



Program Summary

Medicare Inpatient Prospective Payment System

Program Year: FFY 2013

FINAL RULE

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Overview

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

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

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

A copy of the final rule and other resources related to the IPPS are available on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html>.

The major hospital IPPS-related sections of the final rule are summarized below. Adopted program changes are effective for discharges on or after October 1, 2012 unless otherwise noted (at the time of this writing, the official *Federal Register* has not been published. As a result, the page references provided below refer to the unofficial display version of the *Federal Register*).

Inpatient Payment Rates

Updates to the Federal Operating, Hospital-Specific and Federal Capital Rates

Federal Register display pages 617-623 and 1,810-1,815

CMS' Final Rule: Incorporating the adopted updates with the effect of budget neutrality adjustments, the table below lists the federal operating and capital rates for FFY 2013 compared to the rates currently in effect. Additional detail on the factors updating these rates and hospital-specific rates is provided below.

	Final FFY 2012	Final FFY 2013	Percent Change
Federal Operating Rate	\$5,209.74	\$5,348.76	+2.7%
Federal Capital Rate	\$421.42	\$425.49	+1.0%

The table below provides details of the adopted updates for the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2013. Details regarding adjustments to the rates beyond the annual updates that account for wage index, patient condition, the effect of the VBP Program and Readmissions Reduction Program, and other adjustments are provided in the "Modifications to the Inpatient Rates and Payments" section.

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	+2.6% <i>(proposed at +3.0%)</i>	+2.6% <i>(proposed at +3.0%)</i>	+1.2% <i>(proposed at +1.3%)</i>
ACA-Mandated Productivity MB Reduction	-0.7% <i>(proposed at -0.8%)</i>	-0.7% <i>(proposed at -0.8%)</i>	—
ACA-Mandated Pre-Determined MB Reduction	-0.1% <i>(unchanged)</i>	-0.1% <i>(unchanged)</i>	—
Prospective Coding Adjustment Reduction *	-1.9% <i>(proposed at -2.7%)</i>	-0.5% <i>(proposed at -1.3%)</i>	— <i>(proposed at -0.8%)</i>
Restoration of Retrospective Coding Adjustment Applied in FFY 2012 *	+2.9% <i>(unchanged)</i>	—	—
Overall Rate Change (excluding budget neutrality)	+2.8% <i>(proposed at +2.3)</i>	+1.3% <i>(proposed at +0.8)</i>	+1.2% <i>(proposed at +0.5)</i>

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

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

Coding Adjustment for FFY 2013

Federal Register display pages 83-113 and pages 787-793

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

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

CMS' Final Rule: For FFY 2013, CMS is adopting its proposal to apply a final coding adjustment of minus 1.9% to the federal operating rate (minus 0.5% to the hospital-specific rates) to permanently offset the originally estimated 5.4% coding impact CMS believes occurred in claims submitted during FFYs 2008 and 2009.

Based on industry and Congressional concern, CMS is rejecting its proposal to implement a new and additional coding adjustment of minus 0.8% for coding improvements that CMS believes occurred in claims submitted during FFY 2010. CMS states in the final rule that the implementation of additional coding adjustments merits further consideration. Currently, there are no coding adjustments scheduled for future payment years.

As proposed, and as required by law, CMS will apply a 2.9% increase to the federal operating rate signifying the end of CMS' authority to retroactively recoup for increases in payments during FFYs 2008 and 2009 that CMS maintains were due to coding improvements.

Provided in the table below are the details of prior coding adjustments and the adjustments CMS is adopting for the IPPS payment rates in FFY 2013.

	Federal Operating Rate		Hospital-Specific Rates	Federal Capital Rate
	<i>Prospective</i> Coding Adjustment Details	<i>Retrospective</i> Coding Adjustment Details	<i>Prospective</i> Coding Adjustment Details	<i>Prospective</i> Coding Adjustment Details
Original Coding Impacts Estimated by CMS <i>(for claims submitted during FFYs 2008 and 2009)</i>	5.4%	5.8%	5.4%	5.4%
Total Coding Adjustment Reductions Applied Since FFY 2008 <i>(for claims submitted during FFYs 2008 and 2009)</i>	-3.5%	-5.8%	-4.9%	-5.4%
Previously Established/Remaining Coding Adjustment for FFY 2013 <i>(for claims submitted during FFYs 2008 and 2009)</i>	-1.9% <i>(unchanged)</i>	—	-0.5% <i>(unchanged)</i>	—
New Coding Adjustment for FFY 2013 <i>(for claims submitted during FFY 2010)</i>	— <i>(proposed at -0.8%)</i>	N/A	— <i>(proposed at -0.8%)</i>	— <i>(proposed at -0.8%)</i>
Adopted Coding Adjustment for FFY 2013	-1.9% <i>(proposed at -2.7%)</i>	+2.9%*	-0.5% <i>(proposed at -1.3%)</i>	— <i>(proposed at -0.8%)</i>

