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FY15 IPPS Final Rule Overview

Please Note: CMS released a notice correcting several technical and typographical errors appearing in the FY15 IPPS final rule. **The correction notice also includes a table of the final FY15 readmission payment adjustment factors for hospitals under the Hospital Readmissions Reduction Program. This correction notice can be found at: http://www.ofr.gov/OFRUpload/OFRData/2014-23630_PI.pdf. Some of the major corrections appear in this document.**

Overview

CMS issued a final 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 final changes implement certain statutory provisions contained in the Affordable Care Act (ACA), the Protecting Access to Medicare Act of 2014, and other legislation. These changes are applicable to discharges occurring on or after October 1, 2014. CMS also updates 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 final rule include those relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program. While CMS is finalizing its proposal to align the reporting and submission timelines of the Medicare EHR Incentive Program with those of the Hospital IQR Program on the calendar year for clinical quality measures (CQMs) that are reported electronically for 2015, it is not finalizing its proposal to require quarterly submission of CQM data. CMS is also aligning 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: 50409, 50413, 50415

The table below reflects the impact of the final 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 final policies.

The following table has been updated according to CMS's correction notice.

FY15 IPPS Proposed Update Impact Table

	All FY15 Proposed Changes (%)
All Hospitals	-0.6
Urban Hospitals	-0.6
Rural Hospitals	-0.6
Teaching Status	
Non-Teaching	-0.5
Fewer Than 100 Residents	-0.5
100 or More Residents	-0.8
Special Hospital Types	
Rural Referral Center	-0.6
Sole Community Hospital	0.8

FY15 Proposed Inpatient Payment Rate Changes

Federal Register pages: 50420

CMS will make a **1.4 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 1.4 percent update.

Policy	Proposed Impact
Market basket update	2.9%
Multifactor productivity adjustment	-0.5%
ACA mandate	-0.2%
ATRA adjustment	-0.8%
Total	**1.4%**

FY15 Proposed Inpatient Hospital Operating Payment Rate Update

Federal Register pages: 499933-499995, 50405

CMS estimates that the changes for FY15 acute care hospital operating and capital payments will redistribute amounts in excess of $100 million to acute care hospitals. According to CMS's correction notice, the applicable percentage increase to the IPPS rates required by the statute, in conjunction with other payment changes in the final rule, will result in an estimated *$623 million* decrease in FY15 operating payments (or -0.6 percent change) and an estimated *$128 million* increase in FY15 capital payments (or 1.6 percent change). These changes are relative to payments made in FY14. The operating impact estimate of **1.4** percent, includes the **2.2** percent hospital update to the standardized amount (which includes the estimated 2.9 percent market basket update less 0.5 percentage point for the multifactor productivity adjustment and less 0.2 percent required under the ACA), minus the -0.8 percent documentation and coding adjustment applied to the IPPS standardized amount, which represents part of the recoupment required under section 631 of the ATRA. The estimates of 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 (*This does not include the documentation and coding reduction*):

1. For a hospital that submits quality data and is a meaningful EHR user, CMS finalizes an applicable percentage increase to the FY15 operating standardized amount of 2.2 percent (that is, the FY15 estimate of the market basket rate-of-increase of 2.9 percent less an adjustment of 0.5 percent for economy-wide productivity (that is, the MFP adjustment) and less 0.2 percent).

2. For a hospital that submits quality data and is not a meaningful EHR user, CMS finalizes an applicable percentage increase to the operating standardized amount of 1.475 percent (that is, the FY15 estimate of the market basket rate-of-increase of 2.9 percent, less an adjustment of 0.725 percent (the market basket rate-of- increase of 2.9 percent × 0.75)/3) for failure to be a meaningful EHR user, less an adjustment of 0.5 percent for the MFP adjustment, and less an additional adjustment of 0.2 percent).

3. For a hospital that does not submit quality data and is a meaningful EHR user, CMS finalizes an applicable percentage increase to the operating standardized amount of 1.475 percent (that is, the FY15 estimate of the market basket rate-of-increase of 2.9 percent, less an adjustment of 0.725 percent (the market basket rate-of-increase of 2.9 percent/4) for failure to submit quality data, less an adjustment of 0.5 percentage point for the MFP adjustment, and less an additional adjustment of 0.2 percent).

4. For a hospital that does not submit quality data and is not a meaningful EHR user, CMS finalizes an applicable percentage increase to the operating standardized amount of 0.75 percent (that is, the FY15 estimate of the market basket rate-of-increase of 2.9 percent, less an adjustment of 0.725 percent (the market basket rate-of- increase of 2.9 percent/4) for failure to submit quality data, less an adjustment of 0.725 percent (the market basket rate-of-increase of 2.9 percent × 0.75)/3) for failure to be a meaningful EHR user, less an adjustment of 0.5 percent for the MFP adjustment, and less an additional adjustment of 0.2 percent).

The following table summarizes the four final 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.

FINAL FY 2015 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

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	2.9	2.9	2.9	2.9
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act.	0.0	0.0	−0.725	−0.725
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act.	0.0	−0.725	0.0	−0.725
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	−0.5	−0.5	−0.5	−0.5
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	−0.2	−0.2	−0.2	−0.2
Final Applicable Percentage Increase Applied to Standardized Amount	2.2	1.475	1.475	0.75

CMS is revising the existing regulations at 42 CFR 412.64(d) to reflect the current law for the FY15 update, and making technical changes to reflect the order in which it applies the statutory adjustments to the applicable percentage increase.

Standardized Payment Rates

Federal Register pages: 49990 & 49991, 50404

For FY15, CMS continues 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 and available on the CMS web site, reflect this final labor-related share. For FY15, for all IPPS hospitals with wage indexes less than or equal to 1.0000, CMS will apply the wage index to a labor-related share of 62 percent of the national standardized amount. For all IPPS hospitals with wage indexes greater than 1.0000, for FY15, CMS will apply the wage index to a labor-related share of 69.6 percent of the national standardized amount.

The following table contains the FY15 final national standardized amounts for all hospitals, excluding those hospitals in Puerto Rico. *The following tables have been updated according to CMS's correction notice.*

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER 1)--FY15

Hospital submitted quality data and is a meaningful EHR user (Update = 2.2 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 1.475 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = 1.475 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
$3,780.13	$1,651.09	$3,753.31	$1,639.38	$3,753.31	$1,639.38	$3,726.50	$1,627.66

TABLE 1B.—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)--FY 2015

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.2 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.475 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 1.475 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
$3,371.47	$2,066.38	$3,347.55	$2,051.72	$3,347.55	$2,051.72	$3,323.63	$2,037.07

Documentation and Coding Adjustment

Federal Register pages: 49871-49874

Section 631 of the American Taxpayer Relief Act (ATRA) requires the HHS Secretary to make a recoupment adjustment to the standardized amount of Medicare payments to acute care hospitals to account for changes in MS–DRG documentation and coding that do not reflect real changes in case-mix, totaling $11 billion over a 4-year period of FYs 2014, 2015, 2016, and 2017. While its actuaries estimated that a –9.3 percent adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by section 631 of the ATRA in FY14, it is often its practice to delay or phase-in rate adjustments over more than one year, in order to moderate the effects on rates in any one year. Therefore, CMS made a -0.8 percent recoupment adjustment to the standardized amount in FY14, and will make an additional –0.8 percent recoupment adjustment in FY15.

