American Hospital Association

Regulatory Advisory

May 21, 2014

MEDICARE INPATIENT PPS: THE PROPOSED RULE FOR FY 2015

AT A GLANCE

At Issue

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2015 proposed rule for the hospital inpatient and long-term care prospective payment systems (PPS) on April 30. The proposed rule affects inpatient PPS hospitals, critical access hospitals (CAHs), long-term care hospitals (LTCHs) and PPS-exempt cancer hospitals. Major provisions of the rule are described below. The AHA will issue a separate advisory on proposals related to the LTCH PPS.

The proposed rule would increase inpatient PPS rates by 1.3 percent in FY 2015 compared to FY 2014, after accounting for inflation and other adjustments required by law. Hospitals either not submitting quality data or that were not meaningful users of electronic health records in FY 2013 will be subject to market basket penalties.

Documentation and Coding Adjustment: The rule proposes a cut of 0.8 percentage points, or about $900 million, to inpatient PPS payments that would, in part, fulfill a requirement of the American Taxpayer Relief Act of 2012 (ATRA). CMS plans to recoup what the agency claims is the effect of documentation and coding changes from FYs 2010-2012 that the agency says do not reflect real changes in case mix. CMS notes that if it implements additional cuts of 0.8 percentage points in each of FYs 2016 and 2017, it will fulfill the ATRA requirement within the statutory four-year timeline; however, the agency does not make specific proposals for FYs 2016 and 2017. **While we continue to believe these congressionally mandated adjustments are unwarranted, CMS's proposal has provided hospitals with additional time to manage the sizeable ATRA cuts.**

Area Wage Index Update: CMS proposes to apply the most recent labor market areas to the FY 2015 inpatient PPS area wage index. The most recent areas were issued by the Office of Management and Budget (OMB) on Feb. 28, 2013 and include an updated list of core-based statistical areas that reflect the OMB's 2010 standards and 2010 Census data. CMS also proposes transition periods for those hospitals negatively impacted by this update.

Two-Midnight Policy: CMS finalized its two-midnight policy in the FY 2014 inpatient PPS final rule. While CMS proposes no changes to the policy in this rule, it solicits comments on an alternative payment methodology under the Medicare program for short inpatient stays (i.e., medically necessary inpatient stays that span less than two midnights), including comments on how it might be designed, how short inpatient stays would be defined and how the appropriate payment would be determined. **The AHA plans to offer its views on the design of an alternative payment methodology for short inpatient hospital stays.**

Hospital-Acquired Conditions (HACs): As mandated by the ACA, CMS proposes to implement the first year of the HAC Reduction Program, which imposes a 1 percent reduction in total Medicare payments for hospitals scoring in the top quartile of national HAC rates. The measures and scoring methodology being used in the program were finalized in the FY 2014 inpatient PPS final rule, and the agency proposes only minor refinements for FY 2015. It estimates that 753 hospitals will be penalized by about $330 million. **The AHA remains deeply concerned that the HAC policy is misguided and poorly designed. Moreover, the impact analysis provided in rule demonstrates that the program disproportionately penalizes large hospitals and teaching hospitals.**

Disproportionate Share Hospital (DSH) Payment Changes: The Affordable Care Act required changes to the way in which DSH payments are made to hospitals. For FY 2015, CMS proposes that the amount in the 75-percent pool be further decreased to reflect additional decreases in the percentage of uninsured. It also proposes to continue to use inpatient days of Medicaid beneficiaries and Medicare supplemental security income beneficiaries as a proxy for measuring uncompensated care. The agency anticipates that DSH payments would decrease by an additional $132 million in FY 2015 compared to FY 2014, which includes the positive effect Medicaid expansion has on total DSH funds.

What You Can Do:

- ✓ Share this advisory with your senior management team and ask your chief financial officer to examine the impact of the payment changes on your Medicare revenue for FY 2015. Hospitals may assess the impact of these provisions on their organizations by using AHA's calculators:
    - Readmissions Penalty Calculator: http://www.aha.org/readmissionscalc
    - Value-Based Purchasing Calculator: http://www.aha.org/vbpcalc
    - DSH Payment Calculator: http://www.aha.org/dshcalc
    - HAC Calculator: www.aha.org/haccalc
- ✓ **Verify CMS's table listing the factor used to calculate uncompensated care payments in FY 2015 for DSH hospitals.** Hospitals have until June 30 to review this table and notify CMS in writing of a change in a hospital's status.
- ✓ **Verify whether your hospital has attested for meaningful use.** Attestation status can be determined through CMS's EHR Incentive Program registration and attestation website.
- ✓ **In addition, we recommend that hospitals verify that their wage data are accurate.** CMS has posted the data on its website.
- ✓ Share this advisory with your billing, medical records, quality improvement and compliance departments, as well as your clinical leadership team – including the quality improvement committee and infection control officer – to apprise them of the proposals around the diagnosis-related groups and quality measurement requirements.
- ✓ Hospitals qualifying for the low-volume payment adjustment must apply or submit written verification that it continues to be more than 15 miles from any other subsection (d) hospital prior to Sept. 1, 2014.
- ✓ **Submit comments to CMS with your specific concerns by June 30 at www.regulations.gov.**

Further Questions:

For additional questions, please contact Priya Bathija, AHA senior associate director, at (202) 626-2678 or pbathija@aha.org.

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MEDICARE INPATIENT PPS: THE PROPOSED RULE FOR FY 2015

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) released its proposed rule for the fiscal year (FY) 2015 hospital inpatient and long-term care hospital (LTCH) prospective payment systems (PPS) on April 30. The final rule will be published by Aug. 1 and will take effect Oct.1.

The proposed rule would increase operating inpatient PPS rates by 1.3 percent in FY 2015 compared to FY 2014, after accounting for inflation and other adjustments required by law. Specifically, this update includes a 2.7 percent market basket adjustment, less 0.4 percentage points for productivity, less an additional 0.2 percentage points mandated by the Affordable Care Act (ACA), and less 0.8 percentage points for documentation and coding cuts as required by the American Taxpayer Relief Act of 2012 (ATRA). Hospitals that do not submit quality data or were not meaningful users of electronic health records (EHRs) in FY 2013 will be subject to market basket penalties.

A detailed summary of the proposed rule follows. The AHA will issue a separate advisory on proposals related to the LTCH PPS.

SUMMARY

Operating PPS Rate Update

The market basket is an input price index that measures price changes over a fixed period of time. To construct the market basket index, price proxies, such as the U.S Consumer Price Index, are used to estimate the price changes for a mix of goods and services purchased by hospitals. The proposed rate of increase in the hospital market basket for FY 2015 operating PPS payments is 2.7 percent. However, CMS proposes a 0.4 percentage point reduction to this market basket update for productivity, as well as an additional 0.2 percentage point reduction, both as mandated by the ACA. Thus, CMS is proposing an applicable percentage increase to the FY 2015 operating standardized amount of 2.1 percent. This increase applies to those hospitals that submitted quality data and were meaningful users of EHR in FY 2013.

Hospitals either not submitting quality data or that were not meaningful users of EHRs in FY 2013 will be subject to a one-quarter reduction in the initial market basket rate, thus receiving an update to the standardized amount of 1.425 percent instead of 2.1 percent. Hospitals that fail to meet both of these requirements will be subject to a one-half reduction in the initial market basket rate, thus receiving an update to the standardized amount of 0.75 percent instead of 2.1 percent. (See “Inpatient Quality Reporting” and “Penalty for Failing to Meet Meaningful Use” for more information.)

Also by law, CMS must adjust the proportion of the standardized amount that is attributable to wages and wage-related costs (known as the labor-related share) by a factor that reflects the relative difference in labor costs among geographic areas (known as the area wage index). For FY 2015, CMS proposes to continue use of the labor-

related share the agency finalized in FY 2014 – 69.6 percent for those hospitals with wage indices greater than 1.0. By law, the labor-related share for those hospitals with wage indices less than or equal to 1.0 will remain at 62 percent. For Puerto Rico hospitals, CMS proposes to continue to use a labor-related share of 63.2 percent in FY 2015.

The proposed standardized amounts for FY 2015 are:

Area Wage Index Greater Than 1.0

Hospital submitted quality data and is a meaningful use of EHR (update = 2.1 percent)		**Hospital did NOT submit quality data but is a meaningful user of EHR (update = 1.425 percent)**		**Hospital submitted quality data but is NOT a meaningful user of EHR (update = 1.425 percent)**		**Hospital did NOT submit quality data and is NOT a meaningful user of EHR (update = 0.75 percent)**	
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,759.46	$1,642.06	$3,734.61	$1,631.20	$3,734.61	$1,631.20	$3,709.75	$1,620.35

Area Wage Index Less Than 1.0

Hospital submitted quality data and is a meaningful user of EHR (update = 2.1 percent)		**Hospital did NOT submit quality data but is a meaningful user of EHR (update = 1.425 percent)**		**Hospital submitted quality data but is NOT a meaningful user of EHR (update = 1.425 percent)**		**Hospital did NOT submit quality data and is NOT a meaningful user of EHR (update = 0.75 percent)**	
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,348.94	$2,052.58	$3,326.80	$2,039.01	$3,326.80	$2,039.01	$3,304.66	$2,025.44

For Puerto Rico hospitals, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the payment per discharge equal the sum of 25 percent of a Puerto Rico-specific rate, which reflects the base year average costs per case of Puerto Rico hospitals, and 75 percent of the federal national rate.

The operating standardized amounts for Puerto Rico for FY 2015 are:

For Hospitals in Puerto Rico

	Rates if wage index is greater than 1.0		**Rates if wage index is less than or equal to 1.0**	
	Labor	Non-labor	Labor	Non-Labor
National[1]	Not Applicable	Not Applicable	$3,348.94	$2052.58
Puerto Rico	$1,605.07	$934.59	$1,574.59	$965.07

[1] For FY 2015, there are no areas in Puerto Rico with a proposed national wage index greater than 1.

Documentation and Coding Adjustment for MS-DRG Changes

The rule proposes a cut of 0.8 percentage points, or about $900 million, that will fulfill part of the ATRA requirement that CMS recoup what the agency claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that the agency says do not reflect real changes in case-mix. CMS does not propose how it will complete the ATRA cuts, but notes that, if it implements additional cuts of 0.8 percentage points in each of FYs 2016 and 2017, it will fulfill the ATRA requirement within the statutory four-year timeline. Because these are recoupment cuts, they would be restored in FY 2018 through a one-time increase of 3.2 percent in inpatient PPS payments. **While we continue to believe these congressionally mandated adjustments are unwarranted, CMS's policy of gradually phasing in this reduction has provided hospitals with additional time to manage these sizeable cuts.**

This 0.8 percentage point cut does not apply to sole community hospitals' (SCHs) or Medicare Dependent Hospitals' (MDHs) hospital-specific rates, or to the Puerto Rico-specific amount. CMS does not have the authority to apply recoupment cuts to these payments.

CMS indicates that it will not apply a prospective adjustment for FY 2015 to account for any documentation and coding effect that occurred in FY 2010. However, the agency indicates that such an adjustment may be appropriate in future years' rulemaking. In the FY 2013 inpatient PPS rulemaking cycle, CMS proposed, but did not finalize, a prospective documentation and coding cut of 0.8 percentage points for the MS-DRG documentation and coding effect through FY 2010. The agency did not finalize this cut because it stated it needed to further analyze the AHA's assertion that the 0.8 percentage point figure was overstated. In its FY 2014 inpatient PPS final rule, the agency again did *not* impose this prospective cut, but agreed with the AHA that the 0.8 percentage point figure is overstated and a cut of 0.55 percentage points would be more appropriate.

Disproportionate Share Hospital (DSH) Payment Methodology Changes

The ACA requires that, beginning in FY 2014, hospitals initially receive 25 percent of the DSH funds they would have received under the pre-FY 2014 formula (which CMS describes as "empirically justified DSH payments"), with the remaining 75 percent flowing into a separate funding pool for DSH hospitals (the "75-percent pool"). This 75-percent pool will be reduced each year as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. CMS describes payments made from this pool as "uncompensated care DSH payments." These changes apply to DSH payments made through the operating PPS only and not the capital PPS. As required by the ACA, CMS proposes that the amount in the 75-percent pool be further decreased in FY 2015 to reflect additional decreases in the percentage of uninsured that have occurred since FY 2014.

DSH Eligibility. CMS proposes no changes to the eligibility requirements for either the empirically justified Medicare DSH payments or the uncompensated care payments. CMS reiterates that hospitals not eligible to receive empirically justified Medicare DSH

payments in a fiscal year will not receive uncompensated care payments for that year. CMS proposes to continue to determine initial eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year; the final determination on the hospital's eligibility for uncompensated care payments would be based on the hospital's actual DSH status on the cost report for that payment year.

In addition, as finalized in the FY 2014 inpatient PPS final rule, CMS states that Puerto Rico hospitals and hospitals participating in the Bundled Payments for Care Improvement Initiative are eligible for payments under the ACA DSH payment methodology. CMS also indicates that Maryland hospitals, now being paid under the Maryland All-Payor Model, and hospitals participating in the Rural Community Hospital Program are not eligible to receive DSH payments under the revised methodology. With regards to SCHs, which are paid the higher of the federal PPS amount or their hospital-specific amount, only those SCHs paid the federal PPS amount will be eligible for Medicare DSH payments.

Empirically Justified DSH Payments. Empirically justified DSH payments will continue to be distributed in the exact manner in which DSH payments were distributed prior to FY 2014, but at 25 percent of the amount of what otherwise would have been paid. CMS estimates that the empirically justified Medicare DSH payments for FY 2015 will be $3.551 billion (25 percent of the total amount estimated). CMS also proposes, as it did in FY 2014, that it will continue to cost-settle these payments at the appropriate level on the cost report.

Uncompensated Care Payments. The second portion of the DSH payment amount for each DSH hospital – the uncompensated care payment – will remain the product of three factors.

- **Factor One – The Initial Size of the 75-percent Uncompensated Care DSH Payment Pool.** Factor One is the difference between CMS's estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2015 in the absence of the ACA payment provision; and (2) the amount of the empirically justified Medicare DSH payments that are made for FY 2015. The agency uses the most recently available projections of Medicare DSH payments to estimate the final size of this pool. That is, CMS sets the size of the pool prospectively, based on estimated Medicare DSH payments for the year, and will *not* revise or update its estimate after it knows the final Medicare DSH payments for FY 2015.

  In the rule, CMS used data from the Office of the Actuary's (OACT) February 2014 estimate of Medicare DSH payments to determine the proposed size of the 75-percent pool. CMS estimates the total amount of Medicare DSH payments that otherwise would have been paid for FY 2015 to be $14.205 billion. As stated above, the estimate of the empirically justified Medicare DSH payments for FY 2015 is $3.551 billion. Therefore, CMS proposes that the 75-percent pool for FY 2015 be $10.654 billion.

- **Factor Two – Change in the Percentage of Uninsured.** The next step in determining hospitals' uncompensated care DSH payments is to determine how much the 75-percent pool will be reduced as a result of the decline in the uninsured population. Using the Congressional Budget Office's (CBO) February 2014 estimate of the effects of the ACA on health insurance coverage, CMS proposes that the estimate of individuals under the age of 65 with insurance in calendar year 2014 is 84 percent and the rate of uninsurance in calendar year 2014 is 16 percent (i.e., 100 percent minus 86); and the estimate of individuals under the age of 65 with insurance in calendar year 2015 is 86 percent and the rate of uninsurance in calendar year 2015 is 14 percent. CMS then weighted these figures appropriately to determine the rate of uninsurance for FY 2015 and after imputing that rate into the statutory formula proposes that Factor Two equal 0.8036. Accordingly, CMS proposes to retain 80.36 percent – or $8.56 billion – of the 75-percent pool in FY 2015. This amounts to a reduction of about $132 million in Medicare DSH payments in FY 2015 compared to FY 2014, which includes the positive effect Medicaid expansion has on the total amount of DSH funds.

- **Factor Three – Hospitals' Uncompensated Care Payments.** The last step in determining hospitals' uncompensated care DSH payments is to determine the proportion of hospitals' aggregate uncompensated care that each hospital provides. As it did in the FY 2014 inpatient PPS final rule, CMS proposes to use inpatient days of Medicaid beneficiaries, plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides. Specifically, CMS proposes to use the December 2013 update of the 2011/2012 Medicare cost reports for the Medicaid days and the FY 2011 Medicare SSI ratios for the Medicare SSI days.

  The agency calculates the total number of Medicaid inpatient and Medicare SSI days among DSH hospitals; it then determines what percentage of these days each individual DSH hospital accounts for. Hospitals will receive that percentage of what remains of the 75-percent pool as their uncompensated care DSH payment. For example, if Hospital A accounts for 1 percent of the total Medicaid and Medicare SSI days provided by all DSH hospitals, it will receive 1 percent, or $85.6 million, of the $8.56 billion that remains in the 75-percent pool. **CMS has published on its website a table listing Factor 3 for all hospitals it estimates would receive uncompensated care payments in FY 2015. Hospitals have until June 30 to review this table and notify CMS in writing of a change in the hospital's status.**

The AHA has created a DSH calculator for hospitals to assess the impact of the policy on their organizations. It is available at: www.aha.org/dshcalc. The calculator is designed so that you can enter basic financial information regarding your hospital, including its CMS Certification Number, and it will then estimate the dollar amount of your DSH payment.

Worksheet S-10. In the FY 2014 inpatient PPS final rule, CMS discussed the alternative of using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care each hospital provides. However, at that time, because

of concerns regarding variations in the data reported on Worksheet S-10 and the completeness of these data, CMS did not propose to use this data to determine the uncompensated care costs. Instead, CMS used inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients to make this determination.

In the proposed rule, CMS indicates that the agency has continued to evaluate and assess the appropriateness of Worksheet S-10, but that it would be premature to propose its use in FY 2015. However, CMS invites public comment on this conclusion and states it will continue to work with the hospital field and others to develop appropriate clarifications and revisions to Worksheet S-10 for reporting uncompensated care data – including what would be a reasonable timeline for adopting Worksheet S-10 as the data source for determining uncompensated care costs.

Hospital Mergers. The agency proposes to address a discrepancy related to determining the uncompensated care payment, specifically Factor 3, for merged hospitals. CMS proposes to define a merger as *an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving hospital.* Accordingly, acquisitions where the new owner voluntarily terminates the Medicare provider agreement of the hospital it purchased by rejecting assignment of the previous owner's provider agreement would *not* be considered a merger.

In the FY 2014 inpatient PPS final rule, CMS calculated Factor 3 using only the surviving hospital's cost report data and Medicare SSI ratio data from FYs 2010/2011 – which reflect the uncompensated care burden of only that hospital pre-merger and do not accurately reflect the uncompensated care burden for the newly merged hospital. CMS now proposes to use the combined uncompensated care burden of the two hospitals that merged in calculating Factor 3. **The agency has published a table on its website containing a list of the mergers that the agency is aware of and the computed uncompensated care payment for each merged hospital. The effected hospitals now have the opportunity to comment during the public comment period on the accuracy of this information or CMS's proposal on how to handle mergers.**

Impact of Proposed Implementation of New Office of Management and Budget (OMB) Labor Market Delineations. As discussed further in the "Wage Index" section below, CMS proposes to implement the new OMB labor market area delineations (which are based on 2010 Census data) for the FY 2015 wage index. This proposal could have a negative impact on the Medicare DSH payments for certain hospitals. For such hospitals, CMS proposes a two-year transition period. Specifically, any hospital that was previously urban but would be redesignated as rural in FY 2015 would have its DSH payments calculated such that the payment equals the amount of the rural DSH payments (potentially subject to a cap of 12 percent) plus two-thirds of the difference between the urban DSH payment prior to redesignation (not subject to a cap) and the rural DSH payment after redesignation. In the second year, the hospital would have its payments calculated such that the payment equals the amount of the rural DSH payments (potentially subject to a cap of 12 percent) plus one-third of the difference

between the urban DSH payment prior to redesignation (not subject to a cap) and the rural DSH payment after redesignation.