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

Hospital Wage Index and Wage Index Reclassifications

Wage Index Reform

Federal Register display pages 1,631-1,647

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

CMS' Final Rule: CMS did not propose to change the calculation of the wage index or make any other major wage index policy changes for FFY 2013. However, in April 2012, HHS did issue the Report to Congress on wage index reform mandated by the ACA.

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

In addition to the ACA-mandated report, the HHS Secretary commissioned the Institute of Medicine (IOM) to study Medicare's geographic payment adjustments for hospitals and physicians. The first part of IOM's two part report was released in the summer of 2011; part two was released in the summer of 2012. The IOM's approach would replace the current Medicare hospital wage index (which is base on hospital-reported labor

costs) with one based on Bureau of Labor and Statistics (BLS) survey data and redefine the current county-based labor-market areas. The Medicare Payment Advisory Commission (MedPAC) also issued a report on reforming the Medicare wage index in 2007.

While CMS has the administrative latitude to make many changes to the wage index system, significant changes, including data sources/inputs and other factors outlined to implement the reform concepts would likely require both regulatory and statutory changes.

A table that compares the three major wage index reform concepts is available on *Federal Register* display pages 1,646-1,647.

Wage Index, Occupational Mix, and Labor-Related Share

Federal Register display pages 414-454

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

CMS' Final Rule: CMS did not propose and is not adopting any major changes to the calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, or the current administrative reclassification rules.

For the FFY 2013 wage indexes, CMS will use wage data from Medicare cost reports beginning during FFY 2009 and occupational mix survey data from calendar year (CY) 2010. Using this data, the occupational mix adjusted national average hourly wage for FFY 2013 is \$37.4608.

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

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

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

A complete list of the wage indexes for payment in FFY 2013 is available in Table 2 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html>.

Cost-of-Living Adjustment (COLA)

Federal Register display pages 1,798-1,800

Background: Current law allows the HHS Secretary to make an adjustment to take into account the unique high-cost circumstances of hospitals located in Alaska and Hawaii. To account for these circumstances, the IPPS

provides a COLA to payments for hospitals located in these states based upon the city, county, or area in which the hospital is located. The COLA is made by multiplying the nonlabor-related portion of the federal operating rate by the applicable COLA factor.

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

CMS' Final Rule: For FFY 2013, CMS is adopting its proposal to use the same COLA factors used to adjust payments in FFY 2012 (as originally used to adjust payments in FFY 2011, which are based on OPM's 2009 COLA factors). CMS is also adopting a process outlined in the proposed and final rules for updating the COLA factors for FFY 2014. A list of the FFY 2013 COLA factors is available on *Federal Register* display page 1,800.

Expiration of Section 508 Reclassifications

Federal Register display pages 439-440

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

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

Imputed Floor Wage Index

Federal Register display pages 429-433

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

CMS' Final Rule: To address the concerns of several hospitals in Rhode Island that cannot benefit from the imputed floor wage index under the current methodology, CMS is adopting its proposal to implement an alternative methodology for computing this wage index. The alternative methodology will exist alongside the current methodology and allow, for the first time, four hospitals in Rhode Island to benefit from the policy.

MGCRB Reclassification Applications for FFY 2014

Federal Register display page 438

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

CMS' Final Rule: Applications for FFY 2014 reclassifications are due to the MGCRB by September 4, 2012. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at <http://www.cms.gov/MGCRB/>.

Modifications to Inpatient Rates and Payments

Value-Based Incentive Payment Adjustment Factor

Federal Register display pages 1,251-1,298

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

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

Over the past two years, in prior rulemaking, CMS has adopted the eligibility criteria, quality measures, quality performance standards, a scoring methodology, and other rules necessary to implement the FFYs 2013 and 2014 VBP Programs.