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. As estimates of any future adjustments are subject to slight variations in total savings, CMS did not provide for specific adjustments for FYs 15, 16, or 17 at that time. CMS believes that this level of adjustment for FY14 was a reasonable and fair approach that satisfies the requirements of the statute while mitigating extreme annual fluctuations in payment rates.

CMS 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 did not propose such an adjustment for FY15, in light of the ongoing recoupment required by the ATRA. CMS notes that it will consider whether such an additional adjustment is appropriate in future years' rulemaking

Capital Federal Rate for FY14

Federal Register pages: 50386-50390

CMS is establishing an update of 1.5 percent in determining the FY15 capital Federal rate for all hospitals. As a result of this update and the budget neutrality factors, CMS is establishing a national capital Federal rate of $434.26 for FY15 (compared to $429.31 for FY14).

This is a result of the 1.5 percent update factor, the budget neutrality adjustment factor (-0.14%), and the final FY15 outlier adjustment factor (-0.21%). The combined effect of all the proposed changes would increase the proposed national capital Federal rate by **1.15 percent** compared to the FY14 national capital federal rate**.**

These factors are listed in the chart below.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2014 CAPITAL FEDERAL RATE AND FY 2015 CAPITAL FEDERAL RATE

	FY 2014	FY 2015	Change	Percent change
Update Factor [1]	1.0090	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor [1]	0.9987	0.9986	0.9986	−0.14
Outlier Adjustment Factor [2]	0.9393	0.9373	0.9979	−0.21
Capital Federal Rate	429.31	434.26	1.0115	1.15

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2014 to FY 2015 resulting from the application of the 0.9986 GAF/DRG budget neutrality adjustment factor for FY 2015 is a net change of 0.9986 (or –0.14 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2015 outlier adjustment factor is 0.9373/0.9393, or 0.9979 (or – 0.21 percent).

Outlier Payments

Federal Register pages: 50374

For FY15, CMS continues to use the outlier threshold methodology used in FY14. Using this methodology, CMS calculated a final outlier fixed-loss cost threshold for FY15 equal to the prospective payment rate for the MS– DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$24,626**. The final FY15 fixed-loss cost threshold is higher than the FY14 final outlier fixed-loss cost threshold of $21,748. CMS believes that the increase in the charge inflation factor (compared to the FY14 charge inflation factor) contributed to a higher 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: 49951-49968

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under section 1886(d)(3)(E) of the Act, beginning with FY05, CMS delineates hospital labor market areas based on the Core-Based Statistical Areas (CBSAs). The 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.

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 provided 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 is adopting the new OMB labor market area delineations announced on February 28, 2013. Therefore, hospitals should apply for reclassifications based on the new OMB

delineations CMS is using for FY15. Applications and other information about Medicare Geographic Classification Review Board reclassifications may be obtained via the internet on the CMS web site at: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html.

CMS is also including language in the regulations to reflect use of the most recent OMB standards for delineating statistical areas (using the most recent Census Bureau data and estimates) that it adopts in consideration of group reclassification applications submitted for review in FY15.

The FY15 national average hourly wage (unadjusted for occupational mix) is **$39.2971**. The FY15 Puerto Rico overall average hourly wage (unadjusted for occupational mix) is **$16.9893**. The FY15 occupational mix adjusted national average hourly wage (based on the new OMB labor market area delineations) is **$39.2591**. The FY15 occupational mix adjusted Puerto Rico-specific average hourly wage (based on the new OMB labor market area delineations) is **$17.0410**.

Puerto Rico Hospitals

Federal Register pages: 49996, 49991

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. CMS is finalizing an applicable percentage increase to the Puerto Rico-specific operating amount of 2.2 percent for FY 2015.

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 final rule, CMS is continuing 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.

If the hospital has a Puerto Rico-specific wage index greater than 1.0 for FY15, CMS will 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 will result in higher payments.

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

The following table has been updated according to CMS's correction notice.

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1; PUERTO RICO: 63.2 PERCENT LABOR SHARE/36.8 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1 OR 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1—FY 2015

	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	$3,371.47	$2,066.38
Puerto Rico	$1,609.97	$937.45	$1,579.40	$968.02

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

Under the capital IPPS, CMS computes a separate payment rate specific to Puerto Rico hospitals 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 is making to the factors used to determine the capital Federal rate, the FY15 special capital rate for hospitals in Puerto Rico is **$209.10**.

The following table has been updated according to CMS's correction notice.

Final FY15 Capital Standard Federal Payment Rate

	Rate
National	$434.97
Puerto Rico	$209.45

FY15 Hospital-Acquired Condition (HAC) Reduction Program

Federal Register pages: 50087-50104

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 Hospital-Acquired Conditions (HACs). Section 1886(p) of the Act requires the HHS Secretary to make payment adjustments 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 will exclude the Total HAC Scores for Maryland hospitals when identifying the top quartile of all hospitals.

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

Measure Updates:
For FY15, CMS will keep the AHRQ PSI–90 composite measure (in Domain 1) that it adopted in the FY14 IPPS/LTCH PPS final rule because it is currently endorsed by 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 revised composite.

Similarly, the Centers 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. Listed below are the Domain 2 measures:

- Central Line-associated Blood Stream Infection (CLABSI) (FY 2015 onward)
- Catheter-associated Urinary Tract Infection (CAUTI) (FY 2015 onward)
- Surgical Site Infection (SSI) (FY 2016 onward):
    - SSI Following Colon Surgery
    - SSI Following Abdominal Hysterectomy
- Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (FY 2017 onward)
- Clostridium difficile (FY 2017 onward)

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 FY15, CMS will use the 24-month period from July 1, 2011, through June 30, 2013, as the applicable time period for the AHRQ PSI–90 composite measure.

- For the Domain 1 AHRQ PSI-90 composite measure, for FY16, a 24-month period from July 1, 2013 – June 30, 2015, will be 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 will use calendar years 2013 and 2014 for all three Domain 2 measures in the HAC Reduction Program.

The final HAC measurement periods for 2015 and 2016 are listed in the table below.

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

Table extracted from AHA's summary of the FY15 IPPS Final Rule.

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 following two tables.

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 20th 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.

Criteria for Applicable Hospitals and Performance Scoring

For FY16, CMS will change the scoring methodology of the Total HAC Score. This is intended to address the implementation of CDC's NHSN SSI measure in Domain 2 finalized for implementation in FY16. Specifically, CMS will 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 finalized 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 will calculate an abdominal hysterectomy procedure SSI SIR and a colonic procedure SSI SIR, and pool both SIRs for each hospital, as this will 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 will allow a risk-adjusted weighting of the surgical volume among the two procedures. The pooled SSI SIR will be scored in the same manner as all measures finalized for the HAC Reduction Program. To determine a Domain 2 score, CMS will take the average of the three CDC HAI SIR scores. CMS will follow the same finalized rules used to determine scoring of Domains 1 and 2 in the FY14 IPPS/LTCH PPS final rule, and the proposed changes in section IV.J.6.e. of the preamble of the FY15 IPPS proposed rule, which are also included in section IV.J.6.e. of the preamble of the final rule.

