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FY15 IPPS Proposed Rule Overview

Overview

CMS issued a proposed rule updating payment rates under the Medicare inpatient prospective payment system (IPPS) for operating and capital-related costs of acute care hospitals in fiscal year 2015 (FY15). Some of the proposed changes implement certain statutory provisions contained in the Affordable Care Act (ACA), the Protecting Access to Medicare Act of 2014, and other legislation. These proposed changes would be applicable to discharges occurring on or after October 1, 2014. CMS also proposes to update the rate-of-increase limits, effective for cost reporting periods beginning on or after October 1, 2014, for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. CMS notes that while many of the statutory mandates of the Pathway for SGR Reform Act will apply to discharges occurring on or after October 1, 2014, others will not begin to apply until 2016 and beyond.

In addition to these policy updates, others discussed in the proposal include those relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program. CMS also proposes to align the reporting and submission timelines for clinical quality measures for the Medicare Electronic Health Record (EHR) Incentive Program for eligible hospitals and critical access hospitals (CAHs) with the reporting and submission timelines for the Hospital Inpatient Quality Reporting (IQR) Program. Guidance and clarification of certain policies for eligible hospitals and CAHs, such as the policy for reporting zero denominators on clinical quality measures and the policy for case threshold exemptions, is also provided.

Impact Analysis

Federal Register pages: 28361-28362

The table below reflects the impact of the proposed overall percentage change in FY15 IPPS payment rates on different providers. This incorporates the impact of statutory adjustments, budget neutrality adjustments, and provider specific impacts of CMS's various proposed policies. Contents extracted from table appearing on pages 28361-28362.

FY15 IPPS Proposed Update Impact Table

	All FY15 Proposed Changes (%)
All Hospitals	-0.8
Urban Hospitals	-0.9
Rural Hospitals	-0.2
Teaching Status	
Non-Teaching	-0.5
Fewer Than 100 Residents	-0.7
100 or More Residents	-1.3
Special Hospital Types	
Rural Referral Center	-1.0
Sole Community Hospital	2.0

FY15 Proposed Inpatient Payment Rate Changes

Federal Register pages: 28355

CMS proposes to make a 1.3 percent update to the national standardized amount. This update accounts for inflation and other mandatory adjustments required by law. The table below reflects these mandatory adjustments in the 1.3 percent update.

Policy	Proposed Impact
Market basket update	2.7%
Multifactor productivity adjustment	-0.4%
ACA mandate	-0.2%
ATRA adjustment	-0.8%
Total	**1.3%**

FY15 Proposed Inpatient Hospital Operating Payment Rate Update

Federal Register pages: 28355, 28086-28089

The applicable increase to the FY15 standardized amount for hospitals that submit quality data is **2.1** percent, as reflected in the following chart:

FY14 Market Basket	Minus MFP Adjustment	Minus ACA Mandate	**FY15 IPPS Standardized Amount**
2.7%	0.4	0.2	**2.1%**

CMS estimates that the total FY15 operating payments will decrease by 0.8 percent, ($864 million) compared to FY14. CMS projects that total Medicare spending on inpatient hospital services will decrease by about $241 million in FY15. The operating impact estimate includes the proposed -0.8 percent documentation and coding adjustment applied to the IPPS standardized amount. It also includes the proposed 2.1 percent hospital update to the standardized amount (which includes the estimated 2.7 percent market basket update less 0.4 percent for the proposed multifactor productivity adjustment, less 0.2 percentage point required under the ACA). The estimates of proposed IPPS operating payments to acute care hospitals do not reflect any changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

Each year CMS updates the national standardized amount for inpatient operating costs by a factor called the "applicable percentage increase." For FY15, there are three statutory changes to the applicable percentage increase compared to FY14. These changes are as follows:

1. For hospitals that submit quality data and are meaningful EHR users, CMS proposes an increase to the FY15 operating standardized amount of 2.1 percent (that is, the FY15 2.7 percent market basket increase estimate, less an adjustment of 0.4 percent multi-factor productivity (MFP) adjustment, and less 0.2 percent.

2. For hospitals that submit quality data and are not meaningful EHR users, CMS proposes an increase to the FY15 operating standardized amount of 1.425 percent

(that is, the FY15 2.7 percent market basket increase estimate, less an adjustment of 0.675 percent (the market basket increase of 2.7 percent x 0.75) / 3) for failure to be a meaningful EHR user, less an adjustment of 0.4 percent for the MFP adjustment, and less an additional adjustment of 0.2 percent).

3. For hospitals that do not submit quality data and are meaningful EHR users, CMS proposes an increase to the FY15 operating standardized amount of 1.425 percent (that is, the FY15 2.7 percent market basket increase estimate, less an adjustment of 0.675 percent (the market basket rate-of-increase of 2.7 percent / 4) for failure to submit quality data, less an adjustment of 0.4 percent for the MFP adjustment, and less an additional adjustment of 0.2 percent).

4. For hospitals that do not submit quality data and are not meaningful EHR users, CMS proposes an applicable increase to the FY15 operating standardized amount of 0.75 percent (that is, the FY15 estimate of the market basket rate-of-increase of 2.7 percent, less an adjustment of 0.675 percent (the market basket rate-of-increase of 2.7 percent / 4) for failure to submit quality data, less an adjustment of 0.675 percent (the market basket rate-of-increase of 2.7 percent x 0.75) / 3) for failure to be a meaningful EHR user, less an adjustment of 0.4 percent for the MFP adjustment, and less an additional adjustment of 0.2 percent).

The following table summarizes the four proposed applicable percentage increases. Please note that the percentages do not include adjustments for MS-DRG recalibration, and wage index budget neutrality, the Rural Community Demonstration Program, reclassification budget neutrality, operating outlier factor, documentation and coding adjustment, and labor market delineation wage index transition.

FY 2015	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-0.675	0.0	-0.675
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.2	-0.2	-0.2	-0.2
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.1**	**1.425**	**1.425**	**0.75**

CMS is proposing to revise the existing regulations to reflect the current law for the FY15 update, and make technical changes to reflect the order in which it applies the statutory adjustments to the applicable percentage increase.

Standardized Payment Rates

Federal Register pages: 28324-28325, 28344

For FY15, CMS is proposing to continue to use a labor-related share of **69.6** percent for discharges occurring on or after October 1, 2014. Tables 1A and 1B, published in section VI of the rule's addendum, reflect this proposed labor-related share. For FY15, for all IPPS hospitals whose wage indexes are less than or equal to 1.0000, CMS is proposing to apply the wage index to a labor-related share of 62 percent of the national standardized amount. For all IPPS hospitals whose wage indexes are greater than 1.0000, for FY15, CMS proposes to apply the wage index to a proposed labor-related share of 69.6 percent of the national standardized amount.

The following table contains the FY14 final national standardized amounts for all hospitals, excluding those hospitals in Puerto Rico.

Table 1A - Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.6 Percent Labor Share/30.4 Percent Nonlabor Share if Wage Index is Greater Than 1)--FY15

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.1 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.425 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 1.425 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0.75 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,759.46	$1,642.06	$3,734.61	$1,631.20	$3,734.61	$1,631.20	$3,709.75	$1,620.35

Table 1B.—Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share if Wage Index is Less Than or Equal To 1)--FY15

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.1 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.425 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 1.425 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = 0.75 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,348.94	$2,052.58	$3,326.80	$2,039.01	$3,326.80	$2,039.01	$3,304.66	$2,025.44

Documentation and Coding Adjustment

Federal Register pages: 27998

Section 631 of the American Taxpayer Relief Act (ATRA) requires the HHS Secretary to make a recoupment adjustment totaling $11 billion by FY17. CMS actuaries estimate that if CMS were to fully account for the $11 billion recoupment in FY14, a onetime -9.3 percent adjustment to the standardized amount would be necessary. Since it is often CMS's practice to delay or phase-in rate adjustments over more than 1 year in order to moderate the effect on rates in any 1 year, it applied a -0.8 percent adjustment to the standardized amount in FY14. CMS estimated that this level of adjustment would recover $0.96 billion in FY14, with approximately $10.04 billion remaining to be addressed. CMS is proposing to make an additional –0.8 percent recoupment adjustment to the standardized amount in FY 15. CMS estimates that this level of adjustment, combined with leaving the -0.8 percent adjustment made for FY14 in place, will recover up to $2 billion in FY15. Taking into account the $1 billion recovered in FY14, this will leave approximately $8 billion remaining to be recovered by FY17. Estimates of any future adjustments are subject to slight variations in total savings; therefore, CMS is not proposing specific adjustments for FYs 2016 and 2017 at this time. CMS also continues to believe that if it were to apply an additional prospective adjustment for the cumulative MS-DRG documentation and coding effect through FY10, the most appropriate additional adjustment is -0.55 percent. However, it is not proposing such an adjustment in FY15, in light of the ongoing recoupment required by the ATRA. Therefore, it will consider whether such an additional adjustment is appropriate in future years' rulemaking.

Capital Federal Rate for FY14

Federal Register pages: 28331

CMS proposes to establish an update of **1.5** percent in determining the FY15 capital Federal rate for all hospitals. The national capital federal rate would be **$433.01** for FY15 (compared to $429.31 for FY14). This is a result of the 1.5 percent update factor, the budget neutrality adjustment factor (-0.43%), and the proposed FY15 outlier adjustment factor (0.20%). The combined effect of all the proposed changes would increase the proposed national capital Federal rate by **0.86** percent compared to the FY14 national capital federal rate.

These factors are listed in the chart below.

Comparison of Factors and Adjustments: FY14 Capital Federal Rate and Proposed FY15 Capital Federal Rate

	FY 2014	Proposed FY 2015	Change	Percent Change
Update Factor[1]	1.0090	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor[1]	0.9987	0.9957	0.9957	-0.43
Outlier Adjustment Factor[2]	0.9393	0.9374	0.9980	-0.20
Capital Federal Rate	429.31	433.01	1.0086	0.86

Outlier Payments

Federal Register pages: 28321-28323

For FY15, CMS proposes to continue to use the outlier threshold methodology used in FY14. Using this methodology, CMS calculates a proposed outlier fixed-loss cost threshold for FY15 equal to the proposed prospective payment rate for the MS-DRG, plus any indirect medical education (IME), empirically justified Medicare disproportionate share (DSH) payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$25,799** (compared to FY14 $21,748). The proposed FY15 fixed-loss cost threshold is higher than the FY14 final outlier fixed-loss cost threshold. CMS believes that the increase in the charge inflation factor (compared to the FY14 charge inflation factor) contributed to a higher proposed outlier fixed-loss threshold for FY15. As charges increase, so do outlier payments. As a result, it would be necessary for CMS to raise the outlier fixed-loss cost threshold to decrease the amount of outlier payments expended in order to reach the 5.1 percent target.

Changes to the Hospital Area Wage Index

Federal Register pages: 28054-28084

The wage index will continue, for FY15, to be calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. CMS defines hospital labor market areas based on the Core-Based Statistical Areas (CBSAs). The proposed FY15 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY11 (the FY14 wage indexes were based on data from cost reporting periods beginning during FY10).

On February 28, 2013, the Office of Management and Budget (OMB) issued the OMB Bulletin No. 13-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provides guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.

CMS proposes to adopt the new OMB labor market area delineations announced on February 28, 2013. Therefore, hospitals would apply for reclassifications based on the new OMB delineations it proposes to use for FY15. Applications and other information about MGCRB reclassifications may be obtained via CMS web site at: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html. CMS is also proposing changes to the regulations to include reference to the most recent OMB standards for delineating statistical areas (using the most recent Census Bureau data and estimates) that were adopted by CMS.

The proposed FY15 national average hourly wage (unadjusted for occupational mix) is **$39.1525**. The proposed FY15 Puerto Rico overall average hourly wage (unadjusted for occupational mix) is **$17.0010**.

Puerto Rico Hospitals

Federal Register pages: 28084, 28088-28089, 28313-28314, 28344

Puerto Rico hospitals are paid a blended rate for their inpatient operating costs based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. The update to the Puerto Rico-specific operating standardized amount equals the applicable percentage increase, as for all other hospitals subject to the IPPS. Accordingly, CMS is proposing an applicable percentage increase to the Puerto Rico-specific operating standardized amount of **2.1** percent for FY15.

Under the proposal, for FY15, for all IPPS hospitals whose wage indexes are less than or equal to 1.0000, CMS would apply the wage index to a labor-related share of 62 percent of the national standardized amount. For all IPPS hospitals whose wage indexes are greater than 1.0000, for FY15, CMS would apply the wage index to a proposed labor-related share of **69.6** percent of the national standardized amount.

In the FY14 IPPS final rule, CMS rebased and revised the labor-related share for the Puerto Rico-specific standardized amounts using FY10 as a base year. It finalized a labor-related share for the Puerto Rico-specific standardized amounts for FY14 of 63.2 percent. In the FY15 proposed rule, for FY15, CMS proposes to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 63.2 percent for discharges occurring on or after October 1, 2014.

