Program Summary

Medicare Inpatient Prospective Payment System

Program Year: FFY 2013

Proposed Rule
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Overview

On May 11, 2012, the Centers for Medicare and Medicaid Services (CMS) officially released the federal fiscal year (FFY) 2013 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

Significantly, for the first time under the Medicare program, beginning with FFY 2013, IPPS payments will be adjusted based on historical quality performance under the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program. Both programs were mandated by Congress as part of the Affordable Care Act (ACA) of 2010 and this rule includes policies to fully implement these programs. CMS is also proposing to continue to reduce inpatient payment rates through the application of previously established and new coding adjustment reductions.

The expansive rule also includes proposals that would establish new policies for future VBP Program years (FFYs 2015 and 2016); implement new quality reporting programs for cancer hospitals and inpatient psychiatric facilities; update the quality reporting requirements for ambulatory surgical centers; and update the payment rates and policies for long-term care hospitals.

A copy of the proposed rule Federal Register and other resources related to the IPPS are available on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutepatientPPS/FY-2013-IPPS-Proposed-Rule-Home-Page.html.

An online version of the proposed rule Federal Register is available at: https://federalregister.gov/a/2012-9985.

Comments on the proposed rule are due to CMS by Monday, June 25. Instructions for submitting comments are available on the last page of this summary. Proposed program changes, if adopted, would be effective for discharges on or after October 1, 2011 unless otherwise noted.

Complete details of the major hospital IPPS-related sections of the proposed rule are provided below.

Inpatient Payment Rates

Updates to the Federal Operating, Hospital-Specific and Federal Capital Rates
Federal Register pages 27,975-27,976 and 28,150-28,151

CMS’ Proposal: The following table lists the proposed federal operating and capital rates for FFY 2013 compared to the rates currently in effect. Additional detail on the factors updating these rates and hospital-specific rates is provided below.

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2012</th>
<th>Proposed FFY 2013</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$421,42</td>
<td>$5,209.74</td>
<td>$5,325.62</td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$421.42</td>
<td>$424.42</td>
<td>+0.7%</td>
</tr>
</tbody>
</table>
The table below provides details of the proposed updates for the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2013. Details regarding adjustments to the rates beyond the annual updates that account for wage index, patient condition, the effect of the VBP Program and Readmissions Reduction Program, and other adjustments are provided in the “Modifications to the Inpatient Rates and Payments” section.

<table>
<thead>
<tr>
<th>Proposed Coding Adjustment</th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket Update/Capital Input Price Index</td>
<td>+3.0%</td>
<td>+3.0%</td>
<td>+1.3%</td>
</tr>
<tr>
<td>ACA-Mandated Productivity Reduction</td>
<td>-0.8%</td>
<td>-0.8%</td>
<td>—</td>
</tr>
<tr>
<td>ACA-Mandated Pre-Determined Reduction</td>
<td>-0.1%</td>
<td>-0.1%</td>
<td>—</td>
</tr>
<tr>
<td>Proposed Coding Adjustment Reduction (combined previously established and newly proposed)</td>
<td>-2.7%</td>
<td>-1.3%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Proposed Restoration of the Retrospective Coding Adjustment Applied in FFY 2012</td>
<td>+2.9%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Overall Proposed Rate Change (excluding budget neutrality)</td>
<td>+2.3%</td>
<td>+0.8%</td>
<td>+0.5%</td>
</tr>
</tbody>
</table>

* Additional details on the proposed coding adjustments for FFY 2013 are provided below.

Absent from the proposed rule is guidance as to how CMS will implement the 2.0% sequestration reduction to all lines of Medicare payment set to take effect on January 1, 2013. Sequestration reductions were authorized by Congress as part of the Budget Control Act (BCA) of 2011. It is believed that the 2.0% downward reduction will be applied at remittance (the time Medicare contractors pay each Medicare FFS claim) and will be incorporated into the cost report settlement.

**Coding Adjustments for FFY 2013**

*Federal Register* pages 27,886-27,890 and 27,997

**Background:** CMS is proposing to continue to reduce inpatient payment rates in FFY 2013 through the application of previously established and new coding adjustment reductions.

Since FFY 2008, CMS has been prospectively adjusting the IPPS rates to account for an estimated 5.4% impact of hospital coding improvement for claims submitted during FFYs 2008 and 2009. CMS believes this impact was the result of transitioning IPPS payment to the Medicare-Severity Diagnosis Related Groups (MS-DRGs).

Prior to FFY 2013, CMS also had the authority to retrospectively recoup for increases in inpatient payments during FFYs 2008 and 2009 that were due to coding improvement. Retroactive adjustments are one-time adjustments that are factored back into rates the following payment year. Using this authority, CMS applied one-time reductions of 2.9% to the federal operating rate in FFYs 2011 and 2012. CMS does not currently have the authority to make this type of adjustment going forward.

**CMS’ Proposal:** For FFY 2013, CMS is proposing a final adjustment of minus 1.9% to the federal operating rate (minus 0.5% to the hospital-specific rates) to permanently offset the originally estimated 5.4% coding impact. CMS is also proposing a new and additional coding adjustment of minus 0.8% for coding improvements that CMS believes occurred in claims submitted during FFY 2010.

Provided in the table below are the details of prior coding adjustments and the adjustments CMS is proposing to the IPPS payment rates in FFY 2013.
<table>
<thead>
<tr>
<th></th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Prospective</strong> Coding Adjustment Details</td>
<td><strong>Retrospective</strong> Coding Adjustment Details</td>
<td><strong>Prospective</strong> Coding Adjustment Details</td>
</tr>
<tr>
<td>Original Coding Impacts Estimated by CMS (for claims submitted during FFYs 2008 and 2009)</td>
<td>5.4%</td>
<td>5.8%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Total Coding Adjustment Reductions Applied Since FFY 2008 (for claims submitted during FFYs 2008 and 2009)</td>
<td>-3.5%</td>
<td>-5.8%</td>
<td>-4.9%</td>
</tr>
<tr>
<td>Previously Established/Remaining Coding Adjustment Proposed for FFY 2013 (for claims submitted during FFYs 2008 and 2009)</td>
<td>-1.9%</td>
<td>—</td>
<td>-0.5%</td>
</tr>
<tr>
<td>New Coding Adjustment Proposed for FFY 2013 (for claims submitted during FFY 2010)</td>
<td>-0.8%</td>
<td>N/A</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Proposed Adjustments Related to Coding for FFY 2013</td>
<td>-2.7% [(1.9) + (0.8)]</td>
<td>+2.9%*</td>
<td>-1.3% [(0.5) + (0.8)]</td>
</tr>
</tbody>
</table>

* Because retrospective adjustments are one-time reductions, the 2.9% taken out of the FY 2012 rate is returned to the rate for FFY 2013.

Hospital Wage Index and Wage Index Reclassifications

*Wage Index Reform*

*Federal Register* pages 28,116-28,119

**Background:** The ACA mandated that the Health and Human Services (HHS) Secretary recommend comprehensive reform of the Medicare wage index system to Congress.

