Medicare Inpatient Prospective Payment System

Payment Rule Brief — FINAL RULE
Program Year: FFY 2014

Overview and Resources

On August 19, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2014 final payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes proposed and adopted by CMS and legislative changes previously adopted by Congress.

Among other regular updates and policy changes, the expansive rule includes policies that will:

- Implement the Affordable Care Act (ACA)-mandated Medicare Disproportionate Share Hospital (DSH) payment reductions, redistributions, and policy changes for FFY 2014;
- Provide new guidance on determining inpatient status; and
- Update and put in place new policies for the ACA-mandated Value-Based Purchasing (VBP) Program, Readmissions Reduction Program, and Hospital-Acquired Condition (HAC) Reduction Program.

The rule also includes policies that update the quality reporting programs for cancer hospitals and inpatient psychiatric facilities and update the payment rates and policies for long-term care hospitals.

A copy of the final rule Federal Register (FR) 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/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.

An online version of the final rule is available at https://federalregister.gov/a/2013-18956.

A brief summary of the major hospital IPPS sections of the final rule is provided below. Program changes adopted by CMS will be effective for discharges on or after October 1, 2013 unless otherwise noted.

IPPS Payment Rates
FR pages 50,596-50,608 and 50,984-50,985

Incorporating the adopted updates with the effect of budget neutrality adjustments, the table below lists the federal operating and capital rates for FFY 2014 compared to the rates currently in effect:

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2013</th>
<th>Final FFY 2014</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$5,348.76</td>
<td>$5,370.28</td>
<td>+0.4% (proposed at +0.5%)</td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$425.49</td>
<td>$429.31</td>
<td>+0.9% (proposed at +1.5%)</td>
</tr>
</tbody>
</table>
The table below provides details and compares the proposed and adopted updates for the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2014.

<table>
<thead>
<tr>
<th>Marketbasket (MB) Update/Capital Input Price Index</th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>+2.5% (unchanged)</td>
<td>+2.5% (unchanged)</td>
<td>+0.9% (unchanged)</td>
<td></td>
</tr>
</tbody>
</table>

| ACA-Mandated Productivity MB Reduction           | -0.5% (proposed at -0.4%) | -0.5% (proposed at -0.4%) | —                   |

| ACA-Mandated Pre-Determined MB Reduction        | -0.3% (unchanged)         | -0.3% (unchanged)         | —                   |

| American Taxpayer Relief Act (ATRA)-Mandated Retrospective Coding Adjustment Reduction | -0.8% (unchanged) | — | — |

| Inpatient Admission Guidance Offset             | -0.2% (unchanged)       | -0.2% (unchanged)         | -0.2% (unchanged)   |

| Net Rate Change (EXCLUDING BUDGET NEUTRALITY)   | +0.7% (proposed at +0.8%) | +1.5% (proposed at +1.6%) | +0.7% (unchanged)   |

Retrospective Coding Adjustment
*FR pages 50,512-50,517*

CMS is adopting its proposal to apply a retrospective coding adjustment of -0.8% to the federal operating rate in FFY 2014. This reduction was authorized by Congress as part of the American Taxpayer Relief Act (ATRA) to offset a portion of the cost associated with a temporary Medicare physician payment fix. The law requires CMS to reduce inpatient payments by $11 billion (or -9.3%) over a 4-year period. This authority allows CMS to retroactively recoup for increases in inpatient payments that the agency asserts occurred during FFYs 2008 through 2012 due solely to coding improvement by hospitals.

By law, CMS has through FFY 2017 to fully recoup the mandated $11 billion. As a result, additional ATRA-mandated coding adjustment reductions, similar to the level adopted for this year, will be put forward by CMS next year and in future payment years. Because retrospective coding adjustments are one-time adjustments that are not permanently built into the rates, CMS will eventually adjust the federal operating rate upward through a positive adjustment (equivalent to the negative adjustments applied) once the $11 billion is fully recouped. The positive adjustment to “reset” the rates is anticipated in FFY 2018.

