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CMS Releases Proposed IPPS Rule [Ober|Kaler]

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On April 17, 2015, CMS released a copy of its proposed changes and updates to the Medicare inpatient prospective payment system (IPPS) for fiscal year 2016. The official version appears in the April 30th Federal Register, and comments are due by June 16th. Below is a summary of the highlights of the proposed rule.

- **Proposed Changes to Payment Rates.** The rule proposes a market basket increase of 2.7%. This increase is offset against statutorily-mandated adjustments totaling 1.6%, for a total increase of 1.1%.
- **Possible Expansion of Bundled Payments for Care Improvement (BPCI) Initiative.** The agency seeks comments on varying aspects of the BPCI program related to its potential expansion.
- **Reduction of Hospital Payments for Excess Readmissions.** The Hospital Readmissions Reduction Program requires reductions in a hospital's base DRG payment to account for excess readmissions for specific conditions, including acute myocardial infarction, heart failure, and pneumonia, among others. The rule proposes refining the pneumonia readmissions measure and expanding the measure cohort for the FY 2017 payment year. The rule also proposes an extraordinary circumstances exception policy that would allow a hospital to request a waiver for use of data from the affected period.
- **Value-based Purchasing Program.** The total amount available for value-based incentive payments in FY 2016 is $1,489,397,095. Two measures were removed — IMM-2 Influenza Immunization and AMI-7a Fibrinolytic Therapy Received. A new measure was proposed for implementation in FY 2018 relating to care transition management (CTM) and a measure related to 30-day all-cause mortality from chronic obstructive pulmonary disease to be effective in FY 2021. The rule also proposed removing the Clinical Care—Process subdomain and moving its sole measure (PC-01 Elective Delivery) to the Safety subdomain. The Clinical Care—Outcomes subdomain would be designated as the Clinical Care domain.
- **Hospital-Acquired Condition (HAC) Reduction Program Policies.** The rule expands the eligible population for central line-associated blood infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) to non-ICU patients. It adjusts the relative contribution of each domain to the Total HAC Score used to determine whether a HAC adjustment will be made. Finally, it allows for an extraordinary circumstances waiver.
- **Disproportionate share hospital (DSH) Payment Adjustment.** Decreases to DSH payments continue. Hospitals receive 75% of the amount that would have been paid under the prior formula, aggregated nationally and adjusted to reflect decreases in the number of uninsured. This year, approximately $6.4 billion will be distributed.
- **Electronic Health Record (EHR) Incentive Programs and Quality Reporting.** The rule aligns the quality reporting timelines for acute care hospitals and critical access hospitals. It also proposes creating a certification criterion for EHR in the 2015 edition of certification criteria that would require a Health IT Module to enable the creation of a clinical quality measurement data file.
- **Hospital Inpatient Quality Reporting (IQR).** The rule adds eight new measures and removes nine (two of which are suspended) and refines two others to expand measure cohorts. In addition, it aligns the IQR program with the EHR Incentive Program by requiring submission of 16 electronic clinical quality measurements covering three National Quality Strategy domains.

- **Long Term Care Hospital Quality Reporting Program.** The rule continues the implementation of quality reporting measures as required by the IMPACT Act. It proposes beginning public reporting of quality data on a site such as Hospital Compare.
- **PPS-Exempt Cancer Hospital Quality Reporting Program.** The rule adds two and removes six quality measures. The removed measures, related to the Surgical Care Improvement Project, are removed for feasibility reasons.
- **Two Midnight Rule.** The prohibition against recovery audit contractor (RAC) audits of patient status between Oct. 1, 2013 and April 30, 2015, has been extended to Sept. 15, 2015. RACs will be limited, once this prohibition expires, to six months to review a claim for patient status when the hospital bills within 3 months of the date of service to ensure that hospitals can rebill for medically necessary Part B services as appropriate.

Further discussion of the rule is expected in the 2016 OPPS rule.