Two-Midnight Policy

CMS finalized its two-midnight policy in the FY 2014 inpatient PPS final rule. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. In this proposed rule, CMS includes several provisions related to the two-midnight policy, including:

- **Medicare Payment for Short Inpatient Hospital Stays.** CMS solicits comments on an alternative payment methodology under the Medicare program for short inpatient stays (i.e., medically necessary inpatient stays that span less than two midnights), which would supplement the two-midnight policy. Specifically, the agency solicits feedback on how such a policy might be designed, how short inpatient stays would be defined and how the appropriate payment would be determined. **The AHA plans to offer its views on the design of an alternative payment methodology for short inpatient hospital stays.**

- **Suggested Exceptions to the Two-Midnight Benchmark.** CMS reiterates that there may be rare and unusual circumstances not yet identified that justify inpatient admission and payment absent an expectation of care spanning at least two midnights. CMS has previously identified medically necessary, newly initiated mechanical ventilation as the first rare and unusual exception to the two-midnight policy and now invites further comment on this issue. Suggestions should be emailed to SuggestedExceptions@cms.hhs.gov with "Suggested Exceptions to the Two-Midnight Benchmark" in the subject line.

- **Requirements for Physician Certification of CAH Inpatient Services.** CMS proposes a change to the timing of the physician certification requirement for CAHs. This change is discussed in more detail below (See "CAH" section).

Wage Index

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. The proposed rule would base the FY 2015 wage index on data from FY 2011 cost reports. According to CMS, the national average hourly wage increased 1.9 percent compared to FY 2014. As a result, a number of hospitals may see their wage indices decline relative to last year because, even though their wages rose, they did not rise as quickly as those at other hospitals.

Core-based Statistical Areas (CBSAs) for the Hospital Wage Index. CMS proposes to apply the most recent labor market areas in the FY 2015 inpatient PPS wage index. The most recent delineations were issued by the OMB on Feb. 28, 2013 in OMB Bulletin No. 13-01, and include an updated list of CBSAs that reflect the OMB's new 2010 standards and 2010 Census data. In addition to using the new OMB labor market

delineations, CMS proposes to continue to treat Micropolitan Areas as "rural" and to include the Micropolitan Areas in the calculation of each state's rural wage index.

This update will result in a number of significant changes to the existing labor markets, including new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs that are split apart. CMS estimates that approximately 666 hospitals will have their wage index impacted due to the new OMB labor market delineations. As a result, CMS proposes wage index transition periods applicable to all hospitals that experience negative impacts due to the proposed implementation of the new OMB labor market delineations.

- **Urban Counties that Would Become Rural.** CMS states that a total of 37 counties and 12 hospitals that were considered part of an urban CBSA in FY 2014 would be considered to be located in a rural area in FY 2015 under the new OMB labor market delineations. The agency proposes that the wage data for all hospitals in these counties would now be included in the calculation of their respective state's rural wage index. As a result of this proposal, the hospitals in these counties may experience a decline in their wage index.

  However to mitigate a large decline in these hospitals' inpatient PPS payments, CMS proposes to continue to apply the urban wage index value of the CBSA where the hospitals are physically located in FY 2014 for a period of three fiscal years. This three-year transition period also would apply to Lugar hospitals that are deemed to be urban under Section 1886(d)(8)(B) of the Social Security Act in FY 2014 that would no longer be deemed urban under the new CBSAs in FY 2015. The agency explains that this three-year transition period is appropriate because, as a group, these hospitals would experience a steeper and more abrupt reduction in their wage index compared to other hospitals.

  This three-year transition period does have restrictions, including: only applying for purposes of calculating the wage index; not applying to those hospitals that have a wage index reclassification or redesignation in place for FY 2015; and any hospital that is granted reclassification or redesignation in FY 2016 or FY 2017 will lose its three-year transitional assigned wage index status.

- **Hospitals Experiencing Wage Index Decreases Solely Due to New Labor Markets.** CMS proposes to use a one-year blended wage index for all hospitals that would experience a decrease in their actual payment wage index *exclusively* due to the proposed implementation of the new OMB labor market delineations. In this situation, CMS would calculate and compare the post-reclassified wage index for the hospital's FY 2014 and FY 2015 CBSAs. If the proposed FY 2015 wage index with FY 2015 CBSAs would be lower than the proposed FY 2015 wage index with the FY 2014 CBSAs, CMS proposes that the final FY 2015 wage index for the hospital will be a blended wage index that consists of 50 percent of each of the two wage indexes added together.

In addition, for FY 2015, CMS proposes that hospitals utilizing the three-year transition period discussed above may also qualify for this blended rate. This would occur in the first year of that three-year transition period, if the FY 2015 wage index of the CBSA where the hospital is geographically located for FY 2014 is less than the FY 2015 wage index the hospital would have received absent the new OMB labor market delineations.

- **Rural Counties that Would Become Urban.** CMS indicates that 105 counties and 81 hospitals that are located in rural areas in FY 2014 would be located in urban areas in FY 2015 under the new OMB labor market delineations. Although hospitals in urban areas typically receive a higher wage index, CMS proposes to allow these hospitals to utilize the transition periods discussed above if they would receive a lower wage index under the new OMB labor market delineations than under the current labor market delineations.

- **Urban Counties that Would Move to Different Urban CBSAs.** Several urban counties would shift from one urban CBSA to another urban CBSA under the new OMB labor market delineations. This may have either positive or negative impacts on hospitals' wage indexes, and CMS proposes to allow these hospitals to utilize the transition periods discussed above in order to moderate the impact of this change.

Occupational Mix. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. CMS is required to collect data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. The last set of data gathered by CMS was collected on the 2010 Medicare Wage Index Occupational Mix Survey to compute the occupational mix adjustment for FY 2013, 2014 and 2015. Accordingly, CMS proposes to calculate the FY 2015 occupational mix adjustment based on data from the 2010 Medicare Wage Index Occupational Mix Survey. CMS also proposes to apply the occupational mix adjustment to 100 percent of the wage index, as it did for FY 2014.

Because the three-year period of use for the 2010 survey data ends in FY 2015, CMS is required to use a new measurement of occupational mix for FY 2016. **CMS's 2013 Medicare Wage Index Occupational Mix Survey was approved by the OMB in May 2013 and is now available on CMS's website. This survey is largely similar to the 2010 survey, but includes some minor editorial changes. Hospitals are required to complete and submit the 2013 survey to their MACs by July 1, 2014.** The resulting data will be applied to the FY 2016 wage index.

Imputed Rural Floor. CMS proposes an additional one-year extension of the imputed rural floor through Sept. 30, 2015 for those states with no rural counties. CMS proposes to continue using both the original and alternative methodologies for computing the imputed rural floor. Under the alternative methodology, which was finalized in the FY 2014 inpatient PPS final rule, the lowest post-reclassified wage index assigned to a hospital in a state with one CBSA will be increased by a factor equal to the average

percentage difference between the post-reclassified, pre-floor area wage index and the post-reclassified, rural floor wage index.

CMS stated that, in FY 2015, there would be 12 providers in New Jersey and one provider in Delaware benefitting from the imputed rural floor policy under the original methodology and four hospitals in Rhode Island that would benefit from the policy under the alternative methodology.

Hospital Redesignations and Reclassifications. Hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for geographic reclassifications for purposes of inpatient PPS payment. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. In February 2014, the MGCRB completed its review of FY 2015 reclassification requests and 379 hospitals were approved for wage index reclassifications for FY 2015. Hospitals reclassified during FY 2013 (172 hospitals) and FY 2014 (287 hospitals) will continue to be reclassified, because wage index reclassifications are effective for three years. **Applications for hospital reclassifications for FY 2016 are due to the MGCRB by Sept. 2, 2014 and would be based on the new OMB labor market delineations.**

These hospitals that were reclassified for FY 2013, FY 2014 and FY 2015 were reclassified based on the current OMB labor market delineations – not the new OMB labor market delineations proposed for FY 2015, which may change the designation of the areas to which they are reclassified. **Hospitals with current reclassifications are encouraged to verify area wage indexes associated with the proposed rule, and confirm that the areas to which they have been reclassified still result in a higher wage index than their geographic area wage index. Hospitals may withdraw their reclassifications by contacting the MGCRB within 45 days from the publication of the proposed rule.**

CMS also includes descriptions of other specific situations, including, among others, how the agency proposes to handle reclassifications in counties that split apart from CBSAs to form new CBSAs or counties shifting from one CBSA designation to another as a result of the new OMB labor market delineations.

Changes in the Wage Index Timetable. CMS proposes changes to the wage index timetable – the process by which hospitals may review and request revisions to CMS's wage index data files – to allow hospitals, Medicare Administrative Contractors and CMS more time to review CMS's wage index data files and ensure a more accurate wage index. Specifically, effective with the FY 2017 wage index cycle, CMS proposes to adjust the timetable as follows:

Deadlines	FY 2015 Timetable	Proposed FY 2017 Timetable
Posting of preliminary public use file (PUF) on CMS website	Sept. 13, 2013	Mid-May 2015
Deadline for hospitals to request revisions to preliminary PUF	Nov. 21, 2013	Early Aug. 2015
Deadline for MACs to complete desk reviews	Jan. 29, 2014	Mid-Oct. 2015
Posting of Feb. PUF on CMS website	Feb. 20, 2014	Late Jan. 2016
Deadline following posting of Feb. PUF for hospitals to request revisions	March 3, 2014	Mid-Feb. 2016
Completion of appeals by MACs and transmission of final wage data to CMS	April 9, 2014	Mid-to-late March 2016
Deadline for hospitals to appeal in April	April 16, 2014	Early April 2016
Posting of final rule PUF	May 2, 2014	Late April 2016
Deadline for hospitals to appeal in June	June 2, 2014	Late May 2016
Expected issuance of inpatient PPS final rule	Aug. 1, 2014	Aug. 1, 2016

In addition, in order to help transition to the FY 2017 changes, CMS proposes some modifications to the existing FY 2016 wage index cycle. These changes are as follows and should be read in context of the existing timetable:

Deadlines	FY 2015 Timetable	Adjusted FY 2016 Timetable
Posting of preliminary PUF on CMS website	Sept. 13, 2013	Late May 2014
Posting of preliminary CY 2013 occupational mix data PUF on CMS website	Sept. 13, 2013	Early to Mid-July 2014
Deadline for hospitals to request revisions to preliminary PUF	Nov. 21, 2013	Early Oct. 2014
Deadline for MACs to complete desk reviews	Jan. 29, 2014	Mid-Dec. 2014

Hospital-Acquired Conditions (HACs)

As mandated by the ACA, for FY 2015, CMS proposes to implement the HAC Reduction Program, which imposes a 1 percent reduction to Medicare payments for hospitals in the top quartile of risk-adjusted national HAC rates. The HAC Reduction Program's eligibility criteria, basic payment adjustment approach, measures and scoring methodology were finalized in the FY 2014 inpatient PPS final rule. The AHA's Aug. 30,

2013 Regulatory Advisory on the FY 2014 inpatient PPS final rule summarizes these provisions in greater detail. CMS proposes only minor refinements for FY 2015. However, for FY 2016, the agency proposes to place a greater weight on healthcare-associated infection (HAI) measures in determining a hospital's HAC performance.

Estimated FY 2015 Payment Impact to Hospitals. In the proposed rule, CMS estimates that, in FY 2015, the HAC program will penalize 753 hospitals (or 23.2 percent of hospitals eligible for the HAC penalty) by a total of $330 million. The rule provides a table on pp. 28366 and 28367 (page 390 and 391 of the PDF) summarizing the estimated impact by hospital characteristics. Notably, CMS estimates that nearly 53 percent of major teaching hospitals (i.e., hospitals having 100 or more residents), and 42 percent of urban hospitals with more than 500 beds will receive penalties. **The AHA is concerned that the HAC Reduction Program disproportionately penalizes large hospitals and teaching hospitals simply because they tend to treat our nation's sickest patients.**

In the FY 2014 inpatient PPS final rule, CMS finalized a basic payment adjustment methodology for hospitals that score in the top quartile of risk-adjusted national HAC rates. Penalized hospitals will receive a per-discharge payment equal to 99 percent of the payment that would otherwise have applied to such discharges. This payment adjustment will be applied after payment adjustments for the Hospital Readmission Reduction Program (HRRP) and the Value-based Purchasing (VBP) Program. It applies to *total hospital payments*, not to the base operating DRG payment amount used to calculate VBP incentives and HRRP penalties. Thus, the HAC payment adjustment will include a reduction to indirect medical education (IME), DSH and outlier payments.

The AHA has created a HAC penalty calculator for hospitals to assess the impact of the policy on their organizations. It is available at: www.aha.org/haccalc. The calculator is designed so that you can enter your hospital's CMS Certification Number and the calculator will then estimate the dollar amount of your HAC penalty, if applicable.

Quality Measures. CMS proposes no new quality measures for the HAC Reduction Program. As previously finalized, CMS will use two domains of quality measures. Domain 1 is a composite of eight Patient Safety Indicator (PSI) measures calculated using Medicare claims data. Domain 2 is comprised of hospital-acquired infection (HAI) measures currently reported in the Inpatient Quality Reporting (IQR) Program. The specific domains and measures are outlined in Table 1.

The AHA continues to believe the PSI measures have significant methodological flaws rendering them inappropriate for the HAC program, such as inadequate risk adjustment and inconsistent reliability. We also note that five of the eight individual PSI measures that compose the PSI-90 composite are not endorsed by the National Quality Forum (NQF), suggesting that they lack the rigor necessary for a quality accountability program.

Table 1: Measures and Domains for the HAC Reduction Program, FY 2015 – FY 2017

Domain 1: Patient Safety Indicators (PSIs)	Domain 2: HAI Measures
PSI 90 (PSI Composite), comprised of the following 8 PSIs: • Pressure ulcer rate (PSI 3)# • Iatrogenic Pneumothorax rate (PSI 6) • Central venous catheter-related blood stream infection rate (PSI 7)# • Postoperative hip fracture rate (PSI 8)# • Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12) • Postoperative sepsis rate (PSI 13)# • Wound dehiscence rate (PSI 14)# • Accidental puncture and laceration rate (PSI 15)	• Central Line-associated Blood Stream Infection (CLABSI) (FY 2015 onward) • Catheter-associated Urinary Tract Infection (CAUTI) (FY 2015 onward) • Surgical Site Infection (SSI) (FY 2016 onward): o SSI Following Colon Surgery o SSI Following Abdominal Hysterectomy • Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (FY 2017 onward) • *Clostridium difficile* (FY 2017 onward)

#Not NQF-endorsed

In the proposed rule, CMS notes that several HAC program measures—CAUTI, CLABSI and PSI-90—are undergoing NQF endorsement "maintenance" reviews that will determine whether the measures will continue to be NQF-endorsed. CMS indicates that if the measures undergo substantive changes as a result of the NQF review, then the agency will use notice and comment rulemaking to update them.

Measurement Time Period. CMS finalized the measurement timeframe for measures in the FY 2015 HAC Reduction Program and in subsequent fiscal years as a two-year period. The two-year time period finalized for the FY 2015 measures, and proposed for the FY 2016 program, are outlined in Table 2 below.

Table 2: HAC Reduction Program FY 2015 and FY 2016 Measurement Periods

	FY 2015 Finalized Measurement Period	FY 2016 Proposed Measurement Period
Domain 1 (PSI-90 composite measure)	July 1, 2011 – June 30, 2013	July 1, 2013 – June 30, 2015
Domain 2 (HAI measures)	Jan. 1, 2012 – Dec. 31, 2013	Jan. 1, 2014 – Dec. 31, 2015

Scoring Methodology Updates. CMS will continue to use the quality measures selected for the program to calculate a "Total HAC Score," with higher scores indicating worse performance. CMS divides each HAC measure's results into percentiles of 10 points (i.e., deciles), and assigns hospitals one to 10 points in accordance with the decile where the hospitals' performance on that measure falls. The results of the measures in each domain are totaled, and each domain is assigned a weight towards the Total HAC score. CMS finalized the following formula for calculating the FY 2015 Total HAC Score in the FY 2014 inpatient PPS final rule:

Total HAC Score = 35% x (Domain 1 Score) + 65% x (Domain 2 Score)

Hospitals scoring in the top quartile of HAC scores will receive the 1 percent payment penalty. Further details of the methodology used to calculate Total HAC Scores for FY 2015 are provided in the AHA's FY 2014 inpatient PPS Final Rule Regulatory Advisory.

FY 2015 Scoring Updates. CMS proposes a minor modification to the FY 2015 scoring methodology after the issuance of the FY 2014 inpatient PPS final rule. The agency's preliminary analysis of HAC scores indicated that in some cases, the number of hospitals with the same measure results exceeded the number of hospitals in a given decile. For example, the lowest decile of performance for one of the CAUTI measures could be a rate of zero, but 13 percent of hospitals actually attain a rate of zero. **In such instances, the agency will assign the same number of points for all hospitals with the same measure results, and those points would be based on the lowest appropriate percentile.** Using the example above, all 13 percent of hospitals with the same CAUTI score would be assigned the same number of points for that measure. CMS suggests it chose this approach because other options, such as randomly assigning some hospitals with the same measure score a higher number of points, would be "arbitrary and capricious, which is prohibited by the Administrative Procedures Act."

It appears that CMS adopted a similar approach to using Total HAC Scores to assign hospital penalties. Under the ACA, CMS may assign HAC penalties to up to 25 percent of eligible hospitals; however, CMS estimates it will penalize only 23.2 percent of hospitals. An analysis of the impact data by Health Policy Alternatives (HPA) shows that the top quartile of Total HAC scores begins with 7.0 points, but many hospitals have a score exactly equal to 7.0. CMS penalized only those hospitals with a score of ***greater than* 7.0.** If the agency had chosen to penalize hospitals with a score ***greater than or equal to* 7.0**, then it would have penalized more hospitals than permitted by statute.

FY 2016 Scoring Updates. CMS proposes to change the weights assigned to each domain of measures for FY 2016. It would increase the weighting of Domain 2 (HAI measures) from 65 percent to 75 percent, and decrease the weighting of Domain 1 (PSI composite) from 35 percent to 25 percent. As a result, the proposed Total HAC Score formula for FY 2016 would be as follows:

Total HAC Score = 25% x (Domain 1 Score) + 75% x (Domain 2 Score)

CMS suggests that the change in domain weighting is appropriate because several stakeholders have indicated support for reducing the weight on PSI measures, and because the surgical site infection measure will be added to the HAI domain in FY 2016.

Future Use of Electronically Specified Measures. CMS seeks comment on whether it should use a standardized, EHR-based composite measure of all-cause harm in future years of the HAC Reduction Program. The agency's interest in such a measure stems from the early work of some hospitals that are using EHRs to proactively identify

potential and actual harm across their patient populations. CMS specifically solicits comments on whether an EHR-based measure of all-cause harm should be used in addition to, or in place of, the existing claims-based measures assessing HACs. The agency also solicits comment on the perceived value of such a measure, and the timeframe in which such measures could be formally proposed for the program.

Extraordinary Circumstances Exemption. The AHA previously urged CMS to consider implementing a process to exempt from HAC penalties hospitals that experience a natural disaster or other extraordinary circumstances. In the proposed rule, CMS indicates that it "might consider" such a process in future rulemaking, and solicits comments on whether and how it should implement an exemption process.

Maryland Hospitals. CMS proposes to continue exempting Maryland hospitals, now being paid under the Maryland All-Payor Model, from the HAC Reduction Program.