CMS did not propose and is not adopting any additional documentation and coding adjustments beyond the adjustment mandated by the ATRA.

Effect of Sequestration
*FR page reference not available*

While the final rule does not specifically address the 2.0% sequester reductions to all Medicare payments authorized by the Budget Control Act (BCA) of 2011 and currently in effect, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and electronic health record (EHR) incentives are also affected by the sequester reductions.

Wage Index and Labor-Related Share
*FR pages 50,585-50,596*
CMS did not propose and is not adopting any major changes to the calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, the imputed rural floor methodology, or the current administrative reclassification rules. CMS is also not making any changes to current Core-Based Statistical Area (CBSA) definitions; the labor-markets that define an area’s Medicare wage index. CMS states in the final rule that it does plan to pursue CBSA definition changes next year based on newly available census data.

A complete list of the adopted wage indexes for payment in FFY 2014 is available in Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.

As proposed and adopted, CMS will update the labor-related share value for hospitals with a wage index of greater than 1.0 to 69.6% for FFY 2014, a slight increase when compared to the current labor share of 68%. By law, the labor-related share for hospitals with a wage index of less than 1.0 will remain at 62%.


Updates to the MS-DRGs
FR pages 50,512-50,585

CMS did not propose and is not adopting any major changes to the Medicare-Severity Diagnosis Related Group (MS-DRG) classifications and relative weights. For FFY 2014, CMS will maintain a total of 751 MS-DRG groupings. Overall, compared to the current weights, 85% of the MS-DRG weights will change by less than +/- 6% for FFY 2014. The FFY 2014 MS-DRGs and weights are available in Table 5 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.

VBP Adjustment
FR pages 50,676-50,679

Based on previously established program rules, CMS will adjust FFY 2014 IPPS payments to account for historic quality performance under the VBP Program.


The FFY 2014 program will evaluate quality of care data in three areas: process of care; patient experience of care; and patient outcomes. By law, the VBP Program must be budget neutral and the FFY 2014 program will be funded through a 1.25% reduction in IPPS payments (estimated at $1.1 billion) for hospitals that meet the program eligibility criteria. The FFY 2013 program is currently being funded through a 1.0% reduction in IPPS payments. Because the program is budget neutral, hospitals have an opportunity to earn back some, all, or more than the 1.25% reduction in payments used to fund the program.

While the data applicable to the FFY 2014 program year is still being finalized, CMS has calculated and published proxy factors using data from the current year program. According to CMS, these factors will be updated in October with actual program data. The proxy factors published with the final rule can provide an assessment of relative performance and are available in Table 16 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.
The proxy factors range from a low of 0.9888 to a high of 1.0104. The average factor is 1.0002. Under the VBP Program, a factor of less than 1.0 indicates a hospital will see a decrease in IPPS payments; a factor greater than 1.0 indicates a hospital will see an increase in IPPS payments.

**Readmissions Adjustment**  
*FR pages 50,649-50,657 and 50,668-50,676*

Based on previously established and newly adopted program rules, CMS will adjust FFY 2014 IPPS payments to account for excess hospital readmissions under the Readmissions Reduction Program.

Details and information on the program currently in place is available on CMS’ QualityNet Web site at [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458).

By law, the FFY 2014 program is limited to measuring excess readmissions for heart attack (AMI), heart failure (HF), and pneumonia (PN) patients.

In response to stakeholder concern, CMS is adopting its proposal to modify the calculation of readmission rates for FFY 2014 and beyond to better account for planned readmissions. According to analysis by CMS, this policy change will slightly reduce the current national readmission rates for the three conditions evaluated under the program.