CMS' Final Rule: CMS used the proposed and final rules to put policies in place to fully implement the FFY 2013 program.

CMS is adopting the proposed methodologies and data sources put forward for calculating a hospital-specific "value-based incentive payment adjustment factor." In general, this factor will reflect the result of the 1.0% used to fund the program for each hospital multiplied by the VBP payment percentage achieved by each VBP eligible hospital. The VBP payment percentage is the result of how individual hospital performance, as measured by their VBP Total Performance Score (TPS), compares to hospital performance nationwide. Under the adopted methodology, a factor of less than 1.0 indicates a hospital will see a decrease in IPPS payments based on its VBP performance. A factor of more than 1.0 indicates a hospital will see an increase in IPPS payments. An example calculation of exactly how this factor will be calculated is available on *Federal Register* display pages 1,276-1,290.

As adopted, this factor will be applied to the base DRG operating amount of each Medicare inpatient FFS claim for discharges occurring during FFY 2013. The base DRG amount is defined for all VBP eligible hospitals as the wage-adjusted DRG operating payment plus any applicable new technology add-on payment and does not include adjustments for Disproportionate Share Hospital (DSH) and Indirect Medical Education (IME) payments, outlier payments, and low-volume hospital add-on payments. CMS is adopting its proposal to use inpatient claims data from the Medicare Provider Analysis and Review File (MedPAR) for the purposes of estimating the VBP incentive factors/amounts.

Using historical data (CMS is still validating actual program data), CMS has published estimated value-based incentive payment adjustment factors for each hospital in the final rule. Hospitals were also provided "Dry Run" preview reports by CMS in July 2012 via QualityNet that allow for the review of more recent data used to develop similar factors. The estimated factors published with the final rule are available in Table 16 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html>. The proxy factors range from a low of 0.9922 to a high of 1.0091. The average factor is 1.001.

Because CMS is still validating the quality data that will be used to calculate official adjustment factors, the agency will not be ready to adjust claims to account for hospital performance under the VBP Program

beginning October 1, 2012 (FFY 2013). CMS has adopted its proposal to begin adjusting claims to account for the VBP Program beginning January 1, 2013 and reprocess claims submitted prior to January 1. CMS plans to issue official adjustment factors to hospitals before the end of the calendar year.

Readmissions Adjustment Factor

Federal Register display pages 455-565

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

Unlike the Hospital VBP Program, the Readmissions Reduction Program is not budget neutral. Hospital's can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 1.0%. This capped reduction amount will increase over time. CMS estimates that the FFY 2013 program will cut about \$280 million from the IPPS.

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

CMS' Final Rule: CMS used the proposed and final rules to put policies in place to fully implement the FFY 2013 program.

CMS is adopting the proposed methodologies and data sources put forward for calculating a hospital-specific "readmissions adjustment factor." In general, this factor will reflect the result of dividing aggregate payments for excess readmissions (the result of when a hospital's readmission rate is higher than the national average for an eligible condition) by aggregate payments for all discharges. Under the adopted methodology, a readmissions adjustment factor of 1.0 indicates a hospital will see no change in IPPS payment based on its performance under the readmission payment policy. A factor of 0.9900 indicates a hospital will be subject to the maximum penalty and see a 1.0% decrease in IPPS payments. Hospitals with a factor between 0.9900 and 1.0 will see some level of decrease in IPPS payments.

Comparable to how payments are adjusted under the VBP Program, as adopted, this factor will be applied to the base DRG operating amount of each Medicare inpatient FFS claim for discharges occurring during FFY 2013 to account for hospital performance under the program. The base DRG amount is defined for all Readmission Reduction Program eligible hospitals as the wage-adjusted DRG operating payment plus any applicable new technology add-on payment and does not include adjustments for DSH and IME payments, outlier payments, and low-volume hospital add-on payments. CMS is adopting its proposal to use Medicare inpatient FFS payments from 3-years of MedPAR claims data (July 2008-June 2011) to calculate the readmission factors/amounts. This is the same data CMS used to calculate the rates.

