Medicare Inpatient Prospective Payment System

Payment Rule Brief — Proposed Rule
Program Year: FFY 2014

Overview, Resources, and Comment Submission

On May 10, 2013, the Centers for Medicare and Medicaid Services (CMS) published the federal fiscal year (FFY) 2014 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed 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.

Among other regular updates and policy changes, the expansive rule includes proposals that would:

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

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

A copy of the proposed rule Federal Register (FR) and other resources related to the IPPS are available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html.

A brief summary of the major hospital IPPS sections of the proposed rule is provided below. Comments on all aspects of the proposed rule are due to CMS by Tuesday, June 25 and can be submitted electronically at http://www.regulations.gov by using the Web site’s search feature to search for file code “1599-P.”

IPPS Payment Rates for FFY 2014
FR pages 27,572-27,573 and 27,773-27,776

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

<table>
<thead>
<tr>
<th></th>
<th>Final FFY 2013</th>
<th>Proposed FFY 2014</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Operating Rate</td>
<td>$5,348.76</td>
<td>$5,376.04</td>
<td>+0.5%</td>
</tr>
<tr>
<td>Federal Capital Rate</td>
<td>$425.49</td>
<td>$432.03</td>
<td>+1.5%</td>
</tr>
</tbody>
</table>
The table below provides details and compares the proposed updates for the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2014:

<table>
<thead>
<tr>
<th>Description</th>
<th>Federal Operating Rate</th>
<th>Hospital-Specific Rates</th>
<th>Federal Capital Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update/Capital Input Price Index</td>
<td>+2.5%</td>
<td>+2.5%</td>
<td>+0.9%</td>
</tr>
<tr>
<td>ACA-Mandated Productivity MB Reduction</td>
<td>-0.4%</td>
<td>-0.4%</td>
<td>-</td>
</tr>
<tr>
<td>ACA-Mandated Pre-Determined MB Reduction</td>
<td>-0.3%</td>
<td>-0.3%</td>
<td>-</td>
</tr>
<tr>
<td>American Taxpayer Relief Act (ATRA)- Mandated Retrospective Coding Adjustment Reduction</td>
<td>-0.8%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inpatient Admission Guidance Offset</td>
<td>-0.2%</td>
<td>-0.2%</td>
<td>-0.2%</td>
</tr>
<tr>
<td><strong>Net Rate Change (EXCLUDING BUDGET NEUTRALITY)</strong></td>
<td>+0.8%</td>
<td>+1.6%</td>
<td>+0.7%</td>
</tr>
</tbody>
</table>

Retrospective Coding Adjustment for FFY 2014

*FR pages 27,502-27,506*

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

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

Effect of Sequestration for FFY 2014

*FR page reference not available*

While the proposed rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by the Budget Control Act (BCA) of 2011 and currently in effect through FFY 2021, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and electronic health record (EHR) incentives are also affected by the sequester reductions.

Wage Index and Labor-Related Share for FFY 2014

*FR pages 27,552-27,561*

CMS is not proposing any major changes to the calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, the imputed rural floor methodology, or the current administrative reclassification rules. CMS is also not proposing to make any changes to current Core-Based Statistical Area (CBSA) definitions; the labor-
markets that define an area’s Medicare wage index. CMS states in the proposed rule that it does plan to pursue CBSA definition changes next year based on newly available census data.

A complete list of the proposed wage indexes for payment in FFY 2014 is available in Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html. These values will be updated for the final rule.

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

Applications for FFY 2015 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 3, 2013. Applications and other information regarding MGCRB reclassifications are available on the CMS Web site at http://www.cms.gov/MGCRB/. Applications and wage data files for FFY 2015 reclassifications are expected to be posted to this site in mid-July.

Updates to the MS-DRGs for FFY 2014
FR pages 27,502-27,552

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

VBP Adjustment for FFY 2014
FR pages 27,606-27,608 and 27,619-27,621

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

Details and information on the program currently in place and on the programs in place for FFYs 2014 and 2015 are available on CMS’ QualityNet Web site at https://www.qualitynet.org/dcs/ContentServer?c=Page&pasename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

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

While the data applicable to the FFY 2014 program year is still being finalized, CMS has calculated and published proxy factors using data from the current year program. These factors will be updated by CMS for the final rule and again in October with actual program data. The proxy factors published with the proposed rule can provide an assessment of relative performance and are available in Table 16 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html.