To calculate the excess readmissions for FFY 2014, CMS is will evaluate Medicare inpatient FFS claims from a 3-year aggregate period, July 1, 2009 through June 30, 2012. This reflects one year’s worth of new data compared to the data analyzed under the current year program. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes CMS will use to identify the conditions and applicable payments for the FFY 2014 program are listed on FR pages 50,671-50,673. This list is unchanged from current year program.

Unlike the VBP Program, the Readmissions Reduction Program is not budget neutral. Hospitals can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 2.0% (up from 1.0% in the current year). This capped reduction amount will increase to 3.0% next year.

Using the actual program data, CMS has calculated and published final readmissions adjustment factors for each hospital. The factors are available in Table 15 on the CMS Web site at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html).

Based on the factors, 34% of hospitals have a factor of 1.0 and will see no change in IPPS payment. 1% of hospitals have a factor of 0.9800 and will be subject to the maximum penalty of 2.0%. The remaining 65% of hospitals have factors between 0.9800 and 1.0 and will see some level of decrease in IPPS payments. CMS estimates that the FFY 2014 program will cut about $227 million from the IPPS (down from about $300 million decrease in the current year, but up from the estimated $175 million decrease noted in the proposed rule).

**DSH Payment Reductions, Redistributions, and Policy Changes**  
*FR pages 50,613-50,647*

The ACA requires CMS to implement significant changes to the current Medicare DSH payment policies. These changes will reduce and redistribute DSH funding nationwide beginning in FFY 2014.

Under the law, 25% of estimated DSH funding under the traditional formula will continue paid to each DSH-eligible hospital as currently paid. The remaining 75% will be reduced to reflect the impact of insurance expansion and then redistributed to hospitals as a new and separate uncompensated care payment. This payment will be determined based on each hospital’s ratio of uncompensated care relative to the total for all DSH-eligible hospitals. CMS has broad authority on how to implement these program changes and has adopted rules to define:
the amount of funding to be dedicated to the new uncompensated care payment;
how to reduce and distribute that funding as mandated by the ACA;
DSH eligibility; and
DSH payment methods including reconciling payment at cost report settlement.

**Funding Dedicated to the New Uncompensated Care Payment (Factor 1):**

To implement the ACA-mandated DSH payment changes, CMS must project national DSH program expenditures for FFY 2014 under the traditional DSH formula. This projection is critical because it sets the basis for the amount of funding that will be distributed to hospitals as uncompensated care payments under the new DSH payment methodology.

Using its Office of the Actuary’s estimate from July 2013, CMS is projecting DSH program expenditures to be $12.772 billion for FFY 2014 (up 3.5% from the proposed value of $12.338 billion due to changes in how the historical figure is projected to FFY 2014 including the impact Medicaid expansion under the ACA will have on aggregate DSH spending). As adopted, this estimate is based on data from 2010 Medicare cost reports and FFY 2014 IPPS proposed rule Impact File. The estimate includes projections for inflation, utilization, and case mix changes. CMS has only released high-level information on how these national projections were calculated. Hospital-specific factors related to the projections have not been made available.

As mandated by the ACA, 25% of projected DSH funding will continue to be paid to eligible hospitals under the traditional formula. CMS projects this value to be $3.193 billion (proposed at $3.084 billion), but this value can and will fluctuate based on hospital-specific utilization changes. The remaining 75%, projected to be $9.579 billion (proposed at $9.2535 billion), will be reduced and then serve as the basis for funding to be distributed as uncompensated care payments. CMS is adopting its proposal not to revise this estimate upward or downward to reflect actual expenditures in a given year.

**ACA-Mandated DSH Funding Reductions (Factor 2):**

The ACA requires DSH funding dedicated to uncompensated care payments (CMS’ projected $9.579 billion) be reduced by a factor that reflects the impact of insurance expansion before it is distributed to hospitals.