Using the actual program data, CMS has published final readmissions adjustment factors for each hospital in the final rule. Hospitals were provided "Dry Run" preview reports by CMS in June 2012 via QualityNet to review the data used to develop these factors. The factors are available in Table 15 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html>. Based on the factors, 35% of hospitals have a factor of

1.0 and will see no change in IPPS payment. 8% of hospitals have a factor of 0.9900 and will be subject to the maximum penalty of 1.0%. The remaining 57% of hospitals have factors between 0.9900 and 1.0.

Outlier Payments

Federal Register display pages 1,763-1,793

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

CMS' Final Rule: To maintain total outlier payments at 5.1% of total IPPS payments, CMS is adopting an outlier threshold of \$21,821 for FFY 2013. The new threshold amount represents a 2.5% decrease compared to the current threshold. The decreased threshold amount will increase the number of cases eligible for outlier payments.

Hospital-Acquired Condition (HAC) MS-DRG Payment Policy

Federal Register display pages 127-199

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

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

CMS' Final Rule: For FFY 2013, CMS is adopting its proposals to expand the categories/conditions not recognized for Medicare IPPS payment under the HAC payment policy to include:

- Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures
 - CMS had proposed to adopt the SSI Following CIED Procedures as a new HAC category. Instead, CMS' adopted policy will categorize this condition as a sub-HAC condition within the current SSI HAC category. CMS will identify this HAC with diagnosis code 996.61 (Infection and inflammatory reaction due to cardiac device, implant and graft) or 998.59 (Other postoperative infection) in combination with one or more of 21 associated procedure codes listed on *Federal Register* display pages 141-142.
- Iatrogenic Pneumothorax with Venous Catheterization
 - CMS proposed and will adopt this condition as a new HAC category. This addition increases the number of HAC categories subject to the MS-DRG policy to 11. CMS will identify this HAC with diagnosis code 512.1 (Iatrogenic pneumothorax) and procedure code 38.93 (Venous catheterization NEC).

CMS is also adopting its proposal to expand the HAC diagnoses list for FFY 2013 by adding two diagnosis codes to the existing Vascular Catheter-Associated Infection HAC category: 999.32 (Bloodstream infection due to central venous catheter) and 999.33 (Local infection due to central venous catheter).

Graduate Medical Education (GME) and DSH Payments

Federal Register display pages 596-615 and 623-757

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

CMS' Final Rule: CMS did not propose and is not adopting any major changes to the GME and DSH payment policies and the IME adjustment factor will remain at 1.35.

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

CMS is adopting its proposal to include bed days associated with labor and delivery services in the Medicare DSH and IME payment adjustment calculations. In 2009, CMS adopted a policy to include patient days for these services in the DSH adjustment calculation. At the time, CMS did not extend the policy to include beds associated with these services for the purposes of the IME/DSH payment calculations. CMS will extend this policy to beds effective for cost reporting periods beginning on or after October 1, 2012.

In reference to timely claims filing deadlines, CMS clarifies in the final rule that hospitals must meet the existing timely filing deadlines in order to receive supplemental IME, direct GME and/or nursing or allied health education payments for Medicare Advantage enrollees. Also, CMS is adopting its proposal to require hospitals to meet these deadlines when submitting no pay bills for the purpose of calculating the Disproportionate Patient Percentage (DPP).

CMS also used the proposed and final rules to modify how resident caps will be calculated for new residency training programs for the purposes of direct GME and IME. Lastly, CMS has adopted its proposals, with some modifications, to update the policies related to the ACA provisions that allow for the redistribution of unused residency slots and the preservation of residency slots from closed hospitals. For hospitals that achieved additional residency slots, CMS is adopting clarifications to the requirements hospitals must meet to maintain those slots. CMS is also adopting modifications to the application timeline and ranking criteria for hospitals seeking to achieve residency slots from a closed hospital. Full detail on these modifications/clarifications is available on *Federal Register* display pages listed above.

Low-Volume Adjustment

Federal Register display pages 586-596

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

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

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

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

Low-Cost County Add-On

Not addressed in Federal Register

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

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

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

Updates to the MS-DRGs

Federal Register display pages 82-413

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

CMS' Final Rule: CMS did not propose and is not adopting any major changes to the MS-DRGs classifications and relative weights. For FFY 2013, CMS will maintain a total of 751 MS-DRG groupings.

Overall, compared to the current weights, 85% of the MS-DRG weights will change by less than +/-5% for FFY 2013. The updated FFY 2013 MS-DRGs and weights are available in Table 5 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html>.