CMS is also proposing to adopt that the labor-related share of a hospital's Puerto Rico-specific rate would be either the Puerto Rico-specific labor-related share of 63.2 percent or 62 percent, depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0 for FY15, CMS would set the hospital's rates using a labor-related share of 63.2 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount would result in higher payments. A hospital with a Puerto Rico-specific wage index of less than or equal to 1.0 for FY15 would be paid using the Puerto Rico-specific labor-related share of 62 percent of the Puerto Rico-specific rates because the lower labor-related share would result in higher payments.

The proposed Puerto Rico labor-related share of 63.2 percent for FY15 is reflected in Table 1C (below), which is published in section VI of the Addendum to the proposed rule and available on the CMS web site.

Proposed Adjusted Operating Standardized Amounts for Puerto Rico (Labor/Nonlabor)

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
Standardized Amount	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
[1]National	Not Applicable	Not Applicable	$3,348.94	$2,052.58
Puerto Rico	$1,605.07	$934.59	$1,574.59	$965.07

FY14 National Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Non-labor

Federal Register pages: 28331-28332

Under the capital PPS, CMS computes a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national federal rate for capital-related costs. Beginning with discharges occurring on or after October 1, 2004, capital payments made to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital federal rate. For FY14, the special capital rate for hospitals located in Puerto Rico was $209.82.

With the changes CMS proposing to make to the other factors used to determine the proposed capital federal rate, the proposed FY15 special capital rate for hospitals in Puerto Rico is **$206.82**.

Proposed FY15 Capital Standard Federal Payment Rate

	Rate
National	$433.01
Puerto Rico	$206.82

Proposed FY15 Hospital-Acquired Condition (HAC) Reduction Program

Federal Register pages: 28134-28144

Section 3008 of the ACA added section 1886(p) to the Social Security Act "Act" to provide an incentive for applicable hospitals to reduce the incidence of Healthcare Acquired Conditions (HACs). Section 1886(p) of the Act requires the HHS Secretary to a payment adjustment to "applicable hospitals" effective beginning on October 1, 2014, and for subsequent programs years. Section 1886(p)(1) of the Act sets forth the requirements by which payments to "applicable hospitals" will be adjusted to account for HACs with respect to discharges occurring during FY15 or later. The amount of payment shall be equal to **99 percent** of the amount of payment that would otherwise apply to such discharges under section 1886(d) or 1814(b)(3) of the Act, as applicable. CMS refer readers to section V.I.1.a. of the FY14 IPPS final rule for a general overview of the HAC Reduction Program.

Prior to FY15 and each subsequent fiscal year, the HHS Secretary is required to provide the delivery of confidential reports to applicable hospitals with respect to HACs during the applicable period, and make this information available to the public. Hospitals will have the opportunity to review, and submit corrections before the information is made public. Once corrected, the HAC information must be posted on the *Hospital Compare* web site in a format that is easily understood.

In the FY14 IPPS final rule, CMS presented the general framework for implementation of the HAC Reduction Program for FY15, the first year of the payment adjustment under the HAC Reduction Program.

Maryland Hospital Exemption:

Because Maryland hospitals are no longer reimbursed under section 1814(b)(3) of the Act, they are no longer subject to those provisions of the Act and related implementing regulations, including but not limited to, those that provide exemptions for hospitals paid under section 1814(b)(3) from the application of the HAC Reduction Program. However, in order to implement the Maryland All-Payer Model, CMS has waived certain provisions of the Act for Maryland hospitals, including section 1886(p), and the corresponding implementing regulations. Although section 1886(p)(2)(C) of the Act no longer applies to Maryland hospitals, they will not be participating in the HAC Reduction Program because section 1886(p) of the Act and its implementing regulations have been waived for purposes of the model. Consequently, CMS is proposing that the total HAC scores for Maryland hospitals will not be included when identifying the top quartile of all hospitals with respect to their total HAC Score during the applicable period.

Selection of Measures:

CMS is not proposing any new measures for the HAC Reduction Program in the proposed rule, nor is it proposing any measure calculation changes for any of the measures finalized in the FY14 IPPS final rule.

Measure Updates:

For FY15, CMS will keep the Agency for Healthcare Research and Quality (AHRQ) PSI-90 composite measure (in Domain 1) adopted in the FY14 IPPS final rule as it is currently endorsed by National Quality Forum (NQF). However, CMS notes that the AHRQ PSI-90 composite measure is currently undergoing NQF maintenance review. The PSI-90 composite consists of eight component indicators:

- PSI-3 Pressure ulcer rate;
- PSI-6 Iatrogenic pneumothorax rate;
- PSI-7 Central venous catheter-related blood stream infections rate;
- PSI-8 Postoperative hip fracture rate;
- PSI-12 Postoperative PE/DVT rate;
- PSI-13 Postoperative sepsis rate;
- PSI-14 Wound dehiscence rate; and
- PSI-15 Accidental puncture & laceration rate.

AHRQ is considering the addition of PSI-9 (Perioperative hemorrhage rate), PSI-10 (Perioperative physiologic metabolic derangement rate) and PSI-11 (Post-operative respiratory failure rate) or a combination of these three measures into the PSI-90 composite. CMS considers the inclusion of measures in the PSI-90 composite to be a significant change to the PSI-90 composite that it finalized in the FY14 IPPS final rule. Should the changes be significant, CMS will issue notice-and-comment rulemaking prior to requiring reporting of this composite.

Similarly, the Center for Disease Control and Prevention National Healthcare Safety Network (CDC NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) and Central Line-Associated Blood Stream Infection (CLABSI) measures in Domain 2 adopted in the FY14 IPPS final rule for FY15 also are currently undergoing NQF maintenance review. Should the changes be significant, CMS will issue notice-and-

comment rulemaking prior to requiring reporting of the changes made to CDCs NHSN CLABSI and CAUTI measures. For FY15, CMS will keep CDC's NHSN CAUTI and CLABSI measures in Domain 2 as they are currently endorsed.

Applicable Time Period:

In the FY14 IPPS final rule, CMS finalized and codified policy that there will be a 2-year applicable time period to collect data used to calculate the Total HAC Score.

- For the Domain 1 AHRQ PSI-90 composite measure, CMS is proposing for FY16 a 24-month period from July 1, 2012, through June 30, 2014, as the applicable time period. The claims for all Medicare fee-for-service beneficiaries discharged during this period would be included in the calculation of measure results for FY16. This includes claims data from the 2012, 2013, and 2014 Inpatient Standard Analytic Files.

- The Domain 2 CDC NHSN measures (CAUTI, CLABSI, and SSI) are currently collected and calculated on a quarterly basis. However, for the purpose of the HAC Reduction Program, CMS will use two years of data to calculate the Domain 2 score. For FY16, CMS is proposing to use calendar years 2013 and 2014 for all three Domain 2 measures in the HAC Reduction Program.

Performance Scoring Policy:

In the FY14 IPPS final rule, CMS finalized a scoring methodology that aligns with the achievement scoring methodology currently used under the Hospital VBP Program. CMS believes aligning the scoring methodologies reduces confusion associated with multiple scoring methodologies. If a hospital has enough data to calculate the PSI-90 composite score for Domain 1 and "complete data" for at least one measure in Domain 2, the scores of the two domains will contribute to the Total HAC Score at 35 percent for Domain 1 and 65 percent for Domain 2.

For the HAC Reduction Program, CMS finalized the use of a slightly different methodology for scoring points, depending on the specific measure. This is illustrated in the tables below.

Based on the distribution for PSI-90 rates for all hospitals, CMS will divide the results into percentiles in increments of 10 with the lowest percentile ranges meaning better performance. Hospitals with PSI-90 rates within the lowest tenth percentile will be given one point; those with PSI-90 rates within the second lowest percentile range (between the 11th and 20^{th} percentile) will be given 2 points, and so forth.

Table C.--Calculation of Domain 1 and 2 Measures for FY 2015			
Measure Name	**Measure Result**	**Scenario**	**Individual Measure Score (Points)**
Domain 1 AHRQ PSI-90 ***	Weighted average of rates of component indicators	Composite value	1 – 10
Domain 2 CDC NHSN CAUTI CLABSI	Standard Infection Ratio (SIR)	SIR	1 – 10 (refer to Figure A)

***These measure rates are risk-adjusted and reliability-adjusted.

Figure A.--Point Assignment for Hospital A's PSI-90 Score	
If Hospital A's PSI-90 rate falls into this percentile	**Then assign this number of points**
1st – 10th	1
11th – 20th	2
21st - 30th	3
31st - 40th	4
41st - 50th	5
51st - 60th	6
61st - 70th	7
71st - 80th	8
81st - 90th	9
91st - 100th	10

CMS finalized the PSI-90 composite measure for Domain 1. Because hospitals may not have complete data for every AHRQ indicator in the composite measure for this Domain 1 measure, CMS finalized the same methodology used for the Hospital VBP Program to determine the minimum number of indicators with complete data to be included in the calculation of the domain measure. CMS also finalized the rules to determine the number of AHRQ indicators to be included in the calculation for a hospital's Domain 1 score.

For Domain 2, CMS will obtain measure results that hospitals submitted to the CDC NHSN for the Hospital IQR Program. The CDC NHSN measures capture adverse events that occurred within intensive care units (ICUs), including pediatric and neonatal units. For the Hospital IQR Program, hospitals that elected to participate in the reporting program (that is, had an active IQR pledge), but did not have ICUs, can apply for an ICU waiver so that they will not be subject to the 2-percent payment reduction for non-submission of quality reporting data.

Proposed Clarification of FY15 Finalized Rules to Calculate Total HAC Score

In the FY14 IPPS final rule, CMS finalized a series of rules to determine how to calculate the Domain 2 score and ultimately the Total HAC Score when there were waivers for the collection of CDC NHSN healthcare associated infection (HAI) measures. CMS also illustrated and finalized these rules in Figure B of the final rule. CMS is proposing to clarify that the narrative for Figure B, which illustrated and finalized these rules, should also include "other waivers" that waive hospitals from collecting CDC HAI measure data.

Criteria for Applicable Hospitals and Performance Scoring

For FY16, CMS proposes a change to the scoring methodology of the Total HAC Score. This proposal is intended to address the implementation of CDC's NHSN SSI measure in Domain 2 finalized for implementation in FY16. Specifically, CMS proposes to adjust the scoring methodology of Domain 2 and the weighting of Domains 1 and 2. For the scoring of CDC's NHSN surgical site infection (SSI) measure, CMS proposes an identical process of assigning points to the SSI measure results. The SSI measure, reported via CDC's NHSN, is currently specified under the Hospital IQR program and is restricted to colon procedures, and abdominal hysterectomy procedures, including those performed by laparoscope. CMS also notes that patient age and a preoperative health score are risk factors taken into account using the Standardized Infection Ratio (SIR).

Use of an SIR is consistent with CDC's NHSN CLABSI and CAUTI measures that also report SIRs. In order to calculate an SSI measure score for Domain 2, CMS would calculate an abdominal hysterectomy procedure SSI SIR and a colonic procedure SSI SIR, and pool both SIRs for each hospital, as this would provide a single SSI SIR, which is consistent with reporting a single SSI SIR as meant by design of the National Quality Forum (NQF) endorsed measure (NQF #0753), and would allow a risk-adjusted weighting of the surgical volume among the two procedures. The pooled SSI SIR would be scored in the same manner as all measures finalized for the HAC Reduction Program. To determine a Domain 2 score, CMS would take the average of the three CDC HAI SIR scores. CMS is proposing to follow the same finalized rules used to determine scoring of Domains 1 and 2 (FY14 IPPS final rule and the proposed changes in section IV.I.6.b. of the proposed rule). CMS invites public comments on this proposal.

In addition, for FY16, CMS proposes to weight Domain 1 at 25 percent and Domain 2 at 75 percent. CMS would decrease Domain 1's weight from 35 percent to 25 percent for two reasons. First, with the implementation of CDC's SSI measure, the weighting of both domains needs to be adjusted to reflect the addition of a fourth measure; and second, in keeping with public comments from the FY14 IPPS final rule, MedPAC and others stated that Domain 2 should be weighted more than Domain 1. Finally, the Total HAC Score for applicable hospitals would be the sum of the weighted scores from Domain 1 (weighted at 25 percent) and Domain 2 (weighted at 75 percent).

Future Considerations for Use of Electronically Specified Measures

CMS is seeking comment as to whether the use of a standardized electronic composite measure of all-cause harm should be used in the HAC reduction program in future years in addition to, or in place of, claims-based measures assessing HACs. Specifically, CMS invites public comments on the feasibility and the perceived value of such a measure, and what would be the most appropriate weighting of this measure in the Total HAC Performance Score.

Hospital Readmissions Reduction Program

Federal Register pages: 28105-28117

The ACA establishes the Hospital Readmissions Reduction Program, effective for discharges from an "applicable hospital" beginning on or after October 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions. Section 1886(q)(1) of the Act sets forth the methodology by which

payments to "applicable hospitals" will be adjusted to account for excess readmissions. Accordingly, payments for discharges from an "applicable hospital" will be an amount equal to the product of the "base operating DRG payment amount" and the adjustment factor for the hospital for the fiscal year. That is, "base operating DRG payments" are reduced by a hospital-specific adjustment factor that accounts for the hospital's excess readmissions.