**CMS’ Proposal:** CMS is not proposing to change the calculation of the wage index or proposing any other major wage index policy changes for FFY 2013. However, in April 2012, just prior to the release of this proposed rule, HHS did issue the Report to Congress on wage index reform mandated by the ACA.

CMS’ Report recommends a hospital-specific wage index, as opposed to the current labor-market based indexes. The recommended wage indexes would still be based on hospital wage data used currently yet would be made hospital-specific by incorporating hospital worker commuting data. The Report is available on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutInpatientPPS/Wage-Index-Reform.html.

In addition, the ACA-mandated report, the HHS Secretary commissioned the Institute of Medicine (IOM) to study Medicare’s geographic payment adjustments for hospitals and physicians. The first of IOM’s two part report was released in the summer of 2011. The IOM’s approach would replace the current Medicare hospital wage index (which is base on hospital-reported labor costs) with one based on Bureau of Labor and Statistics (BLS) survey data and redefine the current county-based labor-market areas. The Medicare Payment Advisory Commission (MedPAC) also issued a report on reforming the Medicare wage index in 2007.
While CMS has the administrative latitude to make many changes to the wage index system, significant changes to the system, including data sources/inputs and other factors outlined to implement the reform concepts would likely require both regulatory and statutory changes.

A table that compares the three major wage index reform concepts is available on Federal Register pages 28,118-28,119.

**Wage Index, Occupational Mix, and Labor-Related Share**

*Federal Register pages 27,946-27,951*

**Background:** The labor-related portion of the IPPS federal operating payment rate is adjusted for differences in area wage levels using a wage index. The wage index is calculated and assigned to hospitals by labor market area. CMS uses Core-Based Statistical Areas (CBSAs) to define labor-market areas under the IPPS. CMS is required to include an occupational mix adjustment in its calculation of the hospital wage index. The occupational mix adjustment is intended to neutralize the effect of employee mix, resulting in a decreased wage index for hospitals with higher skill mixes and an increased wage index for hospitals with lower skill mixes. The federal capital rate is adjusted by the geographic adjustment factor (wage index to the 0.6848 power).

**CMS’ Proposal:** CMS is not proposing any major changes to the calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, or the current administrative reclassification rules.

For the FFY 2013 wage indexes, CMS would use wage data from Medicare cost reports beginning during FFY 2009 and occupational mix survey data from calendar year (CY) 2010. Using this data, the proposed occupational mix adjusted national average hourly wage is $37.3721.

CBSAs with an occupational mix adjusted average hourly wage (AHW) less than the proposed national AHW of $37.3721 would be subject to a wage index of less than 1.0. CMS will continue to apply the wage index to a labor-related share of 62% for hospitals with a wage index of less than 1.0; 68.8% for hospitals with a wage index of greater than 1.0.

CMS would continue to apply regulatory and legislative adjustments to the wage indexes achieved by certain hospitals for FFY 2013 including:

- the rural, imputed, and Frontier state wage index floors;
- regulatory reclassifications achieved through the Medicare Geographic Classification Review Board (MGCRB);
- Lugar reclassifications; and
- the out-migration adjustment

Generally, hospitals may withdraw from an MGCRB reclassification or request an out-migration adjustment in lieu of a Lugar reclassification within 45 days of the publication of the proposed rule.

A complete list of the proposed wage indexes for payment in FFY 2013 is available in proposed rule Table 2 on the CMS Web site at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutelnpatientPPS/FY-2013-IPPS-Proposed-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutelnpatientPPS/FY-2013-IPPS-Proposed-Rule-Home-Page.html).
Cost-of-Living Adjustment (COLA)
Federal Register pages 28,145-28,146

Background: Current law allows the HHS Secretary to make an adjustment to take into account the unique high-cost circumstances of hospitals located in Alaska and Hawaii. To account for these circumstances, the IPPS provides a COLA adjustment to payments for hospitals located in these states based upon the city, county, or area in which the hospital is located. The COLA adjustment is made by multiplying the nonlabor-related portion of the federal operating rate by the applicable COLA factor.

CMS currently uses the most recent updated COLA factors obtained from the U.S. Office of Personnel Management (OPM) Web site at http://www.opm.gov/oca/cola/rates.asp.

CMS' Proposal: For FFY 2013, CMS is proposing to use the same COLA factors used to adjust payments in FFY 2012 (as originally used to adjust payments in FY 2011, which are based on OPM’s 2009 COLA factors).

CMS outlined a process in the proposed rule for updating the COLA factors for FFY 2014. A list of the proposed FFY 2013 COLA factors is available on Federal Register page 28,146.

Expiration of Section 508 Reclassifications
Federal Register page 27,952

Background: The Medicare Modernization Act (MMA) of 2003 allowed certain hospitals (about 100) to receive wage index reclassifications they otherwise would not have been eligible to receive under the traditional MGCRB wage index reclassification rules. Reclassifications under “Section 508” of the MMA, originally set to expire after a 3-year period, have been legislatively extended several times. Most recently, the Middle Class Tax Relief and Job Creation Act of 2012 extended Section 508 reclassifications through March of 2012.

CMS' Proposal: Special legislated Section 508 wage index reclassifications expired on March 31, 2012. These reclassifications cannot be extended without authorizing legislation.

Imputed Floor Wage Index
Federal Register pages 27,949-27,950

Background: In FFY 2005, CMS adopted the use of an imputed floor wage index. This wage index was developed to address concerns that hospitals in all-urban states (New Jersey and Rhode Island) were disadvantaged by the absence of rural areas, because there is no floor for their wage index. Under the current methodology established by CMS for calculating the imputed floor wage index, at present, only hospitals in New Jersey benefit from this policy. CMS has extended the use of an imputed floor multiple times. This measure is currently set to expire at the end of FFY 2013.

CMS' Proposal: To address the concerns of several hospitals in Rhode Island that cannot benefit from the imputed floor wage index under the current methodology, for FFY 2013, CMS is proposing an alternative methodology for computing this wage index value. The alternative methodology would exist alongside the current methodology. As proposed, CMS anticipates that the alternative methodology would allow, for the first time, four hospitals in Rhode Island to benefit from the imputed floor policy.
**MGCRB Reclassification Applications for FFY 2014**
*Federal Register* page 27,951

**Background:** Individual hospitals or groups of hospitals (defined by counties) can apply to the Medicare Geographic Classification Review Board (MGCRB or “Board”) for reclassification to another area for wage index purposes. Hospitals seeking reclassification must meet specific proximity and wage level criteria. Currently, about 700 hospitals have been approved for Board reclassifications.


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**Modifications to Inpatient Rates and Payments**

**Value-Based Incentive Payment Adjustment Factor**
*Federal Register* pages 28,068-28,078

**Background:** For the first time, beginning with discharges occurring during FFY 2013, Medicare IPPS payments will be adjusted based on historical quality performance under the Hospital VBP Program. Implementation of a budget neutral Hospital VBP Program using a subset of quality measures reported under the Inpatient Quality Reporting (IQR) Program is mandated by the ACA.