For FFY 2014, CMS is adopting, with some modification, its proposals to use Congressional Budget Office (CBO) insurance coverage estimates to calculate this factor. As adopted, CMS will use CBO’s March 2010 and May/July 2013 (most recent) estimates. CMS has modified its methodology to shift CBO’s insurance coverage estimates from a calendar year to a FFY. The effect of this change is a higher rate of uninsured and therefore a lesser DSH funding reduction. The March, May, and July insurance coverage estimates are available on the CBO Web site at http://www.cbo.gov/publication/21351, http://www.cbo.gov/publication/44190, and http://www.cbo.gov/publication/44465.

For FFY 2014, the rate of uninsured is estimated to drop from 18% to 17%, a 5.6% reduction (proposed at 18% to 16%, an 11.2% reduction – the lesser reduction is attributed to a CMS methodology change described above). Factoring in an additional ACA-mandated reduction of 0.1 percentage points, CMS will reduce the funding dedicated to uncompensated care payments by -5.7%, or about -$546 million (proposed at -$1.0365 billion prior to CMS’ methodology change). As a result, for FFY 2014, the fixed amount available for distribution as uncompensated care payments will be $9.033 billion ($9.579 billion x (1 - 5.7%)). As proposed and adopted, this value is fixed and will not be revised upward or downward to reflect more recent insurance expansion estimates.

**Determination of Hospital-Specific Uncompensated Care Payments (Factor 3):**
The ACA-mandated DSH payment methodology requires the funding dedicated to uncompensated care payments (CMS' projected $9.033 billion) be distributed to hospitals based on each hospital's ratio of uncompensated care relative to the total for all DSH-eligible hospitals.

For FFY 2014, CMS is adopting its proposal to use Medicaid days and Medicare SSI days (from the 2010 or 2011 Medicare cost report) as a proxy for uncompensated care. These days currently make up the numerator of the DPP formula used to determine DSH eligibility under the traditional DSH formula. CMS believes the use of low-income patient days is a valid proxy for the treatment costs associated with uninsured patients.

CMS will use the cost report data in its current form and will not provide a review and update/correction period for hospitals. CMS has made a file available on its Web site that includes the patient days relevant to the adopted formula and each hospital's uncompensated care payment factor. The file is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html. This file also includes other data critical to the new DSH payment methodology. CMS has calculated a payment factor for every hospital in the country based on its share of days to total days for all FFY 2014 CMS-projected DSH-eligible hospitals. If a hospital is not determined to be DSH-eligible until cost report settlement, CMS will use this pre-determined payment factor to make the new uncompensated care payment. As proposed and adopted, CMS would not revise these factors upward or downward to reflect actual patient days.

As noted in the proposed rule, CMS indicates in the final rule its desire to ultimately use data on uncompensated care from Worksheet S-10 of the Medicare cost report in the determination of the uncompensated care payment factor. Citing industry concerns regarding data variability and lack of reporting experience with this relatively new cost report Worksheet, CMS actively proposed the alternative low-income patient days proxy for FFY 2014. CMS notes in the final rule that it plans to work with the industry to review and make any necessary revision and clarifications to the S-10 instructions to ensure accurate and consistent reporting across hospitals.

**DSH Eligibility:**

CMS is projecting that 2,437 hospitals will be eligible for DSH payments in FFY 2014. This projection is significant because under the adopted policies, hospitals identified as DSH-eligible will be paid as such during FFY 2014.

CMS' list is based on the Medicaid fraction listed in the March 2013 update of the Provider Specific File (based on 2010 or 2011 cost report data) and the FFY 2011 SSI ratios (based on FFY 2011 Medicare inpatient claims) published on June 27, 2013 on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html. According to CMS, this is the most recently available data on the DPP for hospitals that are qualified to receive Medicare DSH payments.

CMS has made a file available on its Web site that includes DSH eligibility status. The file is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html. This file also includes other data critical to the new DSH payment methodology.

For Sole Community Hospitals (SCHs) that are eligible for DSH payments, CMS will consider the new uncompensated care payments in determining whether a SCH will be paid at the federal or hospital-specific rate. CMS had proposed to disregard these payments in determining SCH payment status.