In the FY14 IPPS final rule, CMS finalized its policies that relate to refinement of the readmissions measures and related methodology for the current applicable conditions, expansion of the "applicable conditions" beginning for FY15, and clarification of the process for reporting hospital specific information, including the opportunity to review and submit corrections. CMS also established policies related to the calculation of the adjustment factor for FY14.

Refinement of the Readmission Measures

In the FY14 IPPS final rule, CMS finalized for FY14 and subsequent years' payment determinations the use of the CMS Planned Readmission Algorithm Version 2.1 in the acute myocardial infarction (AMI), Heart Failure (HF), Pneumonia (PN), Chronic obstructive pulmonary disease (COPD), and total hip arthroplasty/total knee arthroplasty (THA/TKA) readmission measures. The algorithm identifies readmissions that are planned and occur within 30 days of discharge from the hospital. CMS has identified and made improvements to the algorithm, and is proposing to use the revised version, CMS Planned Readmission Algorithm Version 3.0, for these readmission measures for FY15 and subsequent payment determinations. CMS is also proposing to use this algorithm for the coronary artery bypass graft [surgery] (CABG) readmission measure proposed for inclusion in the Hospital Readmissions Reduction Program starting in FY17.

Refinement of Total Hip and Total Knee Arthroplasty (THA/TKA)

Currently, the total hip arthroplasty (THA)/ total knee arthroplasty (TKA) Readmission Measure adopted for the Hospital Readmissions Reduction Program is intended to only include patients who have an elective THA or TKA. This measure therefore excludes patients who have a principal discharge diagnosis of femur, hip, or pelvic fracture on their index admission since hip replacement for hip fracture is not an elective procedure. Upon review of hospital-specific THA/TKA readmission measure data, CMS learned that hospitals code hip fractures that occur during the same admission as a THA as either a principal or secondary diagnosis. To ensure that all such hip fracture patients are excluded from the measure, CMS is proposing to refine the measure to exclude patients with hip fracture coded as either principal or secondary diagnosis during the index admission.

Expansion of the Applicable Conditions for FY16

In the FY14 IPPS final rule, CMS finalized for FY15, two new condition specific readmission measures: (1) Hospital-level 30-day all-cause risk-standardized readmission rate following elective THA and TKA (NQF #1551); and (2) Hospital-level 30-day all-cause risk-standardized readmission rate following chronic obstructive pulmonary disease (COPD) (NQF #1891), bringing the total number of finalized applicable conditions to five over the past two years of implementation. In view of requests to delay adding other condition-specific measures, and CMS's belief that it is reasonable to allow more time for hospitals to become familiar with these 5 applicable conditions before adding others, CMS is not proposing any new applicable conditions for FY16.

Expansion of the Applicable Conditions for FY17 to Include Patients Readmitted Following Coronary Artery Bypass Graft (CABG) Surgery Measure

CMS is proposing the inclusion of the condition of the Coronary Artery Bypass Graft (CABG) readmissions to the Hospital Readmissions Reduction Program based on MedPAC's recommendations. Evidence shows variation in readmissions rates for patients with CABG surgery, supporting the finding that opportunities exist for improving care. The NQF Measure Applications Partnership (MAP) Hospital workgroup conditionally supported this measure for use in the Hospital Readmissions Reduction Program. The condition for support is based on attainment of NQF endorsement. CMS submitted the CABG readmission measure to NQF for endorsement on February 5, 2014. CMS notes that the set of hospitals for which this measure is calculated for the Hospital Readmissions Reduction Program differs from those used in calculations for the Hospital IQR Program. For details, please see pages 28108-28111.

Maintenance of Technical Specifications for Quality Measures

Many of the quality measures used in different Medicare and Medicaid reporting programs are NQF endorsed. As part of its regular maintenance process for NQF-endorsed performance measures, the NQF requires measure stewards to submit annual measure maintenance updates and undergo maintenance of endorsement review every three years. For the Hospital Readmissions Reduction Program, CMS proposes to follow the finalized processes outlined for addressing changes to adopted measures in the Hospital IQR Program "Maintenance of Technical Specifications for Quality Measures" section found in section IX.A.1.b. of the proposed rule's preamble.

Hospital Readmissions Reduction Program Waiver

Section 1886(q)(2)(B)(ii) of the Act allows the HHS Secretary to exempt hospitals from the Hospital Readmissions Reduction Program, provided that the state submit an annual report describing how a similar program to reduce hospital readmissions in that state achieves or surpasses the measured results in terms of health outcomes and cost savings established by Congress for the program as applied to "subsection (d) hospitals." The state of Maryland entered into an agreement with CMS, effective January 1, 2014, to participate in CMS' new Maryland All-Payer Model. As part of this agreement, the state elected to no longer have Medicare pay its hospitals in accordance with section 1814(b)(3) of the Act. Therefore, section 1886(q)(2)(B)(ii) of the Act is no longer applicable to Maryland hospitals, and the exemption from the Hospital Readmissions Reduction Program no longer applies. However, Maryland hospitals will not be participating in the Hospital Readmissions Reduction Program because section 1886(q) and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement. Therefore, CMS is proposing to make conforming changes to the implementing regulations to reflect this change.

Floor Adjustment Factor for FY15

CMS is proposing that for FY15, the floor adjustment factor is **0.97** for FY15 and subsequent fiscal years. CMS will calculate the excess readmission ratios for payment adjustments for hospitals using data from the 3-year time period from July 1, 2010, to June 30, 2013.

Inclusion of THA/TKA and COPD Readmissions Measures for FY15 Excess Readmissions Payment Calculations

In the rule, CMS discusses how the addition of COPD and THA/TKA applicable conditions would be included in the calculation of the aggregate payments for excess readmissions, which is the numerator of the readmissions payment adjustment. CMS notes that this proposal does not alter its established methodology for calculating aggregate payments for all discharges, which is the denominator of the ratio.

For FY 15, CMS is proposing to modify its current methodology to identify the admissions included in the calculation of aggregate payments for excess readmissions for THA/TKA and COPD in the same manner as the original applicable conditions (AMI, HF and PN). ***Appendix 1*** lists the ICD-9-CM codes CMS is proposing to use to identify each applicable condition to calculate the aggregate payments for excess readmissions under this proposal for FY15. The table also includes the ICD-9-CM codes that would be used to identify the two conditions, added to the Hospital Readmissions Reduction Program, beginning in FY15. ***Appendix 2*** displays the formula for the aggregate payment for excess readmission calculation.

Hospital Quality Reporting Program

Federal Register pages: 28218-28278

Annual payment updates for hospitals that do not participate successfully in the Hospital IQR program are reduced by **2.0 percent**. Beginning with FY15, hospitals that do not participate will lose one-quarter of the percentage increase in their payment updates. For a list of IQR impact payment determinations, associated collection periods, and measure information for FY14, FY15, and FY16, see Appendices 3a-3h of HFMA's *FY14 IPPS Final Rule Fact Sheet*.

Removal and Suspension of Hospital IQR Program Measures

CMS generally retains measures from the previous year's Hospital IQR Program measure set for subsequent years' measure sets except when it specifically proposes to remove or replace them. One criterion that CMS uses when deciding to remove a measure is if its performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. Such measures are considered "topped out". In the rule, CMS proposes to change the criteria for determining when a measure is "topped-out."

Removal of Hospital IQR Program Measures for FY17 and Beyond

CMS is proposing to remove the five measures from the Hospital IQR Program for the FY17 payment determination and subsequent years because they have "topped out", but is proposing to retain the electronic version of 10 of the chart abstracted measures for Hospital IQR Program reporting. ***See Appendix 3 for details.***

Previously Adopted Hospital IQR Program Measures for the FY16 Payment Determination and Subsequent Years

For currently adopted and future condition-specific, claims-based measures, beginning with the FY17 payment determination and subsequent years, CMS is proposing to use three years of data to calculate measures. In other words, this reporting period would apply to all future calculations of condition specific measures already adopted in the Hospital IQR Program and any condition specific measures that may be subsequently

adopted in future years. CMS welcomes public comments on its proposal to use three years of data to calculate current and future condition specific, claims-based measures. ***Appendix 4 contains a table showing the Hospital IQR Program Measures adopted for the FY16 payment determination and subsequent years***.

Proposed Additional Hospital IQR Program Measures for the FY17 Payment Determination and Subsequent Years

CMS proposes to add a total of eleven measures to the measure set for the FY17 payment determination and subsequent years. The first nine new measures are as follows:

1. Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery (claims-based);
2. Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery (claims-based);
3. Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia (claims based);
4. Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure (claims based);
5. Severe Sepsis and Septic Shock: Management Bundle (NQF #0500) (chart abstracted);
6. EHDI-1a Hearing Screening Prior to Hospital Discharge (NQF #1354) (electronic health record-based);
7. PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (NQF#0480) (electronic health record-based);
8. CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver (electronic health record-based); and,
9. Healthy Term Newborn (NQF #0716) (electronic health record-based).

To align the Hospital IQR Program with the Medicare EHR incentive program for eligible hospitals and critical access hospitals (CAHs), and allow hospitals as many measure options as possible that overlap both programs, CMS is proposing to readopt two measures previously removed from the Hospital IQR Program as voluntary electronic clinical quality measures:

10. AMI-2 Aspirin Prescribed at Discharge for AMI (NQF #0142) (electronic clinical quality measure); and
11. AMI-10 Statin Prescribed at Discharge (NQF #0639) (electronic clinical quality measure).

These two measures are part of the Stage 2 Medicare EHR Incentive Program measure set for eligible hospitals and CAHs.

Appendix 5 contains a table showing both previously adopted and the proposed quality measures for the FY17 payment determination and subsequent years.

CMS notes that this table does not include suspended measures or measures proposed for removal.

Electronic Clinical Quality Measures

CMS believes that collection and reporting of data through health information technology will greatly simplify and streamline reporting for many quality reporting programs. In the Medicare EHR Incentive Program Stage 2 final rule, CMS finalized a total of 29 clinical quality measures from which hospitals must select at least 16 measures covering three National Quality Strategy (NQS) domains to report beginning in FY14. In the FY14 IPPS final rule, for the STK (with the exception of STK-1), VTE, ED, and PC measure sets, CMS allowed hospitals to either: (1) electronically report at least one quarter of CY14 (Q1, Q2, or Q3) quality measure data for each measure in one or more of those four measure sets; or (2) continue reporting all measures in those four measure sets using chart-abstracted data for all four quarters of CY14.

For the FY17 payment determination, CMS is proposing to expand this policy, such that providers may select to voluntarily report any 16 of the 28 Hospital IQR Program electronic clinical quality measures that align with the Medicare EHR Incentive Program as long as those 16 measures span three different NQS domains. Only 28 of the 29 measures adopted in the Medicare EHR Incentive Program are applicable for the Hospital IQR Program. For the FY17 payment determination, CMS is also proposing to expand the reporting requirement of electronic clinical quality measures to require a full year's data collection and submission instead of a minimum of one quarter. ***These 28 clinical quality measures appear in Appendix 6***. Please note: the Healthy Term Newborn (NQF #0716) measure does not appear to have a short name.

In addition, for the FY17 payment determination, CMS is proposing to require data submission within approximately 60 days after the end of a calendar year quarter. The proposed submission deadlines appear in the following table.

CY 2015/FY 2017 Electronic Clinical Quality Measures Data Reporting Periods and Proposed Submission Deadlines		
CY 2015 Quarter	**Reporting Period (2015)**	**Proposed Submission Deadline (2015)**
1	January 1 -March 31	May 30
2	April 1 - June 30	Aug 30
3	July 1 - September 30	Nov 30
4	October 1 - December 31	Feb 28

As an incentive for hospitals to voluntarily submit electronically-specified clinical quality measures, CMS proposes that for the FY17 payment determination, hospitals successfully submitting electronic clinical quality measures according to its procedures will not have to validate those electronic clinical quality measures by submitting chart-abstracted data to validate the accuracy of the measure data.

Public Reporting of Electronic Clinical Quality Measures

In the FY14 IPPS/LTCH PPS final rule CMS adopted a policy under which it would only publicly report electronic clinical quality measure data under the Hospital IQR Program if it determined that the data are accurate enough to be reported. However, for the FY17 payment determination, CMS now proposes to provide hospitals that voluntarily report

one year of electronic clinical quality measure data (as proposed above) an option to have their data reported on *Hospital Compare* with *a preview period prior to public reporting*. It also proposes to add a footnote next to that publically reported data indicating that it is a result of electronically-specified measures.

Possible New Quality Measures and Measure Topics for Future Years

CMS believes that this voluntary reporting option will provide itself and hospitals with the ability to test systems in CY15 for future quality program proposals that, if finalized, will make electronic reporting a requirement instead of voluntary. CMS intends to propose to require reporting of electronic clinical quality measures for the Hospital IQR Program beginning for the CY16 reporting period or FY18 payment determination. CMS intends to also propose to adopt the following electronic clinical quality measures with data collection beginning with October 1, 2016, discharges (or, as described further above, January 1, 2017, if the proposal to align reporting under the Hospital IQR Program and Medicare EHR Incentive Program is finalized) to coincide with EHR Incentive Program Stage 3 collection:

- Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge NQF #0475
- PC-02 Cesarean Section NQF #0471
- Adverse Drug Events – Hyperglycemia
- Adverse Drug Events – Hypoglycemia

Form, Manner, and Timing of Quality Data Submission

Hospitals choosing to participate in the Hospital IQR Program must also meet specific data collection, submission, and validation requirements. CMS is not proposing any changes to data submission requirements for chart-abstracted measures at this time.