By law, the FFY 2013 VBP Program is funded through a 1.0% reduction in IPPS payments for hospitals that meet the eligibility criteria to participate in the program. Because the program is budget neutral, hospitals, based on their quality performance, have an opportunity to earn back some, all, or more of the 1.0% reduction in payments used to fund the program. CMS estimates that the FFY 2013 VBP program will carve out nearly $1 billion in IPPS funding for redistribution based on quality performance.

In prior rulemaking, CMS adopted the eligibility criteria, quality measures, quality performance standards, a scoring methodology, and other rules necessary to implement the FFYs 2013 and 2014 VBP Programs.

**CMS’ Proposal:** In this proposed rule, CMS has put forward policies for calculating hospital-specific “value-based incentive payment adjustment factor.” This factor would be applied to each hospital claim during FFY 2013 to account for hospital performance under the VBP Program. In general, as proposed, this factor would reflect the result of the 1.0% used to fund the program for each hospital multiplied by the VBP payment percentage achieved by each hospital. The VBP payment percentage is the result of how individual hospital performance, as measured by their VBP Total Performance Score (TPS), compares to hospital performance nationwide. An example calculation of exactly how this factor would be calculated is available on *Federal Register* pages 28,073-28,074.

Under this methodology, a value-based payment adjustment factor of less than 1.0 means a hospital would see a decrease in IPPS payments based on its VBP performance. A factor of more than 1.0 means a hospital would see an increase in IPPS payments.

CMS is still validating the quality data that will be used to calculate official payment adjustment factors. CMS has published estimated value-based incentive payment adjustment factors for each hospital based on historical data. The estimated proxy incentive payment adjustment factors range from a low of 0.9923 to a high of 1.0092 and are available in IPPS proposed rule Table 16 on the CMS Web site at:
CMS is proposing to apply the value-based payment adjustment factor to the “base operating DRG payment amount.” As proposed, this amount would reflect the wage-adjusted DRG operating payment plus any applicable new technology add-on payment. By law, this amount does not include adjustments for DSH and IME payments, outlier payments, and low-volume hospital add-on payments. Recognizing the special payment status of SCHs, CMS is proposing to exclude from this definition of base operating DRG payment amount for these hospitals the difference between the hospital-specific payment rate and the federal rate payment. CMS is proposing to use inpatient claims data from the Medicare Provider Analysis and Review File (MedPAR) for the purposes of estimating the VBP incentive amounts.

For the FFY 2013 program, CMS will not be ready to adjust claims to account for hospital performance under the VBP Program beginning October 1, 2012. CMS is proposing to begin adjusting claims to account for the VBP Program beginning January 1, 2013 and reprocess claims submitted prior to January 1.

**Readmissions Adjustment Factor**

*Federal Register* pages 27,955-27,968

**Background:** For the first time, beginning with discharges occurring during FFY 2013, Medicare IPPS payments will be adjusted based on historical risk-adjusted rates of patient readmissions under the Readmissions Reduction Program. Implementation of a payment policy to account for hospital readmissions rates is mandated by the ACA.

Unlike the Hospital VBP Program, the Readmissions Reduction Program is not budget neutral. Hospital can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 1.0%. This capped reduction amount will increase over time. CMS estimates that the FFY 2013 program will cut about $300 million from the IPPS.

In previous rulemaking, CMS adopted the eligibility criteria, quality measures, methods, and other rules necessary to implement the FFY 2013 payment policy. Generally, hospitals with historical Medicare readmissions rates that are higher than the national average rate for the conditions of heart attack, heart failure, and pneumonia will be subject to some level of payment penalty of up to 1.0% (an adjustment factor of 0.9900). To calculate the readmissions rates, CMS will evaluate claims from a 3-year aggregate period, July 1, 2008 through June 30, 2011. The rates CMS will evaluate are very similar to the rates publicly available on the Hospital Compare Web site.

**CMS' Proposal:** In this proposed rule, CMS has put forward policies and data sources needed to calculate a “readmissions adjustment factor.” This factor would be applied to each hospital claim during FFY 2013 to account for hospital performance under the Readmissions Reduction Program. In general, as proposed, this factor would reflect the result of dividing aggregate payments for excess readmissions (the result of when a hospital’s readmission rate is higher than the national average for an eligible condition) by aggregate payments for all discharges. CMS is proposing to use payments from 3-years of inpatient claims data (July 2008 – June 2011) to calculate this factor. This is the same data CMS will use to calculate the rates.

Under this methodology, a readmissions adjustment factor of 1.0 means a hospital would see no change in IPPS payment based on its performance under the readmission payment policy. A factor of 0.9900 means a hospital would be subject to the maximum penalty and see a 1.0% decrease in IPPS payments. Hospitals with a factor between 0.9900 and 1.0 would see some level of decrease in IPPS payments.
CMS is still validating the quality data that will be used to calculate official payment adjustment factors. CMS has published estimated readmissions adjustment factors for each hospital based on historical data. Based on the estimated proxy factors, 34% of hospitals have a factor of 1.0 and would see no change in IPPS payment. 14% of hospitals have a factor of 0.9900 and would be subject to the maximum penalty of 1.0%. The remaining 51% of hospitals have factors between 0.9900 and 1.0.

The estimated proxy incentive payment adjustment factors are available in IPPS proposed rule Table 15 on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Proposed-Rule-Home-Page-Items/FY-2013-Proposed-Rule-Tables-CMS-1588-P.html.

Similar to the VBP Program, CMS is proposing to apply the readmissions adjustment factor to the “base operating DRG payment amount.” As proposed, this amount would reflect the wage-adjusted DRG operating payment plus any applicable new technology add-on payment. By law, this amount does not include adjustments for DSH and IME payments, outlier payments, and low-volume hospital add-on payments. Recognizing the special payment status of SCHs, CMS is proposing to exclude from this definition of base operating DRG payment amount for these hospitals the difference between the hospital-specific payment rate and the federal rate payment.

The ACA requires the Secretary to ensure that hospitals have the opportunity to review and submit corrections to information that will be made available to the public related to the Readmissions Reduction Program. CMS is proposing to provide confidential detailed discharge level information and a 30-day period for hospitals to review and correct this information. For the FFY 2013 Program, CMS will make this data available via QualityNet by June 20, 2012.

**Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) Payments**  
*Federal Register* pages 27,973-27,975

**Background:** The IPPS provides upward payment adjustments to account for the higher direct and indirect operating costs experienced by hospitals with teaching programs (GME payments) and the cost differences associated with treatment of low-income patients (DSH payments).

**CMS’ Proposal:** For FFY 2103, CMS is not proposing any major changes to the GME and DSH payment policies. The Indirect Medical Education (IME) adjustment factor will remain at 1.35.

CMS is clarifying/proposing the following related to GME and DSH:

CMS is proposing a change that would allow for the inclusion of beds associated with labor and delivery services in the Medicare DSH and IME payment adjustment calculations. In 2009, CMS adopted a policy to include patient days associated labor and delivery services for the purposes of calculating the DSH adjustment. At the time, CMS did not extend the policy to include beds associated with these services for the purposes of the IME and DSH payment calculations. CMS will extend this policy to beds effective for cost reporting periods beginning on or after October 1, 2012.