As proposed and adopted, hospitals participating in the Bundled Payments for Care Improvement (BPCI) initiative and hospitals in Puerto Rico will be eligible for DSH payments. As has been the case in prior years, Maryland hospitals and hospitals participating in the Rural Community Hospital Demonstration Program will not be eligible for DSH payments.

**DSH Payment and Cost Report Settlement:**

CMS is adopting its proposal to continue the practice of determining final DSH-eligibility at cost report settlement. Eligibility would continue to be determined based on the traditional formula's threshold (a DPP of 15% or more).
In response to industry concerns over potential cash flow issues and appropriate payment levels from Medicare Advantage (MA) plans, CMS is not adopting its proposal to make the uncompensated care payment as a lump-sum payment on a periodic basis. Instead, CMS will make these payments on a per-discharge basis through the claims process based on a CMS-estimated claims figure (3-year average, FFY 2010-2012). As a result, CMS will make both the traditional DSH payment at 25% and the uncompensated care payment on a per-discharge basis.

The FFY 2014 Medicare IPPS PRICER software will provide the both the traditional DSH payment at 25% and the uncompensated care per-claim amount. This modification will assist MA plans that use the PRICER to estimate FFS payments and will ensure full DSH payment to hospitals from non-contracting MA plans and hospitals that have contractually linked MA payments to the fee-for-service IPPS rate.

Following current practice, CMS will determine DSH eligibility and reconcile traditional DSH payments (at the 25% level) based on actual program year cost report data.

CMS will also reconcile the new uncompensated care payments to ensure that hospitals receive the exact payment amount adopted in this final rule. CMS will recoup any overpayments that may occur when the actual number of hospital claims is higher than the CMS-estimated claims figure adopted in the final rule and used for distribution of this payment. CMS has made a file available on its Web site that includes each hospital’s uncompensated care payment amount and estimated per-claim payment. The file is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html). This file also includes other data critical to the new DSH payment methodology.

For hospitals projected by CMS to be DSH-eligible, but ultimately determined to be ineligible at cost report settlement, CMS will recoup both the traditional DSH and uncompensated care payments. Alternatively, hospitals not determined to be DSH-eligible until cost report settlement will be paid both the traditional DSH payment amount and the uncompensated care amount based on the pre-determined hospital-specific uncompensated care payment factor (CMS has calculated a payment factor for every hospital in the country based on its share of days to total days for all FFY 2014 CMS-projected DSH-eligible hospitals). As proposed and adopted, the data and factors used to determine the distribution of the uncompensated care payments are fixed and will not be re-estimated at time of settlement.

Unrelated to the ACA-mandated DSH payment changes specifically, CMS finalizing its proposal to readopt its policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP. CMS is appealing a recent court ruling that disallowed the inclusion of these patient days in Medicare fraction the DPP and is seeking to reaffirm its current position using the rulemaking process prior to a decision on the appeal.

**GME Payments**

*FR pages 50,613 and 50,729-50,739*

For the purposes of calculating the Medicare share for direct GME payments, CMS is adopting its proposal to include inpatient days for labor and delivery services effective for cost reporting periods beginning on or after October 1, 2013 (FFY 2014). To implement this policy, CMS will amend the applicable cost report worksheets and instructions. CMS recently adopted this policy change for the Medicare DSH purposes. CMS notes that this policy will reduce direct GME payments to hospitals and may impact the eligibility of hospitals seeking SCH status.

For the purposes of Indirect Medical Education (IME) and direct GME payments, CMS is adopting its proposal to preclude teaching hospitals from claiming the time residents are training at a Critical Access Hospital (CAH). A CAH will still be able incur the costs of training residents and will receive payment based on 101% of its Medicare reasonable costs for the time those residents rotate to the CAH.
The final rule also outlines an ACA-authorized opportunity for hospitals to add new residency slots due to recent hospital closures and provides notice that the legislated freeze applied to hospital-specific per resident amounts (PRAs) that exceed 140% of the locality-adjusted national average PRA expires for FFY 2014.