The proxy factors range from a low of 0.9888 to a high of 1.0104. The average factor is 1.0002. Under the VBP Program, a factor of less than 1.0 indicates a hospital would see a decrease in IPPS payments; a factor greater than 1.0 indicates a hospital would see an increase in IPPS payments.
Readmissions Adjustment for FFY 2014
FR pages 27,593-27,596 and 27,601-27,606

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

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

By law, the FFY 2014 program is limited to measuring excess readmissions for heart attack (AMI), heart failure (HF), and pneumonia (PN) patients. In response to stakeholder concern, CMS is proposing to modify the calculation of readmission rates for FFY 2014 and beyond to better account for planned readmissions. According to CMS, this proposed policy change would reduce the current national readmission rate for AMI by 1.0 percentage point, HF by 1.5 percentage points, and PN by 0.7 percentage points.

To calculate the excess readmissions for FFY 2014, CMS is proposing to evaluate Medicare inpatient FFS claims from a 3-year aggregate period, July 1, 2009 through June 30, 2012. This reflects one year’s worth of new data compared to the data analyzed under the current year program. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes CMS is proposing to use to identify the conditions and applicable payments for the FFY 2014 program are listed on FR pages 27,604-27,605. This list is unchanged from current year program.

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

While the data applicable to the FFY 2014 program year is still being finalized, CMS has calculated and published proxy factors using data from the current year program. These factors will be updated by CMS for the final rule. The proxy factors published with the proposed rule can provide an assessment of relative performance and are available in Table 15 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FFY-2014-IPPS-Proposed-Rule-Home-Page.html.

Based on the proxy factors, 35% of hospitals have a factor of 1.0 and would see no change in IPPS payment. Less than 1% of hospitals have a factor of 0.9800 and would be subject to the maximum penalty of 2.0%. The remaining 64% of hospitals have factors between 0.9800 and 1.0 and would see some level of decrease in IPPS payments. CMS estimates that the FFY 2014 program would cut about $175 million from the IPPS (down from about $300 million in the current year).

DSH Payment Reductions, Redistributions, and Policy Changes for FFY 2014
FR pages 27,577-27,592

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

Under the law, 25% of estimated DSH funding under the traditional formula will continue paid to each DSH-eligible hospital as per-discharge payments. The remaining 75% will be reduced to reflect the impact of insurance expansion and then redistributed to hospitals as a new and separate uncompensated care payment. This payment will be determined based on each hospital’s ratio of uncompensated care relative to the total for all DSH-eligible
hospitals. CMS has broad authority on how to implement these program changes and has proposed rules to define:

- the amount of funding to be dedicated to the new uncompensated care payment;
- how to reduce and distribute that funding as mandated by the ACA;
- DSH eligibility; and
- DSH payment methods including reconciling payment at cost report settlement.

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

Using its Office of the Actuary estimate from February 2013, CMS is projecting DSH program expenditures to be $12.338 billion for FFY 2014. According to CMS, this estimate is based on DSH payment data from the most recently available Medicare cost reports and FFY 2013 IPPS Impact File. The estimate also includes projections for inflation, utilization, and case mix changes. CMS has only released high-level information on how these national projections were calculated. Hospital-specific factors related to the projections have not been made available. CMS plans to update this value for the final rule using July 2013 Office of the Actuary estimates.

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

For defining how DSH funding dedicated to the new uncompensated care payment should be reduced, CMS is proposing to utilize March 2010 and February 2013 insurance coverage estimates from the Congressional Budget Office (CBO). CMS is proposing to utilize CBO estimates for all residents, including unauthorized immigrants. CMS believes the inclusion of unauthorized immigrants more fully reflects the levels of uninsured. As an alternative, CMS could utilize CBO estimates that exclude unauthorized immigrants. The use of the alternate estimate would lead to higher levels of DSH reductions. Based on the CBO’s projections, from FFY 2013 to FFY 2014, the rate of uninsured is estimated to drop from 18% to 16%, an 11.1% reduction. Factoring in an additional ACA-mandated reduction of 0.1 percentage points, CMS is proposing to reduce the funding dedicated to uncompensated care payment by 11.2%, or about $1.0365 billion. As a result, for FFY 2014, CMS is proposing that the fixed amount available for distribution as uncompensated care payments would be $8.217 billion ($9.2535 billion x (1 - 11.2%)). As proposed, CMS would not revise the insurance expansion estimate upward or downward to reflect more recent estimates.