In addition, for FY16, CMS will weight Domain 1 at 25 percent and Domain 2 at 75 percent. CMS will 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 will 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 sought 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. At this time, CMS does not have a specific measure in mind but is soliciting feedback on the feasibility and perceived value of a standardized electronic composite measure of all-cause

harm in the HAC Reduction Program. As it develops a more specific plan it will share that information in future rulemaking.

In the final rule, CMS estimates that the implementation of the HAC Reduction Program, under section 3008 of the ACA will reduce payments by $369 million in FY15. *However, in its correction notice, CMS raised this estimate to $373 million.*

Hospital Readmissions Reduction Program

Federal Register pages: 50024-50048

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 will use the revised version, CMS Planned Readmission Algorithm Version 3.0, for the AMI, HF, PN, THA/ TKA, COPD, Hospital-Wide All-Cause Unplanned Readmission (HWR) and stroke readmission measures for the FY15 payment determination and subsequent years. CMS has also expanded the scope of ''applicable conditions'' to include the coronary artery bypass graft [surgery] (CABG) readmission measure 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 will refine the measure to exclude patients with hip fracture coded as either principal or secondary diagnosis during the index admission.

No 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 five applicable conditions before adding others, CMS will not add 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 will include Coronary Artery Bypass Graft (CABG) readmissions to the Hospital Readmissions Reduction Program for FY17 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 50033-50039.

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 under the terms of the agreement. After consideration of the public comments it received, CMS is finalizing its proposal to make conforming changes to its regulations at § 412.152 and § 412.154(d) to reflect that Maryland elected to no longer have Medicare pay Maryland hospitals in accordance with section 1814(b)(3) of the Act.

Floor Adjustment Factor for FY15

The floor adjustment factor is **0.97** for FY15 and subsequent fiscal years. The applicable period of the 3-year time period of July 1, 2010, to June 30, 2013, will be used to calculate the excess readmission ratios and the readmission payment adjustment factors for FY15.

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

In the FY15 IPPS proposed 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 noted that its proposal does not alter its established methodology for calculating aggregate payments for all discharges, which is the denominator of the ratio.

For FY15, CMS will 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 will 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 will be used to identify the two conditions, added to the Hospital Readmissions Reduction Program, beginning in FY15.

These ICD–9–CM codes also would be used to identify the applicable conditions to calculate the excess readmissions ratios, consistent with its established policy. ***Appendix 2*** displays the formula for the aggregate payment for excess readmission calculation.

In the final rule, CMS estimated that the Hospital Readmissions Reduction Program will result in a 0.4 percent decrease in payments (or a decrease of $424 million). In the correction notice released, CMS revised estimated savings under the program by $4 million, to **$428 million**.

Hospital Quality Reporting Program

Federal Register pages: 50202-50277

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." CMS will change the criteria for determining when a measure is "topped-out." CMS will apply the following two criteria, the first of which was previously adopted by the Hospital VBP Program in the Hospital Inpatient VBP Program final rule, to Hospital IQR Program measures. The second criterion is a modified version of what was previously adopted by the Hospital VBP Program, also in this final rule, with the change from the ''less than'' operator to the ''less than or equal to''

operator. The new criteria is as follows:

- Statistically indistinguishable performance at the 75th and 90th percentiles; and
- Truncated coefficient of variation ≤ 0.10.

Removal of Hospital IQR Program Measures for FY17 and Beyond

CMS will remove 19 measures for the FY17 payment determination and subsequent years, 10 of which are being retained as voluntary electronic clinical quality measures, with the exception of the SCIP–Inf–4 measure, which it is retaining in the Hospital IQR Program measure set in its chart-abstracted form as previously finalized. CMS believes retaining the 10 measures for electronic submission provides an opportunity to monitor topped-out measures for performance decline. This policy simplifies alignment between the Hospital IQR and Medicare EHR Incentive Programs for eligible hospitals and provides a more straight forward approach to educate stakeholders on electronic reporting options. ***See Appendix 3 for details.***

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

For current and future adopted condition-specific, claims-based measures, beginning with the FY17 payment determination and subsequent years, CMS will use three years of data to calculate measures. This three-year reporting period will apply to all future calculations of these measures already adopted in the Hospital IQR Program as well as those measures that may be adopted in future years. ***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

For FY17 payment determination and subsequent years, CMS will adopt 11 total measures. The first nine new measures (4 of which are voluntary electronic clinical quality 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:

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

This gives a total of **63** measures (47 required and 16 voluntary electronic clinical quality measures) in the Hospital IQR Program measure set.

Appendix 5 contains a table showing both previously adopted and newly finalized 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 hospitals that chose to participate in the voluntary electronic reporting option in CY15, CMS finalizes that these providers must 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 across 3 NQS domains. Policies for electronic clinical quality measure reporting in CY16 and subsequent years will be made in future rulemaking.

Only 28 of the 29 measures adopted in the Medicare EHR Incentive Program are applicable for the Hospital IQR Program.

These 28 clinical quality measures appear in Appendix 6.

CMS is modifying its proposal to finalize that hospitals choosing to voluntarily report electronic measures should submit one quarter of electronic clinical quality measure data from Q1, Q2, or Q3 of CY15 for the FY17 payment determination. However, hospitals may voluntarily submit more than one quarter of data. Hospitals choosing to report at least one

quarter of quality measure data electronically are not required, but encouraged to also submit the same data via chart abstraction. CMS will not accept Q4 2015 data for CY15, as this would likely delay EHR Incentive Program payments. Because CMS is modifying its proposal to now only require 1 quarter's worth of data from hospitals that wish to voluntarily submit electronically specified measures, it is also changing the submission deadline to November 30, 2015, regardless of which quarter of data is submitted.

The following table provides a summary of the finalized reporting periods and electronic submission deadlines for the FY17 Hospital IQR Program:

FY 2017 HOSPITAL IQR PROGRAM ELECTRONIC REPORTING PERIODS AND SUBMISSION DEADLINES FOR ELIGIBLE HOSPITALS

Discharge reporting periods	Submission deadline
January 1, 2015–March 31, 2015.	November 30, 2015.
April 1, 2015–June 30, 2015.	November 30, 2015.
July 1, 2015–September 30, 2015.	November 30, 2015.
October 1, 2015–December 31, 2015.	Not Applicable.

Public Reporting of Electronic Clinical Quality Measures

CMS finalizes the public reporting policy for hospitals participating in the voluntary electronic reporting option. CMS will publicly report the names of those hospitals successfully submitting CY15 Q1, Q2, or Q3 data by the Nov. 30, 2015 submission deadline. CMS will not publicly report actual electronic clinical quality measure (eCQM) data or eCQM performance rates at this time. Therefore, hospitals will not have a preview period prior to the public reporting nor will CMS allow hospitals to opt out of public reporting. CMS will distinguish hospitals submitting eCQM data with a symbol on Hospital Compare to recognize their advanced ability to submit data electronically. CMS will use the results of its validation pilot to assist in determining future criteria for identifying eCQM data accuracy.