For FFY 2014, the IME adjustment factor will remain at 1.35.

**Inpatient Admission Guidance**  
*FR pages 50,906-50,954*

To address concerns about appropriate inpatient hospital admission decisions and recent increases in denials of short-stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs), CMS is adopting its proposal, with some modification, to implement time-based admission guidelines.

As adopted, CMS is specifying that inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following a physician’s order will be presumed generally appropriate for payment under Medicare Part A. CMS is expanding its proposal to allow for patient time spent receiving outpatient services (emergency, observation, and operating room services) to count under the 2 midnight threshold.

Under the newly adopted polices, claims that meet the time-based guidelines will be presumed generally appropriate for Part A payment and will not be the focus of federal claims review contractors. However, CMS would presume that hospital services spanning less than two midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician’s order.

CMS has estimated that this policy will increase inpatient payments by about $220 million. To maintain IPPS budget neutrality, CMS is using its “exceptions and adjustment authority” to apply a -0.2% reduction to the federal operating, hospital-specific, and federal capital rates. Complete details on the inpatient admission guidance policies are available on FR pages 50-938-50,954.

CMS also uses the IPPS final rule to adopt policies proposed earlier this year under a separate regulation on Part B inpatient billing. These policies allow hospitals to rebill under Part B, in limited circumstances and within the current timely filing requirements, when a claim is denied under Part A. Complete details on the Part A/Part B rebilling policies are available on FR pages 50-906-50,938.

**Outlier Payments**  
*FR pages 50,977-50,984*

To maintain total outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of $21,748 for FFY 2014 (proposed at $24,140). The new threshold amount represents a -0.3% decrease compared to the current threshold of $21,821. CMS cites a change in DSH payment policy from proposed rule to final rule as a reason for the threshold decrease from proposed to final.

**HAC MS-DRG Payment Policy**  
*FR pages 50,523-50,527*

CMS did not propose and is not adopting any expansion to the categories/conditions under the current HAC MS-DRG payment policy and will continue to recognize 12 HAC categories. As has been the case in prior years, when these defined conditions are not present on admission (POA) and, therefore, considered hospital-acquired, the diagnosis will not be recognized in the assignment of a case to a MS-DRG.
Expiration of the More Inclusive Low-Volume Adjustment Criteria  
*FR pages 50,610-50,613*

For FFYs 2011-2013, the ACA and ATRA mandated changes to the low-volume hospital adjustment criteria that allowed more hospitals to qualify for the adjustment and modified the amount of those adjustments. Absent legislation, beginning FFY 2014, 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, 2013 (FFY 2014) must make a request in writing to their fiscal intermediary (FI)/Medicare Administrative Contractor (MAC) by September 1, 2013. 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/MAC determination.

Expiration of MDH Status  
*FR pages 50,647-50,649*

The ATRA extended the Medicare-Dependent Hospital (MDH) program through FFY 2013. Absent legislation to extend the program, MDH status and the associated IPPS payment benefits will expire at the end of FFY 2013.

RRC Status  
*FR pages 50,608-50,610*

Hospitals that meet certain criteria can be classified as a Rural Referral Center (RRC). This special status allows exemption from the 12% cap on traditional per-discharge DSH payments and special treatment under the geographic reclassification rules. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The FFY 2014 minimum case-mix and discharge values by region are available on FR pages 50,609-50,610.