In reference timely claims filing deadlines, CMS clarifies in the proposed rule that hospitals must meet the existing timely filing deadlines in order to receive supplemental IME, direct GME and/or nursing or allied health education payments for Medicare Advantage enrollees. CMS is also proposing that hospitals must meet the existing timely filing deadlines when submitting no pay bills for the purpose of calculating the Disproportionate Patient Percentage.

CMS also uses the proposed rule to update policies related to the ACA provisions that allowed for the redistribution of unused residency slots and the preservation of residency slots from closed hospitals. For
hospitals that achieved additional residency slots, CMS is proposing clarifications to the requirements hospitals must meet to maintain those slots. CMS is also proposing modifications to the application timeline and ranking criteria for hospitals seeking to achieve residency slots from a closed hospital. Additional details related to these clarifications/proposals are available on Federal Register pages 27,976-27,991.

**Low-Volume Adjustment**
Federal Register pages 27,971-27,973

**Background:** The MMA authorized the low-volume adjustment to account for the higher costs per discharge for low-volume hospitals. The law defined a low-volume hospital as a subsection (d) hospital that is located more than 25 road miles from another subsection (d) hospital and has less than 800 total discharges during the fiscal year. Beginning in FFY 2005, CMS provided an additional payment adjustment of 25% for hospitals determined to be low-volume hospitals. The methodology CMS employed resulted in only a very small number of qualifying hospitals.

For FFYs 2011 and 2012, the ACA temporarily modified the criteria for low-volume hospitals to make it easier for hospitals to qualify for the adjustment; lessening the distance criteria to 15 miles and increasing the discharge criteria to 1,600. The ACA also temporarily modified the payment adjustment methodology, providing higher payment adjustments to hospitals with fewer discharges.

**CMS’ Proposal:** Absent legislation to extend the current qualifying criteria, beginning FFY 2013, the low-volume adjustment criteria will revert to the more restrictive requirements previously in effect (25 mile/800 discharge criteria and 25% payment adjustment).

Potentially eligible hospitals seeking to achieve the 25% adjustment beginning October 1, 2012 (FFY 2013) must make a request in writing to their fiscal intermediary (FI)/Medicare Administrative Contractor (MAC) by September 1, 2012. Hospitals that request the status after September 1 and qualify will be eligible for the adjustment effective prospectively within 30 days of the date of the FI’s/MAC’s determination.

**Outlier Payments**
Federal Register pages 28,142-28,144

**Background:** CMS provides payments for outlier cases—those involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as an outlier, a hospital’s cost for the case must exceed the payment rate for the DRG plus a specified amount called the fixed-loss threshold. The outlier payment is equal to 80% of the difference between the hospital’s cost for the stay and the threshold amount. The threshold is adjusted every year based on CMS’ projections for total outlier payments to ensure that total outlier payments equal 5.1% of total IPPS payments. The fixed-loss threshold is currently $22,385.

**CMS’ Proposal:** To maintain total outlier payments at 5.1% of total IPPS payments, CMS is proposing to increase the outlier threshold by 22.5% from $22,385 in FFY 2012 to $27,425 in FFY 2013.

The increased threshold amount would decrease the number of cases eligible for outlier payments. CMS notes their concern in the proposed rule about the threshold increase for FFY 2013 and believes the increase could potentially be tied to recent large increases charge inflation. CMS believes outlier payment in FFY 2012 will be higher than anticipated at about 6.0% of total IPPS payments.
**Low-Cost County Add-On**  
*Not addressed in Federal Register*

**Background:** The ACA provided new Medicare funding of $400 million over two years to be allocated to IPPS hospitals (including SCHs and MDHs, but excluding Critical Access Hospitals (CAHs)) located in counties within the lowest national quartile for total, risk-adjusted, Medicare Part A and Part B spending per enrollee.

Under a methodology developed by CMS in 2011, about 400 hospitals in 38 states were identified and assigned a payment factor for the distribution of this funding ($150 million in FFY 2011 and $250 million in FFY 2012). Distribution of this funding occurred through one-time annual payments (one in FFY 2011 and one in FFY 2012).

**CMS’ Proposal:** Absent legislation to extend the funding, the low-cost county add-on payments will expire at the end of FFY 2012.

**Hospital-Acquired Condition (HAC) MS-DRG Payment Policy**  
*Federal Register pages 27,892-27,898*

**Background:** Complications such as infections acquired in the hospital can trigger higher payments in the form of case assignments to a higher severity MS-DRG and/or outlier payments. As required by the Deficit Reduction Act (DRA) of 2005, CMS implemented a HAC payment policy beginning October 1, 2008 (FFY 2009), that no longer assigns cases to a higher paying MS-DRG when certain conditions are not present on admission (POA) and, therefore, considered hospital-acquired.

Currently, there are 10 HAC categories subject to the HAC MS-DRG payment policy. CMS has the authority to revise the list of HACs subject to this payment policy.

**CMS’ Proposal:** For FFY 2013, CMS is proposing to add the following two new categories to the 10 HAC categories currently not recognized for Medicare IPPS payment:

- Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures.
  - CMS is proposing to identify this new HAC with diagnosis code 996.61 or 998.59 in combination with one or more of 21 associated procedure codes listed on Federal Register page 27,895.

- Iatrogenic Pneumothorax with Venous Catheterization
  - CMS is proposing to identify this new HAC with diagnosis code 512.1 (iatrogenic pneumothorax) and procedure code 38.93 (Venous catheterization NEC).

The addition of these conditions to the list of HACs would increase the number of HAC categories subject to the MS-DRG policy to 12.

CMS is also proposing to expand the HAC diagnoses list for FFY 2013 by adding two new ICD-9-CM diagnosis codes, 999.32 (Bloodstream infection due to central venous catheter) and 999.33 (Local infection due to central venous catheter), to the existing Vascular Catheter-Associated Infection HAC category.
Updates to the MS-DRGs
*Federal Register* pages 27,885-27,946

**Background:** Each year, CMS updates the MS-DRG classifications and relative weights. These updates are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

**CMS’ Proposal:** For FFY 2013, CMS will maintain a total of 751 MS-DRG groupings.


To develop the proposed MS-DRG weights for FFY 2013, CMS used FFY 2011 Medicare claims data and Medicare cost report data from FFY 2009 and FFY 2010. Typically, CMS develops the DRG weights using cost report data from 3 years prior to the IPPS fiscal year. For FFY 2013, CMS is backfilling with FFY 2009 cost report because many FFY 2010 cost reports, reported on the new cost report Form 2552-10, are not yet accessible in the Medicare cost report database, the Hospital Cost Report Information System (HCRIS).

Related to the updates to the MS-DRGs, the proposed rule also addresses:
- the recently announced delay in implementation of the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10) until FFY 2015 and how that delay effects updates/changes to the current MS-DRG updates and weights;
- proposed changes to the major complication or comorbidity (MCC) and CC lists as a result of a review of the severity levels for several ICD-9 diagnosis codes;
- proposed changes to specific MS-DRG classifications; and
- proposed decisions on new services and technologies that would be eligible for add-on payments;

Additional detail regarding these updates and proposals is available on *Federal Register* listed above.