Hospital Readmissions Reduction Program (HRRP)

The HRRP assesses penalties on hospitals for having "excess" readmission rates when compared to expected rates. For FY 2015, CMS proposes to increase the maximum payment penalty to 3 percent of Medicare base operating payments, as required by the ACA. CMS also proposes modifications to how it excludes planned readmissions from the five 30-day readmissions measures used in the program—heart failure (HF), pneumonia (PN), acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), and total hip and total knee arthroplasties (THA/TKA). While no additional readmission measures are proposed for FY 2016, CMS proposes to add a readmission measure for patients receiving coronary artery bypass grafts (CABG) to the FY 2017 HRRP.

The AHA is disappointed that CMS has again failed to propose a process for excluding readmissions unrelated to the initial reason for admission in calculating the measures, as mandated by the ACA. We are also very concerned that the agency has again not proposed to adjust the program's measures for sociodemographic factors. As demonstrated in numerous peer-reviewed publications and further highlighted by a recent draft report from an NQF-convened expert panel, outcomes such as readmissions can be influenced by community factors outside of the control of providers, such as poverty, access to support resources, etc. **We remain deeply concerned that without sociodemographic adjustment, readmissions penalties will continue to disproportionately accrue to hospitals treating our nation's poorest and most vulnerable patients.**

FY 2015 Updates to Planned Readmission Exclusion. In the FY 2014 inpatient PPS final rule, CMS adopted a "Planned Readmissions Algorithm" intended to exclude planned readmissions from the calculation of readmission rates. CMS uses the Agency for Healthcare Research and Quality's Clinical Classification Software (CCS) to consolidate thousands of procedure and diagnosis codes into broad categories of procedures and diagnoses. CMS's algorithm then always excludes readmissions for obstetrical delivery, transplant surgery, maintenance chemotherapy and rehabilitation.

Readmissions for procedures and surgeries that are considered "potentially planned" also are excluded, as long as the readmission does not have an acute primary discharge diagnosis. Examples of potentially planned procedures include hysterectomies, hernia repairs and varicose vein removal. However, acute primary discharge diagnoses such as infections are always considered "unplanned" and, therefore, are included in the measure calculations.

With a stated purpose of improving the "accuracy" of the planned readmission algorithm, for FY 2015, CMS indicates that it undertook a "validation study" in which it classified readmissions as planned or unplanned based on chart review, and then compared those results to the claims-based planned readmission algorithm. While CMS does not include the detailed methodology of the validation study in the rule, it states that the study was conducted using 634 records from seven different hospitals. Based on that study's findings, CMS proposes to remove two categories of "potentially planned" procedures—therapeutic radiation (CCS 211) and cancer chemotherapy (CCS 224). CMS's validation study found that in general, patients do not require admissions for scheduled therapeutic radiation (CCS 211) treatments, and that readmissions classified as "planned" under the previous algorithm actually were unplanned.

Regarding its proposed removal of cancer chemotherapy (CCS 224) from the list of "potentially planned" procedures, CMS states most patients receiving chemotherapy have both a code for cancer chemotherapy (CCS 224) and a primary discharge diagnosis of maintenance chemotherapy (CCS 45). Under the algorithm, all readmissions for patients with a primary discharge diagnosis of maintenance chemotherapy (CCS 45) are considered "planned" and, therefore, are excluded from the measure calculation. However, CMS indicates that its validation study shows that most readmissions for patients receiving cancer chemotherapy (CCS 24) without a primary principle diagnosis of maintenance chemotherapy (CCS 45) are unplanned.

CMS proposes to add hypertension with complications (CCS 99) to its list of acute principal discharge diagnoses that are always considered "unplanned" and, therefore, would be included in the readmissions rate. CMS also proposes minor updates to the ICD-9 codes included in the CCS categories for pancreatic disorders and biliary tract disease to ensure they capture all unplanned readmissions.

As a result of all of the above modifications, the number of planned readmissions for each measure decreases and the number of unplanned readmissions increases. The overall readmission rate for AMI and COPD would be unchanged, but the readmissions rate for HF and PN would increase by 0.1 percent, and the rate for THA/TKA increases by 0.4 percent.

While the AHA agrees that CMS should periodically reassess and update the planned readmissions algorithm, we are concerned that removing the two cancer-related procedure categories from the algorithm is unwarranted. Indeed, patients with cancer diagnoses often require re-hospitalization as a part of sound medical care.

The AHA will work to obtain additional details on the methodology used in the validation study and will provide comments to CMS on this issue.

Addition of CABG Readmission Measure for FY 2017. Under the ACA, CMS may expand the HRRP to include additional disease conditions beginning in FY 2015. For FY 2017, CMS proposes to add a readmission measures for patients discharged after receiving a CABG surgery. The measure uses the same basic methodology as all other measures currently in the HRRP.

The ACA requires that CMS use only NQF-endorsed measures in the HRRP. While the CABG was recently submitted to the NQF for endorsement, the measure is not yet NQF-endorsed. The AHA will urge CMS not to finalize the measure for the program until it has obtained NQF endorsement. Indeed, when the Measure Applications Partnership (MAP) reviewed this measure for inclusion in the HRRP, it supported the measure on the condition that it receives NQF endorsement before being placed into the program.

Payment Adjustment Factor. Under the statute, the adjustment factor that will be used to penalize hospitals under the HRRP is one minus the ratio of the hospital's aggregate payments for excess readmissions for applicable conditions to the hospital's aggregate payments for all discharges for applicable conditions. An applicable condition is one that falls under one of the previously finalized five readmissions measures. Any penalties would be applied to *each* Medicare discharge during the fiscal year.

For FY 2015, CMS proposes to again determine the hospital's aggregate payments for all discharges for applicable conditions using Medicare Provider Analysis and Review (MedPAR) claims data. It proposes to use claims with discharge dates on or after July 1, 2010, and no later than June 30, 2013. CMS proposes to again link the MedPAR data with the Medicare Enrollment Database to make additional exclusions to the admissions used to calculate aggregate payments for excess readmissions. These exclusions include admissions for patients who did not have Medicare Parts A and B fee-for-service (FFS) enrollment in the 12 months prior to the index admission, patients without at least 30 days post-discharge enrollment in Medicare Parts A and B FFS, and multiple admissions within 30 days of a prior index admission.

CMS estimates that it will assess readmissions penalties on 2,623 hospitals in FY 2015 due to the inclusion of two new readmission measures in the program. This will result in overall penalties $422 million FY 2015, as compared to $280 million in FY 2013 and $227 million in FY 2014.

The AHA has created a readmissions penalty calculator for hospitals to assess the impact of the policy on their organizations. It is available at: www.aha.org/readmissionscalc. The calculator is designed so that you can enter your hospital's CMS Certification Number and the calculator will then estimate the dollar amount of your readmissions penalty, if applicable.

Maryland Hospitals. CMS proposes to continue exempting Maryland hospitals, now being paid under the Maryland All-Payor Model, from the HRRP.

Hospital Value-Based Purchasing (VBP) Program

As required by the ACA, CMS proposes to fund the FY 2015 VBP program by reducing base operating DRG payment amounts to participating hospitals by 1.5 percent. The VBP program is budget neutral; all funds withheld must be paid out to hospitals. CMS estimates that the available pool of funds for VBP payments is $1.4 billion for FY 2015.

The AHA has created a VBP calculator for hospitals to assess the impact of the policy on their organizations. It is available at: www.aha.org/vbpcalc. The calculator is designed so that you can enter your hospital's CMS Certification Number and the calculator will then estimate the dollar amount of your VBP payment.

CMS proposes a number of changes to the program beginning in FY 2017. CMS proposes to remove from the program six clinical process of care measures it believes are "topped out." CMS also proposes to add three new measures in FY 2017, and one new measure in FY 2019. These measure changes are summarized in Tables 1 and 2 of Appendix A at the end of this advisory. In last year's rule, CMS finalized realigned measure domains for FY 2017 based on the National Quality Strategy (NQS). In this year's rule, CMS proposes to change the weighting assigned to the realigned measure domains.

FY 2017 Proposed Removal of Topped Out Measures. Each year, CMS evaluates the measures in the VBP program to determine whether their performance has "topped out"—that is, whether performance on the measure is consistently high and, therefore, unlikely to further improve. CMS deems that measures have topped out when national measure data meet the following criteria:

- The difference in performance between the 75th and 90th percentile is statistically insignificant; and
- The truncated coefficient of variation (TCV) is less than 0.10. TCV is a statistic with a score ranging from 0 to 1 reflecting the variation of scores across a sample. The larger the TCV, the greater the variation in performance.

Based on these criteria, CMS proposes to remove the following six measures from the FY 2017 VBP program:

- PN-6—Initial antibiotic selection for community acquired pneumonia in immunocompetent patients)
- SCIP-Inf-2--Prophylactic antibiotic selection for surgical patients
- SCIP-Inf-3--Prophylactic antibiotics discontinued within 24 Hours after surgery end time
- SCIP-Inf-9--Urinary catheter removed on postoperative day 1 or postoperative day 2

- SCIP-Card-2--Surgery patients on beta-Blocker therapy prior to arrival who received a beta-blocker during the perioperative period)
- SCIP-VTE-2-Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery)

FY 2017 Measurement Proposals. When selecting measures for adoption in the VBP program, CMS is required by statute to use only those measures that are reported as part of the hospital inpatient quality reporting (IQR) program. Moreover, those IQR measures must be publicly reported for at least one year before they become part of the VBP program. CMS proposes to add three new measures to the VBP program in FY 2017 that were previously finalized for the FY 2015 IQR program. However, CMS only recently initiated public reporting of the measures, with the first publicly available data being displayed on *Hospital Compare* in December 2013. The three measures are detailed below.

- ***Methicillin-resistant Staphylococcus aureus* (MRSA) *Bacteremia*.** CMS proposes to add this HAI measure to the "Safety" measure domain it finalized in the FY 2014 inpatient PPS rule. While this measure is NQF-endorsed, the MAP did not fully support the measure for the VBP program. Instead, it voted to "support direction," and noted that that the measure should be publicly reported for a sufficient amount of time before being added to the VBP program. CMS previously finalized the MRSA measure for the FY 2015 IQR program, with data collection beginning on Jan.1, 2013. Hospitals submit measure data using the Centers for Disease Control's National Healthcare Safety Network (NHSN) application. CMS initiated public reporting of MRSA rates on *Hospital Compare* in December 2013.

- ***Clostridium difficile (C Difficile)*.** CMS proposes to also add this HAI measure to the "Safety" measure domain. As with the MRSA measure, this measure is NQF-endorsed, but the MAP only supported its direction, and urged that it be publicly reported for a sufficient amount of time. CMS previously finalized the *C Difficile* measure for the FY 2015 IQR. As with the MRSA measures, hospitals submit measure data using NHSN, and CMS initiated public reporting of *C Difficle* rates on *Hospital Compare* in December 2013.

- **PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation.** This chart-abstracted measure assesses the proportion of patients with elective vaginal deliveries or elective Cesarean sections between 39 and 37 weeks of delivery. It excludes patients aged 65 or older, which excludes the majority of the Medicare population. Nevertheless, CMS indicates that this measure is "specifically relevant to the nearly 2 million Medicare beneficiaries who are aged 44 and under, most of whom are dual-eligible beneficiaries." The agency also states that it paid for approximately 14,000 births in 2011. The measure is NQF-endorsed and was supported for inclusion in VBP by the MAP. CMS previously finalized

the measure for the FY 2015 IQR program, and initiated public reporting of the measure in December 2013.

While all three measures address important topics, the AHA is concerned that proposing these measures for the VBP is premature given that they have not been publicly reported for a full year. Experience with public reporting measures helps all stakeholders to understand and identify any potential negative unintended consequences of measurement and public reporting. We also remain very concerned that the MRSA and C Diff measures overlap with the HAC Reduction Program, leading to the potential for double payment penalties for hospitals.

FY 2019 Measure Proposal. CMS proposes one new measure for the FY 2019 VBP program – Hospital-Level Risk Standardized Complication Rate Following Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA). This measure was previously finalized for the FY 2015 IQR program and uses Medicare claims data to yield a hospital-level, risk-adjusted complication rate for elective primary total hip and total knee arthroplasty procedures. The measure includes a number of different complications that range among several different post-discharge periods, including:

- seven days post-discharge: heart attack, pneumonia or sepsis/septicemia;
- 30 days post-discharge: surgical site bleeding, pulmonary embolism or death; and
- 90 days post-discharge: mechanical complications, periprosthetic joint infection or wound infection.

This measure is NQF-endorsed and was recommended by the MAP. CMS initiated public reporting of the measure on *Hospital Compare* in December 2013. As with CMS's FY 2017 measure proposals, we are concerned that proposing this measure for the program is premature given that it has not yet been publicly reported for a full year.

Scoring Methodology Updates. The measures used in the VBP program are grouped into measure domains, and each domain is assigned a weight that counts towards a hospital's Total Performance Score (TPS). The TPS is used in determining VBP payments back to hospitals. CMS proposes a number of changes that affect how it calculates hospitals' TPS.

Proposed FY 2017 Measure Domain Weights. CMS finalized the measure domains and domain weighting for the VBP program for FY 2013 through FY 2016 in previous rulemaking. With each program year, CMS has gradually increased the weight placed on outcome and efficiency measures, while decreasing the weight on chart-abstracted clinical process measures. The VBP domains and domain weightings for FY 2013 – FY 2016 are outlined in Table 3 below.

Table 3: VBP Domain Weights for FYs 2013 through 2016

Measure Domain	FY 2013 Final	FY 2014 Final	FY 2015 Final	FY 2016 Final
Process	70%	45%	20%	10%
Patient Experience	30%	30%	30%	25%
Outcomes	0%	25%	30%	40%
Efficiency	0%	0%	20%	25%

The VBP's measure domains remained unchanged until last year's inpatient PPS final rule in which CMS adopted, for FY 2017 and beyond, new measure domains aligned with the priority areas of the NQS. As a result of this realignment, CMS also established new domain weights. **However, in the proposed rule, CMS proposes to increase the weight placed on the Safety domain from 20 to 25 percent, and decrease the weight of the Clinical Care—Process sub-domain from 10 to 5 percent.** The measure domains and domain weights adopted in last year's inpatient PPS final rule, as well as CMS's proposed revisions, are outlined in Table 4. CMS suggests that these changes are warranted because it proposes the removal of six "topped out" measures from the Clinical Care—Process sub-domain and proposes two additional measures for the Safety domain. Moreover, the agency states its desire to provide hospitals with a "strong incentive" to improve patient safety.

Table 4: Proposed Revision to FY 2017 VBP Measure Domain Weights

Measure Domain	Weight Adopted in FY 2014 IPPS Final Rule	Proposed Weight per FY 2015 IPPS Proposed Rule
Safety	15%	20%
Clinical Care: • Clinical Care – Outcomes • Clinical Care – Process	35% • 25% • 10%	30% • 25% • 5%
Efficiency and Cost Reduction	25%	25%
Patient and Caregiver Centered Experience of Care / Care Coordination	25%	25%

Scoring for Hospitals with Data on Less than Four Measure Domains. In previous rules, CMS finalized a policy that hospitals must have sufficient data to be scored on at least two measure domains in order for the agency to calculate a TPS and, consequently, for hospitals to be eligible for the VBP program. For hospitals with fewer than four domains, the domains are re-weighted to ensure that the TPS is still a score out of 100 possible points, and so that the relative weights across domains are roughly equivalent to the weights if a hospital had sufficient data in all four measure domains.

However, beginning in FY 2017, CMS proposes to require that hospitals have sufficient data to be scored on at least **three out of four measure domains** in order to receive a

TPS. CMS proposes to continue re-weighting measure domains for hospitals with less than four domains to ensure the TPS is still a score out of 100 possible points, and so that the relative weights across domains remain proportionate to hospitals scored on all domains.

CMS states it is concerned that only requiring two out of four domains is "insufficient to ensure robust quality measurement" in the VBP program. Moreover, since CMS also adopted new domains and domain weights for FY 2017, the agency indicates it is appropriate to reconsider its existing policy. CMS states that its proposed policy change was informed by an "independent analysis" conducted by a CMS contractor, and that the agency will post a summary of the reliability and minimum number analysis during the comment period. As of the publication of this Regulatory Advisory, CMS has not posted the analysis.

Minimum Number of Measures Needed to Receive Domain Scores. For FY 2017, CMS also proposes to update the minimum number of measures needed to receive a score for each measure domain. CMS indicates that each of these proposals is informed by the independent analysis conducted by its contractor. CMS's proposed minimum number of measures and minimum case volume per measure are summarized in Table 5. The measures used in each domain are summarized in Table 2 of Appendix A at the end of this advisory.

Table 5: FY 2017 Proposed Minimum Measures and Case Volume

Measure Domain	Minimum Number of Measures to Receive a Domain Score	Minimum Volume per Measure
Safety	3 measures	• HAI measures: 1 predicted infection • PSI-90: Three cases for any one PSI indicator in the PSI-90 composite
Clinical Care – Outcomes	2 measures	25 cases
Clinical Care – Process	1 measure	10 cases
Efficiency and Cost Reduction	Must have sufficient data to be scored on Medicare Spending per Beneficiary (MSBP)	25 cases
Patient and Caregiver Centered Experience of Care / Care Coordination	Must have sufficient data to be scored on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	100 cases

VBP Baseline and Performance Periods. CMS finalized the baseline and performance periods for the FYs 2015 and 2016 VBP programs in previous rulemaking. The agency also finalized the baseline and performance periods for some of the individual measures in the VBP program through FY 2019. In this rule, CMS proposes the baseline and performance periods for the HAI measures in the Safety domain, all of the Clinical Care—Process measures, the MSPB measure and HCAHPS measures. The previously finalized and proposed baseline and performance periods for the FY 2017 VBP program are outlined in Table 6.

Table 6: Finalized Baseline and Performance Periods for FY 2016

Domain	Measure	Baseline Period	Performance Period
Safety (n=6)	PSI-90*	Oct. 1, 2010 – June 30, 2012	Oct. 1, 2013 – June 30, 2015
	CLABSI	Jan. 1, 2013 – Dec. 31, 2013	Jan. 1, 2015 – Dec. 31, 2015
	CAUTI		
	SSI		
	MRSA		
	C Difficile		
Clinical Care - Process (n=3)	Chart Abstracted Measures	Jan. 1, 2013 – Dec. 31, 2013	Jan. 1, 2015 – Dec. 31, 2015
Clinical Care - Outcome (n=3)	Mortality measures (AMI, PN, HF)*	Oct. 1, 2010 – Jun. 30, 2012	Oct. 1, 2013 – Jun. 30, 2015
Efficiency and Cost Reduction (n=1)	MSBP	Jan. 1, 2013 – Dec. 31, 2013	Jan. 1, 2015 – Dec. 31, 2015
Patient and Caregiver Experience of Care / Care Coordination (n=1)	HCAHPS Measures	Jan. 1, 2013 – Dec. 31, 2013	Jan. 1, 2015 – Dec. 31, 2015

**Baseline and performance periods finalized in previous rulemaking*

In previous rulemaking, CMS also finalized the baseline and performance periods for the three mortality measures through FY 2019, and the PSI measure through FY 2018. In this rule, CMS proposes the baseline and performance periods for the PSI-90 composite measure and the proposed THA/TKA complication measure for FY 2019, and for the mortality and THA/TKA complication measure in FY 2020 (Table 8).

For FY 2019, CMS proposes to use a 36-month baseline period for the THA/TKA complication measure, but only a 30-month performance period. CMS indicates it shortened the performance period so that THA/TKA measure collection could conclude in enough time for the measure to be included in the FY 2019 VBP program. Moreover, the agency states that its analysis of historical measure data suggests that it can make reliable comparisons between 30 months and 36 months of data. For FY 2020, CMS

will use 36 months of THA/TKA measure data for both the baseline and performance periods.