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

CMS requested and received many comments regarding these future proposals, but because it believes these they are not within the scope of this current rulemaking, did not address them in this final rule. However, it intends to consider all of these views for future rulemaking and Hospital IQR Program development.

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 incrementally aligned 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.

While CMS is finalizing its proposal to align the reporting period and submission deadline of the Medicare EHR Incentive Program with those of the Hospital IQR Program on the calendar year for clinical quality measures that are reported electronically, it is not finalizing its proposal to require quarterly submission of clinical quality measure data in CY15. Since CMS is also modifying its proposal in the Hospital IQR Program to finalize that hospitals can voluntarily submit one calendar year (CY) quarter's data for CY Q1 (January 1–March 31, 2015), CY2 (April 1–June 30, 2015), or CY3 (July 1–September 30) by November 30, 2015, it is also applying these modifications to the alignment with the Medicare EHR Incentive Program. As a result, CMS is not incrementally shifting the Medicare EHR Incentive Program reporting period and submission deadlines for clinical quality measures as proposed. It plans to continue to align reporting periods and submission deadlines in CY16 and subsequent years in future policy years. ED–1, ED–2, Stroke-4, Stroke-6, Stroke-8, VTE–1, VTE–2, VTE–3, VTE– 5, VTE–6, AMI–7a, and PC–01 are measures required under the Hospital IQR Program and may be submitted as chart-abstracted or as electronic clinical quality measures. If a hospital chooses to submit one calendar quarter (CY 2015 Q1, Q2, or Q3) as an electronic clinical quality measure by November 30, 2015, a hospital does not need to also submit chart-abstracted data for that measure.

Tables illustrating the current 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: 50048-50087

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.

FY15 Payment Details

Based on the March 2014 update of the FY13 Medicare Provider Analysis and Review (MedPAR) file, CMS continues to estimate that the amount available for value based incentive payments for FY15 is $1.4 billion. 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 the FY15 IPPS 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. CMS expects that Table 16B will be posted on its web site in October 2014.

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 will revise the definition of ‘‘base operating DRG payment amount’’ for Medicare-Dependent Small Rural Hospitals (MDHs) to include the difference between the hospital-specific payment rate and the Federal payment rate (as applicable). CMS is also finalizing the revision to the definition of ‘‘base operating DRG payment amount’’ in section 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). CMS stated its belief that this policy would facilitate measure adoption for the Hospital VBP Program for future years, as well as align the Hospital VBP Program with the Hospital IQR Program.

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.
Outcomes 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 "topped-out" 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. CMS believes that removing these ''topped-out'' measures will continue to ensure that it makes valid statistical comparisons through its finalized scoring methodology and will reduce the reporting burden on participating hospitals.

New Measures for the FY17 Hospital VBP Program

CMS will adopt the following three measures for inclusion in the FY17 Hospital VBP Program because they meet the statutory requirements. 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. CMS is finalizing its proposal to adopt the current CLABSI measure for the FY17 Hospital VBP Program. 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 is adopting for the first time.***

This table also includes the FY17 domains into which it is placing the readopted measures, as well as the domains into which it is placing the newly adopted measures.

Additional Measures for the FY19 Hospital VBP Program

CMS will 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

CMS continues to believe that adopting this Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) composite measure provides strong incentives for hospitals to ensure that patients are not harmed by the medical care they receive, which is a critical consideration in quality improvement. In order to clarify the measure's status under the Hospital VBP Program, and ensure that there is no confusion about its intent, CMS will 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. Currently, the PEC/CC domain is comprised of eight dimensions of the HCAHPS Survey. Scoring in this domain is based on two elements: The HCAHPS Base Score and HCAHPS Consistency Points Score.

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

CMS will consider the comments that it has received regarding expanding the Efficiency domain as it develops future measures for the Hospital VBP Program.

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 table below summarizes the newly finalized 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).

Domain	Baseline period	Performance period
Safety:		
• PSI–90*	• October 1, 2010–June 30, 2012*	• October 1, 2013–June 30, 2015.*
	• January 1, 2013–December 31, 2013	
• NHSN (CAUTI, CLABSI, SSI, C. *difficile* Infection, MRSA Bacteremia).		• 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 intends to propose additional baseline and performance periods for the FY18 Hospital VBP Program in future rulemaking.

CMS also discusses previously adopted and newly finalized performance and baseline periods for certain measures for the FY19 and FY20 Hospital VBP Program in the 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 has adopted 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 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.

CMS notes further that the performance standards for the NHSN measures (CAUTI, SSI, and proposed CLABSI, MRSA Bacteremia, and C. *difficile* Infection), the PSI–90 measure, and the MSPB measure are calculated with lower values representing better performance, in contrast to other measures, on which higher values indicate better performance. The performance standards for SSI are computed separately for each measure stratum. CMS will award achievement and improvement points to each stratum separately, and then compute a weighted average of the points awarded to each stratum by predicted infections. CMS misstated PC–01 measure's benchmark in the proposed rule and has corrected that error in the final rule. ***The updated numerical values for the performance standards for FY17 are listed in Appendix 9***.

CMS 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 requested 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. CMS will consider the responses that it has received on this matter as it plans for the ICD–10–CM/PCS transition under the Hospital VBP Program.

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 finalizing its proposal to remove six "topped out" measures from the FY17 Clinical Care – Process subdomain, it believes that the substantial reduction in the number of measures adopted for this subdomain, warrants reconsideration of the finalized domain weighting for FY17.

Since CMS is also finalizing its proposal to readopt the CLABSI measure, and adopt two new measures (MRSA Bacteremia and C. *difficile* Infection) for the Safety domain for FY17 Hospital VBP Program and subsequent years, this raises the total number of measures in this domain to six. Because CMS continues to believe that hospitals should be provided strong incentives to perform well on measures of patient safety, in view of the new measures CMS has added to that domain, it revises the previously finalized domain weighting for the FY17 Hospital VBP Program for hospitals receiving a score on all newly aligned domains as follows:

Domain	Weight
Safety	20 percent.
Clinical Care	30 percent.
• Clinical Care—Outcomes	• 25 percent.
• Clinical Care—Process	• 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 will 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 will 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 will 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, will adopt the specified case minimums for the FY16 Hospital VBP Program and subsequent years. CMS will also specify minimum numbers of measures for the FY17 Hospital VBP Program and subsequent years based on the new domain structure.

Minimum Number of Measures – Safety Domain

CMS has adopted 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 will adopt a minimum number of three measures for the Safety domain for FY17 and subsequent years. CMS has not determined this number yet.

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 will adopt a minimum number of two measures in the Clinical Care—Outcome subdomain for FY17 and subsequent years. CMS will also require hospitals to report a minimum of one measure in the Clinical Care—Process domain 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. If CMS adopts additional measures for this domain in the future, it will consider if it should revisit this policy.

Proposed Minimum Number of Measures – Patient and Caregiver Centered Experience of Care/Care Coordination (PEC/CC) Domain

As with the MSPB measure adopted for the Efficiency and Cost Reduction domain, CMS has not adopted additional measures for the 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 will 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 is currently in the process of revising the Extraordinary Circumstances/Disaster Extension or Waiver Request form, previously approved under OMB control number 0938–1171.