Rural Hospital Inpatient Payment and Policy Issues

*Expiration of Medicare Dependent Hospital (MDH) Status*
*Federal Register* page 27,969

**Background:** Hospitals that meet defined criteria can achieve special rural status as a MDH. Hospitals that achieve this status can benefit from special payment rules that allow for payment under the IPPS at a blend of the federal rate and a hospital-specific rate. The status also allows for higher levels of DSH payments if the hospital exceeds certain thresholds.

**CMS’ Proposal:** The ACA extended the MDH program through FFY 2012. Absent legislation to extend the program, MDH status and the IPPS payment benefits of the status will expire at the end of FFY 2012.

With the expiration of the MDH program approaching, CMS believes that some hospitals with MDH status may seek to achieve SCH status. To accommodate MDHs seeking to convert to SCH status, CMS is proposing to apply approved SCH status congruent with the expiration of the MDH program as long as the MDH applies for the SCH classification at least 30 days prior to the end of FFY 2012.
**Incorrectly Classified Sole-Community Hospitals (SCHs) and Retroactive Status Cancellation**
*Federal Register* pages 27,968-27,968

**Background:** Hospitals that meet defined criteria can achieve special rural status as a SCH. Hospitals that achieve this status can benefit from special payment rules that allow for payment under the IPPS at the higher of the federal rate or a hospital-specific rate.

Under current rules, once a hospital achieves SCH status, the status remains in effect without the need for reapproval unless there is a change in circumstances that could change the special status. Changes in circumstances could include changes within and outside the control of the hospital that would affect how the hospital originally met the bed size, mileage, and geographic location criteria to achieve SCH status. Current regulations outline policies and procedures as to how SCH status would be terminated for hospitals that have a change in circumstances. Current regulations do not address the situation where a hospital never met the criteria to achieve SCH status and was incorrectly classified as a SCH.

**CMS' Proposal:** CMS, citing its authority under current law, is proposing to revise the SCH regulations to clarify that if the agency determines a hospital was incorrectly classified as a SCH, the status and the special payment consideration connected to the status could be cancelled retroactively.

**Updates to Minimum Criteria for Hospitals Seeking Rural Referral Center (RRC) Status**
*Federal Register* pages 27,969-27,970

**Background:** Rural hospitals that meet certain criteria can be classified as a RRC under the IPPS. This special rural status allows:
- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals; and
- special treatment under the geographic reclassification rules including:
  - exemption from the proximity criteria; and
  - exemption from the requirement that a hospital’s AHW must exceed 106% or 108% of the AHW of the labor market area where the hospital is located.

A hospital may voluntarily cancel its RRC status, in which case it will lose the DSH cap exemption. However, it will continue to be exempt from the geographic reclassification requirement.

To obtain RRC status, a rural hospital must have 275 or more beds available for use. As an alternative, a rural hospital can obtain RRC status if it meets certain minimum case-mix index (CMI) and discharge criteria and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume).

**CMS' Proposal:** As it does each year, CMS is proposing to update the minimum CMI and discharge values required for hospitals seeking RRC status that do not meet the 275 bed criteria. The proposed FFY 2013 minimum values by region are available on *Federal Register* page 27,970.

**Updates to the Hospital VBP Program for FFYs 2015 and 2016**
*Federal Register* pages 28,068-28,091

**Background:** Included as part of the IPPS rule are proposals related to the FFYs 2015 and 2016 Hospital VBP Program established by the ACA. Complete program polices for the FFYs 2013 and 2014 programs have already been adopted by CMS in prior rulemaking.
The FFY 2013 VBP Program will assess hospital quality performance using quality measures from two domains (categories of quality measures):

- **Process of Care** (12 measures in the areas of heart attack, heart failure, pneumonia, surgeries and healthcare-associated infections); and
- **Patient Experience of Care** (1 measure consisting of 8 HCAHPS survey dimensions).

The FFY 2014 VBP Program will assess hospital quality performance using quality measures from three domains:

- **Process of Care** (13 measures consisting of the 12 FFY 2013 program measures and 1 new measure);
- **Patient Experience of Care** (same HCAHPS measures as FFY 2013 program); and
- **Patient Outcomes** (3 new mortality measures).

CMS is using the FFY 2013 IPPS proposed rule to propose significant changes to how the VBP Program would function in future years (FFYs 2015 and 2016). CMS is proposing measure additions/deletions, new quality domains for evaluation, new data collection time periods, new national performance standards, and new measure weighting schemes for calculating a hospital’s TPS and subsequent incentive payment adjustment factor. These proposed changes, if adopted, would create future VBP Programs that are substantially different from the programs established for FFYs 2013 and 2014.

The IPPS rule proposes the following program changes related to the FFYs 2015 and 2016 VBP Programs:

**Measures and Domains**

*Federal Register* pages 28,078-28,091

**CMS’ Proposal:** CMS is proposing to remove 1 chart-abstracted process measure, SCIP- VTE-1, from the VBP Program beginning FFY 2015. This measure is also proposed for removal from the IQR Program.

CMS is proposing to add the following measures and domain (efficiency domain) to the FFYs 2015 and 2016 VBP Programs:

- **Process of Care Domain:**
  - 1 chart-abstracted process measure – AMI-10: Statin Prescribed at Discharge

- **Patient Outcomes Domain:**
  - 2 claims-based outcomes measures:
    - PSI-90, a composite measure of patient safety indicators developed and maintained by AHRQ; and
    - CLABSI, a hospital-acquired infection (HAI) measure (FFY 2015 Program only)

- **Efficiency Domain (new domain proposed for FFY 2015):**
  - 1 claims-based efficiency measure – Medicare Spending Per Beneficiary (MSPB)

As proposed, the FFY 2015 VBP will assess hospital quality performance using quality measures from four domains:

- **Process of Care** (13 measures consisting of 12 FFY 2014 program measures and 1 new measure);
- **Patient Experience of Care** (same HCAHPS measures as FFY 2014 program);
- **Patient Outcomes** (3 mortality measures from the FFY 2014 program, 1 new AHRQ composite measure (PSI-90), and 1 new HAI measure (CLABSI)); and
- **Efficiency** (1 new MSPB measure)
For future program years, CMS is proposing to automatically re-adopt measures from year to year unless the agency decides to propose to add or remove measures from the program through rulemaking in response to public comments.

**Baseline and Performance Periods**

*Federal Register* pages 28,082-28,085

**CMS’ Proposal:** VBP scores will be calculated for each hospital based on its performance on the selected quality measures during two specific time periods. These time periods are defined by CMS as “baseline periods” and “performance periods.”

All quality measures used under the VBP Program must be reported on CMS’ Hospital Compare Web site for at least one year prior to the beginning of the performance period. This requirement results in baseline/performance periods that vary in length.