Table 7: Finalized and Proposed Baseline and Performance Periods for VBP Mortality, PSI and THK/TKA Complication Measures, FY 2018 - FY 2020

Measure	Baseline Period	Performance Period
FY 2018 Final		
Mortality	Oct. 1, 2009 – June 30, 2012	Oct. 1, 2013 – June 30, 2016
PSI-90	July 1, 2010 – June 30, 2012	July 1, 2014 – June 30, 2016
FY 2019 Final		
Mortality	July 1, 2009 – June 30, 2012	July 1, 2014 – June 30, 2017
FY 2019 Proposed		
PSI-90	July 1, 2011 – June 30, 2013	July 1, 2015 – June 30, 2017
THA/TKA Complications	July 1, 2010 – June 30, 2013	Jan. 1, 2015 – June 30, 2017
FY 2020 Proposed		
Mortality	July 1, 2010 – June 30, 2013	July 1, 2015 – June 30, 2018
THK/TKA Complications	July 1, 2010 – June 20, 2013	July 1, 2015 – June 30, 2018
PSI-90	Not Proposed	Not Proposed

Performance Standards. CMS proposes the performance standards for many of the FY 2017 VBP measures. The agency also proposes the performance standards for the proposed THA/TKA complication measure in FY 2019 and FY 2020, the PSI-90 performance standard for FY 2019, and the mortality measure performance standards for FY 2020. The previously finalized and proposed achievement thresholds and benchmarks for the measures are detailed in Tables 3, 4 and 5 of Appendix A in this advisory. Hospitals will need to score at or above the achievement threshold to receive any achievement points. Hospitals will need to score at or above the benchmark to receive the maximum number of achievement points (10). In contrast, improvement points are calculated by comparing a hospital's performance in the baseline period to its performance in the performance period.

CMS also proposes to modify the process by which it updates VBP performance standards. To date, the agency has incorporated the VBP program's numerical performance standards in rulemaking. However, CMS states that measures often undergo "non-substantive technical updates" between the time standards are issued in rules and when CMS actually calculates achievement and improvement scores. Indeed, the measures used in the VBP program are NQF-endorsed, and NQF's process requires that measures be reviewed on an annual basis to determine whether non-substantive updates are required. Such updates do not fundamentally change a measure's methodology, but may impact hospital performance scores and, therefore, CMS's ability to make comparisons between the baseline and performance periods.

Therefore, CMS proposes a process to update the numerical performance standards issued in rulemaking in order to incorporate non-substantive technical updates. CMS indicates that it would inform hospitals of any updates using the VBP program's website, QualityNet, and other venues. CMS specifically states that this process "may have the effect of superseding the performance standards that [it] establish[es] prior to the start of the performance period for the affected measures." The agency states it makes the determination of what constitutes a "non-substantive" update on a case-by-case basis, and would continue to use the formal rulemaking process to propose substantive measure changes.

Future Measurement Topics. CMS solicits comment on specific measures and general measurement topics it is considering for future years of the VBP program.

Care Transition Measure (CTM-3) Items. The NQF-endorsed CTM-3 was incorporated in the HCAHPS survey for the FY 2015 IQR program, and is designed to solicit patient information on hospital care transition planning. CMS will publicly report the first year of CTM-3 data (Jan-Dec 2013) on *Hospital Compare* in October 2014. CMS indicates that it may propose the CTM-3 for the FY 2018 VBP program in future rulemaking, and solicits comment on how the CTM-3 should be incorporated into the scoring methodology of the Patient and Caregiver Experience of Care/Care Coordination measure domain. CMS indicates that if it proposes the CTM-3 in the future, it would have a baseline period of calendar year (CY) 2014, and a performance period of CY 2016.

Future Efficiency and Cost Reduction Measure Topics. CMS solicits comment on whether it should add condition-specific, episode-of-care payment measures to the VBP program in future years. CMS is considering three episode of care measures reflecting medical care (i.e., kidney/urinary tract infection, cellulitis, and gastrointestinal hemorrhage) and three measures reflecting surgical care (i.e., hip replacement/revision, knee replacement/revision and lumbar spine fusion/refusion). The measures are constructed in a similar manner to MSPB. That is, the measures include payments for Medicare part A and B payments services provided by all providers during a period of three days prior to 30 days after an initial hospital discharge. The measures also would be risk-adjusted using a methodology similar but not identical to MSPB. However, the measures would include only those payments related to the health conditions treated during the initial hospital stay that triggered the care episode. CMS posted the episode of care payment measure specifications to the hospital VBP program website.

CMS indicates that the six condition-specific measures would need to be finalized for the hospital IQR program and publicly reported on *Hospital Compare* for one year before they would be included in the VBP program. CMS indicates that the use of condition-specific payment measures could improve alignment with the physician value-based payment modifier (VM) program, and encourage greater coordination of efforts to manage cost between physicians and hospitals. However, these measures are not currently in the physician VM program, and the agency does not explicitly state whether it also intends to propose them for the physician VM.

ICD-9 to ICD-10 Transition. CMS had designated Oct. 1, 2014 as the date to transition to ICD-10. However, the Protecting Access to Medicare Act of 2014 (PAMA) prohibited CMS from implementing ICD-10 before Oct. 1, 2015. CMS subsequently announced that it intends to enforce the transition on Oct. 1, 2015. **The AHA will work with CMS to ensure successful implementation of ICD-10.**

In the proposed rule, CMS solicits comment on how the agency should adjust VBP performance scoring to accommodate quality data coded in ICD-10. CMS also indicates it intends to analyze the impact of ICD-10 on the VBP program in two ways. The agency will "assess measure specifications to qualitatively assess impact to measure denominators after CMS releases ICD-10-CM/PCS-based measures in the future." CMS also indicates it will "voluntarily solicit information from no more than nine hospitals before Oct. 1, 2015 to estimate the impact of ICD-10-CM/PCS on their Hospital VBP measure rates and counts" in order to inform future VBP policy decisions.

Maryland Hospitals. CMS proposes to continue exempting Maryland hospitals, now being paid under the Maryland All-Payor Model, from the VBP program.

IQR Program

CMS proposes substantial changes to the IQR program beginning in FY 2017. The agency proposes new criteria for determining which IQR measures have "topped out" and are, therefore, suitable for removal from the program. It then uses these criteria to propose the removal of 15 chart-abstracted measures for FY 2017. CMS also proposes to add 11 measures to the IQR program.

However, CMS's proposed measure additions and removals have taken on greater complexity because the agency also proposes to retain and expand the option for hospitals to report electronic versions of IQR measures, thereby receiving credit in both the IQR and Medicare EHR incentive programs. While CMS proposes to remove 15 chart-abstracted measures for the FY 2017 IQR program because their performance is "topped out," it also proposes to retain the electronic versions of 10 of them to support the voluntary electronic reporting option. Moreover, six of the 11 proposed measures *only* would be part of the voluntary electronic reporting option. Of those six electronic measures, two are actually electronic versions of measures that were previously retired from the program because they were "topped out." Lastly, the agency indicates its intention to propose mandatory reporting of certain electronic clinical quality measures for FY 2018 IQR payment determination.

While the AHA supports the long-term goal of transitioning to EHR-enabled measurement, we are very concerned by the aggressive pace that CMS proposes for adopting electronic measures in the IQR. Serious questions remain about the feasibility and accuracy of electronically specified measures.

The IQR program changes are detailed in the sections below. A summary of the finalized and proposed changes to the measures in the program through FY 2017 can be found in Appendix B of this advisory.

Proposed Criteria for Identifying "Topped Out" Measures. CMS states that, in previous years, it has used several general criteria to determine whether measures should be removed from the IQR program, including a consideration of whether "measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made." In the proposed rule, CMS proposes to adopt additional quantitative criteria for identifying topped out measures that are very similar to those used in the hospital VBP program. Specifically, the agency proposes to remove measures from the IQR if national measure data meet two specific criteria:

- The difference in performance between the 75th and 90th percentile is statistically insignificant; and
- The coefficient of variation (CV) is less or equal to 0.10.

FY 2017 Proposed Measure Removal. Using its criteria for "topped out" measures, CMS proposes to remove 15 chart-abstracted measures from the IQR program. However, it proposes to retain the electronic versions of 10 of those measures for use in the voluntary electronic reporting option. CMS also proposes to remove a structural measure—Participation in a Systematic Database for Cardiac Surgery—from the program on the recommendation of the MAP. Finally, CMS proposes to permanently remove four additional measures from the program that it had previously suspended from IQR for being topped out. These changes are summarized below.

Topped-Out Measures Proposed for Permanent Removal:

- Participation in a systematic database for cardiac surgery
- HF-2-- Evaluation of left ventricular systolic function
- SCIP-Inf-3--Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)
- SCIP-Inf-4--Cardiac surgery patients with controlled postoperative blood glucose
- SCIP-Card-2--Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period
- SCIP-VTE-2--Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Topped-Out Measures Proposed for Removal as Chart-Abstracted Measures and Retention for the Voluntary Electronic Reporting Option:

- AMI-8a: Primary PCI received within 90 minutes of hospital arrival
- PN-6: Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients
- SCIP-Inf-1: Prophylactic antibiotic received within one hour prior to surgical incision
- SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients

- SCIP-Inf-9: Urinary catheter removed on postoperative day 1 (POD1) or postoperative day 2 (POD2) with day of surgery being day zero
- STK-2: Discharged on antithrombotic therapy
- STK-3: Anticoagulation therapy for atrial fibrillation/flutter
- STK-5: Antithrombotic therapy by the end of hospital day two
- STK-10: Assessed for rehabilitation
- VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol

Topped-Out, Previously Suspended Measures Proposed for Permanent Removal:

- AMI-1: Aspirin at arrival
- AMI-3: ACEI or ARB for left ventricular systolic dysfunction- AMI Patients
- AMI-5: Beta-blocker prescribed at discharge for AMI
- SCIP-Inf-6: Surgery patients with appropriate hair removal

FY 2017 Proposed Measure Additions. For FY 2017, CMS proposes to add a total of 11 measures to the IQR. **However, six of the 11 measures only would be available to hospitals participating in the IQR's voluntary electronic reporting option.** Each measure is briefly described below.

Proposed Measures Using Regular IQR Reporting Mechanisms. CMS proposes five measures that would be collected and reported for hospitals not participating in the voluntary electronic reporting option. CMS indicates its desire to gradually transition the IQR away from chart-abstracted process of care measures, and to use a greater number of measures assessing outcomes, efficiency and cost. **However, the AHA is concerned that four of the five measures are not yet NQF-endorsed. Moreover, the MAP only conditionally supported these measures, and urged that they receive NQF endorsement before being placed into the IQR.**

- **CABG Readmissions (not NQF-endorsed).** CMS proposes to add a measure assessing the rate of hospital readmissions within 30 days for patients discharged following CABG surgery. It uses the same measure calculation methodology as the other readmission measures previously finalized for the IQR. CMS would calculate the measure using Medicare claims data. It is the same measure that CMS also proposes for the HRRP.

- **CABG Mortality (not NQF-endorsed).** CMS proposes to add a measure assessing risk-adjusted hospital mortality rates within 30 days for patients discharged following CABG surgery. The measure uses the same basic methodology as the other mortality measures previously finalized for the IQR, and is calculated using Medicare claims data. The measure is not yet NQF-endorsed, and the MAP only supported the measure on the condition that it receive NQF endorsement before being added to the program.

- **Pneumonia Payment Per Episode of Care.** This proposed measure calculates total payments for Medicare FFS patients with a primary discharge diagnosis of pneumonia from the date of the initial hospital admission through 30 days post-admission. Payments for the initial hospitalization are included in the measure, as are payments for a broad range of subsequent care, including inpatient, outpatient, physician, laboratory and post-acute care services. The measure also includes a risk adjustment methodology to account for patient characteristics, such as age, prior procedures and co-morbid conditions, which influence resource use and, therefore, payment. CMS indicates that the measure, when paired with the pneumonia mortality and readmission measures already in the IQR, can provide insight into the "value" of the care that hospitals deliver.

  The AHA opposed the adoption of a similarly constructed AMI payment-per-episode measure for the FY 2016 IQR, and we have similar concerns about the proposed pneumonia measure. Like the AMI measure, the pneumonia payment is not yet NQF-endorsed. Moreover, the measure is being proposed for hospital-level quality measurement despite the fact that it reflects the actions of a multitude of health care entities, many of which are beyond hospitals' control.

- **Heart Failure Payment Per Episode of Care.** This measure is constructed in a very similar manner to the proposed pneumonia payment per episode of care measure, and the finalized AMI payment measure. The AHA is similarly concerned that this measure is not yet NQF-endorsed, and may not be appropriate as a hospital-level measure.

- **Severe Sepsis and Septic Shock Management Bundle (NQF #500).** CMS proposes to add a chart-abstracted measure assessing whether hospitals implement certain care processes that may lead to decreased mortality for patients with severe sepsis and septic shock. For patients with severe sepsis or septic shock, timely intervention is critically important to reducing the risk of death from sepsis. CMS states that timely implementation of all of the interventions included in the measure—i.e., measuring patient lactate levels, administration of antibiotics, adequate fluids, monitoring and management of blood pressure and oxygen levels—are associated with lower mortality rates for severe sepsis and septic shock.

  Thus, the measure focuses on patients 18 years and older who present with symptoms of severe sepsis or septic shock, and assesses the proportion of those patients who receive specific interventions within three and six hours. The measure specifically excludes patients with advance directives, clinical conditions precluding the completion of the measure steps, contraindications for central lines, and patients transferred into the hospital. The measure also excludes patients who refuse the therapy or for whom a central line could not be successfully inserted.

The care steps required within three hours apply to all patients, while the steps required within six hours apply only to patients with septic shock. For the purposes of the measure, septic shock is defined as either hypotension or lactate levels of greater than or equal to 4 mmol/L.

- Care steps within three hours (required for all patients):
    1. Measure lactate level
    2. Obtain blood cultures prior to administration of antibiotics
    3. Administer broad spectrum antibiotics

- Care steps within six hours (required only for patients with septic shock):
    4. Administer 30 ml/kg crystalloid (i.e., fluids) for hypotension of lactate levels of greater than or equal to 4 mmol/L
    5. Apply vassopressors (for hypotension that does not respond to initial fluid resuscitation to maintain arterial pressure of greater than or equal to 65)
    6. If the patient does not respond to steps 4 and 5, measure central venous pressure and central venous oxygen saturation
    7. Re-measure lactate if the initial lactate level in step 1 is elevated

Proposed new measures for voluntary electronic reporting option. CMS proposes a total of six electronic clinical quality measures (eCQMs) that can only be reported if hospitals participate in the IQR's voluntary electronic reporting option. While four of the proposed measures are entirely new to the IQR, the chart-abstracted (i.e., non-eCQM) versions of two proposed measures were previously retired from the IQR because they were "topped out." We briefly summarize all six measures below. Details on CMS's other proposed changes to the voluntary electronic reporting option are detailed in the next section of this advisory.

- **Hearing Screening Prior to Hospital Discharge (NQF #1354).** The proposed measure assesses the proportion of all live births at a hospital that have been screened for hearing loss prior to hospital discharge. The measure is NQF-endorsed and was supported for inclusion in the IQR by the MAP.

- **PC-05 Exclusive Breast Milk Feeding (NQF #0480).** This measure is intended to assess the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization. The measure actually reports two different rates. The first rate reflects the proportion of *all* newborns fed only breast milk during their entire hospitalization. The second rate is intended to account for whether a mother chooses to breastfeed, and excludes newborns whose mothers choose *not* to breastfeed. The measure is NQF-endorsed, and was supported by the MAP for inclusion in the IQR.

- **Home Management Plan of Care (HMPC) Document Given to Patient / Caregiver.** The proposed measure assesses the proportion of pediatric asthma patients (aged 2-17) who are discharged from the hospital with a HMPC

document. The HMPC document must address arrangements for follow-up care, control of environmental and other asthma triggers, methods for asthma rescue actions, and the use of asthma controllers and relievers. The AHA is concerned that this measure was recently de-endorsed by the NQF. Moreover, the measure was not supported by the MAP. Nevertheless, CMS states that the inclusion of the measure in IQR would help encourage the appropriate treatment of a highly prevalent disease among children.

- **Healthy Term Newborn (NQF #0716).** The proposed measure is intended to capture the percentage of term (i.e., 37 or more weeks of gestation) live births that do not have significant complications during birth or in subsequent nursery care. The measure excludes births with congenital abnormalities, multiple gestations (e.g., twins) and fetuses affected by selected maternal conditions. **The AHA is concerned that the measure is not yet appropriate for public reporting purposes.** Indeed, while the measure is NQF-endorsed, the MAP recommended that the measure be removed from the Medicare EHR incentive programs due to significant technical issues.

- **AMI-2: Aspirin Prescribed at Discharge (NQF #0142).** This proposed measure assesses the proportion of AMI patients prescribed aspirin at hospital discharge. The chart-abstracted version of this proposed measure was removed from the IQR program in previous rulemaking for being "topped out." Moreover, while the measure is NQF-endorsed, it has been placed in "reserve status." In general, NQF uses "reserve" status for measures whose level of national performance is high. The MAP also recommended that CMS remove the measure from the IQR given its high level of performance. Nevertheless, CMS proposes to include the eCQM version of the measure in the voluntary reporting option to provide hospitals with "an opportunity to test the accuracy of their electronic health record reporting systems.

  Given the consistently high level of performance on the measure, and serious questions about the accuracy of eCQM data, the AHA believes that the use of this measure would neither lead to improved hospital quality nor facilitate CMS's understanding of how to improve eCQMs.

- **AMI-10: Statin Prescribed at Discharge (NQF #0639).** This proposed measure assesses the proportion of AMI patients prescribed a statin at hospital discharge. Similar to AMI-2, the measure is considered "topped out," and was removed from the IQR in previous rulemaking. The MAP also recommended its removal from the IQR.

Voluntary Electronic Reporting Option for IQR Measures. With a stated goal of improving the timeliness and efficiency of the Hospital IQR Program and continue the field experience with electronic reporting into the program, CMS will maintain the option to report a subset of measures electronically in CY 2015 for the FY 2017 payment determination. CMS proposes to increase the flexibility of measures available for

voluntary eCQM reporting by permitting reporting of any 16 of the 28 eCQMs available in the IQR. The 28 eCQMs proposed for CY 2015 data reporting represent the inpatient eCQMs currently available to satisfy the clinical quality reporting requirement in the Medicare EHR Incentive Program for Eligible Hospitals and CAHs. Hospitals would be required to report eCQMs from at least three different NQS domains. The list of available eCQMs and the NQS domain to which they are assigned is provided in Table 8.

CMS proposes to achieve this increased measure optionality and alignment with the Medicare EHR Incentive Program by re-adopting two measures in their eCQM specification previously removed from Hospital IQR Program as chart-abstracted measures, and adding four additional measures to the IQR that are currently part of the Medicare EHR Incentive Program. The details of these measures are described in the previous section of this advisory. CMS states that allowing hospitals the option to electronically report re-adopted measures will provide an opportunity to test the accuracy of their electronic health record reporting systems. CMS claims that continuing efforts to align Hospital IQR Program and the EHR Incentive Program will minimize reporting burden and continue the transition to reporting of eCQMs.