Alignment of the EHR Incentive Program Reporting and Submission Timelines for Clinical Quality Measures with Hospital IQR Program

As a result of the different and incongruent Hospital IQR and Medicare EHR Incentive Programs' schedules, hospitals reporting and submitting measure data to both programs would have to do so multiple times in a calendar year, which may create confusion and additional burden for hospitals attempting to do so. To alleviate this possible confusion and reduce provider burden, beginning with the CY15 reporting period /FY17 payment determination, CMS is proposing to incrementally align the data reporting and submission periods for clinical quality measures for the Medicare EHR Incentive Program and the Hospital IQR Program on a calendar year basis. Also, in order to ease the transition and prevent the delay of Medicare EHR Incentive Program payments, CMS is proposing to align the reporting and submission periods of the Medicare EHR Incentive Program clinical quality measures with that of the Hospital IQR Program for CYs 2015 and 2016. ***The proposed reporting timeline to align the EHR Incentive Program with proposed hospital IQR Program submission periods can be found in Appendix 7.***

Hospital Value-Based Purchasing (VBP) Program

Federal Register pages: 28117-28134

The Hospital VBP Program applies to payments for hospital discharges occurring on or after October 1, 2012. CMS is required to make value-based incentive payments under the Hospital VBP Program to hospitals that meet or exceed performance standards for a performance period for a fiscal year. The total amount available for value-based incentive payments for a fiscal year will be equal to the total amount of the payment reductions for all participating hospitals for such fiscal year, as estimated by the HHS Secretary. For FY14, the available funding pool is equal to 1.25 percent of the base-operating DRG payments to all participating hospitals. The size of the applicable percentage has increased to 1.50 percent for FY15, and will increase to 1.75 percent for FY16, and to 2.0 percent for FY17, and successive fiscal years.

FY 2015 Payment Details

CMS estimates that the total amount available for value-based incentive payments for FY15 is $1.4 billion, based on the December 2013, update of the FY13 Medicare Provider Analysis and Review File (MedPAR file). CMS intends to update this estimate for the FY15 IPPS final rule, using the March 2014 update of the FY13 MedPAR file. CMS will utilize a linear exchange function to translate this estimated amount available into a value-based incentive payment percentage for each hospital, based on its total performance score (TPS). It will then calculate a value-based incentive payment adjustment factor that will be applied to the base operating DRG payment amount for each discharge occurring in FY15, on a per-claim basis. CMS published proxy value-based incentive payment adjustment factors in Table 16 of this proposed rule (which is available on the CMS web site). The proxy factors are based on the TPSs from the FY14 Hospital VBP Program. These FY14 performance scores are the most recently available performance scores that hospitals have been given the opportunity to review and correct. After hospitals have been given an opportunity to review and correct their actual TPSs for FY15, CMS will add Table 16B (which will be available on the CMS web site) to display the actual value-based incentive payment adjustment factors, exchange function slope, and estimated amount available for the FY15 Hospital VBP Program.

Base Operating DRG Payment Amount Definition for Medicare-Dependent Small Rural Hospitals (MDHs)

For FY15 and subsequent years, for purposes of calculating the payment adjustment factors and applying the payment methodology, CMS is proposing that the base operating DRG payment amount for Medicare-Dependent Small Rural Hospitals (MDHs) will include the difference between the hospital-specific payment rate and the federal payment rate (as applicable), and to revise the definition of base operating DRG payment amount in § 412.160 paragraph (2) of its regulations to reflect this change.

FY17 Hospital VBP Program Measures

In the FY13 IPPS final rule, CMS finalized its proposal to readopt measures from the prior program year for each successive program year, unless proposed and also finalized otherwise (for example, because one or more of the measures is “topped-out” or for other policy reasons).

The FY16 Hospital VBP Program includes the following measures:

Finalized Measures for the FY 2016 Hospital VBP Program

Clinical Process of Care Domain	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
IMM-2	Influenza Immunization
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
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

Patient Experience of Care Domain	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey

Outcome Domain	
CAUTI	Catheter-Associated Urinary Tract Infection
CLABSI	Central Line-Associated Blood Stream Infection
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate
MORT-30-HF	Heart Failure (HF) 30-day mortality rate
MORT-30-PN	Pneumonia (PN) 30-day mortality rate
PSI-90	Complication/patient safety for selected indicators (composite)
SSI	Surgical Site Infection: • Colon • Abdominal Hysterectomy

Efficiency Domain	
MSPB-1	Medicare Spending per Beneficiary

Removal of Six Topped-Out Measures

Based on its evaluation of the most recently available data, CMS believes that the following measures are now "topped-out":

- PN-6
- SCIP-Inf-2
- SCIP-Inf-3
- SCIP-Inf-9
- SCIP-Card-2
- SCIP-VTE-2

Therefore, CMS is proposing to remove these six measures from the FY17 Hospital VBP measure set because measuring hospital performance on these measures will have no meaningful effect on a hospital's TPS.

New Measures for the FY17 Hospital VBP Program

CMS believes that the following three proposed measures meet the statutory requirements for inclusion in the FY17 Hospital VBP Program. These measures also represent important components of quality improvement in the acute inpatient hospital setting.

- Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia (NQF #1716)
- *Clostridium difficile* Infection (NQF #1717)
- PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation (NQF #0469)

Adoption of the Current CLABSI Measure (NQF #0139) for the FY17 Hospital VBP Program

In the FY14 IPPS final rule, CMS adopted the CLABSI measure for the FY16 Hospital VBP Program. CMS believes that adopting the current CLABSI measure is consistent with the MAP's recommendations to use the standardized infection ratio version of the measure until the reliability-adjusted CLABSI measure is NQF-endorsed. Therefore, CMS is proposing to adopt the current version of the CLABSI measure for the FY17 Hospital VBP Program and subsequent years. If a reliability-adjusted version of the measure becomes available in the future, CMS will consider adopting it.

Appendix 8 contains a table that outlines the measures for the FY17 Hospital VBP Program that CMS is readopting, as well as those measures that it proposes to adopt.

The table includes the FY17 domains in which it would place the previously adopted measures, as well as the proposed domains in which it would place the newly proposed measures.

Additional Measures for the FY19 Hospital VBP Program

CMS is proposing to adopt the following measures for the FY19 VBP Program:

- Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (NQF #1550) – (to be placed in the Clinical Care – Outcomes domain)
- PSI-90 Measure

In the FY14 IPPS final rule, CMS declined to finalize the PSI–90 measure for the FY19 Hospital VBP Program in order to adopt a more recent baseline period than would have been possible at that time. However, CMS did not intend to signal that it would not adopt the PSI– 90 measure for FY19 and subsequent years. In order to clarify the measure's status under the Hospital VBP Program, and ensure that there is no confusion about its intent, CMS proposes to readopt the PSI–90 measure for FY 19 Hospital VBP Program and subsequent years.

Possible Measure Topics for Future Program Years

CMS is considering proposing to add the Care Transition Measure from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey to the Patient and Caregiver Centered Experience of Care/Care Coordination (PEC/CC) domain of the FY18 Hospital VBP Program. The Care Transition Measure (CTM) was added to the HCAHPS Survey of hospital inpatients in January 2013. Three items were added to the HCAHPS Survey to create the new CTM composite. After collecting four quarters of data on these items (January 2013 through December 2013), CMS intends to publicly report CTM scores for the first time on its *Hospital Compare* web site in October 2014. CMS intends to propose that the PEC/CC domain in the FY18 Hospital VBP Program would have a baseline period of January 1, 2014, through December 31, 2014, and a performance period of January 1, 2016, through December 31, 2016.

Possible Future Efficiency and Cost Reduction Domain Measure Topics

In the interest of expanding the Efficiency domain to include a more robust measure set, including measures that supplement the Medicare Spending per Beneficiary (MSPB) measure with more condition and/or treatment specific episodes, as well as facilitating alignment with the Physician Value-Based Payment Modifier (VM) Program, CMS is considering proposing to add six new episode-based payment measures to the Hospital VBP Program through future rulemaking. Three medical and three surgical episodes are being considered for the initial expansion of the Efficiency domain.

The medical episodes would address the following conditions:

- kidney/urinary tract infection;
- cellulitis; and
- gastrointestinal hemorrhage.

The surgical episodes currently under consideration are:

- hip replacement/revision;
- knee replacement/revision; and
- lumbar spine fusion/refusion

Previously Adopted and Proposed Performance Periods and Baseline Periods for the FY17 Hospital VBP Program

The HHS Secretary must establish a performance period for the Hospital VBP Program for a fiscal year that begins and ends prior to the beginning of the fiscal year. In the FY14 IPPS final rule, CMS adopted new NQS-based quality domains for FY17, and is proposing to adopt performance and baseline periods using those new domains for the FY17 Hospital VBP Program. The chart below summarizes the proposed baseline and performance periods for the FY17 Hospital VBP Program (with previously adopted baseline and performance periods for the mortality and AHRQ PSI composite (PSI-90) measures noted).

Previously Adopted and Proposed Performance and Baseline Periods for the FY 2017 Hospital VBP Program		
Domain	**Baseline Period**	**Performance Period**
Safety • PSI-90* • NHSN (CAUTI, CLABSI, SSI, C. difficile Infection, MRSA Bacteremia)	• October 1, 2010 – June 30, 2012* • January 1, 2013 – December 31, 2013	• October 1, 2013 – June 30, 2015* • January 1, 2015 – December 31, 2015
Clinical Care – Outcomes • Mortality* (MORT-30-AMI, MORT-30-HF, MORT-30-PN)	• October 1, 2010 – June 30, 2012*	• October 1, 2013 – June 30, 2015*
Clinical Care – Process • (AMI-7a, IMM-2, PC-01)	January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015
Efficiency and Cost Reduction (MSPB-1)	January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015
Patient and Caregiver-Centered Experience of Care/Care Coordination (HCAHPS)	January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

* Previously adopted performance and baseline periods.

To review the final baseline and performance periods for the FY14, FY15, and FY16 Hospital VBP Program measures, see the chart appearing on page 16 and 17 of HFMA's *FY14 IPPS Final Rule Fact Sheet*. CMS notes that it intends to propose additional baseline and performance periods for the FY18 Hospital VBP Program in future rulemaking. CMS also discusses previously adopted and proposed performance and baseline periods for certain measures for the FY19 and FY20 Hospital VBP Program in the proposed rule.

Performance Standards for the FY16 Hospital VBP Program

In the FY13 IPPS final rule, CMS adopted performance standards for FY15 and certain FY16 Hospital VBP Program measures. CMS also finalized its policy to update performance periods and performance standards for future Hospital VBP Program years via notice on its web site or another publicly available web site. To review the FY16 VBP performance standards, as well as those for FY15 and FY14, see Appendices 4b, 5b, and 6b of HFMA's *FY14 IPPS Final Rule Fact Sheet*.

Proposed Additional Performance Standards for the FY17 Hospital VBP Program

In accordance with the finalized methodology for calculating performance standards (discussed more fully in the Hospital Inpatient VBP Program final rule published May 6, 2011), CMS is proposing to adopt additional performance standards for the FY17 Hospital VBP Program. The numerical values for the performance standards represent estimates based on the most recently available data, and CMS intends to update the numerical values in the FY15 IPPS PPS final rule. CMS notes further that the MSPB

measure's performance standards are based on performance period data; therefore, it is unable to provide numerical equivalents for the standards at this time. ***The numerical values for the performance standards for FY17 are listed in Appendix 9***. CMS notes that it intends to propose additional performance standards for the FY18 Hospital VBP Program in future rulemaking. In the rule, CMS also discusses its proposals to adopt performance standards for the FY19 and FY20 Hospital VBP Program.

ICD-10-CM/PCS Transition

The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-CM/PCS) transition is scheduled to take place on October 1, 2015. After that date, CMS will collect non-electronic health record-based quality measure data coded only in ICD-10-CM/PCS. Even though CMS expects that the endorsement status of the measures it has adopted for the Hospital VBP Program will remain the same, it is concerned that the transition to a new coding system might have unintended consequences on quality measure data denominators, statistical adjustment coefficients, and measure rates. CMS is concerned about the possible impacts on the Hospital VBP Program, and requests public comments on how it should accommodate the transition. CMS intends to take two steps to analyze ICD-10-CM/PCS potential impact before receiving ICD-10-CM/PCS-based fall 2015 discharge data in May 2016. First, it will assess measure specifications to qualitatively assess the impact to measure denominators after CMS releases ICD-10-CM/PCS-based measure specifications in the future. Second, it intends to voluntarily solicit information from no more than 9 hospitals before October 1, 2015, to estimate the impact of ICD-10-CM/PCS on their Hospital VBP measure rates and denominator counts. CMS intends to use this information to inform both proposed and future Hospital VBP Program policy and measures.