For the FFY 2015 VBP Program, CMS is proposing the following baseline and performance periods:

- **Process of Care and Patient Experience of Care Domains:**
  - Baseline Period: January 1, 2011 through December 31, 2011 (12-months)
  - Performance Period: January 1, 2013 through December 31, 2013 (12-months)

CMS is proposing a slightly different baseline/performance period for the AMI-10 measure. As proposed the baseline period would be April 1, 2011 through December 31, 2011 (9-months) and the performance period would be April 1, 2013 through December 31, 2013 (9-months).

- **Patient Outcomes Domain – Mortality measures:**
  - Baseline Period: October 1, 2010 through June 30, 2011 (9-months)
  - Performance Period: October 1, 2012 through June 30, 2013 (9-months)

- **Patient Outcomes Domain – AHRQ composite measure:**
  - Baseline Period: October 15, 2010 through June 30, 2011 (about 9-months)
  - Performance Period: October 15, 2012 through June 30, 2013 (about 9-months)

- **Patient Outcomes Domain – CLABSI measure:**
  - Baseline Period: January 26, 2011 through December 31, 2011 (about 11-months)
  - Performance Period: January 26, 2013 through December 31, 2013 (about 11-months)

- **Efficiency Domain – MSPB measure:**
  - Baseline Period: May 1, 2011 through December 31, 2011 (8-months)
  - Performance Period: May 1, 2013 through December 31, 2013 (8-months)

For the FFY 2016 VBP Program, CMS is proposing the following baseline and performance periods for the mortality and AHRQ outcomes measures:

- **Patient Outcomes Domain – Mortality and AHRQ measures:**
  - Baseline Period: October 1, 2010 through June 30, 2011 (9-months and the same period proposed for use under the FFY 2015 program)
  - Performance Period: October 1, 2012 through June 30, 2014 (21-months)

CMS is proposing to expand the performance period for the mortality and AHRQ measures to nearly 24-months because the agency believes that a 24-month performance period would yield more
reliable results for these measures under the VBP program. CMS will put forward the other baseline/performance periods at a later date.

**National Performance Standards**

*Federal Register pages 28,085-28,087*

**CMS’ Proposal:** Generally, national data from the baseline period is used to set the VBP national performance standards for each program measure. The national benchmarks represent high achievement quality standards and the national achievement thresholds and floors represent the minimum quality standards (national floors are taken into consideration for the HCAHPS measures only). Hospitals’ performance scores on each individual quality measures will be compared to these national performance standards to calculate VBP points for achievement, improvement, and consistency (HCAHPS measures only). These points are used to calculate overall domain scores and ultimately a Total Performance Score.

With the exception of the efficiency measure, the National Benchmark for each program measure is set at the average performance score for the top 10% of all eligible hospitals during the baseline period. The National Threshold for each program measure is set at the median performance score (50th percentile) for all eligible hospitals during the baseline period. The National Floors for the HCAHPS measures is set at the lowest performance score (0th percentile) for all eligible hospitals during the baseline period.

The proposed national benchmarks, achievement thresholds, and floors (HCAHPS measures only) for each program measure, by domain, for FFY 2015 are shown in the table below.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure</th>
<th>National Threshold</th>
<th>National Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI–7a</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival</td>
<td>72.727%</td>
<td>100%</td>
</tr>
<tr>
<td>AMI–8a</td>
<td>Primary PCI Received Within 90 Minutes of Hospital Arrival</td>
<td>92.857%</td>
<td>100%</td>
</tr>
<tr>
<td>AMI–10</td>
<td>Statin Prescribed at Discharge</td>
<td>90.474%</td>
<td>Not Published</td>
</tr>
<tr>
<td>PN–3b</td>
<td>Blood Cultures Performed in the Emergency Department Prior to Initial Anti-biotic Received in Hospital</td>
<td>97.129%</td>
<td>100%</td>
</tr>
<tr>
<td>PN–6</td>
<td>Initial Antibiotic Selection for CAP in Immunocompetent Patient</td>
<td>93.671%</td>
<td>99.832%</td>
</tr>
<tr>
<td>SCIP–Card–2</td>
<td>Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period</td>
<td>95.122%</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP–Inf–1</td>
<td>Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision</td>
<td>97.872%</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP–Inf–2</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>97.882%</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP–Inf–3</td>
<td>Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time</td>
<td>96.154%</td>
<td>99.905%</td>
</tr>
<tr>
<td>SCIP–Inf–4</td>
<td>Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose</td>
<td>94.799%</td>
<td>99.824%</td>
</tr>
<tr>
<td>SCIP–Inf–9</td>
<td>Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2</td>
<td>93.333%</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP–VTE–2</td>
<td>Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery</td>
<td>94.118%</td>
<td>99.938%</td>
</tr>
<tr>
<td>HCAHPS Dimension</td>
<td>Patient Experience of Care Domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication with Nurses</td>
<td>49.22% (floor)</td>
<td>76.28%</td>
</tr>
<tr>
<td></td>
<td>Communication with Doctors</td>
<td>57.31% (floor)</td>
<td>79.61%</td>
</tr>
<tr>
<td></td>
<td>Responsiveness of Hospital Staff</td>
<td>34.83% (floor)</td>
<td>62.75%</td>
</tr>
<tr>
<td></td>
<td>Pain Management</td>
<td>43.05% (floor)</td>
<td>69.24%</td>
</tr>
<tr>
<td></td>
<td>Communication about Medicines</td>
<td>28.11% (floor)</td>
<td>60.46%</td>
</tr>
<tr>
<td></td>
<td>Hospital Cleanliness &amp; Quietness</td>
<td>40.35% (floor)</td>
<td>63.79%</td>
</tr>
<tr>
<td></td>
<td>Discharge Information</td>
<td>55.10% (floor)</td>
<td>83.29%</td>
</tr>
<tr>
<td></td>
<td>Overall Rating of Hospital</td>
<td>29.26% (floor)</td>
<td>67.73%</td>
</tr>
</tbody>
</table>

| MORT–30–AMI      | Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (shown as survival rate) | 84.77% | 86.73% |
| MORT–30–HF       | Heart Failure (HF) 30-Day Mortality Rate (shown as survival rate)               | 88.61% | 90.42% |
| MORT–30 PN       | Pneumonia (PN) 30-Day Mortality Rate (shown as survival rate)                   | 88.18% | 90.21% |
| PSI–90           | Patient safety for selected indicators (composite)                              | 0.4006 | 0.2754 |
| CLABSI           | Central Line-Associated Blood Stream Infection                                  | 0.4420 | 0.0000 |

| MSPB-1           | Medicare Spending Per Beneficiary                                              | Median Medicare spending per beneficiary ratio across all hospitals during the performance period | Mean of the lowest decile of Medicare spending per beneficiary ratios across all hospitals during the performance period |

For FFY 2016, because CMS is proposing to use the same baseline period for the mortality and AHRQ outcomes measures, CMS is proposing to use the same national performance for these measures that are proposed for the FFY 2015 VBP Program.