Table 8: Comparison of eCQMs available for the voluntary electronic data reporting option in CY 2015 and eCQMs available for voluntary electronic data reporting option in CY 2014, by National Quality Strategy Domain

NQF Number	eCQMs Included in CY 2015 IQR Voluntary Electronic Reporting Option and Aligned with EHR Incentive Program	Included in CY 2014 IQR Voluntary Electronic Reporting Option
Patient and Family Engagement		
0495	ED-1: Emergency Department – Median time from ED arrival to ED departure for admitted ED patients	X
0497	ED-2: Emergency Department Throughput – Admit decision time to ED departure time for admitted patients	X
N/A	STK-8: Stroke – education	X
N/A	VTE-5: Venous Thromboembolism – Discharge Instructions	X
N/A	CAC-3: Home Management Plan of Care (HMPC) document given to patient/caregiver	
Clinical Process/Effectiveness		
0435	STK-2: Stroke – Discharged on anti-thrombotic therapy	X
0436	STK-3: Stroke – Anticoagulation therapy for Atrial Fibrillation/Flutter	X
0437	STK-4: Stroke – Thrombolytic Therapy	X

NQF Number	eCQMs Included in CY 2015 IQR Voluntary Electronic Reporting Option and Aligned with EHR Incentive Program	Included in CY 2014 IQR Voluntary Electronic Reporting Option
0438	STK -5: Stroke – Antithrombotic therapy by end of hospital day two	X
0439	STK -6: Stroke – Discharged on Statin Medication	X
0373	VTE -3: VTE Patients with Anticoagulation Overlap Therapy	X
N/A	VTE- 4: VTE Patients receiving unfractionated heparin (UFH) with dosages/platelet count by Protocol (or Nomogram)	X
0142	AMI-2: Acute myocardial infarction (AMI) – Aspirin prescribed at discharge for AMI	
0469	PC -01: Elective delivery prior to 39 completed weeks gestation	X
0164	AMI-7a: AMI – Fibrinolytic Therapy received within 30 minutes of hospital arrival	
0163	AMI-8a: Primary PCI received within 90 minutes of hospital arrival	
0639	AMI -10: Statin prescribed at discharge	
0480	PC-05: Exclusive Breast Milk Feeding	
1354	EHDI -1a: Hearing screening prior to hospital discharge	
Care Coordination		
0441	STK-10:STK Stroke – Ischemic or hemorrhagic stroke – assessed for rehabilitation	X
Patient Safety		
0371	VTE -1: VTE prophylaxis	X
0372	VTE -2: VTE Intensive Care Unit (ICU) VTE prophylaxis	X
0376	VTE-6: VTE Incidence of potentially preventable VTE	X
0527	SCIP-INF -1: Prophylactic antibiotic received within 1 hour prior to surgical incision	
0453	SCIP-INF-9: Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2)	
0716	Healthy Term Newborn	
Efficient Use of Healthcare Resources		

NQF Number	eCQMs Included in CY 2015 IQR Voluntary Electronic Reporting Option and Aligned with EHR Incentive Program	Included in CY 2014 IQR Voluntary Electronic Reporting Option
0147	PN -6: PN Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients	
0528	SCIP-INF -2: Prophylactic antibiotic selection for surgical patients	

For the FY 2017 payment determination, CMS proposes to expand the voluntary eCQM reporting of IQR measures to include a full year's data collection, an increase from the current voluntary electronic reporting requirement of one quarter of data collection. In addition, CMS proposes to require a data submission period within approximately 60 days after the end of each calendar year quarter, rather than within 60 days of the end of the fiscal year, as currently required. The details of the proposed changes are outlined in Table 9.

Table 9: Hospital IQR Proposed eCQM Data Reporting Periods and Data Submission Deadlines for CY 2015 for FY 2017 Payment Determination

CY 2015 Quarter	CY 2015 Data Reporting Period	CY 2015 Proposed Data Submission Deadline
1	Jan. 1 - March 31	May 30, 2015
2	April 1 - June 30	Aug. 30, 2015
3	July 1 - September 30	Nov. 30, 2015
4	Oct. 1 - December 31	Feb. 28, 2016

CMS states in the proposed rule that hospitals successfully submitting eCQMs in the voluntary electronic reporting option will not have to validate those eCQMs by additionally submitting chart-abstracted data to validate the accuracy of the measure data submitted electronically.

The voluntary electronic reporting option will allow hospitals to meet both the CY 2015 IQR reporting requirement for the selected measures, as well as the EHR Incentive Program eCQM reporting requirements in FY 2017. To support this alignment, CMS proposes to incrementally align the data reporting and submission periods for clinical quality measures on a calendar year basis for the Medicare EHR Incentive Program with those of the Hospital IQR Program beginning with the CY 2015 reporting period /FY 2017 payment determination.

Public Reporting under the Voluntary Electronic Reporting Option. In the FY 2014 inpatient PPS proposed rule, CMS considered proposing a non-public reporting policy for data collected from hospitals participating in the voluntary eCQM reporting option in CY 2014. The agency expressed concern that abnormalities in the data and/or the

submission process could occur during the first year of electronic reporting to CMS. However, in the FY 2014 IPPS final rule, CMS indicated it would make the electronically reported data public on *Hospital Compare* if deemed accurate enough to be publicly reported.

In the FY 2015 inpatient PPS proposed rule, CMS reiterates that the agency will publicly report eCQM data submitted for the voluntary electronic reporting option in CY 2014 for the FY 2016 payment determination if the data are deemed accurate enough. In addition, for the CY 2015 and FY 2017 payment determination, CMS proposes that hospitals participating in the voluntary electronic reporting would have a data preview period prior to any public reporting. CMS indicates it would add a footnote next to that publicly reported data indicating that it is a result of electronically-specified measures. **CMS does not indicate in the proposed rule whether it also would provide a preview period for CY 2014 data reported under the voluntary reporting option.**

Validation of eCQMs. CMS does not propose any requirements for validation of eCQMs submitted to the IQR program for the CY 2015 data collection and FY 2017 payment determination. However, CMS intends to conduct a pilot test of validation activities in FY 2015. The pilot test will engage up to 100 volunteer hospitals in an interactive test abstraction of their EHR systems using a secure remote access, real-time abstraction technology that meets the HIPAA Privacy and Security Rules' requirements. Hospitals that volunteer to participate must meet the EHR Incentive Program Stage 2 criteria and be able to produce Quality Data Reporting Architecture (QRDA) Category 1 Revision 2 extracted data (individual patient data) for at least 6 of the 16 measures in the STK, VTE, ED and PC topic areas. Interested hospitals will be invited to attend a pre-briefing session where they will be provided with detailed instructions about the process and a demonstration explaining how to install needed software and have any concerns about security or systems requirements addressed. The software to be installed, Bomgar, is approved by CMS and meets the agency's security requirements allowing Clinical Data Abstraction Centers (CDACs) to remotely view isolated records in real-time under hospital supervision, comparing all abstracted data with QRDA Category 1 file data and summarizing the results after the real-time session.

Mandatory Electronic Reporting to Meet Hospital IQR Requirements. CMS states that it intends to propose to require reporting of eCQMs for the Hospital IQR Program beginning in the CY 2016 reporting period that supports the FY 2018 payment determination. In the FY 2015 IPPS proposed rule, the agency states that hospitals, after two years with the voluntary reporting option, will be more prepared and thus should be required to report Hospital IQR Program measures as eCQMs beginning in CY 2016. Although CMS states that it intends to propose this policy in future rulemaking, it nonetheless requests comment on this intention now.

Refinements to Existing IQR Measures.

Planned Readmission Algorithm Updates. CMS proposes the same updates to its planned readmission algorithm for the readmissions measures in the IQR that it

proposes for the HRRP. Additional details on this proposed update can be found in the HRRP section of this advisory.

Data Reporting Period for Condition-Specific Claims-Based Measures. Beginning with the FY 2017 IQR program, CMS proposes to use three years of Medicare claims data to calculate all of its condition-specific, claims-based measures "unless otherwise specified." This data reporting period would apply to all current and future condition-specific measures calculated using Medicare claims. Appendix B of this advisory includes the condition-specific mortality, readmission and complication measures that are affected by this proposal. This proposal does not apply to the hospital-wide all-cause readmission measure, or the episode-of-care payment measures finalized and proposed for the IQR.

Healthcare Personnel (HCP) Influenza Vaccination Measure. CMS does not make any new proposals for this measure, but does clarify how the measure should be reported. In the CY 2014 outpatient PPS rule, CMS finalized the addition to the outpatient quality reporting (OQR program) of the HCP flu vaccination measure currently used in the IQR. In response to the concerns raised by the AHA and others about the burden of separately collecting and reporting HCP flu vaccination status for inpatient and outpatient settings, CMS clarified through Operational Guidance that facilities should collect and report a single vaccination count by CMS Certification Number (CCN). That single count would include both inpatient and outpatient settings.

Validation. Hospitals must meet all IQR data submission deadlines, as well as validation requirements, in order to receive a full annual payment update. CMS proposes a number of detailed changes to the validation process for chart-abstracted IQR measures. The most notable of these changes are summarized below.

Number of Charts Required for Validation. CMS's current policy requires that hospitals selected for validation submit a total of 15 charts per quarter for clinical process of care measures, and nine charts per quarter for HAI measures, a total of 96 charts for a full calendar year of data. However, CMS has proposed to significantly reduce the number of clinical process of care measures beginning with the FY 2017 IQR program. Moreover, CMS indicates that a slightly lower number of charts would still yield an adequate sample size for validation.

Thus, beginning in FY 2017, CMS proposes that hospitals will need to submit 10 charts per quarter for HAI measures, and eight charts per quarter on clinical process of care measures. This lowers the number of charts required for a full year of data to 72 charts.

Selection of the Measures and Sampling of Charts in Validation. For FY 2017, CMS proposes to continue validating all of the HAI measures in IQR, but would modify how it validates the process of care measures. Because the agency proposes the removal of chart-abstracted versions of the AMI, HF, PN and SCIP measures, CMS proposes to only validate the chart-abstracted versions of the stroke, VTE, ED, immunization (IMM) and proposed sepsis measures. Additionally, across all hospitals selected for

validation, CMS proposes to select the process of care validation charts using a "systematic random sample" across all the topic areas except IMM. This means that each hospital could be validated on different topics. CMS indicates that this approach will ensure that "charts are sample proportionate to the number of charts submitted on each topic."

CMS proposes to use a separate process for the IMM measure. Instead of being made part of the systematic random sample, CMS would validate the IMM measure for three of the eight charts per quarter validated for clinical process of care.

Validation Score Weighting. As a result of changes outlined above, CMS also proposes to increase the weight place of HAI measures and decrease the weight of process measures in determining a hospital's overall validation score. The HAI score would count toward 66.7 percent of a hospital's validation score, while process measures would count towards 33.3 percent. However, within process of care measure category, CMS would assign a greater weight to the IMM measure. The proposed changes are outlined in Table 10 below.

Table 10: FY 2017 Proposed IQR Measure Validation Score Weights

Topic Area	Weight
Healthcare Associated Infections (HAIs)	66.7 %
Process of Care • Immunizations • Stoke, VTE, Sepsis, Emergency Department	 22.2 % 11.1 %
Total	100%

EHR Incentive Program

The inpatient PPS proposed rule also includes proposed changes to the regulations governing the Medicare and Medicaid EHR incentive programs to support the alignment of quality measurement with the hospital IQR program. CMS also clarifies its policy on reporting of zero-denominator Clinical Quality Measures (CQMs) under the Medicare EHR Incentive Program, and proposes changes to the case threshold policy.

Alignment of Hospital IQR Program Reporting and Submission Timelines with EHR Incentive Program Reporting and Submission Timelines. CMS proposes to incrementally shift the Medicare EHR Incentive Program reporting and submission periods for eCQMs from fiscal year reporting to a calendar year reporting. Specifically, in CYs 2015 and 2016, the EHR Incentive Program will require reporting eCQM data during the first three calendar quarters. This shift will allow CMS to align clinical quality measure data reporting and submission periods of the EHR Incentive Program with the hospital IQR program while allowing the reporting period, incentive eligibility assessment and incentive payments in the overall EHR Incentive Program to remain on their current schedule.

This proposal would only apply to eligible hospitals and CAHs submitting clinical quality measures electronically in CYs 2015 and 2016. The proposal would not change the reporting periods or requirements for the functional objectives and associated measures of meaningful use or for eCQMs that are reported by attestation via the Registration and Attestation System. Eligible hospitals participating in the EHR Incentive Program for the first time in CY 2015 or 2016 would still be required to report CQMs by attestation for a continuous 90-day period in FY 2015 or 2016, or report CQMs electronically for a three-month calendar year quarter, and do so by July 1 of the given year to avoid a payment penalty.

CMS also proposes to require quarterly reporting of electronically reported CQMs for the Medicare EHR Incentive Program to align with the currently established quarterly electronic CQM reporting periods for the hospital IQR program.

Table 11: Proposed Alignment of EHR Incentive Program Electronic Reporting and Hospital IQR Program Data Capture and Reporting Submission Timelines

Proposed Reporting Timeline to Align the EHR Incentive Program with Proposed Hospital IQR Program Submission Periods				
	CY	**EHR Incentive Program Reporting Requirements***	**Hospital IQR Program Reporting Requirements**	**Submission Period****
2015 Reporting Period	Q1	Jan. 1 – March 31, 2015	Jan. 1 – March 31, 2015	Data must be submitted by May 30, 2015
	Q2	April 1 – June 30, 2015	April 1 – June 30, 2015	Data must be submitted by Aug. 30, 2015
	Q3	July 1 – Sept. 30, 2015	July 1 – Sept. 30, 2015	Data must be submitted by Nov. 30, 2015
	Q4	N/A for EHR Incentive Program	Oct. 1 – Dec. 31, 2015	For Hospital IQR Program, data must be submitted by Feb. 28, 2016
2016 Reporting Period	Q1	Jan. 1 – March 31, 2016	Jan. 1 – March 31, 2016	Data must be submitted by May 30, 2016
	Q2	April 1 – June 30, 2016	April 1 – June 30, 2016	Data must be submitted by Aug. 30, 2016
	Q3	July 1 – Sept. 30, 2016	July 1 – Sept. 30, 2016	Data must be submitted by Nov. 30, 2016

	Q4	N/A for EHR Incentive Program	Oct. 1 – Dec. 31, 2016	For Hospital IQR Program, data must be submitted by Feb. 28, 2017

**Calendar year alignment and quarterly reporting for 2015 and 2016 would apply for electronically reported CQM data only.*
***Proposed EHR Incentive Program and Hospital IQR Program submission period would allow data submission on an ongoing basis starting January 2 of the reporting year, and ending approximately 60 days after the end of the quarter.*

Quality Reporting Data Architecture Category III (QRDA-III) Option in 2015. CMS announces that the electronic submission of aggregate-level data using QRDA–III will not be feasible in 2015 for eligible hospitals and CAHs under the Medicare EHR Incentive Program. Therefore, for the 2015 reporting period under the Medicare EHR Incentive Program, eligible hospitals and CAHs will retain the option to report aggregate CQM results through attestation. CMS notes that the submission of aggregate CQM data via attestation will not satisfy the reporting requirements for the hospital IQR program. In order to support alignment of the EHR Incentive Program and the Hospital IQR program, attested CQM data would need to be submitted for one full fiscal year in 2015 via the Registration and Attestation System, and would not require quarterly submissions. Hospitals in their first year of demonstrating meaningful use in 2015 would still be required to report CQMs by attestation for a continuous 90-day period in FY 2015, or report CQMs electronically for a three-month calendar year quarter, by July 1, 2015 to avoid the Medicare penalty in FY 2016.

Electronically Specified Clinical Quality Measures Reporting for 2015. For 2015, CMS announces that is not technically feasible for CMS to accept data that is electronically reported according to the older versions of electronic specifications (e-specifications) of the eCQMs, including versions that may be allowed for reporting under the EHR Incentive Program. Therefore, as CMS does not have the capacity to receive CQM data electronically, eligible hospitals and CAHs may continue to report aggregate CQM results through attestation for reporting under the EHR Incentive Program. CMS proposes to require that eligible hospitals and CAHs that seek to report CQMs electronically under the Medicare EHR Incentive Program use the most recent version of the e- specifications for the CQMs and have a certified EHR that is tested and certified to the most recent version of the e-specifications for the CQMs. EHR vendors, however, are not required to re-certify their products conformance to updated e-specifications in order to maintain their EHR certification status. Eligible hospitals and CAHs that do not wish to report CQMs electronically using the most recent version of the electronic specifications (for example, if their certified EHR has not been certified for the most recent version) would be allowed to report CQM data by attestation for the Medicare EHR Incentive Program.

Clarification on Zero Denominators Reported in eCQMs for the EHR Incentive Program and the Hospital IQR Program. CMS clarifies its policy on the reporting of a zero denominator due to the absence of data to report on a particular eCQM. This clarification is applicable to situations in which an eligible hospital or CAH lacks data to

report on a particular CQM and its certified EHR is not certified to additional eCQMs that might otherwise be used to replace the CQM with another for which there is data. CMS states that if the certified EHR is certified to a CQM, but the eligible hospital or CAH does not have patients that meet the denominator criteria of that CQM, the eligible hospital or CAH can submit a zero in the denominator for that CQM. Submitting a zero in the denominator will count as a successful submission for that CQM for both the EHR Incentive Program and the hospital IQR program. The rule does not state if this clarification is proposed to be effective in CY 2015 or a date prior.

Case Threshold Exemption Policy. In the EHR Incentive Program Stage 2 final rule, CMS finalized a policy that eligible hospitals and CAHs with five or fewer discharges per quarter in the same quarter as their reporting period in FY 2014, or 20 or fewer discharges per full fiscal year reporting period for which data are electronically submitted, as defined by the eCQM denominator population, are exempted from reporting the eCQM. Beginning in 2015, CMS proposes to change the case threshold exemption policy so that if an eligible hospital or CAH qualifies for an exemption from reporting on a particular CQM, the exemption would count toward the 16 required CQMs.

Under the proposed policy, if the EHR of an eligible hospital or CAH is certified to report 16 CQMs, and for one of the CQMs the eligible hospital or CAH has five or fewer discharges during the relevant EHR reporting period or 20 or fewer discharges during the year, then the eligible hospital or CAH would report data for the 15 CQMs for which the case threshold exemption does not apply and invoke a case threshold exemption for the CQM for which the exemption does apply. CMS states their expectation that eligible hospitals and CAHs will adopt EHR technology that includes the CQMs relevant to the hospital's or CAH's case mix but understands that the hospital or CAH may not meet the case threshold of discharges for a particular CQM and some EHRs are certified to a limited number of CQMs.

Changes to Graduate Medical Education (GME) Payments

Proposed Indirect Medical Education (IME) Medicare Part C Add-On Payments to SCHs. SCHs are paid their hospital-specific rate or the inpatient PPS Federal rate, whichever is higher. Typically, hospitals providing services to Medicare Part C Medicare Advantage patients receive add-on IME payments to account for the additional costs incurred in treating these patients. Because of the way payments to SCHs are structured, however, SCHs that are teaching hospitals and paid on their hospital-specific rate do not currently receive IME add-on payments for Medicare Part C patient discharges. However, CMS proposes to provide all SCHs that are teaching hospitals with IME add-on payments for Medicare Part C patients, regardless of whether the SCH is paid on its hospital-specific rate or the federal rate. In addition, CMS proposes that these add-on payments would not be included in the comparison of whether the SCH should receive the hospital-specific or the federal rate, but would be added after the higher of those two rates is determined.

Proposed Changes in the Effective Date of the Full-Time Equivalent (FTE) Resident Cap, Three-year Rolling Average, and Intern- and Resident-to-Bed (IRB) Ratio Cap for New Programs in Teaching Hospitals. In an effort to simplify and streamline the timing of these policies, CMS proposes to make the three-year rolling average used in calculating the FTE cap and the IRB ratio cap effective simultaneously with the FTE resident cap.

- **FTE Resident Cap.** New teaching hospitals currently have a five-year window during which to establish new residency programs before FTE caps take effect. A hospital's FTE resident cap is then effective beginning with the sixth program year of the first new program's existence.