FY17 Hospital VBP Program Scoring Methodology

CMS adopted a methodology for scoring clinical process of care, patient experience of care, and outcome measures. CMS is proposing to adopt the general scoring methodology it adopted for the FY16 Hospital VBP Program for the FY17 Hospital VBP Program, with modifications to accommodate the new quality domains. These proposed modifications to the scoring methodology are limited to reclassified quality domains, new placements for measures within those domains, and domain weighting. In the FY14 IPPS final rule, CMS adopted its proposal to align the Hospital VBP Program's quality measurement domains with the NQS' quality priorities, with certain modifications, beginning with the FY17 Hospital VBP Program. However, since CMS is proposing to remove six "topped out" measures from the FY17 Clinical Care – Process subdomain, it believes that the proposed substantial reduction in the number of measures adopted for this subdomain, if finalized, warrants reconsideration of the finalized domain weighting for FY17.

In view of the new measures CMS proposes to add to that domain, it would revise the previously finalized domain weighting for the FY 17 Hospital VBP Program for hospitals receiving a score on all newly aligned domains as follows:

Proposed Revised Domain Weights for the FY 2017 Hospital VBP Program for Hospitals Receiving a Score on All Newly Aligned Domains	
Domain	**Weight**
Safety	20 percent
Clinical Care • Clinical Care – Outcomes • Clinical Care – Process	30 percent • 25 percent • 5 percent
Efficiency and Cost Reduction	25 percent
Patient and Caregiver Centered Experience of Care/Care Coordination	25 percent

Proposed Domain Weighting for the FY17 Hospital VBP Program for Hospitals Receiving Scores on Fewer than Four Domains

CMS is proposing to require that, for the FY17 Hospital VBP Program and subsequent years, hospitals must receive domain scores on at least three quality domains in order to receive a total performance score (TPS). For purposes of the Clinical Care domain score, CMS is proposing to consider either the Clinical Care – Process or Clinical Care – Outcome subdomains as one domain in order to meet this proposed requirement. By adopting this policy, CMS believes it will continue to allow as many hospitals as possible to participate in the program, while ensuring that reliable TPSs result. However, it would only reweight hospitals' TPSs once, and will therefore, not reallocate the Clinical Care – Process and Clinical Care – Outcome subdomains' weighting within the Clinical Care domain if a hospital does not have sufficient data for one of the subdomains.

To review the final domain weights for FY14, FY15 and FY16, see tables appearing on page 20 of *HFMA's FY14 IPPS Final Rule Fact Sheet*.

Proposed Minimum Numbers of Cases and Measures for the FY16 and FY17 Hospital VBP Program's Quality Domains

In the FY13 IPPS/LTCH PPS final rule, CMS adopted a new minimum number of 25 cases for the mortality measures for FY15. In the same final rule, CMS adopted a minimum number of 25 cases for the MSPB measure, a minimum of three cases for any underlying indicator for the PSI-90 measure based on AHRQ's measure methodology, and a minimum of one predicted infection for NHSN-based surveillance measures based on CDC's minimum case criteria. CMS adopted these case minimums for FY 15 only, although it intended to adopt them for FY15 and subsequent years. CMS continues to believe that the finalized minimum numbers of cases are appropriate and provide sufficiently reliable data for scoring purposes under the Hospital VBP Program, and therefore, is proposing to adopt the specified case minimums for the FY16 Hospital VBP Program and subsequent years. CMS also notes that it is proposing to specify minimum numbers of measures for the FY17 Hospital VBP Program and subsequent years based on the new domain structure.

Proposed Minimum Number of Measures – Safety Domain

CMS has proposed to adopt six quality measures in the Safety domain for the FY17 Hospital VBP Program. Of these measures, five are NHSN-based surveillance measures, and one is the PSI-90 measure. After consideration of these measures and of previous independent analyses of the necessary minimum number of measures adopted for the Outcome domain, whose measures formed the basis for part of the new Safety domain,

CMS is proposing to adopt a minimum number of three measures for the Safety domain for FY17 and subsequent years.

Proposed Minimum Number of Measures – Clinical Care Domain
In the FY14 IPPS final rule, CMS adopted a new domain structure for the FY17 Hospital VBP Program and subsequent years based on the National Quality Strategy. In that final rule, it adopted a Clinical Care domain that was subdivided into the Clinical Care–Process and Clinical Care–Outcomes subdomains. CMS adopted these subdomains in order to ensure that it placed the appropriate domain weighting on measures of clinical processes and measures of clinical outcomes. It believes the same consideration is appropriate for determining minimum numbers of measures for each subdomain. Therefore, CMS is proposing to adopt a minimum number of two measures in the Clinical Care – Outcomes subdomain for FY17 and subsequent years. CMS is also proposing to require hospitals to report a minimum of one measure in the Clinical Care – Process subdomain for the FY17 Hospital VBP Program and subsequent years to receive a domain score.

Proposed Minimum Number of Measures – Efficiency and Cost Reduction Domain
Because the MSPB measure remains the only measure within the Efficiency and Cost Reduction domain for FY17, CMS proposes to require that hospitals receive a MSPB measure score in order to receive an Efficiency and Cost Reduction domain score.

Proposed Minimum Number of Measures – Patient and Caregiver Centered Experience of Care/Care Coordination (PEC/CC) Domain
Because the HCAHPS survey measure remains the only measure within the Patient and Caregiver Centered Experience of Care/Care Coordination (PEC/CC) Domain for FY17, CMS proposes to require that hospitals receive an HCAHPS survey measure score in order to receive a PEC/CC domain score. If CMS adopts additional measures for this domain in the future, it will consider if it should revisit this policy.

Disaster/Extraordinary Circumstance Exception under the Hospital VBP Program
In the FY14 IPPS final rule, CMS adopted a disaster/extraordinary circumstance exception. Readers are referred to that final rule for the policy's details. CMS notes that it is currently in the process of revising the Extraordinary Circumstances/Disaster Extension or Waiver Request form.

Suggested Exceptions to the 2-Midnight Benchmark

Federal Register pages: 28170

In the FY14 IPPS final rule CMS, discussed modifications and clarifications to its longstanding policy on how Medicare contractors review inpatient hospital and CAH admissions for payment purposes. Under that final rule, CMS established a two midnight benchmark for determining the appropriateness of an inpatient hospital admission versus treatment on an outpatient basis. The FY14 policy responded to both hospital calls for more guidance about when an inpatient admission and Part A payment are appropriate, and beneficiaries' concerns about increasingly long stays as outpatients due to hospital uncertainties about payment.
CMS recognized that if an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least two midnights, the patient may be considered to be appropriately treated on an inpatient

basis and hospital inpatient payment may be made under Medicare Part A. The FY14 IPPS final rule also indicated that there are exceptions to the two-midnight benchmark. In other words, CMS expects there to be cases in which an admitting practitioner expects the beneficiary's length of stay to last less than two midnights, and yet inpatient admission would still be appropriate.

In addition to procedures contained on the OPPS inpatient only list, CMS noted in the FY14 IPPS final rule that there may be other rare and unusual circumstances in which a hospital stay expected to last less than two midnights would nonetheless be appropriate for inpatient hospital admission and Part A payment. In January 2014, CMS identified medically necessary, newly initiated mechanical ventilation (excluding anticipated intubations related to minor surgical procedures or other treatment) as the first rare and unusual exception to the two-midnight rule and announced it on its website.

CMS also recognizes that there could be additional rare and unusual circumstances that it has not identified that justify inpatient admission and Part A payment absent an expectation of care spanning at least two midnights and are inviting further feedback on this issue. Suggestions can be sent to CMS via written correspondence or emailed to SuggestedExceptions@cms.hhs.gov with **"Suggested Exceptions to the Two-Midnight Benchmark"** in the subject line. CMS will continue to respond to these suggestions through subregulatory guidance, such as postings on its web site or manual instruction.

LTCH PPS Payment Rates for FY15

Federal Register pages: 28333-28338

CMS is proposing to establish an update to the long-term care hospital (LTCH) PPS standard Federal rate for FY15 based on the full LTCH PPS market basket increase estimate (estimated to be 2.7 percent in the proposed rule), subject to an adjustment based on changes in economy-wide productivity and an additional reductions required by sections 1886(m)(3)(A)(ii) and (m)(4)(E) of the Act. Accordingly, CMS is proposing to establish an annual update to the LTCH PPS standard Federal rate of 2.1 percent (that is, an update factor of 1.021) and 0.1 percent for those facilities that fail to submit quality data, as calculated in the table below.

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	**FY15 Payment Rate Update**
2.7%	0.4%	0.2%	**2.1 %**

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	Minus Quality Data Penalty	**FY15 Payment Rate Update**
2.7%	0.4%	0.2%	2.0%	**0.1%**

Furthermore, CMS is proposing an adjustment for the final year of the 3-year phase-in of the one-time prospective adjustment to the standard federal rate by applying a factor of 0.98734 (or approximately –1.3 percent) in FY15, consistent with current law to account for the estimated difference between projected aggregate FY03 LTCH PPS payments and the projected aggregate payments that would have been made in FY03 under the Tax

Equity and Fiscal Responsibility Act of 1982 payment system if the LTCH PPS had not been implemented.

Additionally, CMS proposes to apply an area wage level budget neutrality factor of 1.0002034 to the standard Federal rate to ensure that any proposed changes to the area wage level adjustment (that is, the proposed annual update of the wage index values and labor-related share) would not result in any change (increase or decrease) in estimated aggregate LTCH PPS payments. Accordingly, CMS proposes to establish a standard Federal rate of **$40,943.51** (calculated as $40,607.31 × 1.021 × 0.98734 × 1.002034) for FY15. The proposed standard Federal rate of $40,943.51 would apply in determining the payments for FY15 discharges from LTCHs that submit quality reporting data for FY15 in accordance with the requirements of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. The current rate is $40,607.31. For LTCHs that fail to submit quality reporting data, CMS is proposing to establish a standard Federal rate of **$40,141.47** (calculated as $40,607.31 × 1.001 × 0.98734 × 1.002034) for FY15.

The labor-related share that CMS is adopting to use for LTCH PPS in FY14 would be **62.571** percent, up from the current value, 62.537 percent. CMS is proposing a fixed-loss amount of **$15,730** for FY15. The current amount is $13,314.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)

Federal Register pages: 28094-28104

Section 1886(d)(5)(F) of the Social Security Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. Section 3133 of the ACA modified the methodology for computing the Medicare DSH payment adjustment beginning in FY14. Currently, Medicare DSHs qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income benefits and their Medicaid utilization.

Beginning with discharges in FY14, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments. The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care.

The payments to each hospital for a fiscal year are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all hospitals that receive Medicare DSH payments for that fiscal year. In addition to this payment, the HHS Secretary will pay an additional amount equal to the product of three factors to these hospitals in FY14 and each subsequent fiscal year.

The first factor is the difference between CMS's estimates of: (1) The amount of Medicare DSH payments that would have been paid for FY14 and subsequent years, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY14 and subsequent years, which takes into account the requirement to reduce Medicare DSH payments by 75 percent. The second factor is, for FY14 through FY17, 1 minus the percent change in the percent of individuals under 65 who are uninsured, determined by comparing the percent of those individuals who are uninsured in 2013, the last year before coverage expansion under the ACA, minus 0.1 percent for FY14, and minus 0.2 percent for FY15 through FY17. For FY14 through FY17, the baseline for the estimate of the change in uninsurance is fixed by the most recent estimate of the Congressional Budget Office before the final vote on the Health Care and Education Reconciliation Act of 2010. For FY18 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who are uninsured in 2013 minus 0.2 percent for FY18 and FY19.

The third factor represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percent. For each hospital, the product of these three factors represents its additional payment for uncompensated care for the applicable fiscal year. CMS refers to the additional payment determined by these factors as the ''uncompensated care payment.'' As a result of 1886(r)(3) of the Act, there can be no administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care payments, or the periods selected in order to develop such estimates.

Eligibility

Consistent with the law, hospitals must receive empirically justified Medicare DSH payments in a fiscal year to receive an additional Medicare uncompensated care payment for that year. In the FY14 IPPS final rule and interim final rule with comment period CMS provided that hospitals that are not eligible to receive empirically justified Medicare DSH payments in a fiscal year will not receive uncompensated care payments for that year. CMS also specified that it would make a determination concerning eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year (using the most recent data that are available). Its 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.

Puerto Rico hospitals that are eligible for DSH payments also are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology. Also, IPPS hospitals that have elected to participate in the Bundled Payments for Care Improvement initiative receive a payment that links multiple services furnished to a patient during an episode of care. CMS will apply the new DSH payment methodology to the hospitals participating in this initiative, so that eligible hospitals will receive empirically justified Medicare DSH payments and uncompensated care payments. Because Maryland waiver hospitals were not paid under the IPPS (section 1886(d) of the Act), in the FY14 IPPS final rule, these hospitals are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the payment methodology.