**Performance Periods and Performance Standards in Future Years**

*Federal Register* page 28,087

**CMS’ Proposal:** Currently, CMS updates the VBP Program using annual rulemaking cycles that update the payment rates and policies of the IPPS and outpatient PPS. CMS is seeking to modify this approach and is proposing to update performance periods and performance standards for future program years via notice on the CMS Web site or another publicly-available Web site. Under this approach, CMS would establish future performance standards for previously adopted measures using the previously adopted methods. CMS believes that this approach would ensure that hospitals are kept fully aware VBP performance periods and standards.
**Domain Weighting**

*Federal Register* pages 28,087-28,088

**CMS’ Proposal:** A hospital’s overall VBP score, or TPS, will determine its payments from the VBP incentive pool. For FFY 2015, CMS will calculate a TPS for each hospital by combining the four domain scores. CMS is required by the ACA to assign weights to each domain. For FFY 2015, CMS is proposing the following domain weighting scheme:

<table>
<thead>
<tr>
<th>Domain</th>
<th>FFY 2015 Domain Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>(set at 70% for the FFY 2013 Program and 45% for the FFY 2014 Program)</td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>(set at 30% for the FFYs 2013 and 2014 Programs)</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>(set at 25% for the FFY 2014 Program)</td>
</tr>
<tr>
<td>Efficiency</td>
<td>20%</td>
</tr>
</tbody>
</table>

For FFY 2016, CMS is proposing significant regrouping of the measures into 6 new domains based on 6 priorities of the National Quality Strategy. As an example, this new method would group mortality outcomes measures with process of care measures. Currently, these measures are separated into 2 distinct domains. These new groupings, if adopted would require CMS to put forward a new domain weighting scheme for FFY 2016.

**Exclusion Criteria**

*Federal Register* pages 28,088-28,091

**CMS’ Proposal:** As required by the ACA and as determined by CMS, hospitals that do not meet minimum case counts related to a VBP measure are not scored for that particular measure. Currently, hospitals that do not meet minimum measure counts are excluded from the VBP Program completely. CMS has already adopted the FFY 2013 and 2014 minimum case/measure counts for the process, patient experience of care, and outcomes (FFY 2014 only) measures. CMS is proposing the following minimum case/measure counts for the FFY 2015 VBP Program:

- **Patient Outcomes Domain:**
  - Mortality measures: Increase the case minimum from 10 in FFY 2014 to 25 for FFY 2015;
  - AHRQ composite measures: 3 case minimum; and
  - CLABSI measure: 1 case minimum;

  CMS is proposing that the minimum number of useable outcomes measures is 2 out of the 5 measures in the domain for FFY 2015. Hospitals with fewer than 2 useable measures for the performance period would not achieve an outcomes domain score.

- **Efficiency Domain:**
  - MSPB measure: 25 case minimum

For the FFYs 2013 and 2014 VBP Programs, hospital must receive domain scores on all domains in order to be included in the program. Hospitals that do not achieve domain scores do not meet the minimum case and measure counts established by CMS for the domains. Excluded hospitals are not be subject to the VBP pool contribution reductions and would not be eligible for VBP payment incentives. For FFY 2015 and subsequent
years, CMS is proposing hospitals only need domain scores in 2 out of the 4 domains in order to be included in the program. Under this policy, the TPS would be reweighted proportionately to the scored domains.

Review/Correction and Appeals Process
Federal Register pages 42,363-42,365

CMS’ Proposal: The ACA requires the Secretary to ensure that hospitals have the opportunity to review and submit corrections to information that will be made available to the public related to the VBP Program. CMS has established a review and correction process for chart-abstracted process of care measures and HCAHPS measures. In this rule, CMS is proposing a review and correction processes for the claims-based VBP measures. Under the process, CMS would provide confidential detailed discharge level information and a 30-day period for hospitals to review and correct this information.

The ACA also requires the Secretary to establish a process by which hospitals may appeal the calculation of the VBP performance assessment by CMS. In this rule, CMS puts forward an administrative appeal process. A list of issues that can be appealed and instructions on how to submit an appeal are available on Federal Register page 28,078.

Updates to the Hospital IQR Program
Federal Register pages 28,032-28,060

Background: The MMA authorized the HHS Secretary to develop a quality data pay-for-reporting program for hospitals paid under the IPPS. Subsequent legislation has substantially expanded this program, now known as the Hospital IQR Program. Hospitals that fail to successfully participate in the IQR Program receive reduced payments through a reduction of 2.0 percentage points to the hospital marketbasket update. CMS makes these payment determinations each year.

Quality data is currently collected on an array of quality measures related to heart attack, heart failure, pneumonia, surgical care, Agency for Healthcare Research and Quality (AHRQ) indicators, mortality, readmissions, HACs, participation in systematic clinical database registries for various topics, efficiency, and patient satisfaction. Some of this data is reported by hospitals to CMS and some is calculated using information from Medicare claims data.

Most quality measures collected under the IQR Program are made available to the public on the Hospital Compare Web site at http://www.hospitalcompare.hhs.gov/. A subset of the measures collected under the IQR Program are being used by CMS to implement two mandatory delivery system reforms for hospitals mandated by the ACA; the Hospital VBP Program and the Hospital Readmissions Reduction Program. These programs will affect IPPS payments beginning FFY 2013 (see “Modifications to Inpatient Rates and Payments” section).

Each year, CMS updates the IQR measures and policies. In prior rulemaking, CMS has adopted measures for the IQR Program through FFY 2015.

As previously adopted, for FFY 2013 payment determinations, hospitals were required to report on a total of 57 quality measures. A complete list of the IQR Program measures for FFY 2013 payment determinations is available on Federal Register pages 50,208-50,209 of the FFY 2011 IPPS final rule at: https://federalregister.gov/a/2010-19092.
For FFY 2014 payment determinations, hospitals are currently reporting on a total of 55 quality measures. CMS also adopted a total of 72 measures for FFY 2015 payment determinations. A complete list of the previously adopted IQR Program measures for FFYs 2014 and 2015 payment determinations is available on Federal Register pages and pages 51,628-51,629 and 51,636-51637 of the FFY 2012 IPPS final rule at: https://federalregister.gov/a/2011-19719.

**CMS’ Proposal:** CMS is proposing refinements to the IQR Program for FFY 2015 payment determinations and proposing to adopt measures for FFY 2016 payment determinations. These refinements not only update the IQR Program but also remove and/or potentially put in place measures for use under the Hospital VBP Program and Readmissions Reduction Program. The updates also maintain a level of alignment with the quality measures adopted and proposed for use under the electronic health record (EHR) incentive program.

**FFY 2015 and FFY 2016 Payment Determinations**
*Federal Register* pages 28,035-28,050

For FFY 2015 payment determinations, CMS is proposing to reduce the number of measures it will evaluate from 72 measures (as adopted in prior rulemaking) to 59 measures.