Suggested Exceptions to the Two-Midnight Benchmark

Federal Register pages: 50147- 50148

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 indicated that it would explore other potential exceptions to the generally applicable benchmark, and detail any such rare and unusual circumstances in subregulatory guidance. As part of this process, throughout the year, it has accepted and considered suggestions from stakeholders on this topic.

CMS will notify providers of any additional guidance regarding two- midnight exceptions through subregulatory means, such as postings on the CMS web site or manual instruction. Although the FY15 IPPS proposed rule did not include any proposed regulatory changes relating to the two-midnight benchmark, CMS received a number of public comments regarding the current regulation. During the summer and fall of 2014, CMS plans to evaluate the results of the ''probe & educate'' process and issue additional subregulatory guidance to its claim review contractors, if necessary, to ensure consistency in application of the two-midnight policy. CMS will consider all suggestions as it develops this subregulatory

guidance, and continue to maintain open communication with stakeholders to ensure that the inpatient classification and payment policies provide a uniform process for beneficiary treatment and claim submission.

LTCH PPS Payment Rates for FY15

Federal Register pages: 50176- 50402

CMS will 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 (2.9 percent). CMS will reduce the FY15 full market basket estimate of 2.9 percent by the FY15 MFP adjustment of **0.5** percent. Following application of the productivity adjustment, the adjusted market basket update of 2.4 percent is then reduced by 0.2 percent, as required by sections 1886(m)(3)(A)(ii) and 1886(m)(4)(E) of the Act, for an annual market basket update under the LTCH PPS for FY15 of **2.2** percent. For LTCHs that fail to submit quality reporting data CMS is further reducing the annual update by 2.0 percent, resulting in an annual update of **0.2** percent for these facilities.

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	**FY15 Payment Rate Update**
2.9%	0.5%	0.2%	**2.2 %**

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	Minus Quality Data Penalty	**FY15 Payment Rate Update**
2.9%	0.5%	0.2%	2.0%	**0.2%**

In the final rule, for FY15, CMS is applying a permanent one-time prospective adjustment factor of 0.98734 (or approximately –1.3 percent) to the standard Federal rate under the last year of the 3-year phase-in of the one-time prospective adjustment, in accordance with the existing regulations under § 412.523(d)(3). This adjustment factor will 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 will apply an area wage level adjustment budget neutrality factor of **1.0016703** to the standard Federal rate to ensure that the updates to the area wage level adjustment (that is, the final annual update of the wage index values and labor-related share) for FY15 will be implemented in a budget neutral manner. Accordingly, CMS is establishing a standard Federal rate of **$41,043.71** (calculated as $40,607.31 x 1.022 x 0.98734 x 1.0016703) for FY15. The standard Federal rate of $41,043.71 will apply in determining the payments for FY15 discharges from LTCHs that submit quality reporting data for FY15 in accordance with the requirements of the LTCHQR Program under section 1886(m)(5) of the Act. For LTCHs that fail to submit quality reporting data for FY15 in accordance with the requirements of the LTCHQR Program, CMS is establishing a standard Federal rate of **$40,240.51** (calculated as $40,607.31 x 1.002 x 0.98734 x 1.0016703) for FY15.

For FY15, CMS is establishing a labor-related share under the LTCH PPS of **62.306** percent based on IGI's second quarter 2014 forecast of the FY09-based LTCH-specific market basket. The current value is 62.537 percent. CMS is proposing a fixed-loss amount of **$14,792** for FY15. The current amount is $13,314.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)

Federal Register pages: 50004-50022

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 hospitals 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 ''the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply'' and ''the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1)'' for each fiscal year. Therefore, this factor amounts to 75 percent of the payments that would otherwise be made under section 1886(d)(5)(F) of the Act. 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 final rule, CMS uses the July 2014 Medicare DSH estimates to determine Factor 1 and to model the impact of this provision.

The July 2014 Medicare DSH estimate for FY 2015, without regard to the application of section 1886(r)(1) of the Act, is $13,383,462,195.71. This estimate excludes Maryland hospitals participating in the Maryland All-Payer Model, SCHs paid under their hospital

specific payment rate, and hospitals participating in the Rural Community Hospital Demonstration as discussed above. 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 $3,345,865,548.93 (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, in the final rule, CMS provides that Factor 1 for FY15 is **$10,037,596,646.78** ($13,383,462,195.71 minus $3,345,865,548.93).

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 final rule, CMS uses the CBO's April 2014 estimates of the effects of the ACA on health insurance coverage. The CBO's April 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.) Similarly, the CBO's April 2014 estimate of individuals under the age of 65 with insurance in CY15 is 87 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY15 available for this final rule is 13 percent (that is, 100 percent minus 87 percent.)

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

- CY14 rate of insurance coverage (April 2014 CBO estimate): 84 percent.
- CY15 rate of insurance coverage (April 2014 CBO estimate): 87 percent.
- FY15 rate of insurance coverage: (84 percent * .25) + (87 percent * .75) = 86.25 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent.
- Percent of individuals without insurance for FY15 (weighted average): 13.75 percent.

1 - |((0.1375 - 0.18)/0.18)| = 1 - 0.2361 = .7639 (76.39 percent)
0.7639 (76.39 percent) - .002 (0.2 percentage points for FY15 under section 1886(r)(2)(B)(i) of the Act) = 0.7619 or 76.19 percent 0.7619 = Factor 2

Therefore, the final Factor 2 for FY15 is **76.19** percent. The FY15 final uncompensated care amount is: $10,037,596,646.78 x 0.7619 = $7,647,644,885.18. The FY15 final uncompensated care total available is **$7,647,644,885.18**.

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 will 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 will 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

Direct Graduate Medical Education (GME)

Federal Register pages: 50022- 50141

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 established on or after January 1, 1995. 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. CMS will 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.

The methodology for calculating the FTE resident caps for hospitals that participate in training residents in new medical residency training programs will 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 calculated in this manner, CMS is finalizing a policy that, instead of the FTE resident caps being effective beginning with the sixth program year of the first new program started, those FTE resident caps, the 3-year rolling average, and the IRB ratio cap would be effective beginning with the applicable hospital's cost reporting period that ***coincides with or follows*** the start of the sixth program year of the first new program started.

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. As a result of the implementation of the new OMB delineations, some teaching hospitals may be redesignated from being located in a rural area to an urban area, thereby losing their ability to increase their caps again after their initial 5-year cap-building period.

CMS finalized a policy that if a rural hospital is training residents in a rural training track and is in an area redesignated by OMB as urban during the 3-year period that is used to calculate the ''original'' urban hospital's rural track FTE limitation, the ''original'' urban hospital may receive a cap adjustment for that rural track after the rural hospital has been redesignated as urban. However, regardless of whether the redesignation of the rural hospital occurs during or even after the 3-year period that is used to calculate the ''original'' urban hospital's rural track FTE limitation, the redesignated urban hospital may continue to be considered a rural hospital for purposes of the rural track for the term of a transition period. That transition period begins effective with the date the new OMB delineations are implemented by CMS and lasts through the end of the second residency training year following the implementation date of the new OMB delineations.

