)
- D. Payment to Grandfathered Tribal FQHCs That Were Provider-Based Clinics on or Before April 7, 2000
- E. Part B Drugs—Biosimilars
- F. Productivity Adjustment for the Ambulance, Clinical Laboratory, and DMEPOS Fee Schedules
- G. Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- H. Physician Compare Website
Other Provisions of the Proposed Regulations

I. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

J. Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program—Comprehensive Primary Care

(CPC) Initiative and Medicare Meaningful Use Aligned Reporting

K. Potential Expansion of the Comprehensive Primary Care (CPC) Initiative

L. Medicare Shared Savings Program

M. Value-Based Payment Modifier and Physician Feedback Program

N. Physician Self-Referral Updates

O. Private Contracting/Opt-Out
Conversion Factor

- CMS estimates the CY 2016 PFS conversion factor to be $36.1096, which reflects a budget neutrality adjustment of 0.9999 and a 0.5 percent update factor specified under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The current CY 2015 CF is $35.9335

- CMS estimates the CY 2016 anesthesia conversion factor to be $22.6296, which reflects the 0.9999 budget neutrality adjustment, a 0.99602 anesthesia fee schedule practice expense and malpractice adjustment, and the 0.5 percent update specified under the MACRA.
MPFS

- Quality items on line
Published July 10th


Provides 60-day comment period ending Sep 4th

Correction notice on Aug 4th to revise all the case-mix weights

Rebasing adjustment reduces the national, standardized 60-day episode payment amount by $80.95

Market basket update for CY 2016 is 2.9 percent
  - Reduced by multifactor productivity (MFP) adjustment of 0.6 percent, resulting in a net increase of 2.3 percent
  - These amounts will change in final

Overall economic impact is an estimated -$350 million (-1.8 percent) in payments to HHAs

Continuing to reduce for case-mix growth not related to patient severity
Rebasing adjustment reduces the national, standardized 60-day episode payment amount by $80.95.

Market basket update for CY 2016 is 2.9 percent. Reduced by multifactor productivity (MFP) adjustment of 0.6 percent, resulting in a net increase of 2.3 percent.

These amounts will change in final.

Overall economic impact is an estimated -$350 million (-1.8 percent) in payments to HHAs.

Continuing to reduce for case-mix growth not related to patient severity.
Area wage index – fully implemented with revised CBSAs

Proposed national standardized 60-day episode payment rate would be $2,938.37. The current rate is $2,961.38
More rates for

- Home health aide (HH aide);
- Medical Social Services (MSS);
- Occupational therapy (OT);
- Physical therapy (PT);
- Skilled nursing (SN); and
- Speech-language pathology (SLP)

No Quality
More rates for

- Non routine medical supplies
- Rural add-ons
Outliers

- Not proposing a change to the FDL ratio or loss-sharing ratio for CY 2016 at this time
Quality

- The initial set of measures proposed for PY1 of the model utilizes data collected via OASIS, Medicare claims, HHCAHPS survey data, and data reported directly from the HHAs to CMS
- In total there are 10 process measures and 15 outcome measures plus 4 New Measures

29 measures in total
Questions