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

Related to the updates to the MS-DRGs, the final rule also addresses:

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

Additional detail regarding these updates is available on *Federal Register* display pages listed above.

Rural Hospital Inpatient Payment and Policy Issues

Expiration of MDH Status

Federal Register display pages 576-579

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

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

With the expiration of the MDH program approaching, CMS believes that some hospitals with MDH status may seek to achieve SCH status. To accommodate MDHs seeking to convert to SCH status, CMS is adopting its proposal to apply approved SCH status congruent with the expiration of the MDH program as long as the MDH applies for the SCH classification at least 30 days prior to the end of FFY 2012 (August 31, 2012).

Incorrectly Classified SCHs and Retroactive Status Cancellation

Federal Register display pages 565-576

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

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

CMS' Final Rule: CMS is adopting its proposal, with some modifications, to recoup overpayments associated with initial incorrect SCH classifications. Under this policy, CMS could withdraw SCH status and any payments associated with the status for cost report periods within a 3-year reopening period. CMS is modifying its proposal in a way to allow hospitals, effective October 1, 2012, to report any factors/information that could have affected its initial classification. Under this circumstance, if CMS determines that the hospital never met the criteria to achieve SCH status, the status would be revoked prospectively (as opposed to retrospectively) effective 30 days from the determination.

Updates to Minimum Criteria for Hospitals Seeking Rural Referral Center (RRC) Status

Federal Register display pages 579-585

Background: Rural hospitals that meet certain criteria can be classified as a RRC under the IPPS. This special rural status allows:

- exemption from the 12% cap on DSH payments that is applicable to other rural hospitals; and
- special treatment under the geographic reclassification rules including:
 - exemption from the proximity criteria; and
 - exemption from the requirement that a hospital's AHW must exceed 106% or 108% of the AHW of the labor market area where the hospital is located and application of the rural AHW threshold requirement (82% rather than 84%) for the labor market area where the hospital wants to reclassify.

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

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

CMS' Final Rule: As it does each year, CMS is adopting updates to the minimum CMI and discharge values required for hospitals seeking RRC status that do not meet the 275 bed criteria. The FFY 2013 minimum values by region are available on *Federal Register* display pages 582-584.

Updates to the Hospital VBP Program for FFYs 2015 and Beyond

Federal Register display pages 1,313-1,414

Background: Included as part of the IPPS rule are policies related to the Hospital VBP Program established by the ACA for FFYs 2015 and beyond. Complete program policies for the FFYs 2013 and 2014 programs have already been adopted by CMS in prior rulemaking.

The FFY 2013 VBP Program will assess hospital quality performance using quality measures from two domains (categories of quality measures):

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

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

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

CMS used the IPPS rulemaking cycle to propose and adopt significant changes to how the VBP Program will function in future years (FFY 2015 and beyond). CMS is adopting measure additions/deletions, new quality domains for evaluation, new data collection time periods, new national performance standards, and new measure weighting schemes for calculating a hospital's TPS and subsequent incentive payment adjustment factor. The adopted changes create future VBP Programs that are substantially different from the programs established for FFYs 2013 and 2014.

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

Measures and Domains

Federal Register display pages 1,313-1,354

CMS' Final Rule: CMS is adopting its proposal to remove 1 chart-abstracted process measure, Surgical Care Improvement Project (SCIP)-Venous Thromboembolism (VTE)-1, from the VBP Program beginning FFY 2015. This measure has also been removed from the IQR Program.

CMS is adopting, without modification or adjustment, its proposals to add the following 3 measures and domain (efficiency domain) to the VBP Program FFYs 2015 and beyond:

- Patient Outcomes Domain:
 - 2 claims-based outcomes measures:
 - Patient Safety Indicator (PSI)-90, a composite measure of patient safety indicators developed and maintained by Agency for Healthcare Research and Quality (AHRQ); and
 - Central Line- Associated Bloodstream Infection (CLABSI), a hospital-acquired infection (HAI) measure (FFY 2015 Program only);
- Efficiency Domain (new domain adopted for FFY 2015):
 - 1 claims-based efficiency measure – Medicare Spending Per Beneficiary (MSPB-1)

CMS is not adopting its proposal to add to the VBP Program the chart-abstracted process measure Acute Myocardial Infarction (AMI)-10: Statin Prescribed at Discharge. CMS believes this measure is “topped-out” and not appropriate for inclusion in the VBP Program.