FY15 Methodology to Calculate Factor 1

In order to determine the two elements of Factor 1 (Medicare DSH payments *prior* to the application of section 1886(r)(1) of the Act, and empirically justified Medicare DSH payments *after* application of section 1886(r)(1) of the Act), CMS uses the most recently available projections of Medicare DSH payments for the fiscal year, as calculated by CMS' Office of the Actuary. The Office of the Actuary projects Medicare DSH payments on a biannual basis, typically in February of each year (based on data from December of the previous year) as part of the President's Budget, and in July (based on data from June) as part of the Midsession Review. The estimates are based on the most recently filed Medicare hospital cost report with Medicare DSH payment information, supplemental cost report data provided by Indian Health Service hospitals to CMS, and the most recent Medicare DSH patient percentages and Medicare DSH payment adjustments provided in the IPPS Impact File. For purposes of the proposed rule, CMS uses the February 2014 Medicare DSH estimates to calculate Factor 1 and to model the proposed impact of this provision.

For the final rule, CMS intends to use the July 2014 Medicare DSH estimates to determine Factor 1 and to model the impact of this provision. The February 2014 Office of the Actuary estimate for Medicare DSH payments for FY15, without regard to the application of section 1886(r)(1) of the Act, is $14.205 billion. This estimate excludes Maryland hospitals participating in the Maryland All-Payer Model, sole community hospitals paid under their hospital-specific payment rate, and hospitals participating in the Rural Community Hospital Demonstration. Therefore, based on this estimate, the estimate for empirically justified Medicare DSH payments for FY15, with the application of section 1886(r)(1) of the Act, is **$3.551** billion (25 percent of the total amount estimated). Under § 412.l06 (g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, for the purpose of modeling Factor 1, CMS is proposing that Factor 1 for FY15 would be **$10.654 billion** ($14.205 billion minus $3.551 billion).

FY15 Methodology to Calculate Factor 2

Section 1886(r)(2)(B)(i) of the Act provides that for fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of unisured individuals in 2013, the last year before coverage expansion under the ACA, and who are uninsured in the most recent period for which data is available (as so calculated), minus 0.1 percent for FY14 and minus 0.2 percent for each of fiscal years 2015, 2016, and 2017. In the FY14 IPPS final rule, CMS used the same data source, CBO estimates, to calculate this percent of individuals without insurance. In response to public comments, CMS also agreed that it should normalize the CBO estimates, which are based on the calendar year, for the Federal fiscal years for which each calculation of Factor 2 is made.

For the FY15 proposed rule, CMS has used CBO's February 2014 estimates of the effects of the ACA on health insurance coverage. The CBO's February 2014 estimate of individuals under the age of 65 with insurance in CY14 is 84 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY14 is 16 percent (that is, 100 percent minus 84 percent.). The CBO's most recent estimate of the rate of uninsurance in CY15 available during the development of the proposed rule is 14 percent (that is, 100 percent minus 86 percent.)

The calculation of the proposed Factor 2 for FY15, employing a weighted average of the CBO projections for CY14 and CY15, is as follows:

- CY14 rate of insurance coverage (February 2014 CBO estimate): 84 percent.
- CY15 rate of insurance coverage (February 2014 CBO estimate): 86 percent.
- FY15 rate of insurance coverage: (84 percent * .25) + (86 percent * .75) =85.5 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent
- Percent of individuals without insurance for FY15 (weighted average): 14.5 percent
  1 – |[(0.145 - 0.18)/0.18]| = 1 - 0.19444 = 0.80556 (80.556 percent)
  0.80556 (80.556 percent) - 0.002 (0.2 percentage points for FY 2015 under section 1886(r)(2)(B)(i) of the Act) = 0.8036 (80.36 percent)
  0.8036 = Factor 2

Therefore, CMS is proposing that Factor 2 for FY15 would be 0.8036. CMS's proposal for Factor 2 is subject to change if more recent CBO estimates of the insurance rate become available at the time of the preparation of the final rule. CMS is inviting public comments on its proposed calculation of Factor 2 for FY15.

FY15 Proposed Methodology to Calculate Factor 3

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY14 and subsequent fiscal years. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made.

In order to implement the statutory requirements for this factor of the uncompensated care payment formula, it was necessary to determine:

1. The definition of uncompensated care or, in other words, the specific items that are to be included in the numerator (the estimated uncompensated care amount for an individual hospital) and denominator (the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the applicable fiscal year);
2. The data source(s) for the estimated uncompensated care amount; and
3. The timing and manner of computing the quotient for each hospital estimated to receive DSH payments.

For FY15, CMS is proposing to continue to employ the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients, respectively, to determine Factor 3 for FY15. Accordingly, CMS is proposing to revise the regulations at 42 CFR 412.106(g)(1)(iii)(C) to state that, for FY15, it will base its estimates of the amount of hospital uncompensated care on the most recent available data on utilization for Medicaid and Medicare SSI patients, as

determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of that section of the regulations.

In the FY14 IPPS final rule, CMS indicated that it remained convinced that the Worksheet S-10 could ultimately serve as an appropriate source of more direct data regarding uncompensated care costs for purposes of determining Factor 3 once hospitals are submitting more accurate and consistent data through this reporting mechanism. In the interim, CMS indicated that it would take steps such as revising and clarifying cost report instructions, as appropriate. Although it has not yet developed revisions to the Worksheet S-10 instructions at this time, it remains committed to making improvements to Worksheet S-10. For that reason, CMS believes it would be premature to propose the use of Worksheet S-10 data for purposes of determining Factor 3 for FY15. CMS will continue to work with the hospital community and others to develop the appropriate clarifications and revisions to Worksheet S-10 of the Medicare cost report for reporting uncompensated care data.

As CMS did for the FY14 IPPS/LTCH PPS proposed rule, it is publishing, on its web site, a table listing Factor 3 for all hospitals that are estimated to receive empirically justified Medicare DSH payments in a fiscal year and for the remaining subsection (d) and subsection (d) Puerto Rico hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified Medicare DSH payment for the fiscal year as determined at cost report settlement. This table can be found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

Since the publication of the FY14 IPPS final rule, CMS has continued to consider whether to propose employing the wage index to adjust insured low-income days in determining Factor 3. After this consideration, it continues to believe that a wage index adjustment to insured low-income days is not an appropriate measure to account for variations in the costs of uncompensated care among hospitals. The intensity of such care, and therefore the costs, may vary by hospital, but CMS still lacks convincing evidence that the wage index data are an accurate measure of that intensity. Therefore, it is not proposing to adopt such an adjustment to low-income days for purposes of calculating Factor 3 in FY15.

Direct Graduate Medical Education (GME)

Federal Register pages: 28144-28165

Section 1886(d)(5)(B) of the Act provides for a payment adjustment known as the indirect medical education (IME) adjustment under the IPPS for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count. The ACA made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances.

Proposed Changes in the Effective Date of the FTE Resident Cap, 3-Year Rolling Average, and Intern- and Resident-to-Bed (IRB) Ratio Cap for New Programs in Teaching Hospitals

The HHS Secretary is required to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs. Integrating the rolling average, the *Intern- and Resident-to-Bed* (IRB) ratio cap, and the FTE resident caps for residents in new medical residency training programs in an accurate manner on the Medicare cost report has proved challenging to the point where CMS has had to deal with each instance brought to its attention by the new teaching hospital or by a Medicare contractor on an individual and manual basis, in order to ensure application of a consistent methodology. In the rule, CMS proposes to simplify and streamline the timing of when FTE residents in new medical residency training programs are subject to the FTE resident cap, the 3-year rolling average, and the IRB ratio cap. This would apply to urban teaching hospitals that have not yet had FTE resident caps, and for rural teaching hospitals that may or may not have FTE resident caps.

Under this proposal, the methodology for calculating the FTE resident caps for hospitals that participate in training residents in new medical residency training programs would continue to be the same methodology instituted in the FY13 IPPS final rule for new training programs started on or after October 1, 2012. However, once the FTE resident caps are calculated, CMS proposes to change the timing of when the FTE resident caps would be effective, to synchronize the effective dates and the application of the 3-year rolling average and the IRB ratio cap with each applicable hospital's fiscal year begin date. The FTE resident caps would continue to be calculated as finalized in the FY13 IPPS final rule. However, once calculated, instead of the FTE resident caps being effective beginning with the sixth program year of the first new program start, the ***FTE resident caps, rolling average, and IRB ratio cap would be effective beginning with the applicable hospital's cost reporting period that precedes the start of the sixth program year of the first new program start.***

Also, CMS is proposing that, for all new medical residency training programs in which the hospital participates during the 5-year growth window, the FTEs in those new programs would also be subject to the 3-year rolling average and the IRB ratio cap simultaneously, with the effective date of the FTE resident caps at the beginning of the applicable hospital's cost reporting period that precedes the beginning of the sixth program year of the first new program start.

Participation of Redesignated Hospital in Rural Training Track

A provision has been established that, in a case where a hospital that is not located in a rural area (an urban hospital) that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, the HHS Secretary shall adjust the urban hospital's cap on the number of FTE residents under subparagraph (F), in order to encourage training of physicians in rural areas. Subject to certain criteria, an urban hospital may count the FTE residents in the rural track in addition to those FTE residents subject to its cap up to a "rural track FTE limitation" for that hospital.

In the FY06 IPPS final rule, CMS revised the regulations to add a new paragraph that states that if an urban hospital had established a rural track program with a rural hospital and that hospital subsequently becomes urban due to the implementation of the new labor

market area definitions announced by the OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit for rural track programs established before the implementation of the new labor market area definitions. CMS also stated that, in order for the urban hospital to receive a cap adjustment for a new rural track program, the hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location designations adopted by CMS.

Because CMS is proposing to implement, effective October 1, 2014, the new OMB labor market area delineations announced in the February 28, 2013, OMB Bulletin No. 13-01, under which, certain areas can be redesignated from urban to rural or from rural to urban. This may, in turn, affect GME policies that require the participation of rural teaching hospitals. CMS is proposing to address the status of the "original" urban hospital's rural track FTE limitation, in the situation where a rural hospital that is participating in the original urban hospital's rural track is located in an area redesignated by OMB as urban *during the 3-year period* that is used to calculate the urban hospital's rural track FTE limitation.

Existing regulations state that if an urban hospital had established a rural track with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of new labor market area definitions announced by OMB June 6, 2003, the urban hospital may continue to adjust its FTE resident limit for the rural track programs established prior to the adoption of the new labor market area definitions. Therefore, consistent with the existing regulations, and its proposal to allow rural hospitals redesignated as urban to continue receiving a FTE resident cap adjustment for new programs that started while the redesignated hospital was still rural, CMS would revise the existing regulations applicable to urban hospitals. Specifically, CMS is proposing that any time a rural hospital participating in a rural track is in an area redesignated by OMB as urban after residents started training in the rural track and during the 3-year period that is used to calculate the urban hospital's rural track FTE limitation, the urban hospital may receive a cap adjustment for that rural track after it has been redesignated as urban.

Furthermore, CMS is proposing that, regardless of whether the redesignation of the rural hospital occurs during or after the 3-year period used to calculate the urban hospital's rural track FTE limitation, the redesignated urban hospital can continue to be considered a rural hospital for purposes of the rural track for up to two years. However, by the end of those two years, either the redesignated urban hospital must reclassify as rural under for purposes of IME payment only or the "original" urban hospital must have found a new site in a geographically rural area that will serve as the rural site for purposes of the rural track in order for the "original" urban hospital to receive payment. CMS is proposing to revise the regulations to implement these provisions and to establish that these changes would be effective for cost reporting periods beginning on or after October 1, 2014.

Requirement for Transparency of Hospital Charges under the Affordable Care Act

Federal Register, pages: 28169

Hospitals determine their charges for items and services provided to patients.

While Medicare does not pay billed charges, hospital reported charges are used in determining Medicare's national payment rates. In 2013, CMS released data that demonstrated significant variation across the country and within communities in what hospitals charge for a number of common inpatient and outpatient services. These data also showed that hospital charges for services furnished in both the inpatient and the outpatient setting were, in general, significantly higher than the amount paid by Medicare under the IPPS or the OPPS. The intent in releasing these data was to enable the public to examine the relationship between the amounts charged by individual hospitals for comparable services and Medicare's payment for that inpatient or outpatient care.

Transparency Requirement under the Affordable Care Act

The ACA contains a provision that is consistent with CMS's effort to improve the transparency of hospital charges. As a result of the ACA, section 2718(e) the Public Health Service Act requires that hospitals operating within the United States establish, update, and make public (in accordance with guidelines developed by the HHS Secretary) a list of the its standard charges for items and services provided, including DRGs. In the proposed rule, CMS reminds hospitals of their obligation to comply with the provisions of the Public Health Service Act.

Hospitals are responsible for establishing their charges and are in the best position to determine the exact manner and method by which to make those charges available to the public. Therefore, CMS is providing hospitals with the flexibility to determine how they make this list of their standard charges public. Its implementation guidelines are that hospitals either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry.

CMS encourages hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals. CMS expects that hospitals will update the information at least annually, or more often as appropriate, to reflect current charges. As hospitals make data publicly available in compliance with the Public Health Service Act, CMS will continue to review and post relevant charge data in a consumer friendly way, as it previously has done, by posting on the information on its web site.