By the end of the transition period, either the redesignated urban hospital must reclassify as rural under § 412.103 for purposes of IME payment only (in addition, this reclassification option only applies to IPPS hospitals, not nonprovider sites), 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.

Requirement for Transparency of Hospital Charges under the Affordable Care Act

Federal Register, pages: 50145-50146

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 each year that hospitals operating within the United States establish, update, and make public (in accordance with guidelines developed by the HHS Secretary) a

list of its standard charges for items and services provided, including for DRGs, established under section 1886(d)(4) of the Social Security Act.

In the FY15 IPPS/LTCH PPS proposed rule, CMS reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the Public Health Service Act. CMS appreciates the widespread public support it received for including the reminder in the proposed rule. CMS reiterates that its guidelines for this section of the Public Health Service Act 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.

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 the information on its web site.

More Information

The final rule is published in the August 22, 2014, *Federal Register*, and the rule is effective on October 1, 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.

ICD–9–CM CODES TO IDENTIFY PNEUMONIA (PN) CASES—Continued

ICD–9–CM Code	Description of code
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.

ICD–9–CM CODES TO IDENTIFY CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CASES—Continued

ICD–9–CM Code	Description of code
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

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI × (Excess Readmissions Ratio for AMI–1)] + [sum of base operating DRG payments for HF × (Excess Readmissions Ratio for HF–1)] + [sum of base operating DRG payments for PN × (Excess Readmissions Ratio for PN–1)] + [sum of base operating DRG payments for COPD) × (Excess Readmissions Ratio for COPD–1)] + [sum of base operating DRG payments for THA/TKA × (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–Card–2: Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period (NQF #0284)
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–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–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–10: Assessed for rehabilitation* (NQF #0441)
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)
VTE–4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol*
Participation in a systematic database for cardiac surgery (NQF #0113)

* To be retained as an electronic clinical quality measure.

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

Short name	Measure name	NQF No.	FY 2016 payment determination
AMI–1	Aspirin at Arrival	N/A	Data collection suspended.
AMI–3	ACEI or ARB for LVSD	NQF #0137	Data collection suspended.
AMI–5	Beta-Blocker Prescribed at Discharge	NQF #0160	Data collection suspended.
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.	NQF #0164	Required.
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival.	NQF #0163	Required.
HF–2	Evaluation of LVS Function	NQF #0135	Required.
PN–6	Initial Antibiotic Selection for community-acquired pneumonia (CAP) in Immunocompetent Patients.	NQF #0147	Required.
SCIP–Inf–1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.	NQF #0527	Required.
SCIP–Inf–2	Prophylactic Antibiotic Selection for Surgical Patients	NQF #0528	Required.
SCIP–Inf–3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time—Overall Rate.	NQF #0529	Required.
SCIP–Inf–4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose.	NQF #0300	Refined measure specifications.
SCIP–Inf–6	Surgery Patients with Appropriate Hair Removal	NQF #0301	Data collection suspended.
SCIP–Inf–9	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero.	NQF #0453	Required.
SCIP–Card–2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period.	NQF #0284 NQF #0218	Required. Required.
SCIP–VTE–2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery.	NQF #0139 NQF #0753	Required. Required.
CLABSI	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure.	NQF #0138	Required.
SSI	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.		Required.
CAUTI	Colon procedures Hysterectomy procedures National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.		

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

Short name	Measure name	NQF No.	FY 2016 payment determination
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	NQF #1716	Required.
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure.	NQF #1717	Required.
HCP	Influenza vaccination coverage among healthcare personnel (HCP).	NQF #0431	Required.
ED–1	Median time from ED arrival to ED departure for admitted ED patients.	NQF #0495	Required submission, but voluntary electronic clinical quality measure.
ED–2	Admit Decision Time to ED Departure Time for Admitted Patients.	NQF #0497	Required submission, but voluntary electronic clinical quality measure.
Imm-1	Pneumoccocal Immunization	NQF #1653	Data collection suspended.
Imm-2	Influenza Immunization		Required.
Stroke-1	Venous thromboembolism (VTE) prophylaxis	NQF #1659	Required.
Stroke-2	Discharged on antithrombotic therapy		Required submission, but voluntary electronic clinical quality measure.
Stroke-3	Anticoagulation therapy for atrial fibrillation/flutter	NQF #0434	Required submission, but voluntary electronic clinical quality measure.
Stroke-4	Thrombolytic therapy	NQF #0435	Required submission, but voluntary electronic clinical quality measure.
Stroke-5	Antithrombotic therapy by the end of hospital day two	NQF #0436	Required submission, but voluntary electronic clinical quality measure.
Stroke-6	Discharged on statin medication		Required submission, but voluntary electronic clinical quality measure.
Stroke-8	Stroke education	NQF #0437	Required submission, but voluntary electronic clinical quality measure.
Stroke-10	Assessed for rehabilitation	NQF #0438	Required submission, but voluntary electronic clinical quality measure.
VTE–1	Venous thromboembolism prophylaxis	NQF #0439	Required submission, but voluntary electronic clinical quality measure.
VTE–2	Intensive care unit venous thromboembolism prophylaxis		Required submission, but voluntary electronic clinical quality measure.
VTE–3	Venous thromboembolism patients with anticoagulation overlap therapy.	N/A	Required submission, but voluntary electronic clinical quality measure.
VTE–4	Patients receiving un-fractionated Heparin with doses/labs monitored by protocol.	NQF #0441	Required submission, but voluntary electronic clinical quality measure.
VTE–5	VTE discharge instructions	NQF #0371	Required submission, but voluntary electronic clinical quality measure.
VTE–6	Incidence of potentially preventable VTE		Required.
PC–01	Elective delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	NQF #0372	Required.
MORT–30–AMI	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older.	NQF #0373	Required.
MORT–30–HF	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older.	N/A	Required.
MORT–30–PN	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization.	N/A	Required.
		N/A	
		NQF #0469	
		NQF #0230	

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

Short name	Measure name	NQF No.	FY 2016 payment determination
COPD Mortality	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	NQF #1893	Required.
STK Mortality	Stroke 30-day mortality rate	N/A	Required.
READM–30–AMI	Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	NQF #0505	Required.
READM–30–HF	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization.	NQF #0330	Required.
READM–30–PN	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.	NQF #0506	Required.
READM–30–TH/TKA.	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	Required.
READM–30–HWR.	Hospital-Wide All-Cause Unplanned Readmission (HWR)	NQF #1789	Required.
COPD READMIT.	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	NQF #1891	Required.
STK READMIT	30-day risk standardized readmission rate (RSMR) following Stroke hospitalization.	N/A	Required.
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB).	NQF #2158	Required.
AMI payment	AMI Payment per Episode of Care	NQF #1550	Required.
Hip/knee complications.	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).	NQF #0351	Required.
PSI 4 (PSI/NSI)	Death among surgical inpatients with serious, treatable complications.	NQF #0531	Required.
PSI 90	Patient safety for selected indicators (composite)	NQF #0113	Required.
Database for Cardiac Surgery.	Participation in a systematic database for cardiac surgery	N/A	Required.
Registry for Nursing Sensitive Care.	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.	N/A	Required.
Registry for General Surgery.	Participation in a Systematic Clinical Database Registry for General Surgery.	NQF #0166	Required.
Safe Surgery Checklist.	Safe Surgery Checklist Use	NQF #0228	Required.
HCAHPS	HCAHPS + CTM–3		

Appendix 5: Previously Adopted and Newly Finalized 2017 IQR Program Measures

Please see CMS's correction notice for updates to this table.