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

- Process of Care (consisting of 11 FFY 2014 program measures);
- Patient Experience of Care (same HCAHPS measures as FFY 2014 program);
- Patient Outcomes (3 mortality measures from the FFY 2014 program, 1 new AHRQ composite measure (PSI-90), and 1 new HAI measure (CLABSI)); and
- Efficiency (1 new MSPB measure)

For future program years, CMS is adopting its proposal to automatically re-adopt measures from year to year unless the agency decides to propose to add or remove measures from the program through rulemaking in response to public comments. Currently, CMS proposes to retain measures on a year-by-year basis.

Baseline and Performance Periods

Federal Register display pages 1,364-1,383

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

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

For the FFY 2015 VBP Program, CMS is adopting its proposals to establish, with slight modifications related to the CLABSI measure, the following baseline and performance periods:

- Process of Care and Patient Experience of Care Domains:
 - Baseline Period: January 1, 2011 through December 31, 2011 (12-months)
 - Performance Period: January 1, 2013 through December 31, 2013 (12-months)
- Patient Outcomes Domain – Mortality measures:
 - Baseline Period: October 1, 2010 through June 30, 2011 (9-months)
 - Performance Period: October 1, 2012 through June 30, 2013 (9-months)
- Patient Outcomes Domain – AHRQ composite measure:
 - Baseline Period: October 15, 2010 through June 30, 2011 (about 9-months)
 - Performance Period: October 15, 2012 through June 30, 2013 (about 9-months)
- Patient Outcomes Domain – CLABSI measure:
 - Baseline Period: January 1, 2011 through December 31, 2011 (12-months)
 - Performance Period: February 1, 2013 through December 31, 2013 (11-months)

CMS had proposed to begin these periods on January 26 to comply with certain requirements of the law. CMS slightly modified the proposed baseline/performance periods to achieve the most accurate and useable data for this measure within the parameters of the law.

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

For the FFY 2016 VBP Program, CMS is adopting its proposals to establish, with slight modifications related to the AHRQ composite measure, the following baseline and performance periods for the mortality and AHRQ outcomes measures:

- Patient Outcomes Domain – Mortality measures:
 - Baseline Period: October 1, 2010 through June 30, 2011 (9-months and the same period adopted for use under the FFY 2015 program)
 - Performance Period: October 1, 2012 through June 30, 2014 (21-months)
- Patient Outcomes Domain – AHRQ composite measure:
 - Baseline Period: October 15, 2010 through June 30, 2011 (9-months and the same period adopted for use under the FFY 2015 program)
 - Performance Period: October 15, 2012 through June 30, 2014 (21-months)

CMS is adopting the October 15 starting date for the AHRQ composite measure baseline/performance periods to comply with certain timing requirements of the law.

CMS is expanding the performance period for the mortality and AHRQ measures to nearly 24-months because CMS believes a 24-month performance period will yield more reliable results for these measures under the VBP Program.

CMS will put forward the baseline/performance periods for the other domain measures at a later date.

National Performance Standards

Federal Register display pages 1,383-1,394

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

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

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

Measure ID	Measure	National Threshold	National Benchmark
Process of Care Domain			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	80.000%	100%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	95.349%	100%
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Anti-biotic Received in Hospital	94.118%	100%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	97.783%	100%
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	95.918%	100%
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	97.175%	100%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	98.639%	100%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	98.637%	100%
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	97.494%	100%
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	95.798%	99.767%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	94.891%	99.991%
Patient Experience of Care Domain			
HCAHPS Dimension	Communication with Nurses	47.77% (floor)	76.56%
	Communication with Doctors	55.62% (floor)	79.88%
	Responsiveness of Hospital Staff	35.10% (floor)	63.17%

	Pain Management	43.58% (floor)	69.46%	78.17%
	Communication about Medicines	35.48% (floor)	60.89%	71.85%
	Hospital Cleanliness & Quietness	41.94% (floor)	64.07%	78.90%
	Discharge Information	57.67% (floor)	83.54%	89.72%
	Overall Rating of Hospital	32.82% (floor)	67.96%	83.44%
Patient Outcomes Domain				
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (shown as survival rate)		84.7472%	86.2371%
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate (shown as survival rate)		88.1510%	90.0315%
MORT-30 PN	Pneumonia (PN) 30-Day Mortality Rate (shown as survival rate)		88.2651%	90.4181%
PSI-90	Patient safety for selected indicators (composite)		0.622879	0.451792
CLABSI	Central Line-Associated Blood Stream Infection		0.437	0.000
Efficiency Domain				
MSPB-1	Medicare Spending Per Beneficiary		Median Medicare spending per beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile of Medicare spending per beneficiary ratios across all hospitals during the performance period