More Information

The proposed rule is published in the May 15, 2014, *Federal Register*, and comments on the rule are due on June 30, 2014.

Appendix 1 – ICD-9-CM Codes for Excess Readmission Calculation for FY15

ICD-9-CM CODES TO IDENTIFY PNEUMONIA (PN) CASES

ICD-9-CM Code	Description of Code
480.0	Pneumonia due to adenovirus
480.1	Pneumonia due to respiratory syncytial virus
480.2	Pneumonia due to parainfluenza virus
480.3	Pneumonia due to SARS-associated coronavirus
480.8	Viral pneumonia: pneumonia due to other virus not elsewhere classified
480.9	Viral pneumonia unspecified
481	Pneumococcal pneumonia [streptococcus pneumoniae pneumonia]
482.0	Pneumonia due to klebsiella pneumoniae
482.1	Pneumonia due to pseudomonas
482.2	Pneumonia due to hemophilus influenzae [h. influenzae]
482.30	Pneumonia due to streptococcus unspecified
482.31	Pneumonia due to streptococcus group a
482.32	Pneumonia due to streptococcus group b
482.39	Pneumonia due to other streptococcus
482.40	Pneumonia due to staphylococcus unspecified
482.41	Pneumonia due to staphylococcus aureus
482.42	Methicillin Resistant Pneumonia due to Staphylococcus Aureus
482.49	Other staphylococcus pneumonia
482.81	Pneumonia due to anaerobes
482.82	Pneumonia due to escherichia coli [e.coli]
482.83	Pneumonia due to other gram-negative bacteria
482.84	Pneumonia due to legionnaires' disease
482.89	Pneumonia due to other specified bacteria
482.9	Bacterial pneumonia unspecified
483.0	Pneumonia due to mycoplasma pneumoniae
483.1	Pneumonia due to chlamydia
483.8	Pneumonia due to other specified organism
485	Bronchopneumonia organism unspecified
486	Pneumonia organism unspecified
487.0	Influenza with pneumonia
488.11	Influenza due to identified novel H1N1 influenza virus with pneumonia

ICD-9-CM CODES TO IDENTIFY HEART FAILURE (HF) CASES

ICD-9-CM Code	Code Description
402.01	Hypertensive heart disease, malignant, with heart failure
402.11	Hypertensive heart disease, benign, with heart failure
402.91	Hypertensive heart disease, unspecified, with heart failure
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified failure and chronic kidney disease stage V or end stage renal disease
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
428.xx	Heart Failure

ICD-9-CM CODES TO IDENTIFY ACUTE MYOCARDIAL INFARCTION (AMI) CASES

ICD-9-CM Code	Description of Code
410.00	AMI (anterolateral wall) – episode of care unspecified
410.01	AMI (anterolateral wall) – initial episode of care
410.10	AMI (other anterior wall) – episode of care unspecified
410.11	AMI (other anterior wall) – initial episode of care
410.20	AMI (inferolateral wall) – episode of care unspecified
410.21	AMI (inferolateral wall) – initial episode of care
410.30	AMI (inferoposterior wall) – episode of care unspecified
410.31	AMI (inferoposterior wall) – initial episode of care
410.40	AMI (other inferior wall) – episode of care unspecified
410.41	AMI (other inferior wall) – initial episode of care
410.50	AMI (other lateral wall) – episode of care unspecified
410.51	AMI (other lateral wall) – initial episode of care
410.60	AMI (true posterior wall) – episode of care unspecified
410.61	AMI (true posterior wall) – initial episode of care
410.70	AMI (subendocardial) – episode of care unspecified
410.71	AMI (subendocardial) – initial episode of care
410.80	AMI (other specified site) – episode of care unspecified
410.81	AMI (other specified site) – initial episode of care
410.90	AMI (unspecified site) – episode of care unspecified
410.91	AMI (unspecified site) – initial episode of care

ICD-9-CM CODES TO IDENTIFY CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CASES

ICD-9-CM Code	Description of Code
491.21	Obstructive chronic bronchitis; With (acute) exacerbation; acute exacerbation of COPD, decompensated COPD, decompensated COPD with exacerbation
491.22	Obstructive chronic bronchitis; with acute bronchitis
491.8	Other chronic bronchitis. Chronic: tracheitis, tracheobronchitis.
491.9	Unspecified chronic bronchitis
492.8	Other emphysema; emphysema (lung or pulmonary): NOS, centriacinar, centrilobular, obstructive, panacinar, panlobular, unilateral, vesicular. MacLeod's syndrome; Swyer-James syndrome; unilateral hyperlucent lung
493.20	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, unspecified
493.21	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with status asthmaticus
493.22	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with (acute) exacerbation
496	Chronic: nonspecific lung disease, obstructive lung disease, obstructive pulmonary disease (COPD) NOS. NOTE: This code is not to be used with any code from categories 491-493.
518.81*	Other diseases of lung; acute respiratory failure; respiratory failure NOS
518.82*	Other diseases of lung; acute respiratory failure; other pulmonary insufficiency, acute respiratory distress
518.84*	Other diseases of lung; acute respiratory failure; acute and chronic respiratory failure
799.1*	Other ill-defined and unknown causes of morbidity and mortality; respiratory arrest, cardiorespiratory failure
**Principal diagnosis when combined with a secondary diagnosis of AECOPD (491.21, 491.22, 493.21, or 493.22)*	

ICD-9-CM CODES TO IDENTIFY TOTAL HIP ARTHROPLASTY/TOTAL KNEE ARTHROPLATY (THA/TKA) CASES

ICD-9-CM Code	Description of Code
81.51	Total hip arthroplasty
81.54	Total knee arthroplasty

Appendix 2 – Aggregate Payment for Excess Readmission Calculation

FORMULAS TO CALCULATE THE READMISSIONS ADJUSTMENT FACTOR

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (Excess Readmissions Ratio for THA/TKA-1)].

*Note, if a hospital's excess readmissions ratio for a condition is less than/equal to 1, then there are no aggregate payments for excess readmissions for that condition included in this calculation.

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

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

Proposed Readmissions Adjustment Factor for FY 2015 is the higher of the ratio or 0.9700.

*Based on claims data from July 1, 2010 to June 30, 2013 for FY 2015.

Appendix 3 – "Topped Out" Measures for FY17

"Topped Out" Chart-Abstracted Measures Proposed for Removal for the FY 2017 Payment Determination
• AMI-1: Aspirin at Arrival (previously suspended)
• AMI-3: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients (previously suspended) (NQF #0137)
• AMI-5: Beta-Blocker Prescribed at Discharge for AMI (previously suspended) (NQF #0160)
• AMI-8a: Primary PCI received within 90 minutes of hospital arrival * (NQF #0163)
• HF-2: Evaluation of left ventricular systolic function (NQF #0135)
• PN-6: Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients* (NQF #0147)
• SCIP-Inf-1: Prophylactic antibiotic received within one hour prior to surgical incision* (NQF #0527)
• SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients* (NQF #0528)

"Topped Out" Chart-Abstracted Measures Proposed for Removal for the FY 2017 Payment Determination
• SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery) (NQF #0529)
• SCIP-Inf-4: Cardiac surgery patients with controlled postoperative blood glucose (NQF #0300)
• SCIP-Inf-6: Surgery patients with appropriate hair removal (previously suspended) (NQF #0301)
• SCIP-Inf-9: Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero.* (NQF #0453)
• SCIP-Card-2: Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period (NQF #0284)
• SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)
• STK-2: Discharged on antithrombotic therapy * (NQF #0435)
• STK-3: Anticoagulation therapy for atrial fibrillation/flutter* (NQF #0436)
• STK-5: Antithrombotic therapy by the end of hospital day two* (NQF #0438)
• STK-10: Assessed for rehabilitation* (NQF #0441)
• VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol*
• Participation in a systematic database for cardiac surgery (NQF #0113)

* Proposed to be retained as an electronic clinical quality measure

Appendix 4 - Hospital IQR Program Measures for FY16 and Subsequent Years

Topic	Hospital IQR Program Measures Previously Adopted for the FY 2016 Payment Determination and Subsequent Years
Acute Myocardial Infarction (AMI) Measures	
	• AMI-1: Aspirin at Arrival (previously suspended)
	• AMI-3: ACEI or ARB for left ventricular systolic dysfunction-Acute Myocardial Infarction (AMI) Patients (previously suspended) (NQF #0137)
	• AMI-5: Beta-Blocker Prescribed at Discharge for AMI (previously suspended) (NQF #0160)
	• AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival (NQF #0164)
	• AMI-8a : Primary PCI received within 90 minutes of hospital arrival (NQF #0163) *
Heart Failure (HF) Measure	
	• HF-2 Evaluation of left ventricular systolic function (NQF #0135) *
Stroke (STK) Measure Set	
	• STK-1 Venous thromboembolism (VTE) prophylaxis (NQF #0434)
	• STK-2 Discharged on antithrombotic therapy (NQF #0435) *
	• STK-3 Anticoagulation therapy for atrial fibrillation/flutter (NQF #0436) *
	• STK-4 Thrombolytic therapy (NQF #0437)
	• STK-5 Antithrombotic therapy by the end of hospital day two (NQF #0438)
	• STK-6 Discharged on statin medication (NQF #0439)
	• STK-8 Stroke education
	• STK-10 Assessed for rehabilitation (NQF #0441)
Venous Thromboembolism (VTE) Measure Set	
	• VTE-1 Venous thromboembolism prophylaxis (NQF #0371)
	• VTE-2 Intensive care unit venous thromboembolism prophylaxis (NQF #0372)
	• VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy (NQF #0373)
	• VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol
	• VTE-5 VTE discharge instructions
	• VTE-6 Incidence of potentially preventable VTE

Topic	Hospital IQR Program Measures Previously Adopted for the FY 2016 Payment Determination and Subsequent Years
Pneumonia (PN) Measure	
	• PN-6 Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (NQF #0147)
Surgical Care Improvement Project (SCIP) Measures	
	• SCIP INF-1 Prophylactic antibiotic received within one hour prior to surgical incision (NQF #0527) *
	• SCIP INF-2 Prophylactic antibiotic selection for surgical patients (NQF #0528)
	• SCIP INF-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery) (NQF #0529)
	• SCIP INF-4 Cardiac surgery patients with controlled postoperative blood glucose (NQF #0300)
	• SCIP INF-9 Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero (NQF #0453)
	• SCIP Card-2 Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period (NQF #0284)
	• SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)
Mortality Measures	
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older (NQF #0230)
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older (NQF #0229)
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization (NQF #0468)
	• Stroke 30-day mortality rate
	• Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893)
Patient Experience of Care Measure	
	• HCAHPS survey (NQF #0166) (expanded to include two new "About You" items and the 3-item Care Transition Measure) (NQF #0228)
Readmission Measures	
	• Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

Topic	Hospital IQR Program Measures Previously Adopted for the FY 2016 Payment Determination and Subsequent Years
	(NQF #0505)
	• Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization (NQF #0330)
	• Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization (NQF #0506)
	• Hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1551)
	• Hospital-Wide All-Cause Unplanned Readmission (HWR) (NQF #1789)
	• 30-day risk standardized readmission rate (RSMR) following Stroke hospitalization
	• Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891)
AHRQ Patient Safety Indicators (PSIs) Composite Measure	
	• PSI-90 Patient safety for selected indicators (composite) (NQF #0531)
AHRQ PSI and Nursing Sensitive Care Measure	
	• PSI-4 Death among surgical inpatients with serious treatable complications (NQF #0351)
Structural Measures	
	• Participation in a Systematic Database for Cardiac Surgery (NQF #0113)
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
	• Participation in a Systematic Clinical Database Registry for General Surgery
	• Safe Surgery Checklist Use
Healthcare-Associated Infections (HAI) Measures	
	• National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
	• American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) - SSI following Colon Surgery - SSI following Abdominal Hysterectomy
	• National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
	• National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus

Topic	Hospital IQR Program Measures Previously Adopted for the FY 2016 Payment Determination and Subsequent Years
	(MRSA) Bacteremia Outcome Measure (NQF #1716)
	• National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
	• Influenza vaccination coverage among healthcare personnel (HCP) (NQF #0431)
Surgical Complications Measures	
	• Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1550)
Emergency Department (ED) Throughput Measures	
	• ED-1 Median time from ED arrival to ED departure for admitted ED patients (NQF #0495)
	• ED-2 Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497)
Prevention: Global Immunization (IMM) Measures	
	• IMM-1 Pneumococcal Immunization (previously suspended) (NQF #1653)
	• IMM-2 Influenza Immunization (NQF #1659)
Cost Efficiency Measures	
	• Payment-Standardized Medicare Spending Per Beneficiary (MSPB) (NQF #2158)
	• AMI Payment per Episode of Care
Perinatal Care (PC) Measure	
	• PC-01 Elective delivery (NQF #0469)

*Measures proposed for removal for the FY 2016 payment determination and subsequent years.