PREVIOUSLY ADOPTED HOSPITAL IQR PROGRAM MEASURES AND MEASURES NEWLY FINALIZED IN THIS FINAL RULE FOR THE FY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

Short name	Measure name	NQF No.	Submission methods for FY 2017 payment determination	New for FY 2017 payment determination
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.	NQF #0164	Electronic clinical quality measure or chart-abstracted REQUIRED.	
SCIP–Inf–4	Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose.	NQF #0300	Chart-abstracted only REQUIRED	
Sepsis	Severe sepsis and septic shock: management bundle.	NQF #0500	Chart-abstracted only REQUIRED	New for FY 2017.
Imm-2	Influenza Immunization	NQF #1659	Chart-abstracted only REQUIRED	
Stroke-1	Venous thromboembolism (VTE) prophylaxis.	NQF #0434	Chart-abstracted only REQUIRED	
ED–1	Median time from ED arrival to ED departure for admitted ED patients.	NQF #0495	Electronic clinical quality measure or chart-abstracted REQUIRED.	
ED–2	Admit Decision Time to ED Departure Time for Admitted Patients.	NQF #0497	Electronic clinical quality measure or chart-abstracted REQUIRED.	
Stroke-4	Thrombolytic therapy	NQF #0437	Electronic clinical quality measure or chart-abstracted REQUIRED.	
Stroke-6	Discharged on statin medication	NQF #0439	Electronic clinical quality measure or chart-abstracted REQUIRED.	
Stroke-8	Stroke education	N/A	Electronic clinical quality measure or chart-abstracted REQUIRED.	
VTE–1	Venous thromboembolism prophylaxis	NQF #0371	Electronic clinical quality measure or chart-abstracted REQUIRED.	
VTE–2	Intensive care unit venous thromboembolism prophylaxis.	NQF #0372	Electronic clinical quality measure or chart-abstracted REQUIRED.	
VTE–5	VTE discharge instructions	N/A	Electronic clinical quality measure or chart-abstracted REQUIRED.	
VTE–6	Incidence of potentially preventable VTE.	N/A	Electronic clinical quality measure or chart-abstracted REQUIRED.	
PC–01	Elective delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	NQF #0469	Electronic clinical quality measure or chart-abstracted REQUIRED.	
CLABSI	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure.	NQF #0139	NHSN REQUIRED	

Appendix 5: Previously Adopted and Newly Finalized 2017 IQR Program Measures - Continued

Short name	Measure name	NQF No.	Submission methods for FY 2017 payment determination	New for FY 2017 payment determination
SSI	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure. Colon procedures Hysterectomy procedures	NQF #0753	NHSN REQUIRED	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.	NQF #0138	NHSN REQUIRED	
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	NQF #1716	NHSN REQUIRED	
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure.	NQF #1717	NHSN REQUIRED	
HCP	Influenza vaccination coverage among healthcare personnel (HCP).	NQF #0431	NHSN REQUIRED	
MORT–30–AMI	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older.	NQF #0230	Claims REQUIRED	
MORT–30–HF	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older.	NQF #0229	Claims REQUIRED	
MORT–30–PN	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization.	NQF #0468	Claims REQUIRED	
COPD Mortality	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	NQF #1893	Claims REQUIRED	
STK Mortality	Stroke 30-day mortality rate	N/A	Claims REQUIRED	
CABG mortality	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery.	N/A	Claims REQUIRED	New for FY 2017.
READM–30–AMI	Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	NQF #0505	Claims REQUIRED	
READM–30–HF	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization.	NQF #0330	Claims REQUIRED	
READM–30–PN	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.	NQF #0506	Claims REQUIRED	
READM–30–TH/TKA.	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	Claims REQUIRED	
READM–30–HWR	Hospital-Wide All-Cause Unplanned Readmission (HWR).	NQF #1789	Claims REQUIRED	
COPD READMIT	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	NQF #1891	Claims REQUIRED	

Appendix 5: Previously Adopted and Newly Finalized 2017 IQR Program Measures - Continued

Short name	Measure name	NQF No.	Submission methods for FY 2017 payment determination	New for FY 2017 payment determination
STK READMIT	30-day risk standardized readmission rate (RSMR) following Stroke hospitalization.	N/A	Claims REQUIRED	
CABG READMIT	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery.	N/A	Claims REQUIRED	New for FY 2017.
PSI 4 (PSI/NSI)	Death among surgical inpatients with serious, treatable complications.	NQF #0351	Claims REQUIRED	
PSI 90	Patient safety for selected indicators (composite).	NQF #0531	Claims REQUIRED	
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB).	NQF #2158	Claims REQUIRED	
AMI payment	AMI Payment per Episode of Care	N/A	Claims REQUIRED	
HF Payment	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure.	N/A	Claims REQUIRED	New for FY 2017.
PN payment	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia.	N/A	Claims REQUIRED	New for FY 2017.
Hip/knee complications.	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).	NQF #1550	Claims REQUIRED	
Registry Nursing Sensitive Care.	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.	N/A	Web-based REQUIRED	
Registry for General Surgery.	Participation in a Systematic Clinical Database Registry for General Surgery.	N/A	Web-based REQUIRED	
Safe Surgery Checklist.	Safe Surgery Checklist Use	N/A	Web-based REQUIRED	
HCAHPS	HCAHPS + CTM–3	NQF #0166 NQF #0228	Patient Survey REQUIRED	
AMI–2	Aspirin Prescribed at Discharge for AMI.	NQF #0142	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival.	NQF #0163	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
AMI–10	Statin Prescribed at Discharge	NQF #0639	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
SCIP–Inf–1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.	NQF #0527	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
SCIP–Inf–2a	Prophylactic Antibiotic Selection for Surgical Patients.	NQF #0528	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
SCIP–Inf–9	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero.	NQF #0453	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
Stroke-2	Discharged on antithrombotic therapy	NQF #0435	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
Stroke–3	Anticoagulation therapy for atrial fibrillation/flutter.	NQF #0436	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
Stroke–5	Antithrombotic therapy by the end of hospital day two.	NQF #0438	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
Stroke–10	Assessed for rehabilitation	NQF #0441	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
VTE–3	Venous thromboembolism patients with anticoagulation overlap therapy.	NQF #0373	Electronic clinical quality measure	Voluntary electronic clinical quality measure.

Appendix 5: Previously Adopted and Newly Finalized 2017 IQR Program Measures - Continued

Short name	Measure name	NQF No.	Submission methods for FY 2017 payment determination	New for FY 2017 payment determination
VTE–4	Patients receiving un-fractionated Heparin with doses/labs monitored by protocol.	N/A	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
PC–05	Exclusive Breast Milk Feeding and the subset measure PC–05a Exclusive Breast Milk Feeding Considering Mother's Choice.	NQF #0480	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
EHDI–1a	Hearing Screening Prior to Hospital Discharge.	NQF #1354	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
CAC–3	Home Management Plan of Care (HMPC). Document Given to Patient/Caregiver	N/A	Electronic clinical quality measure	Voluntary electronic clinical quality measure.
HTN	Healthy Term Newborn	NQF #0716	Electronic clinical quality measure	Voluntary electronic clinical quality measure.