Quality-Based Payment Policies—FFYs 2015 and Beyond

For FFYs 2015 and beyond, CMS is adopting proposals that put in place new quality-based payment policies and measures for the VBP Program, Readmissions Reduction Program, and HAC Reduction Program. The following provides a brief description of the policies by program:

- **VBP Program — FFYs 2016-2019 (FR pages 50,679-50,707):** CMS is adopting its proposed changes, with slight modifications in some instances, to how the VBP Program will function in future years (FFYs 2016-2019). CMS has already adopted program rules through FFY 2015. CMS is adopting:
  - Measure additions/deletions for FFY 2016. These changes will retain the patient experience of care and efficiency measures, add 1 and eliminate 3 process of care measures, and add 2 patient outcomes measures;
  - New data collection time periods for FFY 2016 for all measures and through FFY 2019 for a subset of measures;
  - National performance standards for FFY 2016 for all measures and through FFY 2019 for a subset of measures; and
  - New measure weighting formulas for FFYs 2016 and 2017 that are used for calculating each hospital’s VBP Total Performance Score (TPS). The new weighting formulas will assign greater weight to the patient outcomes and efficiency measures and lesser weight to the process of care and patient experience of care measures.

Details and CMS tables on the newly adopted measures, collection time periods, performance standards and measure weighting is available on the FR pages listed above. Other details and information on the program currently in place and on the programs in place for FFYs 2014 and 2015 are available on CMS’ QualityNet Web
CMS is also adopting a new waiver process to recognize the effect that natural disasters might have on a hospital’s performance under VBP. Under the policy, hospitals would be required to submit the waiver request at the same time it requests an extraordinary circumstance waiver under the Inpatient Quality Reporting (IQR) Program (within 30 days of the date that the extraordinary circumstance occurred).

CMS used both the proposed and final rule to discuss expanding the use of efficiency measures for future VBP program years. The FFY 2015 VBP Program will evaluate efficiency using one measure of Medicare spending per beneficiary. According to CMS, the expansion may include a measure that evaluates the rate and/or dollar amount of hospital inpatient services billed to Medicare Part B subsequent to the denial of a Part A hospital inpatient claim and the addition of Medicare spending measures specific to physician services such as Radiology, Anesthesiology, and Pathology that occur during a hospital stay.

- **Readmissions Reduction Program – FFY 2015** (FR pages 50,657-50,664): For FFY 2015, CMS is adopting its proposal to add 2 readmissions measures for evaluation under the Readmissions Reduction Program. In addition to the current AMI, HF, and PN measures, CMS will evaluate readmissions for patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD) and patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). CMS has the authority to expand the policy to additional conditions, including coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA), but did not pursue such expansion. Detailed policies related to how this payment program functions were adopted in prior rulemaking.

  Details and information on the program currently in place is available on CMS' QualityNet Web site at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagemain=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.

- **HAC Reduction Program – FFYs 2015-2017** (FR pages 50,707-50,729): CMS is adopting, with some modification, its proposed policies for the implementation of the ACA-mandated Hospital Acquired Condition (HAC) Reduction Program beginning in FFY 2015. By law, hospitals with a total HAC score—as calculated under the adopted policies—that fall within the top quartile (the worst performing quartile) of total HAC scores for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. This program is expected to reduce IPPS payments by about $300 million per year. For the FFY 2015 HAC reduction program, CMS is adopting policies for:
  - Measures, domains, and timeframes for the evaluation of HAC rates—CMS is adopting program policies to evaluate hospitals on risk-adjusted HAC rates from all or portions of care provided in 2011, 2012, and 2013 on a total of 3 measures across 2 domains (CMS had proposed to evaluate performance on a total of 8 measures across the same 2 domains but selected this alternative to capture a measure that has been broadly reviewed and endorsed). Domain 1 will include 1 Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) composite measure calculated from Medicare claims data, PSI-90. This composite measure includes 8 individual PSI measures. Domain 2 will include 2 Center for Disease Control and Prevention (CDC) Healthcare Associated Infection (HAI) measures collected via the National Healthcare Safety Network (NHSN)—Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI). CMS notes that the two different domains were created to separate the AHRQ and CDC measures due to significant differences between the measure sources, risk-adjustment, and calculation methodologies.