- **Three-year Rolling Average.** Currently, a teaching hospital is paid for GME based on the number of FTE residents it trains over the course of three years. Specifically, the three-year rolling average interacts with the FTE cap to pay for the number of residents a hospital trains up to its cap. The three-year average is the average of the hospital's FTE resident count in the current cost reporting period and the counts in the two preceding period. When new programs are created, under existing regulations, the three-year rolling average begins to be calculated when the period of years the new program is in existence equals the minimum accredited length for the new program (for a three-year residency program, this would be three years). Therefore, the three-year rolling average currently takes effect on different dates based on the length of each new program. Under CMS's proposal, the three-year rolling average would be effective with each hospital's cost-reporting period that precedes the start of the sixth program year of the first new program, simultaneous with the effective date of the FTE resident cap.

- **IRB Ratio Cap.** The IRB ratio cap caps the individual resident-to-bed ratio on a hospital-specific basis at the level prior to implementation of the FTE cap to prevent a teaching hospital's IRB ratio, which in part determines IME payments, from increasing because of a decrease in the hospital's inpatient bed capacity. Currently, the IRB ratio cap takes effect on different dates based on the length of each new program started during the five-year cap building window. Under CMS's proposal, the IRB ratio cap would be effective with each hospital's cost-reporting period that precedes the start of the sixth program year of the first new program, simultaneous with the effective date of the FTE resident cap.

Changes to GME Policies as a Result of the New OMB Labor Market Delineations. CMS makes two proposals to GME programs as a result of the agency's proposal to use the new OMB labor market delineations (see the "Wage Index" section above for more information on these new delineations).

- **Rural Teaching Hospitals.** Under existing regulations, a new teaching hospital that starts training residents for the first time on or after Oct. 1, 2012 has five years from when it first begins training residents in its first new program to build its permanent FTE resident cap. If a teaching hospital is rural, it can continue to receive

permanent cap increases for training residents in new programs after the initial five-year cap-building period ends. As a result of CMS's proposal to use the new OMB labor market delineations, some rural teaching hospitals may be redesignated from a rural area to an urban area, thereby losing their ability to increase FTE resident caps for new programs started after the initial five-year cap building period ends. CMS proposes to allow hospitals in this situation to continue to grow that program for the remainder of the period and receive a permanent cap adjustment for the new program.

- **Participation of Redesignated Hospital in Rural Training Track.** To encourage the training of residents in rural areas, urban hospitals that establish separately accredited approved medical residency training programs (or tracks) in a rural area or have an accredited training program with an integrated rural track, may count the FTE residents in the rural track in addition to those FTE residents allowed under the cap up to a "rural track FTE limitation." As a result of CMS's proposal to use the new OMB labor market delineations, some rural teaching hospitals may be redesignated from a rural area to an urban area, which would impact this policy that requires the participation of a rural teaching hospital. Therefore, CMS proposes that in this situation, where the rural hospital is redesignated as urban, the urban hospital would continue to receive the rural track FTE limitation for new programs that started while the redesignated hospital was still rural and for the duration of the three-year period in which the rural track FTE limitation is calculated. Additionally, CMS proposes a two-year transition period during which the either of the following conditions must be met in order for the urban hospital to be able to count the residents under its rural FTE limitation when the two-year transition period ends – (1) the redesignated newly urban hospital must reclassify back to rural; or (2) the original urban hospital must find a new geographically rural site to participate for purposes of the rural track.

Changes to the Review and Awards Process for Resident Slots. The ACA authorized CMS to redistribute residency cap slots after a hospital that trained residents in an approved medical residency program closes (section 5506 slot awards). As part of that redistribution, CMS now proposes to eliminate cap relief as one of the uses of these FTE slots from closed hospitals, therefore, those hospitals requesting slots because they are training residents over their cap will not receive priority in the re-distribution of slots from closed hospitals. Under this proposal, slot awards would be made for: i) taking over a closed hospital's residency training program, ii) having participated with a closed hospital in a Medicare GME affiliated group, iii) taking over part of a closed hospital's program, iv) expanding or starting a new geriatrics program, v) expanding or starting a new primary care or general surgery program, and vi) expanding or starting a new non-primary care or non-general surgery program.

CMS also proposes to provide priority under Ranking Criterion One to a hospital whose FTE residency caps were wrongly reduced by CMS under ACA section 5503 (contrary to the specific statutory exception at section 1886(h)(8)(A)(i)(I) of the Social Security Act) and the CMS Central Office is made aware of the error before this proposed rule

was posted. In addition, CMS proposes minor changes to the other ranking criteria used for hospitals applying for slots from closed hospitals.

Bundled Payments for Care Improvement (BPCI) initiative

The BPCI initiative, developed under the ACA, is comprised of four broadly defined models of care, which link payment for multiple services beneficiaries receive during an episode of care. The first group of participants was announced by CMS on Jan. 31, 2013 and each participant entered into a payment arrangement that includes financial and performance accountability for these episodes of care. In the FY 2013 inpatient PPS final rule, CMS finalized a policy for FY 2013 and subsequent years, whereby hospitals participating in the BPCI initiative were treated as though they were not participating in the BPCI initiative and were included for purposes of inpatient PPS payment modeling and the rate-setting process. CMS proposes to do the same for FY 2015.

Outlier Payments

CMS proposes that cases would qualify for outlier payments in FY 2015 if their costs exceed the hospital's inpatient PPS rate for the MS-DRG, including IME, DSH and new technology payments, plus a proposed fixed-loss threshold of $25,799. This proposed threshold is higher than the final FY 2014 outlier fixed-loss threshold of $21,748. For FY 2015, CMS projects this threshold will result in outlier payments that will equal 5.1 percent of operating DRG payments and 6.26 percent of capital payments based on the Federal rate.

Capital PPS Rate Update

CMS is required to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate capital PPS, which is structured similarly to the operating PPS. Under the capital PPS, there is a standard federal payment rate that is adjusted by the MS-DRG relative weight for each discharge, with additional payment adjustments for teaching and disproportionate share hospitals.

CMS proposes a FY 2015 update of 1.5 percent to the capital federal rate (after accounting for budget neutrality and the outlier adjustment factor, this update has the effect of increasing the capital Federal rate by 0.86). As a result, CMS proposes that the capital standard federal payment rate for FY 2015 would be $433.01. Capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the federal capital rate. The agency proposes that the FY 2015 capital rate for Puerto Rico would be $206.82.

Changes to MS-DRG Classifications

FY 2015 MS-DRG Updates. CMS proposes the following changes to the MS-DRGs. CMS's analysis is based on claims data from the December 2013 update of the FY 2013 MedPAR file.

- **Major Diagnostic Category (MDC 5) (Diseases and Disorders of the Circulatory System): Endovascular Cardiac Valve Replacement Procedures.** CMS received a request to create a new MS-DRG that would only include the various types of cardiac valve replacements performed by an endovascular or transcatheter technique (ICD-9-CM procedure codes 35.05 through 35.09). Based on claims review and input from their clinical advisors that patients receiving endovascular cardiac valve replacements are significantly different from those patients who undergo an open chest cardiac valve replacement; CMS proposes to create the following MS-DRGs for endovascular cardiac valve replacements:

    - Proposed new MS-DRG 266 (Endovascular Cardiac Valve Replacement with MCC); and
    - Proposed new MS-DRG 267 (Endovascular Cardiac Valve Replacement without MCC).

- **Major Diagnostic Category MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).** CMS received a request to change the MS-DRG assignment for shoulder replacement procedures involving the following two procedure codes:

    - 81.88 (Reverse total shoulder replacement); and
    - 81.97 (Revision of joint replacement of upper extremity).

    CMS's examination of the claims data showed that there is no longer enough difference between the two severity levels to justify separate severity subgroups for MS-DRGs 483 and 484, which include a variety of upper joint replacements. Based on the claims data and recommendations from their clinical advisors, CMS is proposing to collapse MS-DRGs 483 and 484 (Major Joint/Limb Reattachment Procedure of Upper Extremities with CC/MCC and without CC/MCC, respectively) into a single MS-DRG by deleting MS-DRG 484 and revising the title of MS-DRG 483 to read "Major Joint/Limb Reattachment Procedure of Upper Extremities." CMS would maintain the current MS-DRG assignments for revisions of upper joint replacement procedures in MS-DRGs 515, 516, and 517.

    CMS received a request to reassign cases identified with a complication or comorbidity (CC) in MS-DRG 490 (Back & Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator) to MS-DRG 491 (Back & Neck Procedures Except Spinal Fusion without CC/MCC or Disc Device/Neurostimulator). The requester suggested that CMS create a new MS-DRG that would be subdivided based solely on the "with MCC or Disc Device/Neurostimulator" and the "without MCC" (and no device) criteria. Based on its data analysis and input from its clinical advisors, CMS proposes the deletion of MS-DRGs 490 and 491, and the creation of three new MS-DRGs to better capture a patient's severity level and utilization of resources:

- Proposed new MS-DRG 518 (Back & Neck Procedures Except Spinal Fusion with MCC or Disc Device/Neurostimulator);
- Proposed new MS-DRG 519 (Back & Neck Procedures Except Spinal Fusion with CC); and
- Proposed new MS-DRG 520 (Back & Neck Procedures Except Spinal Fusion without CC/MCC).

- **Major Diagnostic Category MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period).** CMS received a request to evaluate the MS–DRG assignment of seven ICD–9–CM diagnosis codes in MS-DRG 794 (Neonate with Other Significant Problems) under MDC 15. The requestor stated that these codes have no bearing on the infant, and are not representative of a neonate with a significant problem. CMS's clinical advisors agreed with the requestor and therefore CMS is proposing to reassign the following ICD-9-CM diagnoses to the "only secondary diagnosis list" under MS–DRG 795 (Normal newborn) so that the case would be assigned to that MS–DRG:

  - V17.0 (Family history of psychiatric condition);
  - V17.2 (Family history of other neurological diseases);
  - V17.49 (Family history of other cardiovascular diseases);
  - V18.0 (Family history of diabetes mellitus);
  - V18.19 (Family history of other endocrine and metabolic diseases);
  - V18.8 (Family history of infectious and parasitic diseases); and
  - V50.3 (Ear piercing).

Medicare Code Editor (MCE) Changes. In November 2013, CMS posted a "Definitions of Medicare Code Edits" Manual of the ICD-10 MCE Version 31.0 on the ICD-10 MS-DRG Conversion Project website. CMS has also produced mainframe and computer software for Version 31.0 of the MS-DRG GROUPER with Medicare Code Editor, which was made available to the public in December 2013.

For FY 2015, CMS is proposing to remove extracranial-intracranial (EC-IC) bypass surgery from the "Noncovered Procedure" edit code list for Version 32.0 of the MCE, because of the complexity of appropriately classifying the circumstances under which the EC-IC bypass surgery may, or may not, be considered reasonable and necessary for certain conditions. This procedure is identified by ICD-9-CM procedure code 39.28 (Extracranial intracranial (EC-IC) vascular bypass).

Surgical Hierarchies. The surgical hierarchy is a decision rule within the GROUPER, which orders surgical classes from most resource intensive to least resource intensive. This rule is used to assign a single DRG when an inpatient stay entails multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Application of this hierarchy ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource intensive surgical class.

Based on the MS-DRG changes proposed for FY 2015, CMS is proposing to revise the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System) and MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) as follows:

- In MDC 5, CMS proposes to sequence proposed new MS-DRG 266 (Endovascular Cardiac Valve Replacement with MCC) and proposed new MS-DRG 267 (Endovascular Cardiac Valve Replacement without MCC) above MS-DRG 222 (Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/HF/Shock with MCC).

- In MDC 8, CMS proposes to delete MS-DRGs 490 (Back & Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator) and MS-DRG 491 (Back & Neck Procedures Except Spinal Fusion without CC/MCC or Disc Device/Neurostimulator) from the surgical hierarchy. CMS proposes to sequence proposed new MS-DRG 518 (Back & Neck Procedure Except Spinal Fusion with MCC or Disc Device/Neurostimulator), proposed new MS-DRG 519 (Back & Neck Procedure Except Spinal Fusion with CC), and proposed new MS-DRG 520 (Back & Neck Procedure Except Spinal Fusion without CC/MCC) above MS-DRG 492 (Lower Extremity and Humerus Procedure Except Hip, Foot, Femur with MCC).

Major Complications or Comorbidities (MCCs) and Complications or Comorbidities (CC) Severity Levels. For FY 2015, there are no proposed changes to the CC/MCC list.

CC Exclusion List. For FY 2015, there are no proposed changes to the CC Exclusion List. Therefore, CMS is not developing or publishing Tables 6G (Additions to the CC Exclusion List) or Table 6H (Deletions from the CC Exclusion List). It has developed Table 6K (Complete List of CC Exclusions), which is available only via the Internet on the CMS website.

Changes to the ICD-9-CM Coding System. For FY 2015, there are no proposed new, revised or deleted ICD-9-CM diagnosis or procedure codes.

Conversion of MS-DRGs to the International Classification of Diseases, 10th Revision (ICD-10). The anticipated move to ICD-10 necessitated the development of an ICD-10-CM/ICD-10-PCS version of the MS-DRGs. In the last few years, CMS has been actively involved in converting current MS-DRGs from ICD-9-CM codes to ICD-10-CM and ICD-10-PCS codes. CMS has posted several versions of ICD-10 MS-DRGs and refined the conversion based on public comments. The most recent version of the ICD-10 MS-DRGs, which included the Definitions Manual, mainframe and computer software, was Version 31.0 based on the FY 2014 ICD-9-CM MS-DRGs. Based on public comments, CMS developed and updated this version to Version 31.0-R.

At the March 5, 2013 ICD-9-CM Coordination and Maintenance Committee meeting, CMS presented the updated results of a study on the impact of converting MS-DRGs to

ICD-10. The study found that moving from an ICD-9-CM-based system to an ICD-10 MS-DRG replicated system would lead to DRG reassignments on only 1 percent of the 10 million MedPAR sample records used in the study. Ninety-nine percent of the records did not shift to another MS-DRG when using an ICD-10 MS-DRG system. For the 1 percent of the records that shifted, 45 percent of the shifts were to a higher weighted MS-DRG, while 55 percent of the shifts were to lower weighted MS-DRGs. The net impact across all MS-DRGs was a reduction in payment of 4/10000 or minus 4 pennies per $100. The updated paper is posted on the CMS website under the "Downloads" section. CMS will continue to share ICD-10-MS-DRG activities through this website.

CMS had designated Oct. 1, 2014 as the date to transition to ICD-10. However, the PAMA prohibits CMS from implementing ICD-10 before Oct. 1, 2015. CMS has subsequently stated that it intends to enforce the transition on Oct. 1, 2015. The AHA will work with CMS to ensure successful implementation of ICD-10 and will communicate extensively with the field on implementation of ICD-10 and the ICD-10 MS-DRGs.

New Technology Payments

The inpatient PPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies. New technology add-on payments are not subject to budget neutrality and, therefore, do not reduce payments for all other inpatient services. To gain approval for such payments, a technology must be considered new, be inadequately paid otherwise and represent a substantial clinical improvement over previously available technologies. The cost threshold for new technologies to qualify for add-on payments is the lesser of either 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation above mean charges for the MS-DRG involved.

CMS previously approved an application for new technology add-on payments for Glucarpidase (Voraxaze®) – a drug used in the treatment of patients who have been diagnosed with toxic methotrexate concentrations as a result of renal impairment. CMS considers the beginning of the newness period for this technology to begin when it was first available on the market – April 30, 2012. Therefore, the device will be considered "new" until April 30, 2015. Because the three-year anniversary date for Voraxaze® will occur in the latter half of FY 2015, CMS proposes to continue new technology add-on payments for Voraxaze® in FY 2015.

CMS previously approved an application for new technology add-on payments for DIFICID™ (Fidaxomicin) Tablets – an oral antibiotic that provides potent bactericidal activity against *C. Diff.* and moderate bactericidal activity against certain other gram-positive organisms. The agency considers the beginning of the newness period for this device to have commenced on the date the Food and Drug Administration (FDA) approved it, which was May 27, 2011. Because the three-year anniversary date will occur on May 27, 2014, CMS proposes to discontinue new technology add-on payments for DIFICID™ in FY 2015.

CMS previously approved an application for new technology add-on payments for the Zenith® Fenestrated Abdominal Aortic Aneurysm Endovascular Graft – an implantable device designed to treat patients who have an abdominal aortic aneurysm and who are anatomically unsuitable for existing treatments. The agency considers the beginning of the newness period for this device to have commenced on the date the FDA approved it, which was April 4, 2012. Because the three-year anniversary date for the Zenith® F. Graft will occur in the second half of the fiscal year (April 4, 2015), CMS proposes to continue new technology add-on payments for the Zenith® F. Graft in FY 2015.

CMS previously approved an application for new technology add-on payments for Kcentra™ – a replacement therapy for fresh frozen plasma for patients with an acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed. The agency considers the beginning of the newness period for this therapy to have commenced on the date the FDA approved it, which was April 29, 2013. Because the Kcentra™ is still within the three-year newness period, CMS proposes to continue new technology add-on payments for Kcentra™ in FY 2015.

CMS previously approved an application for new technology add-on payments for Argus® II Retinal Prosthesis System – an active implantable medical device that is intended to provide electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa. The agency considers the beginning of the newness period for this therapy to have commenced on the date the FDA approved it, which was Feb. 14, 2013. Because Argus® II Retinal Prosthesis System is still within the three-year newness period, CMS proposes to continue new technology add-on payments in FY 2015.

CMS previously approved an application for new technology add-on payments for Zilver® PTX® Drug Eluting Stent – a stent used for the treatment of peripheral artery disease of superficial femoral arteries. The agency considers the beginning of the newness period for this stent to have commenced on the date the FDA approved it, which was Nov. 15, 2012. Because Zilver® PTX® Drug Eluting Stent is still within the three-year newness period, CMS proposes to continue new technology add-on payments in FY 2015.

CMS received seven applications for new technology add-on payments for FY 2015. Once applicant withdrew its application but the agency solicits comments on the remaining six applications and whether they meet the criteria for additional payments:

- Dalbavancin – an intravenous lipoglycopeptide antibiotic administered as a once-weekly 30-minute infusion via a peripheral line for the treatment of patients with acute bacterial skin and skin structure infections.

- Heli-FX™ EndoAnchor System – indicated for use in treatment of patients whose endovascular grafts during treatment of aortic aneurysms have exhibited migrations or endoleaks, or in the treatment of patients who are at risk of such complications,

and in whom augmented radial fixation and/or sealing is required to regain or maintain adequate aneurysm exclusion.

- WATCHMAN® Left Atrial Appendage Closure Technology – an implant that acts as a physical barrier to prevent blood clots and reducing the risk of stroke and potentially eliminating the need for Warfarin therapy for those patients diagnosed with atrial fibrillation.

- CardioMEMS™ HF (Heart Failure) System – an implantable hemodynamic monitoring system comprised of an implantable sensor/monitor placed in the distal pulmonary arterm to monitor and manage the condition of heart failure patients.

- MitraClip® System – a transcatheter mitral valve repair system that is designed to perform reconstruction of the insufficient mitral valve for high-risk patients who are not candidates for conventional open mitral valve repair surgery.

- Responsive Neurostimulator (RNS®) System – an implantable device for treating patients diagnosed with epilepsy whose partial onset seizures have not been adequately controlled with antiepileptic medications.

Penalty for Failing to Meet Meaningful Use

Under statute, both inpatient PPS hospitals and CAHs are subject to Medicare payment penalties in FY 2015 and later years if they fail to meet meaningful use. However, the two programs have different penalty structures based on different performance periods. All hospitals must meet either meaningful use or receive a hardship exception each and every year to avoid penalties.