Appendix 5: Previously Adopted and Proposed 2017 IQR Program Measures

Topic	Previously Adopted Hospital IQR Program Measures and Measures Proposed in this Proposed Rule for the FY 2017 Payment Determination and Subsequent Years
Acute Myocardial Infarction (AMI) Measures	
	• AMI-2 Aspirin Prescribed at Discharge for AMI*/ /† (NQF #0142)
	• AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival (NQF #0164)
	• AMI-8a Primary PCI received within 90 minutes of hospital arrival /† (NQF #0163)
	• AMI-10 Statin Prescribed at Discharge*/ /† (NQF #0639)
Stroke Measure (STK) Set	
	• STK-1 Venous thromboembolism (VTE) prophylaxis (NQF #0434)
	• STK-2 Discharged on antithrombotic therapy /† (NQF #0435)
	• STK-3 Anticoagulation therapy for atrial fibrillation/flutter /† (NQF #0436)
	• STK-4 Thrombolytic therapy (NQF #0437)
	• STK-5 Antithrombotic therapy by the end of hospital day two /† (NQF #0438)
	• STK-6 Discharged on statin medication (NQF #0439)
	• STK-8 Stroke education
	• STK-10 Assessed for rehabilitation /† (NQF #0441)
Venous Thromboembolism (VTE) Measure Set	
	• VTE-1 Venous thromboembolism prophylaxis (NQF #0371)
	• VTE-2 Intensive care unit venous thromboembolism prophylaxis (NQF #0372)
	• VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy (NQF #0373)
	• VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol /†

Topic	Previously Adopted Hospital IQR Program Measures and Measures Proposed in this Proposed Rule for the FY 2017 Payment Determination and Subsequent Years
	• VTE-5 VTE discharge instructions □
	• VTE-6 Incidence of potentially preventable VTE □ (NQF #0376)
Sepsis Measure	
	• Severe sepsis and septic shock: management bundle* (NQF #0500)
Pneumonia (PN) Measure	
	• PN-6 Initial Antibiotic Selection for community-acquired pneumonia (CAP) in Immunocompetent Patients □ /† (NQF #0147)
Surgical Care Improvement Project (SCIP) Measures	
	• SCIP INF-1 Prophylactic antibiotic received within one hour prior to surgical incision □ /† (NQF #0527)
	• SCIP INF-2 Prophylactic antibiotic selection for surgical patients □ /† (NQF #0528)
	• SCIP INF-9 Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero □ /† (NQF #0453)
Mortality Measures	
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older (NQF #0230)
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older (NQF #0229)
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization (NQF #0468)
	• Stroke 30-day mortality rate
	• Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893)
	• Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery (NQF #1893)*
Patient Experience of Care Measure	
	• HCAHPS survey (NQF #0166) (expanded to include two new "About You" items and the 3-item Care Transition Measure) (NQF #0228)
Readmission Measures	
	• Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization (NQF #0505)
	• Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization (NQF #0330)

Topic	Previously Adopted Hospital IQR Program Measures and Measures Proposed in this Proposed Rule for the FY 2017 Payment Determination and Subsequent Years
	• Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization (NQF #0506)
	• Hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1551)
	• Hospital-Wide All-Cause Unplanned Readmission (HWR) (NQF #1789)
	• Stroke 30-day Risk Standardized Readmission
	• Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891)
	• Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery*
AHRQ Patient Safety Indicators (PSIs) Composite Measure	
	• PSI-90 Patient safety for selected indicators (composite) (NQF #0531)
AHRQ PSI and Nursing Sensitive Care	
	• PSI-4 Death among surgical inpatients with serious treatable complications (NQF #0351)
Structural Measures	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care (NQF #0113)
	• Participation in a Systematic Clinical Database Registry for General Surgery (NQF #0493)
	• Safe Surgery Checklist Use
Healthcare-Associated Infections (HAI) Measures	
	• National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
	• American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) - SSI following Colon Surgery - SSI following Abdominal Hysterectomy
	• National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
	• National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

Topic	Previously Adopted Hospital IQR Program Measures and Measures Proposed in this Proposed Rule for the FY 2017 Payment Determination and Subsequent Years
	• National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
	• Influenza vaccination coverage among healthcare personnel (HCP) (NQF #0431)
Surgical Complications	
	• Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (NQF #1550)
Emergency Department (ED) Throughput Measures	
	• ED-1 Median time from ED arrival to ED departure for admitted ED patients (NQF #0495) □
	• ED-2 Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497) □
Prevention: Global Immunization (IMM) Measure	
	• Influenza Immunization (NQF #1659)
Cost Efficiency	
	• Payment-Standardized Medicare Spending Per Beneficiary (MSPB) (NQF #2158)
	• AMI Payment per Episode of Care
	• Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure*
	• Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia*
Perinatal Care (PC)	
	• PC-01 Elective delivery □ (NQF #0469)
	• PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (NQF #0480) */□ /†
	• Children's Asthma Care-3 Home Management Plan of Care (HMPC) document given to patient/caregiver*/□ /†
	• Healthy Term Newborn (NQF #0716) */□ /†
	• Hearing Screening Prior to Hospital Discharge (NQF #1354) */□ /†

* New or expanded measures for FY 2017 payment determination and subsequent years.

□ Electronic clinical quality measure.

† Voluntary measure.

Appendix 6 - Previously Adopted and Proposed Electronic Clinical Quality Measures for FY17

Previously Adopted Voluntary Electronic Clinical Quality Measures and Proposed Voluntary Electronic Clinical Quality Measures for the FY 2017 Payment Determination and Associated NQF Domains			
Short name	**Measure Name**	**NQF #**	**Domain as assigned in Stage 2 Final Rule[76]**
ED-1	Emergency Department Throughput – Median time from ED arrival to ED departure for admitted ED patients	0495	Patient and Family Engagement
ED-2	Emergency Department Throughput – admitted patients – Admit decision time to ED departure time for admitted patients	0497	Patient and Family Engagement
STK-2	Discharged on antithrombotic therapy	0435	Clinical Process/ Effectiveness
STK-3	Anticoagulation therapy for atrial fibrillation/flutter	0436	Clinical Process/ Effectiveness
STK-4	Thrombolytic Therapy	0437	Clinical Process/ Effectiveness
STK-5	Antithrombotic therapy by end of hospital day two	0438	Clinical Process/ Effectiveness
STK-6	Discharged on Statin Medication	0439	Clinical Process/ Effectiveness
STK-8	Stroke education	N/A	Patient and Family Engagement
STK-10	Assessed for rehabilitation	0441	Care Coordination
VTE-1	Venous thromboembolism prophylaxis	0371	Patient Safety
VTE-2	Intensive care unit venous thromboembolism prophylaxis	0372	Patient Safety
VTE-3	Venous thromboembolism patients with anticoagulation overlap therapy	0373	Clinical Process/ Effectiveness
VTE-4	Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	N/A	Clinical Process/ Effectiveness
VTE-5	VTE discharge instructions	N/A	Patient and Family Engagement
VTE-6	Incidence of potentially preventable VTE	0376	Patient Safety
PC-01	Elective Delivery	0469	Clinical Process/

76 Medicare EHR Incentive Program Stage 2 final rule (77 FR 54083 through 54087)

Previously Adopted Voluntary Electronic Clinical Quality Measures and Proposed Voluntary Electronic Clinical Quality Measures for the FY 2017 Payment Determination and Associated NQF Domains			
Short name	**Measure Name**	**NQF #**	**Domain as assigned in Stage 2 Final Rule[76]**
			Effectiveness
PC-05	Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice *	0480	Clinical Process/ Effectiveness
EHDI-1a	Hearing screening prior to hospital discharge*	1354	Clinical Process/ Effectiveness
	Healthy Term Newborn*	0716	Patient Safety
CAC-3	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	N/A	Patient and Family Engagement
AMI-2	Aspirin Prescribed at Discharge for AMI*	0142	Clinical Process/ Effectiveness
AMI-7a	Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival	0164	Clinical Process/ Effectiveness
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163	Clinical Process/ Effectiveness
AMI-10	Statin Prescribed at Discharge*	0639	Clinical Process/ Effectiveness
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	0147	Efficient Use of Healthcare Resources
SCIP-Inf-1a	Prophylactic Antibiotic Received within one Hour Prior to Surgical Incision	0527	Patient Safety
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients	0528	Efficient Use of Healthcare Resources
SCIP-Inf-9	Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero	0453	Patient Safety

* Measure proposed for adoption or readoption in Hospital IQR Program

Appendix 7- Reporting Timeline to Align the EHR Incentive Program with Proposed Hospital IQR Program Submission Periods

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	January 1 – March 31, 2015	January 1 – March 31, 2015	Data must be submitted by May 31, 2015
	Q2	April 1 – June 30, 2015	April 1 – June 30, 2015	Data must be submitted by August 31, 2015
	Q3	July 1 – September 30, 2015	July 1 – September 30, 2015	Data must be submitted by November 30, 2015
	Q4	N/A for EHR Incentive Program	October 1 – December 31, 2015	For Hospital IQR Program, Data must be submitted by February 28, 2016
2016 Reporting Period	Q1	January 1 – March 31, 2016	January 1 – March 31, 2016	Data must be submitted by May 31, 2016
	Q2	April 1 – June 30, 2016	April 1 – June 30, 2016	Data must be submitted by August 31, 2016
	Q3	July 1 – September 30, 2016	July 1 – September 30, 2016	Data must be submitted by November 30, 2016
	Q4	N/A for EHR Incentive Program	October 1 – December 31, 2016	For Hospital IQR Program, Data must be submitted by February 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 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.

Appendix 8 - Previously Adopted and New FY17 Measures

Previously Adopted and Proposed New Measures for the FY 2017 Hospital VBP Program		
Measure	**Description**	**Domain**
CAUTI*	Catheter-Associated Urinary Tract Infection (NQF #0138)	Safety
CLABSI**	Central Line-Associated Blood Stream Infection (NQF #0139)	Safety
C. difficile***	*Clostridium difficile* Infection (NQF #1717)	Safety
MRSA***	Methicillin-Resistant *Staphylococcus aureus* Bacteremia (NQF #1726)	Safety
PSI-90*	Complication/patient safety for selected indicators (composite) (NQF #0531)	Safety
SSI*	Surgical Site Infection: (NQF #0753) • Colon • Abdominal Hysterectomy	Safety
MORT-30-AMI*	Acute Myocardial Infarction (AMI) 30-day mortality rate (NQF #0230)	Clinical Care -- Outcomes
MORT-30-HF*	Heart Failure (HF) 30-day mortality rate (NQF #0229)	Clinical Care -- Outcomes
MORT-30-PN*	Pneumonia (PN) 30-day mortality rate (NQF #0468)	Clinical Care -- Outcomes
AMI-7a*	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival (NQF #0164)	Clinical Care -- Process
IMM-2*	Influenza Immunization (NQF #1659)	Clinical Care -- Process
PC-01***	Elective Delivery Prior to 39 Completed Weeks Gestation (NQF #0469)	Clinical Care -- Process
MSPB-1*	Medicare Spending per Beneficiary (NQF #2158)	Efficiency and Cost Reduction
HCAHPS*	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (NQF #0166)	Patient and Caregiver Centered Experience of Care/Care Coordination

* Measures readopted for the FY 2017 Hospital VBP Program.
** Measure adopted for the FY 2016 Hospital VBP Program but not previously subject to automatic readoption.
*** Measures proposed for the FY 2017 Hospital VBP Program.

Appendix 9 - FY17 Adopted and Proposed Performance Standard Values

Previously Adopted and Proposed Performance Standards for the FY 2017 Hospital VBP Program: Safety, Clinical Care – Outcomes, Clinical Care – Process, and Efficiency and Cost Reduction Measures			
Measure ID	**Description**	**Achievement Threshold**	**Benchmark**
Safety Measures			
CAUTI	Catheter-Associated Urinary Tract Infection	0.8371	0.0000
CLABSI	Central Line-Associated Blood Stream Infection	0. 4483	0.0000
C. difficile	*Clostridium difficile* Infection	0.7927	0.0000
MRSA bacteremia	Methicillin-Resistant *Staphylococcus aureus* Bacteremia	0.8613	0.0000
PSI-90*	Complication/patient safety for selected indicators (composite)*	0.577321*	0.397051*

Previously Adopted and Proposed Performance Standards for the FY 2017 Hospital VBP Program: Safety, Clinical Care – Outcomes, Clinical Care – Process, and Efficiency and Cost Reduction Measures			
Measure ID	**Description**	**Achievement Threshold**	**Benchmark**
SSI	Surgical Site Infection • Colon • Abdominal Hysterectomy	 • 0.7117 • 0.7509	 • 0.0000 • 0.0000
Clinical Care – Outcomes Measures			
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*
Clinical Care – Process Measures			
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
Efficiency and Cost Reduction Measure			
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

*Previously adopted performance standards.

Proposed Performance Standards for the FY 2017 Hospital VBP Program Patient and Caregiver-Centered Experience of Care/Care Coordination Domain			
HCAHPS Survey Dimension	**Floor**	**Achievement Threshold**	**Benchmark**
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%

HCAHPS Survey Dimension	**Floor**	**Achievement Threshold**	**Benchmark**
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%