For FFY 2016, because CMS has adopted its proposal to use the same baseline period for the mortality and AHRQ outcomes measures, CMS will use the same national performance standards for these measures that are adopted for the FFY 2015 VBP Program. CMS will put forward the national performance standards for the other measures at a later date.

Performance Periods and Performance Standards in Future Years

Federal Register display pages 1,394-1,397

CMS' Final Rule: Currently, CMS updates the VBP Program using annual rulemaking cycles that update the payment rates and policies of the IPPS and outpatient PPS. CMS, seeking to modify this approach, is adopting its proposal to update performance periods and performance standards for future program years via notice on the CMS Web site or another publicly-available Web site. Under this approach, CMS will establish future performance standards for previously adopted measures using the previously adopted methods. Stakeholder comment on these performance periods and standards will be considered by CMS during the traditional rulemaking process when CMS puts forward policies for future VBP Program years. CMS believes that this approach will ensure that hospitals are kept fully aware VBP performance periods and standards.

Domain Weighting

Federal Register display pages 1,401-1,408

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

Domain	FFY 2015 Domain Weight
Clinical Process of Care	20% <i>(set at 70% for the FFY 2013 Program and 45% for the FFY 2014 Program)</i>
Patient Experience of Care	30% <i>(set at 30% for the FFYs 2013 and 2014 Programs)</i>
Patient Outcomes	30% <i>(set at 25% for the FFY 2014 Program)</i>
Efficiency	20% <i>(new domain)</i>

CMS is not adopting its proposal to regroup the FFY 2016 VBP measures into 6 new domains based on 6 priorities of the National Quality Strategy. As an example, this method would have grouped mortality outcomes measures with process of care measures. Currently, these measures are separated into 2 distinct domains. CMS will maintain the four-domain structure for FFY 2016 and put forward the domain weighting scheme at a later date.

Exclusion Criteria

Federal Register display pages 1,408-1,410 and 1,414-1,422

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

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

CMS is adopting its proposal to recognize the minimum number of useable outcomes measures as 2 out of the 5 measures in the domain for FFY 2015. Hospitals with fewer than 2 useable measures for the performance period will not achieve an outcomes domain score.

- Efficiency Domain:
 - MSPB measure: 25 case minimum

For FFY 2015 and subsequent years, CMS is adopting its proposed policy that will require hospitals to only need domain scores in 2 out of the 4 domains in order to be included in the program. For the FFYs 2013 and 2014 VBP Programs, hospital must receive domain scores on all domains in order to be included in the program. Hospitals that do not achieve domain scores do not meet the minimum case and measure counts established by CMS for the domains. Excluded hospitals are not be subject to the VBP pool contribution reductions and are not be eligible for VBP payment incentives. Under the new policy for FFY 2015, the TPS will be reweighted proportionately to the scored domains. As an example, a hospital that has only Process and Patient Experience domain scores will have their domains reweighted to 40% for the Process domain (as opposed to 20%) and 60% for the Patient Experience domain (as opposed to 30%).

Review/Correction and Appeals Process

Federal Register display pages 1,298-1,312

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

The ACA also requires the Secretary to establish a process by which hospitals may appeal the calculation of the VBP performance assessment by CMS. In this rule, CMS puts forward an administrative appeal process. A list of issues that can be appealed and instructions on how to submit an appeal are available on *Federal Register* display pages 1,310-1,311.

Updates to the Hospital IQR Program

Federal Register display pages 984-1,250

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

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

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

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

As previously adopted, for FFY 2013 payment determinations, hospitals were required to report on a total of 57 quality measures. A complete list of the IQR Program measures for FFY 2013 payment determinations is available on *Federal Register* pages 50,208-50,209 of the FFY 2011 IPPS final rule at <https://federalregister.gov/a/2010-19092>.