Inpatient PPS Hospitals. FY 2015 is the first year that CMS is required to impose a meaningful use penalty on inpatient PPS hospitals. Under this penalty, hospitals that were not meaningful users of EHRs in FY 2013 will be subject to a one-quarter reduction in the initial market basket rate. However, the proposed rule does not address how CMS will identify and notify hospitals subject to the penalty, nor does it include an estimate in the impact table of lost payments due to the penalty. Based on CMS data on meaningful use attestations through December 2013, the AHA estimates that more than 500 hospitals could be subject to the penalty, leading to approximately $100 million in penalties. **The AHA will work with CMS to ensure that the process to identify and notify hospitals subject to the penalty is transparent and fair.**

In general, hospitals paid under the inpatient PPS are subject to this penalty in FY 2015 if they did not attest to meaningful use for FY 2013. There is a one-time exception, however, for hospitals attesting to meaningful use for the first time in FY 2014. Specifically, an inpatient PPS hospital that is attesting to meaningful use for the first time must attest for a 90-day reporting period on or before July 1, 2014 to avoid the penalty in FY 2015. Alternatively, a hospital may have received an individual hardship exception for FY 2015 (applications for the hardship exception were due on April 1, 2014; CMS has separately stated that 66 hospitals received exceptions).

The AHA recommends that all inpatient PPS hospitals verify whether they attested to meaningful use for FY 2013 or received a hardship exception. Attestation status can be determined through CMS's EHR Incentive Program registration and attestation website. CMS notifies hospitals about the hardship exceptions on a case-by-case basis.

The penalty for failing to meet meaningful use will also be applied in future years, and will lead to a 50 percent reduction to the market basket update in FY 2016 and a 75 percent in FY 2017 and beyond. These reductions are made before other cuts are applied. In general, the penalty is based on whether a hospital met meaningful use two years prior. For example, the FY 2016 penalty will be based on performance in FY 2014. CMS will continue the one-time exception for hospitals in their first year of meaningful use that requires attestation on or before July 1 of the previous fiscal year. For example, a hospital first attesting to meaningful use in FY 2015 must do so on or before July 1, 2015 to avoid the penalty in FY 2016. In the first year of meaningful use, hospitals must attest to a continuous 90-day reporting period that ends no later than the last day of the fiscal year.

The hardship exception policy will also continue to be available to hospitals in certain circumstances, with annual applications due by April 1 of the preceding fiscal year and subject to case-by-case review. CMS originally established hardship exceptions for hospitals facing infrastructure limitations, new hospitals, and hospitals in unforeseen circumstances such as natural disasters. CMS recently added a new hardship exception category of "2014 EHR Vendor Issues" that will apply to hospitals seeking an exception for FY 2016 based on challenges implementing technology in FY 2014. Specifically, hospitals may apply for an exception if the "hospital's EHR vendor was unable to obtain 2014 certification or the hospital was unable to implement meaningful use due to 2014 EHR certification delays."

CAHs. CAHs that fail to meet meaningful use also face penalties in FY 2015 and later years under statute. The penalty will reduce cost-based payments from 101 percent to 100.66 percent in FY 2015, 100.33 percent in FY 2016, and 100 percent in FY 2017 and beyond. However, penalties to CAHs are based on same-year performance, which is determined by whether the CAHs attested to meaningful use by Nov. 30 of the following fiscal year. For example, the FY 2015 penalty will be based on whether the CAH attested to meaningful use for FY 2015 by Nov. 30, 2015.

CMS also has made hardship exceptions available to CAHs, with applications due by Nov. 30 of the fiscal year following the payment adjustment year. For example, to avoid a penalty for FY 2015, CAHs must apply for a hardship exception by Nov. 30, 2015 if they did not attest to meaningful use for FY 2015.

Payment Adjustment for Low-Volume Hospitals

The PAMA extended the enhanced low-volume payment adjustment for an additional year, through March 31, 2015; CMS proposes to implement this change in the proposed rule. During this time, low-volume hospitals will continue to be defined as those that are

more than 15 road miles from another comparable hospital and that have up to 1,600 Medicare discharges. Qualifying hospitals will receive an add-on payment to their PPS rate that ranges from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. As of April 1, 2015, under current law, the definition of low-volume will revert back to the original, more restrictive, statutory definition, which requires qualifying hospitals to be more than 25 miles from a comparable hospital and have less than 200 discharges (i.e., less than 200 discharges total, including both Medicare and non-Medicare discharges).

Table 14 listed in the addendum to this proposed rule lists those hospitals with fewer than 1,600 Medicare discharges and their proposed low-volume adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible). Table 14 does not reflect whether the hospital meets the mileage criterion, which is also necessary to qualify for the low volume adjustment.

For FY 2015, CMS proposes that a hospital must make a written request for low-volume hospital status and such request must be received by its MAC no later than Sept. 1, 2014 in order for the applicable low-volume payment adjustment to be applied to payments for its discharges occurring on or after Oct. 1, 2014 and through March 31, 2015. If the hospital will also meet the post-April 1, 2015 qualifications the hospital must make a written request for low-volume hospital status for the post-April 1, 2015 time period before Sept. 20, 2015. A hospital that qualified for the low-volume payment adjustment for FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion. However, the hospital must send written verification that is received by its MAC no later than Sept. 1, 2014, that it continues to be more than 15 miles from any other subsection (d) hospital.

Medicare-Dependent Hospital (MDH) Program

The PAMA also extended the MDH program for one year, through March 31, 2015; CMS proposes to implement this change in the proposed rule. Under current law, beginning April 1, 2015, the MDH program will no longer be in effect and all hospitals that previously qualified for MDH status will be paid based on the federal rate. CMS reiterates its existing SCH policy that allowed MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program. Hospitals wishing to apply for SCH status must apply at least 30 days before the end of the MDH program, or by March 1, 2015, in order for SCH status to be effective upon expiration of the MDH program.

Rural Referral Centers (RRC)

If a hospital wants to become an RRC, but does not have 275 or more beds, it must meet two mandatory criteria – a minimum case-mix index and a minimum number of discharges – and one of three additional criteria relating to specialty composition of

medical staff, source of inpatients or referral volume. CMS proposes updates to the alternative criteria for RRC designation in FY 2015 to include:

- A case-mix index that is at least equal to either the median case-mix index for urban hospitals in its census region (excluding hospitals with approved teaching programs) or the median case-mix index for urban hospitals nationally (1.5730), whichever is lower; or
- At least 5,000 discharges per year (at least 3,000 for osteopathic hospitals) or, if fewer, the median number of discharges for urban hospitals in its census region.

The median case-mix index values and number of discharges are listed below.

Region	Median Case-mix Index Value	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	1.3602	7,679
2. Middle Atlantic (PA, NJ, NY)	1.4334	10,661
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4815	10,591
4. East North Central (IL, IN, MI, OH, WI)	1.4915	8,130
5. East South Central (AL, KY, MS, TN)	1.4099	7,065
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5498	7,925
7. West South Central (AR, LA, OK, TX)	1.6041	4,524
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6583	8,830
9. Pacific (AK, CA, HI, OR, WA)	1.5680	8,261

Rural Community Hospital (RCH) Demonstration Program

The Medicare Modernization Act of 2003 required CMS to conduct a demonstration program in rural areas under which up to 15 qualifying hospitals with fewer than 51 beds receive cost-based reimbursement (rather than PPS payment) for inpatient acute-care and swing-bed services for a five-year period. Hospitals located in rural areas in 10 states with low-population densities were eligible, but they could not be CAHs. The ACA extended the demonstration for five additional years, through Dec. 31, 2014. It also increased the maximum number of participating hospitals from 15 to 30 and expanded the eligible sites from rural areas in 10 states to those in 20 states with low-population densities. For hospitals that were in the original demonstration, their payment amounts were rebased.

CMS implements this program in a budget-neutral manner, as required by law. For FY 2015, CMS proposes to offset inpatient PPS payments to all hospitals by close to $64.1 million to account for the additional spending by the participating hospitals. This is an increase from the proposed $53.6 million that reflects inclusion of final FY 2008 cost reports (approximately $10.3 million for actual costs that exceeded the budget neutrality amount in the FY 2008 inpatient PPS final rule).

Hospitals and Hospital Units Excluded from the Inpatient PPS

Only cancer hospitals, children's hospitals and religious, non-medical health care institutions remain subject to the historical Tax Equity and Fiscal Responsibility Act of 1982 limits, with payments based on reasonable costs subject to rate-of-increase limits. CMS proposes a 2.7 percent increase in the rate-of-increase limits for FY 2015, which is based on the inpatient PPS operating market basket, excluding the ACA-mandated market basket cuts (which do not apply to these hospitals).

Updates to the Reasonable Compensation Equivalent Limits on Compensation for Physician Services

CMS proposes to update its formula for calculating the amount of allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis, known as reasonable compensation equivalent (RCE) limits. CMS proposes to update the RCE limits using the most recent Medicare Economic Index data, replacing the current limits which have been in place since Jan. 1, 2004. In addition, CMS proposes to eliminate its current practice of adjusting the RCE limits to account for differences in salary levels by location. CMS has historically made such an adjustment based on Metropolitan Statistical Areas (MSAs) as defined by the OMB. However, since OMB no longer updates or uses MSAs, CMS does not believe it is appropriate to continue an adjustment that relies on MSAs. Further, CMS states in the proposed rule that it does not believe there is an appropriate alternative data source that would allow it to accurately make geographical adjustments.

Critical Access Hospitals (CAHs)

CMS includes two proposals that apply specifically to CAHs.

Impact of Proposed Implementation of New OMB Labor Market Delineations. A facility must be located in a rural area in order to be eligible for designation as a CAH. CMS proposes to implement the most recently published OMB labor market delineations in this proposed rule, which may redesignate areas from rural to urban and affect the status of a facility that is currently a CAH and had met the CAH location requirements prior to the OMB labor market delineations. As a result, CMS proposes to amend the regulations to provide for a two-year transition period during which CAHs that are currently located in rural areas but, as a result of the new OMB labor market delineations, will be located in urban areas, can reclassify as rural. These CAHs will continue to be treated as rural through Sept. 30, 2016 (or when they reclassify, if sooner) and would be required to reclassify as a rural area during that same two-year time period.

Requirements for Physician Certification of CAH Inpatient Services. In order for a CAH to receive payment for inpatient services, a physician must certify that the beneficiary may reasonably be expected to be discharged or transferred within 96 hours of admission to the CAH. Prior to FY 2014, this physician certification was required no later than one day before the date on which the claim for payment for the inpatient CAH service was submitted. CMS modified this timeframe in the FY 2014 inpatient PPS final

rule, as well as in its guidance related to the two-midnight policy, requiring CAHs to complete, sign and document this certification prior to a beneficiary's discharge.

CMS now proposes to revert back to the previous timeframe and allow CAHs to complete this certification no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted. **We appreciate CMS's efforts to provide CAHs with additional flexibility in meeting this requirement. However, the AHA continues to support the Critical Access Hospital Relief Act of 2014 (S. 2037/H.R. 3991), which would remove the 96-hour condition of payment all together.**

Price Transparency

The ACA requires each hospital to establish, update and make public a list of its standard charges for items and services it provides. In the proposed rule, CMS "reminds" hospitals of this obligation and indicates that it will provide hospitals with the flexibility to determine how they make their list of standard charges public. Specifically, CMS indicates that hospitals must either make public a list of their standard charges (whether that be the charge master itself or another form) or their policies for allowing the public to view a list of those charges in response to an inquiry. CMS also indicates that hospitals are expected to update this information at least annually.

Cost Report Requirements and Provider Reimbursement Review Board (PRRB) Jurisdiction

CMS proposes to eliminate the requirement that a provider either claim reimbursement on its cost report for a specific item or self-disallow the item and file the cost report under protest in order for the PRRB to have jurisdiction over that item. Instead, CMS proposes that a provider must include all items for which it is requesting payment on its cost report as a condition for payment for those items. This requirement would apply even if the provider believes the payment requested may not comply with Medicare policy. If a provider does not include an appropriate claim for an item in its cost report, it would not receive payment for that item and would also lose the ability to appeal that item to the PRRB. Under the proposed change, a provider that fails to include an item on its cost report could file an amended cost report or request a reopening by its MAC to add the excluded item; however, whether to accept an amended cost report or issue a reopening is entirely at the MAC's discretion under current Medicare regulations.

Enforcement Provisions for Organ Transplant Centers

To participate in Medicare, transplant centers must meet certain Conditions of Participation (CoPs) that set forth explicit expectations for outcomes, patient safety, informed choice, and quality of transplantation services. Failure to meet transplant center requirements can lead CMS to deny approval or reapproval of a center's Medicare agreement. However, CMS can consider mitigating factors in determining approval or reapproval. In current regulations, these factors include (but are not limited to) the extent to which outcomes measures are met or exceeded, the availability of Medicare-approved transplant centers in the area, and extenuating circumstances that

may have a temporary effect on the ability of the transplant center to meet the requirements.

CMS proposes to expand the mitigating factors it may consider for approval or reapproval of a Medicare agreement, but would not consider mitigating factors in situations of immediate jeopardy. While the proposed regulatory language is not completely clear, AHA interprets the new factors essentially to include the following:

- Program improvements that substantially address root causes of graft failures or patient deaths and that have been implemented and institutionalized on a sustainable basis;

- Data that is more recent than what is available from the Scientific Registry of Transplant Recipients showing that the Center is in compliance with CMS requirements.

- Evidence that allows CMS to find that the center uses evidence-based or Institutional Review Board approved innovative practices to address the needs of complex patients, such as children who have undergone a Fontan procedure or individuals who are highly sensitized patients, where the SRTR risk-adjustment methodology does not take the relevant key factors into consideration; and

- Whether the program's performance, based on the Organ Procurement and Transplantation Network (OPTN) method of calculating patient and graft survival, is within the OPTN's thresholds for acceptable performance and does not flag OPTN performance review under the applicable OPTN policy.

CMS also proposes to expand current regulations to: (1) describe the content transplant centers can include in their requests for consideration of mitigating factors, (2) establish a timeframe for these requests, and (3) clarify the actions CMS can take after a mitigating factors review, which includes offering a Systems Improvement Agreement (SIA).

Content of Requests. Specifically, CMS would like the requests for consideration of mitigating factors to include "sufficient information to permit an adequate review and understanding of the transplant program, the factors that have contributed to outcomes, program improvements or innovations that have been implemented or planned, and, in the case of natural disasters, the recovery actions planned." CMS provides a list of the types of information to be submitted, which includes root cause analysis, program improvements or innovations, patient and donor selection criteria and evaluation protocols, organizational charts, waitlist management protocols and practices, preoperative management protocols and practices, immunosuppression/infection protocols, post-transplant monitoring and management protocols and practices, Quality Assessment and Performance Improvement (QAPI) program meeting minutes, quality dashboard and other performance indicators, recent outcomes data, and documentation of whether the program has engaged with the OPTN to review program outcomes, the status of any such review, and steps taken to address outcomes per the OPTN review.

Timing for Requests. CMS also proposes a timeline for submission of a request related to mitigating factors. Within 10 days after CMS has issued formal written notice of a condition-level deficiency to the program, CMS must receive notice of the program's intent to seek consideration of mitigating factors. CMS would require that all information necessary for consideration be received within 30 days of CMS's initial notification for any deficiency, except a deficiency based upon insufficient clinical experience or outcomes; and within 120 days of CMS's written notification for a deficiency based upon insufficient clinical experience or outcomes.

CMS Actions Subsequent to a Mitigating Factors Review, including the offer of a SIA. CMS proposes to alter the regulations to outline three outcomes of mitigating factors decisions:

(1) approval/reapproval of Medicare participation based on mitigating factors, although CMS reiterates it will not approve any program with a condition-level deficiency;
(2) denial of the request; or
(3) offer of a time-limited SIA to the hospital in which a transplant center operates.

Where a transplant center demonstrates that it is making significant progress toward correction and program improvement, but does not yet qualify for approval based on mitigating factors, CMS believes there may be merit in some cases to temporarily extend the effective date of termination from Medicare in exchange for an agreement to engage in a significant and directed regimen of improvement under a SIA. A SIA would be defined in the regulations as a binding agreement, entered into voluntarily by the hospital and CMS, through which CMS extends a prospective Medicare termination date and offers the program additional time to achieve compliance with the CoPs, contingent on the hospital's agreement to participate in a structured regimen of quality improvement activities, demonstrate improved outcomes, and waive the right to appeal termination based on the identified deficiency or deficiencies that led to the agreement in consideration for more time to demonstrate compliance.

CMS envisions that SIAs would be used more often in cases where transplant centers need additional time to correct its one-year post transplant patient or graft survival or low-volume performance rates. CMS proposes to add new language that sets forth the purpose, content, and timeframes of SIAs. See pp. 28286-28288 of the proposed rule for these details.

Revision of Regulations Governing Use and Release of Medicare Advantage Risk Adjustment Data

CMS is proposing an expansion of the allowable uses and reasons for disclosure of risk adjustment data submitted to CMS by Medicare Advantage Organizations (MAOs), including clarification that disclosure would be permitted to contractors or other agents that conduct activities or analysis on behalf of CMS.

The existing purposes for which CMS may use or disclose this data are to:

- Determine risk adjustment factors used to adjust MA payments;
- Update risk adjustment models;
- Calculate Medicare DSH percentages;
- Conduct quality review and improvement activities; and
- Determine Medicare coverage.

CMS proposes to add the following purposes:

- Conduct evaluation and other analysis to support the Medicare program (including demonstrations) and to support public health initiatives and other health care related research;
- Activities to support the administration of the Medicare program;
- Activities to support program integrity; and
- Purposes permitted by other laws.

The proposal also would allow other HHS agencies, other federal executive branch agencies, states and external entities to obtain and use these data from CMS, but only for one of the specified purposes. The notice states that CMS "anticipates that nongovernmental external entities would generally only gain access to risk adjustment data in connection with public health initiatives and health care related research…" CMS also proposes conditions for the release of the risk adjustment data. The data could not include medical records and other data collected for purposes of risk adjustment data validation (RADV) audits. Rather, CMS proposes to authorize use or release of encounter data records, including contract, plan and provider identifiers, but not payment information, and seeks comment on approaches to aggregating payment data for release as well as whether releasing payment data at the level of an encounter record would reveal proprietary negotiated payment rates. CMS proposes to release the least amount of data required to accomplish the goal for a project. Additionally, data would be released subject to federal law and regulations, CMS data sharing practices, aggregation of payment data (to protect commercially sensitive data), and protection of beneficiary identifier elements and confidentiality.

PPS-Exempt Cancer Hospital (PCH) Quality Reporting (PCHQR) Program

The ACA mandated a quality reporting program for PCHs, beginning in FY 2014. All PCHs are required to comply with all PCHQR program requirements. For FY 2016, the agency proposes one additional measure for the PCHQR program. CMS also proposes a number of updates to the program's data reporting requirements.

FY 2017 Proposed Measure. CMS proposes to add one chart-abstracted measure to the FY 2017 PCHQR program—External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822). The measure is NQF-endorsed, and was supported by the MAP for inclusion in the PCHQR. The measure assesses the percentage of patients with painful bone metastases with no previous radiation to the same site who receive EBRT using certain "fractionation," or dosing, schedules. In the proposed rule, CMS indicates its hope that reporting the measure will encourage PCHs to deliver no more radiation therapy to bone metastasis patients than is necessary.

Data Collection and Reporting. CMS proposes several changes to PCHQR program data collection and reporting requirements beginning in FY 2016:

- **All-payer Data Collection.** For the five clinical process/oncology care specific treatment measures in the PCHQR, CMS proposes to require that PCHs to report data on all patients, regardless of payer. CMS states that this requirement is consistent with that for the SCIP measures that also are part of the PCHQR. It is also consistent with the data reporting requirements for chart-abstracted measures in other CMS quality reporting programs (e.g., hospital IQR).