CMS is also adopting its proposal to evaluate additional measures under the HAC Reduction Program in FFYs 2016 and 2017. For FFY 2016, CMS will add one surgical site infection measure and for FFY 2017,
CMS will add two measures to evaluate Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia and Clostridium difficile (*C. difficile*) infection.

- **Scoring methodology**—
  CMS is adopting a scoring methodology that calculates a Total HAC Score for each eligible hospital. The finalized methodology scores each individual risk-adjusted HAC measure on a scale from 1 to 10 points, where deciles are created between the top performing hospital in the nation and the worst performing hospital in the nation. A measure score of 1 represents the best performers and a measure score of 10 represents the worst performers. CMS had proposed an alternative scoring methodology, but concerns over the differences in performance variation between the individual HAC measures has resulted in this alternative method.

  Once all useable measures are scored, CMS will calculate domain scores for each of the proposed domains by averaging the useable measure scores within the domain. CMS will then combine the domain scores by weighting them. For FFY 2015, CMS will weight Domain 1 at 35% and Domain 2 at 65% (proposed at 50% each). The result of the combined domain score will be the hospital’s Total HAC Score. CMS will use the Total HAC Score to determine the top quartile (worse performing) hospitals subject to the 1.0% payment penalty.

CMS also adopted minimum measure requirements and hospital exclusion policies, policies that provide hospitals with a data review and correction period, and a process for making hospital-specific performance under the program available to the public.

**Updates to the IQR Program and Voluntary EHR-Based Reporting Under the Program**

*FR pages 50,774-50,837*

As previously adopted, for FFY 2014 payment determinations under the Inpatient Quality Reporting (IQR) Program, hospitals were required to report on a total of 55 quality measures. Hospitals that do not successfully participate in the IQR Program are subject to a 2.0 percentage point reduction to the IPPS marketbasket update for the applicable year—the reduction factor has not changed.

For FFY 2015 and FFY 2016 payment determinations, CMS is adopting its proposals to refine and make specification changes to several previously adopted program measures. For FFY 2016 payment determinations specifically, CMS is adopting its proposal to make several measure additions and deletions to the program reporting requirements. Of note, CMS is adopting its proposal to collect and publicly report data on:

- 30-day stroke readmission and mortality rates;
- 30-day COPD readmission and mortality rates; and
- payment per episode of care data for AMI patients.

These and other refinements not only update the IQR Program but also remove and/or potentially put in place measures for use under the VBP Program, Readmissions Reduction Program, and HAC Reduction Program. The updates also maintain a level of alignment with the quality measures used under the EHR incentive program.

In total, hospitals will be required to report data on 59 measures for FFY 2015 payment determinations; 57 measures for FFY 2016 payment determinations.

A table that lists the 59 measures CMS will collect for FFY 2015 payment determinations is available on FR pages 50,784-50,785.
A table that lists the 57 measures CMS is proposing to collect for FFY 2016 payment determinations is available on FR pages 50,805-50,807 (a table that lists the 8 measures CMS is proposing to remove from the IQR Program for FFY 2016 payment determinations is available on FR pages 50,782).

As it does each year, 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 FR pages 50,810-50,837.

Regarding quality reporting through the EHR, CMS is adopting its proposal to allow voluntary EHR-based reporting on a subset of IQR Program measures during calendar year 2014 (for FFY 2016 payment determinations). Specifically, CMS will allow hospitals to electronically report 16 measures across 4 measure sets, (stroke [STK], venous thromboembolism [VTE], emergency department [ED] and perinatal care [PC]). As proposed and adopted, hospitals that voluntarily participate will be required to collect some measures using current methods and the 16 specified measures through the EHR. CMS is encouraging hospitals to participate in voluntary electronic reporting during CY 2014. CMS states that it intends to propose required electronic reporting for certain measures beginning in CY 2015 (for FFY 2017 payment determinations). Complete detail on this policy is available on FR pages 50,807-50,810.

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