For FFY 2014 payment determinations, hospitals are currently reporting on a total of 55 quality measures. CMS also adopted a total of 72 measures for FFY 2015 payment determinations. A complete list of the previously adopted IQR Program measures for FFYs 2014 and 2015 payment determinations is available on *Federal Register* pages and pages 51,628-51,629 and 51,636-51,637 of the FFY 2012 IPPS final rule at <https://federalregister.gov/a/2011-19719>.

CMS' Final Rule: CMS is adopting all of the proposed IQR Program refinements put forward for FFY 2015 and FFY 2016 payment determinations. These refinements not only update the IQR Program but also remove and/or potentially put in place measures for use under the Hospital VBP Program and Readmissions Reduction Program. The updates also maintain a level of alignment with the quality measures adopted and proposed for use under the Electronic Health Record (EHR) Incentive Program.

FFY 2015 and FFY 2016 Payment Determinations

Federal Register display pages 1,001-1,114

CMS' Final Rule: For FFY 2015 payment determinations, CMS is adopting its proposals to reduce the number of measures it will evaluate from 72 measures (as adopted in prior rulemaking) to 59 measures.

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

- 1 chart-abstracted measure:
 - SCIP- VTE-1

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

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

- 5 claims-based AHRQ PSI measures:
 - PSI 06: Iatrogenic pneumothorax, adult
 - PSI 11: Postoperative Respiratory Failure
 - PSI 12: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)
 - PSI 14: Postoperative Wound Dehiscence
 - PSI 15: Accidental Puncture or Laceration

CMS will add the following measures to the IQR Program beginning with FFY 2015 payment determinations:

- 5 HCAHPS survey items:
 - 1 three-item care transition set (CTM-3) (National Quality Forum (NQF) #0228); and
 - 2 items to the “About You” section of the survey (“were you admitted through the emergency room” and “rate your overall mental or emotional health”).

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

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

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

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

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

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

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

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

For FFY 2016 payment determinations, CMS will collect quality data on a total of 60 measures, retaining all adopted measures for FFY 2015 payment determinations, and adding the following measure:

- 1 structural measure
 - Safe Surgery Checklist Use (not NQF endorsed)

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

A complete list of the previously and newly adopted IQR Program measures for FFY 2015 and FFY 2016 payment determinations is available on *Federal Register* display pages 1,100-1,102 and 1,112-1,114.

Measure Retainment for Future Years

Federal Register display pages 1,024-1,030

CMS' Final Rule: CMS is adopting its proposal to modify how measures are adopted and retained under the IQR Program. Under the adopted policy, once a measure is adopted for use, that measure is automatically adopted for all subsequent year determinations unless CMS proposes to remove, suspend, or replace the measure. Currently, CMS proposes to retain measures on a year-by-year basis. Stakeholder comment on the IQR Program measures will be considered by CMS during the traditional rulemaking process when CMS puts forward policies for future IQR Program years. CMS has adopted a similar policy for the VBP Program and quality reporting programs in other care settings.

Alignment of Quality Reporting Between Programs and Possible New Measures and Topics for Future Years

Federal Register display pages 1,114-1,122

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

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

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

- Smoking Cessation Set
 - TAM-1: Tobacco Use Screening; TAM-2: Tobacco Use Treatment Provided or Offered; TAM-3: Tobacco Use Treatment Management at Discharge; and TAM-4: Assessing Status after Discharge, and
- Alcohol Cessation Set
 - TAM-5: Alcohol Use Screening; TAM-6: Alcohol Use Brief Intervention Provided or Offered; TAM-7: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; and TAM-8: Substance Use: Assessing Status after Discharge.

CMS also stated in the proposed and final rules its intent to propose the collection of data for non-ICU patients for the CLABSI (NQF #139) and Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #138) measures.

Lastly, CMS also noted in the proposed and final rules that it intends to align the measures collected for the IQR Program under six domains based on the six priorities of the National Quality Strategy. This would include:

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

CMS believes that this approach will enhance better patient care while bringing the Hospital IQR Program in line with other established quality reporting and pay-for-performance programs. CMS proposed, but did not adopt a similar adjustment to the quality domains used under the VBP Program beginning with FFY 2016.

Updates to the IQR Program Participation Policies

Federal Register display pages 1,122-1,250

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

CMS' Final Rule: As it does each year, CMS is used the proposed and final rules to update the IQR Program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes. Complete detail on these updates is available on *Federal Register* pages listed above.