- **Alignment of Reporting Deadlines.** With a stated purpose of reducing data reporting burden, CMS proposes to align the data collection and reporting periods for most of the PCHQR program's measures. Specifically, the three clinical process/cancer specific treatment measures, the five clinical process/oncology care measures and the six SCIP measures would all share the same data collection periods and data submission deadlines. Currently, CMS requires that SCIP measures be submitted once per quarter, while the other measures are submitted once per year. Beginning in FY 2016, all of the measures in the above categories will be submitted once per year using the same submission deadline. The updated reporting periods and deadlines are outlined in Table 12. CMS's proposals do not affect the reporting deadlines for the HAI and HCAHPS measures in the PCHQR program.

  The reporting deadlines for the newly proposed EBRT for Bone Metastases measure will be largely aligned with those of the other measures. However, for the first year of reporting (FY 2017), CMS proposes that PCHs include measure data from Q1 of 2015. In subsequent years, the reporting periods and deadlines would be aligned.

Table 12: Proposed Reporting Periods and Data Submission Deadlines for Clinical Process/Cancer Specific Treatment and SCIP Measures, FY 2016 and Beyond

Program Year (or FY)	Reporting Period	Data Submission Deadline
FY 2016	Q1 2015 Discharges: Jan. 1, 2015 – Mar. 31, 2015	Jul. 1- Aug. 15, 2015
FY 2017	Q2 2015 Discharges: Apr. 1, 2015 – Jun. 30, 2015	Jul. 1 – Aug. 15, 2016
	Q3 2015 Discharges Jul. 1, 2015 – Sep. 30, 2015	
	Q4 2015 Discharges Oct. 1, 2015 – Dec. 31, 2015	
Subsequent Years	Q1 Discharges: Jan. 1 – Mar. 31 of each year 2 years before the program year	Jul. 1 – Aug. 15 of each year before the program year

	Q2 Discharges: Apr. 1– Jun. 30 of each year 2 years before the program year	
	Q3 Discharges: Jul. 1 – Sep. 30 of each year 2 years before the program year)	
	Q4 Discharges: Oct. 1 - Dec. 31 of each year 2 years before the program year	

- **Data Format Requirements.** Beginning in FY 2016, CMS proposes that PCHs will have two options for submitting the clinical process/cancer specific treatment, clinical process/oncology care measures and SCIP measures. These same options also would apply to the EBRT for Bone Metastases measure proposed for the FY 2017 PCHQR program. PCHs or their authorized vendors can either enter aggregate numerator and denominator data, or submit an aggregate data file via CMS's *QualityNet* website.

- **Sampling.** At the urging of the AHA and other groups, CMS last year finalized a policy allowing for PCHs to submit data on a sample of patients for the clinical process/oncology care measures. CMS indicated the methodology would be the same specified in the Physician Quality Reporting System (PQRS) specification manual.

  However, given that the PQRS sampling methodology is intended for the physician office setting, for FY 2016, CMS proposes to replace it with the sampling methodology developed for SCIP measures since that methodology was developed for hospital-level reporting. The methodology is based on the size of the initial measure population, and is outlined in Table 13. CMS also proposes that PCHs would be required to report the initial population and sample size counts for Medicare and non-Medicare discharges.

Table 13: Proposed FY 2016 PCHQR Program Sampling Methodology for Clinical Process/Oncology Care Measures

Average Quarterly Sample Size (number of eligible patients)	**Minimum Required Sample Size**
More than 125	25
51-125	20 percent of the initial patient population
10-50	10
Less than 10	No sampling—100 percent of the initial patient population

Public Reporting. The ACA requires that measures from the PCHQR program be publicly reported. As finalized in the FY 2014 inpatient PPS proposed rule, CMS will

report data on two PCHQR chemotherapy process measures during 2014. CMS proposes to expand public reporting of measures by reporting the adjuvent hormonal therapy measure in 2015, and displaying CAUTI and CLABSI data no later than 2017.

NEXT STEPS

Given the changes included in this year's proposed rule, the AHA encourages hospital leaders to estimate the impact of the provisions on their facilities. To that end, the **AHA has created a readmissions penalty calculator, a VBP calculator and a DSH payment calculator for hospitals to assess the impact of these policies on their organizations. They are available at:**

- ✓ **Readmissions Penalty Calculator: www.aha.org/readmissionscalc**
- ✓ **VBP Calculator: www.aha.org/vbpcalc**
- ✓ **DSH Payment Calculator: www.aha.org/dshcalc**
- ✓ **HAC Calculator: www.aha.org/haccalc**

The calculators are designed so that you enter your hospital's CMS Certification Number (and some additional financial information for the DSH calculator) and the calculator will then estimate the dollar amount of your readmissions penalty, your HAC penalty, your net VBP gain or loss, and your potential DSH payment.

The AHA also encourages hospitals to verify CMS's table listing the factor used to calculate uncompensated care payments in FY 2015 for DSH hospitals. Hospitals have until June 30 to review this table and notify CMS in writing of a change in a hospital's status.

In addition, hospitals should verify whether they have attested to meaningful use. Attestation status can be determined through CMS's EHR Incentive Program registration and attestation website.

We recommend that hospitals verify that their wage data are accurate. CMS has posted the data on its website.

We recommend that hospitals verify that their wage data are accurate. If they are not, hospitals must submit a letter requesting correction of errors and supporting documentation by June 3 (materials must be received by June 3). CMS has posted the data on its website.

All comments are due to CMS by June 30 and may be submitted electronically at www.regulations.gov. Follow the instructions for "Comment or Submission" and enter the file code CMS-1607-P to submit comments on this proposed rule.

You also may submit written comments (an original and two copies) to CMS.

Via regular mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1607-P
P.O. Box 8011
Baltimore, MD 21244-1850

Via overnight or express mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1607-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

FURTHER QUESTIONS

For additional questions, please contact Priya Bathija, AHA senior associate director, at (202) 626-2678 or pbathija@aha.org.

Appendix A: Hospital Value-Based Purchasing (VBP)

Table 1: Finalized VBP Measures, FY 2014 – FY 2016

Measure	FY 2014	FY 2015	FY 2016
Clinical Process of Care Domain			
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X	X
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)	X	X	
HF-1 Discharge instructions	X	X	
PN-3b Blood culture performed before first antibiotic received in hospital	X	X	
PN-6 Appropriate initial antibiotic selection	X	X	X
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	X	X	
SCIP-INF-2: Prophylactic antibiotic selection for surgical patients	X	X	X
SCIP-INF 3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	X	X	X
SCIP-INF-4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	X	X	Suspended*
SCIP–INF-9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero	X	X	X
SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period	X	X	X
SCIP-VTE-1: Surgery patients with Venous thromboembolism (VTE) prophylaxis ordered	X		
SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery	X	X	X
Global influenza immunization			X
Outcomes Domain			
AMI 30-day mortality rate	X	X	X
Heart Failure 30-day mortality rate	X	X	X
Pneumonia 30-day mortality rate	X	X	X
Central Line Associated Bloodstream Infection (CLABSI)		X	X
PSI 90: Complication/patient safety for selected indicators (composite)		X	X
Surgical Site Infection			X
Catheter-Associated Urinary Tract Infection (CAUTI)			X
Patient Experience of Care Domain			
HCAHPS survey	X	X	X
Efficiency Domain			
Medicare spending per beneficiary		X	X

**SCIP-Inf-4 will not be used in the calculation of FY 2016 VBP incentives because the measure underwent specification changes. These changes mean that the performance period data would have been calculated using specifications different from the baseline period.*

Table 2: Proposed VBP Measures FY 2017 – FY 2019*

Measure	FY 2017	FY 2018	FY 2019
Domain: Safety			
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X
PSI 90: Complication/patient safety for selected indicators (composite)	X	X	X
Surgical Site Infection	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X
Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia	X**	X**	X**
Clostridium Difficile (C Difficile)	X**	X**	X**
Domain: Clinical Care—Process			
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X	X
PN-6 Appropriate initial antibiotic selection	Removal**		
SCIP-INF-2: Prophylactic antibiotic selection for surgical patients	Removal**		
SCIP-INF 3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	Removal**		
SCIP–INF-9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero	Removal**		
SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period	Removal**		
SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery	Removal**		
IMM-2: Global Flu Immunization	X	X	X
PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation	X**	X**	X**
Domain: Clinical Care—Outcomes			
Acute myocardial infarction (AMI) 30-day mortality rate	X	X	X
Heart failure (HF) 30-day mortality rate	X	X	X
Pneumonia (PN) 30-day mortality rate	X	X	X
Hospital-Level Risk Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty			X**
Domain: Patient and Caregiver Centered Experience of Care / Care Coordination			
HCAHPS survey	X	X	X
Domain: Efficiency and Cost Reduction			
Medicare spending per beneficiary	X	X	X

***** *This table uses the realigned measure domains for FY 2017 finalized in the FY 2014 inpatient PPS Final Rule*
****** *Proposed in FY 2015 inpatient PPS Proposed Rule*

Table 3: Finalized and Proposed Performance Standards for FY 2017 Safety, Clinical Care and Efficiency Domains

Measure	Description	Achievement Threshold	Benchmark
Domain: Safety			
PSI-90	Complication/patient safety for selected indicators (composite)	0.577321*	0.397051*
CAUTI	Catheter-associated urinary tract infection	0.8371	0.0000
CLABSI	Central line-associated blood stream infection	0.4483	0.0000
SSI	Surgical site infection • Colon • Abdominal hysterectomy	• 0.7117 • 0.7509	• 0.0000 • 0.0000
MRSA	*Methicillin-resistant Staphylococcus aureus* bacterimia	0.8613	0.0000
C Difficile	Clostridium Difficile	0.7927	0.0000
Domain: Clinical Care--Process			
AMI-7a	Fibrinolytic therapy received within 30 minutes of hospital arrival	0.954545	1.000000
IMM-2	Influenza immunization	0.995882	1.000000
PC-01	Elective delivery prior to 39 completed weeks gestation	0.031250	1.000000
Domain: Clinical Care—Outcomes			
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	0.851458*	0.871669*
MORT-30-HF	Heart failure (HF) 30-day mortality rate	0.881794*	0.903985*
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.882986*	0.908124*
Domain: Efficiency and Cost Reduction			
MSPB-1	Medicare spending per beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Finalized in previous rulemaking

Table 4: Proposed FY 2017 Performance Standards for Patient and Caregiver Centered Experience of Care / Care Coordination (HCAHPS Survey)

HCAHPS Survey Dimension	Floor (percent)	Achievement Threshold (percent)	Benchmark (percent)
Communication with nurses	56.90%	78.08%	86.41%
Communication with doctors	62.03%	80.43%	88.71%
Responsiveness of hospital staff	36.46%	64.83%	79.62%
Pain management	49.47%	70.20%	78.18%
Communication about medicines	42.89%	62.82%	73.15%
Hospital cleanliness & quietness	43.46%	65.26%	79.06%
Discharge information	61.86%	85.59%	91.04%
Overall rating of hospital	35.00%	69.81%	84.27%

Table 5: Finalized and Proposed Standards for 30-Day Mortality, PSI-90 and THA/TKA Complications, FY 2018 – FY 2020

Measure	Description	Achievement Threshold	Benchmark
FY 2018			
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	0.850916*	0.873053*
MORT-30-HF	Heart failure (HF) 30-day mortality rate	0.883421*	0.907656*
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.882860*	0.907900*
PSI-90	Complication/patient safety for selected indicators (composite)	0.582626*	0.398030*
FY 2019			
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	0.850671*	0.873263*
MORT-30-HF	Heart failure (HF) 30-day mortality rate	0.883472*	0.908094*
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.882334*	0.907906*
PSI-90	Complication/patient safety for selected indicators (composite)	0.840421	0.589716
THA/TKA	Hospital-level risk standardized complication rate (RSCR) following elective primary total hip and/or total knee arthroplasty	0.032521	0.022895

Measure	Description	Achievement Threshold	Benchmark
FY 2020			
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	0.853511	0.875840
MORT-30-HF	Heart failure (HF) 30-day mortality rate	0.881394	0.905962
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.882281	0.909460
THA/TKA*	Hospital-Level risk standardized complication rate (RSCR) following elective primary total hip and/or total knee arthroplasty	0.032521	0.022895

***Finalized in previous rulemaking*

Appendix B: Inpatient Quality Reporting Program Measures for FY 2013 through FY 2017

Key:

*	Proposed in FY 2015 Inpatient PPS Proposed Rule
X^e	Electronically-specified version of measure available for hospitals participating in IQR voluntary electronic data reporting option
eCQM only	Measure can **only** be reported if hospital participating in IQR voluntary electronic data reporting option

Measure	FY 2014	FY 2015	FY 2016	FY 2017
Acute Myocardial Infarction (AMI) Measures				
AMI-2 Aspirin prescribed at discharge	X	X		eCQM only*
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X	X	X^{e*}
AMI-8a Timing of receipt of primary percutaneous coronary intervention (PCI)	X	X	X	eCQM only*
AMI-10 Statin prescribed at discharge	X	X		eCQM only*
Heart Failure (HF) Measures				
HF-1 Discharge instructions	X	X		
HF-2 Evaluation of left ventricular systolic function	X	X	X	Removal*
HF-3 Angiotensin converting enzyme inhibitor (ACE-I) or angiotensin II receptor blocker (ARB) for left ventricular systolic dysfunction	X	X		
Stroke (STK) Measures				
STK-1 VTE prophylaxis		X	X	X
STK-2 Antithrombotic therapy for ischemic stroke		X	X^e	eCQM only*
STK-3 Anticoagulation therapy for Afib/flutter		X	X^e	eCQM only*
STK-4 Thrombolytic therapy for acute ischemic stroke		X	X^e	eCQM only*
STK-5 Antithrombotic therapy by the end of hospital day 2		X	X^e	eCQM only*
STK-6 Discharged on Statin		X	X^e	X^e
STK-8 Stroke education		X	X^e	X^e
STK-10 Assessed for rehabilitation services		X	X^e	eCQM only*
Venous Thromboembolism (VTE) Measures				
VTE-1 VTE prophylaxis		X	X^e	X^e
VTE-2 ICU VTE prophylaxis		X	X^e	X^e

Measure	FY 2014	FY 2015	FY 2016	FY 2017
VTE-3 VTE patients with anticoagulation overlap therapy		X	X[e]	X[e]
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol		X	X[e]	eCQM only*
VTE-5 VTE discharge instructions		X	X[e]	X[e]
VTE-6 Incidence of potentially preventable VTE		X	X[e]	X[e]
Pneumonia (PN) Measures				
PN-3b Blood culture performed before first antibiotic received in hospital	X	X		
PN-6 Appropriate initial antibiotic selection	X	X	X	*eCQM only
Surgical Care Improvement Project (SCIP) Measures				
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	X	X	X	eCQM only*
SCIP-INF-2: Prophylactic antibiotic selection for surgical patients	X	X	X	eCQM only*
SCIP-INF 3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	X	X	X	Removal*
SCIP-INF-4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	X	X	X	Removal*
SCIP–INF-9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero	X	X	X	eCQM only*
SCIP-INF-10: Surgery patients with perioperative temperature management	X	X		
SCIP-Cardiovascular-2: Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	X	X	X	Removal*
SCIP-VTE-1: Surgery patients with Venous thromboembolism (VTE) prophylaxis ordered	X			
SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery	X	X	X	Removal*
Mortality Measures				
AMI 30-day mortality rate	X	X	X	X
Heart Failure 30-day mortality rate	X	X	X	X

Measure	FY 2014	FY 2015	FY 2016	FY 2017
Pneumonia 30-day mortality rate	X	X	X	X
Chronic Obstructive Pulmonary Disease 30-day mortality rate			X	X
Acute Ischemic Stroke 30-day mortality			X	X
CABG surgery 30-day mortality				X*
HCAHPS Patients' Experience of Care Measures				
HCAHPS survey	X	X	X	X
Readmission Measures				
Acute myocardial infarction (AMI) 30-day risk standardized readmission	X	X	X	X
Heart failure (HF) 30-day risk standardized readmission	X	X	X	X
Pneumonia (PN) 30-day risk standardized readmission	X	X	X	X
Total Hip/Total Knee Arthroplasty (THA/TKA) 30-day risk standardized readmission		X	X	X
Hospital-wide all cause unplanned readmission		X	X	X
Chronic obstructive pulmonary disease (COPD) 30-day risk standardized readmission			X	X
Acute ischemic stroke 30-Day risk standardized readmission			X	X
Coronary artery bypass graft (CABG) 30-day risk standardized readmission				X*
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures				
PSI 06: Iatrogenic pneumothorax, adult	X			
PSI 11: Postoperative respiratory failure	X			
PSI 12: Postoperative pulmonary embolism or deep vein thrombosis	X			
PSI 14: Postoperative wound dehiscence	X			
PSI 15: Accidental puncture or laceration	X			
IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)	X			
IQI 19: Hip fracture mortality rate	X			
PSI 90: Complication/patient safety for selected indicators (composite)	X	X	X	X
Mortality for selected medical	X			

Measure	FY 2014	FY 2015	FY 2016	FY 2017
conditions (composite)				
PSI 04 Death among surgical inpatients with serious, treatable complications	X	X	X	X
Structural Measures				
Participation in a systematic database for cardiac surgery	X	X	X	Removal*
Participation in a systematic clinical database registry for stroke care	X	X		
Participation in a systematic clinical database registry for nursing sensitive care	X	X	X	X
Participation in a systematic clinical database registry for general surgery	X	X	X	X
Safe surgery checklist use			X	X
Healthcare-Associated Infections Measures				
Central-line associated bloodstream infection (CLABSI)	X	X	X	X
Surgical site infection	X	X	X	X
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia		X	X	X
Clostridium Difficile (C Difficile)		X	X	X
Healthcare personnel influenza vaccination		X	X	X
Surgical Complications				
Hospital-Level risk standardized complication rate (RSCR) following elective primary total hip and/or total knee arthroplasty		X	X	X
Hospital-Acquired Condition (HAC) Measures				
Foreign object retained - After surgery	X			
Air embolism	X			
Blood Incompatibility	X			
Pressure ulcer stages III & IV	X			
Falls and trauma (Includes: fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)	X			
Vascular catheter-associated infection	X			
Catheter-associated urinary tract infection (CAUTI)	X			
Manifestations of poor glycemic control	X			
Emergency Department (ED) Throughput Measures				
ED-1 Median time from ED arrival to	X	X	X[e]	X[e]

Measure	FY 2014	FY 2015	FY 2016	FY 2017
departure from the emergency room for patients admitted to the hospital				
ED-2 – Median time from admit decision to time of departure from the ED for ED patients admitted to the inpatient status	X	X	X[e]	X[e]
Prevention				
Global influenza immunization	X	X	X	X
Global pneumonia immunization	X	X	Suspended	Suspended
Cost Efficiency				
Medicare spending per beneficiary	X	X	X	X
Acute Myocardial Infarction (AMI) payment per episode of care			X	X
Pneumonia (PN) payment per episode of care				X*
Heart Failure (HF) payment per episode of care				X*
Perinatal Care				
PC-01: Elective delivery < 39 completed weeks gestation		X	X[e]	X[e]
PC-05: Exclusive Breast Milk Feeding and the subset measure PC-05a: Exclusive Breast Milk Feeding Considering Mother's Choice				eCQM only*
Children's asthma care- Home Management Plan of Care (HMPC) document given to patient/ caregiver				eCQM only*
Healthy term newborn				eCQM only*
Hearing screening prior to hospital discharge				eCQM only*
Sepsis				
Severe sepsis and septic shock: Management bundle				X*