CMS is proposing to **remove** the following 17 measures (1 chart-abstracted measure and 16 claims-based measures) from the IQR Program for FFY 2015 payment determinations and subsequent payment determination years:

- **1 chart-abstracted measure:**
  - Surgical Care Improvement Project (SCIP)-Venous Thromboembolism (VTE)-1

- **8 claims-based HAC measures:**
  - Foreign Object Retained After Surgery
  - Air Embolism
  - Blood Incompatibility
  - Pressure Ulcer Stages III & IV
  - Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)
  - Vascular Catheter-Associated Infection
  - Catheter-Associated Urinary Tract Infection (UTI)
  - Manifestations of Poor Glycemic Control

- **3 claims-based AHRQ Inpatient Quality Indicators (IQI) measures:**
  - IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
  - IQI 19: Hip fracture mortality rate
  - IQI 91: Mortality for selected medical conditions (composite)

- **5 claims-based AHRQ Patient Safety Indicators (PSI) measures:**
  - PSI 06: Iatrogenic pneumothorax, adult
  - PSI 11: Post Operative Respiratory Failure
  - PSI 12: Post Operative PE or DVT
  - PSI 14: Postoperative wound dehiscence
  - PSI 15: Accidental puncture or laceration

CMS is proposing to **add** the following measures to the IQR Program beginning with FFY 2015 payment determinations:
5 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey items:
   - 1 three-item care transition set (CTM-3) (NQF #0228); and
   - 2 items to the “About You” section of the survey (“were you admitted through the emergency room” and “rate your overall mental or emotional health”).

CMS is proposing to add these items to the HCAHPS survey beginning with discharges occurring on or after January 1, 2013. CMS is proposing not to include the new “About You” items on the Hospital Compare Web site.

1 claims-based surgical complication measure:
   - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (NQF #1550)

This measure assesses complications occurring after THA and TKA surgery from the date of the index admission to 90 days post date of the index admission. The outcomes would be one or more of the following complications: acute myocardial infarction (AMI), pneumonia (PN), or sepsis/septicemia within 7 days of admission; surgical site bleeding, pulmonary embolism or death within 30 days of admission; or mechanical complications, periprosthetic joint infection or wound infection within 90 days of admission.

2 claims-based readmissions measures:
   - Hip/Knee Readmission: Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (NQF #1551); and
   - 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate (tentative NQF #1789)

CMS states that the objective of the proposed hip/knee readmissions measure is to assess readmission from any cause within 30 days of the initial total hip arthroplasty and total knee arthroplasty admissions for patients discharged from the hospital following elective primary THA and TKA.

CMS states that the objective of the proposed hospital-wide readmission measure is to assess the hospital-level, risk-standardized rate of unplanned, all-cause readmissions after admissions for any eligible condition within 30 days of hospital discharge. The proposed measure would be comprised of a single summary score, derived from the results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology; cardiopulmonary; cardiovascular; and neurology. CMS is proposing to use on year of data to calculate the rate for this proposed measure.

1 chart-abstracted perinatal care measure:
   - Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (NQF # 0469)

CMS is proposing to collect data on this measure beginning with discharges occurring on or after January 1, 2013. Although this measure is chart-abstracted, CMS is proposing that this measure would be collected in aggregated numerator, denominator, and exclusion counts per hospital via a Web-based tool (as opposed to collecting patient-level data from hospitals).

For FFY 2016 payment determinations, CMS is proposing to evaluate a total of 60 measures. CMS is proposing to retain all adopted/proposed measures for FFY 2015 payment determinations and is proposing to add the following measure:
1 structural measure
   - Safe Surgery Checklist Use (not NQF endorsed)

For this proposed structural measure, a hospital inpatient department would indicate whether or not it uses a safe surgery checklist for its surgical procedures during three distinct perioperative periods: (1) the period prior to the administration of anesthesia; (2) the period prior to skin incision; and (3) the period of closure of incision and prior to the patient leaving the operating room.

A complete list of the previously adopted and newly proposed IQR Program measures for FFY 2015 and FFY 2016 payment determinations is available on Federal Register pages 28,047-28,050.

Alignment of Quality Reporting Between Programs and Possible New Measures and Topics for Future Years
Federal Register page 28,050

Background: Each year, CMS solicits comment on measures and topics under consideration for future years of the IQR program.

CMS’ Proposal: CMS reiterates in the proposed rule its continued desire to eventually (possibly by 2015) use EHR-based reporting for many of the chart-abstracted measures collected under the IQR Program. CMS does indicate its understanding of how much work needs to be done to achieve such a goal.

Citing this goal, CMS intends to propose two Joint Commission (TJC) smoking and alcohol cessation measure sets for inclusion in the Hospital IQR Program once the e-specifications and the EHR-based collection mechanisms are available for the measures. Each of these TJC sets consists of four measures:

- Smoking Cessation Set
  - TAM-1: Tobacco Use Screening;
  - TAM-2: Tobacco Use Treatment Provided or Offered;
  - TAM-3: Tobacco Use Treatment Management at Discharge; and
  - TAM-4: Assessing Status after Discharge, and

- Alcohol Cessation Set
  - TAM-5: Alcohol Use Screening;
  - TAM-6: Alcohol Use Brief Intervention Provided or Offered;
  - TAM-7: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; and
  - TAM-8: Substance Use: Assessing Status after Discharge.

CMS also states its intent to propose the collection of data for non-ICU patients for the Central Line-Associated Bloodstream Infection (CLABSI) (NQF #139) and Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #138) measures. CMS is seeking comment on these potential proposals.

Further, CMS also notes that it intends to align the measures collected for the IQR Program under six domains based on the six priorities of the National Quality Strategy. This would include:

- clinical quality (i.e., the AMI, heart failure (HF), PN, stroke (STK), and VTE measures);
• care coordination (i.e., the mortality measures);
• patient safety (i.e., the SCIP and HAI measures);
• patient and caregiver experience of care (i.e., the HCAHPS measures);
• population/community health (i.e., the global immunization measures); and
• efficiency (i.e., the MSPB measure)

CMS believes that this approach would enhance better patient care while bringing the Hospital IQR Program in line with other established quality reporting and pay-for-performance programs. CMS is also proposing a similar adjustment to the quality domains used under the VBP Program beginning with FFY 2016.

**Updates to the IQR Program Participation Policies**
*Federal Register* pages 28,050-28,060

**Background:** Hospitals must follow a number of steps to satisfy the IQR Program requirements and qualify for the full marketbasket update. These steps are continuously updated by CMS and available in detail on the QualityNet Exchange Web site at [https://www.qualitynet.org/](https://www.qualitynet.org/).

**CMS’ Proposal:** CMS is using the proposed rule to update the IQR Program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes. Complete detail on these updates is available on *Federal Register* pages listed above.

**Submission of Comments**
*Federal Register* pages 27,870-27,871

Comments on the proposed must be submitted by Monday, June 25 at 5 p.m. CMS requests that comments reference the file code CMS-1588-P. Comments can be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov). Follow the instructions for “Comment or Submission” and enter the file code CMS-1588-P to submit comments on this proposed rule.

-OR-

Regular Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1588-P
P.O. Box 8011
Baltimore, MD 21244-1850

Express/Overnight Mail (an original and two copies):
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Department of Health and Human Services
Attention: CMS-1588-P
Mail Stop C4-26-05
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Hand-Delivered (an original and two copies):
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