Appendix 6: IQR Program Electronic Clinical Quality Measures Aligning Medicare EHR Incentive Program

Short name	Measure name	NQF number	NQS domain [121]	Available data submission modes
ED–1	Median time from ED arrival to ED departure for admitted ED patients.	NQF #0495	Patient and Family Engagement.	Electronic clinical quality measure or chart-abstracted.
ED–2	Admit Decision Time to ED Departure Time for Admitted Patients.	NQF #0497	Patient and Family Engagement.	Electronic clinical quality measure or chart-abstracted.

Short name	Measure name	NQF number	NQS domain [121]	Available data submission modes
PC–01	Elective delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	NQF #0469	Clinical Process/Effectiveness.	Electronic clinical quality measure or chart-abstracted aggregated with Web-based submission.
Stroke-2	Discharged on antithrombotic therapy	NQF #0435	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
Stroke-3	Anticoagulation therapy for atrial fibrillation/flutter.	NQF #0436	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
Stroke-4	Thrombolytic therapy	NQF #0437	Clinical Process/Effectiveness.	Electronic clinical quality measure or chart-abstracted.
Stroke-5	Antithrombotic therapy by the end of hospital day two.	NQF #0438	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
Stroke-6	Discharged on statin medication	NQF #0439	Clinical Process/Effectiveness.	Electronic clinical quality measure or chart-abstracted.
Stroke-8	Stroke education	N/A	Patient and Family Engagement.	Electronic clinical quality measure or chart-abstracted.
Stroke-10	Assessed for rehabilitation	NQF #0441	Care Coordination	Voluntary electronic clinical quality measure.
VTE–1	Venous thromboembolism prophylaxis	NQF #0371	Patient Safety	Electronic clinical quality measure or chart-abstracted.
VTE–2	Intensive care unit venous thromboembolism prophylaxis.	NQF #0372	Patient Safety	Electronic clinical quality measure or chart-abstracted.
VTE–3	Venous thromboembolism patients with anticoagulation overlap therapy.	NQF #0373	Clinical Process/Effectiveness.	Electronic clinical quality measure or chart-abstracted.
VTE–4	Patients receiving un-fractionated Heparin with doses/labs monitored by protocol.	N/A	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
VTE–5	VTE discharge instructions	N/A	Patient and Family Engagement.	Electronic clinical quality measure or chart-abstracted.
VTE–6	Incidence of potentially preventable VTE	N/A	Patient Safety	Electronic clinical quality measure or chart-abstracted.
AMI–2	Aspirin Prescribed at Discharge for AMI	NQF #0142	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
AMI–7a	Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival.	NQF #0164	Clinical Process/Effectiveness.	Electronic clinical quality measure or chart-abstracted.
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival.	NQF #0163	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
AMI–10	Statin Prescribed at Discharge	NQF #0639	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
PN–6	Initial Antibiotic Selection for community-acquired pneumonia (CAP) in Immunocompetent Patients.	NQF #0147	Efficient Use of Healthcare Resources.	Voluntary electronic clinical quality measure.
SCIP–Inf–1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.	NQF #0527	Patient Safety	Voluntary electronic clinical quality measure.
SCIP–Inf–2a	Prophylactic Antibiotic Selection for Surgical Patients.	NQF #0528	Efficient Use of Healthcare Resources.	Voluntary electronic clinical quality measure.
SCIP-Inf-9	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero.	NQF #0453	Patient Safety	Voluntary electronic clinical quality measure.
PC–05	Exclusive Breast Milk Feeding and the subset measure PC–05a Exclusive Breast Milk Feeding Considering Mother's Choice.	NQF #0480	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
EHDI–1a	Hearing Screening Prior to Hospital Discharge.	NQF #1354	Clinical Process/Effectiveness.	Voluntary electronic clinical quality measure.
CAC–3	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver.	N/A	Patient and Family Engagement.	Voluntary electronic clinical quality measure.
HTN	Healthy Term Newborn	NQF #0716	Patient Safety	Voluntary electronic clinical quality measure.

[121] Medicare EHR Incentive Program Stage 2 final rule (77 FR 54083 through 54087).

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

CURRENT (2014) TIMELINES FOR EHR INCENTIVE PROGRAM AND HOSPITAL IQR PROGRAM REPORTING AND SUBMISSION

	EHR incentive program CQM reporting requirements		Hospital IQR program reporting requirements for FY 2016 payment determination	
2014 Reporting Period	FY 2014 October 1, 2013–September 30, 2014.	Report one full year OR	Q4 CY 2013	October 1, 2013–December 31, 2013. N/A for 2014 Hospital IQR Pro- gram reporting.
Submission Period		Report one three-month quarter OR. Report any continuous 90-day period.	Q1 CY 2014 ..... Q2 CY 2014 ..... Q3 CY 2014	January 1–March 31, 2014. April 1–June 30, 2014. July 1–September 30, 2014.
	Jan 2, 2014–Nov 30, 2014		October 1, 2013–November 30, 2014.	

Appendix 8 - Previously Adopted and New Measures for the FY17 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 #1716)	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 2017 Hospital VBP Program that were not previously subject to automatic readoption.
*** Measures newly adopted for the FY 2017 Hospital VBP Program in this final rule.

Appendix 9 - FY17 Adopted and Proposed Performance Standard Values (Updated)

PREVIOUSLY ADOPTED AND NEWLY FINALIZED 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	0.845	0.000.
CLABSI	Central Line-Associated Blood Stream Infection.	0.457	0.000.
C. *difficile*	*Clostridium difficile* Infection	0.750	0.000.
MRSA Bacteremia	Methicillin-Resistant *Staphylococcus aureus* Bacteremia.	0.799	0.000.
PSI–90*	Complication/patient safety for selected indicators (composite)*.	*0.577321	*0.397051.
SSI	Surgical Site Infection.		
	• Colon	• 0.751	• 0.000.
	• Abdominal Hysterectomy	• 0.698	• 0.000.
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	0.951607	0.997739.

Measure ID	Description	Achievement threshold	Benchmark
PC–01	Elective Delivery Prior to 39 Completed Weeks Gestation.	0.031250	0.000000.
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.

PERFORMANCE STANDARDS FOR THE FY 2017 HOSPITAL VBP PROGRAM PATIENT AND CAREGIVER-CENTERED EXPERIENCE OF CARE/CARE COORDINATION DOMAIN

HCAHPS survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	58.14	78.19	86.61
Communication with Doctors	63.58	80.51	88.80
Responsiveness of Hospital Staff	37.29	65.05	80.01
Pain Management	49.53	70.28	78.33
Communication about Medicines	41.42	62.88	73.36
Hospital Cleanliness & Quietness	44.32	65.30	79.39
Discharge Information	64.09	85.91	91.23
Overall Rating of Hospital	35.99	70.02	84.60