For defining how DSH funding dedicated to the new uncompensated care payment should be distributed to DSH hospitals, CMS is proposing to use Medicaid days and Medicare Supplemental Security Income (SSI) days as a proxy for uncompensated care. These days currently make up the numerator of the disproportionate patient percentage (DPP) formula used to determine DSH eligibility under the traditional per-discharge formula. CMS believes the use of low-income patient days is a valid proxy for the treatment costs associated with uninsured patients. To calculate the uncompensated care payment factor, CMS is proposing to use patient days data from the most recently available Medicare cost reports (FFY 2010 or 2011). CMS has made a file available on its Web site that includes the patient days relevant to the proposed formula and each hospital’s proposed uncompensated care payment factor. The file is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Proposed-Rule-Home-Page.html. CMS has calculated a payment factor for every hospital in the country based on its share of days to total days for all FFY 2014 CMS-projected DSH-eligible hospitals. If a hospital is not determined to be DSH-eligible until cost report settlement, CMS would use this pre-calculated payment factor to make the lump-sum uncompensated care payment. As proposed, CMS would not revise these factors upward or downward to reflect actual patient days.
CMS considered using data on uncompensated care as reported on worksheet S-10 of the Medicare cost report to calculate the uncompensated care payment factor. CMS believes that the S-10 has the potential to be the most comprehensive source for obtaining uncompensated care data. However, citing stakeholder concerns regarding data variability and lack of reporting experience with this relatively new cost report worksheet, CMS is proposing the use of the low-income patient days proxy for FFY 2014. CMS indicates that it may propose the use of worksheet S-10 uncompensated care data in the future, once hospitals are submitting accurate and consistent data.

CMS is projecting that 2,349 hospitals will be eligible for DSH payments in FFY 2014. This projection is significant because CMS is proposing that hospitals identified as DSH-eligible would receive per-discharge payments and new lump-sum uncompensated care payments during FFY 2014. For hospitals identified by CMS as DSH-eligible for a given year, CMS would make per-discharge DSH payments at 25% of the traditional value. Uncompensated care payments would be made on a periodic basis throughout the FFY.

CMS is proposing to continue the practice of determining final DSH-eligibility at cost report settlement. Eligibility would continue to be determined based on the traditional formula’s threshold (a DPP of 15% or more). Following current practice, CMS would determine DSH eligibility and reconcile the per-discharge payments based on actual program year cost report data. For hospitals projected by CMS to be DSH-eligible, but ultimately determined to be ineligible at cost report settlement, CMS is proposing to recoup both the per-discharge and uncompensated care payments. Alternatively, hospitals not determined to be DSH-eligible until cost report settlement would be paid both the per-discharge payment amount and the uncompensated care amount based on the pre-calculated hospital-specific uncompensated care payment factor. As described above, the data and factors used to determine the distribution of the uncompensated care payments would be fixed, once finalized by CMS, and would not be re-estimated at time of settlement.

For Sole Community Hospitals (SCHs) that are eligible for DSH payments, CMS is proposing that the lump-sum uncompensated care payments would not be considered in determining whether a SCH would be paid at the federal or hospital-specific rate. As a result, payment determinations for SCHs would be based on a federal rate calculated with a DSH adjustment at 25% of the traditional value.

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

**GME Payments**

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

For the purposes of Indirect Medical Education (IME) and direct GME payments, CMS is reevaluating its policy for hospitals and Critical Access Hospitals (CAHs) related to the counting of time for residents that train in approved residency program at CAHs. The proposed change is related to an ACA-mandated policy that allows hospitals to count the time that residents train in patient care activities in non-provider sites. Beginning in FFY 2014, CMS is proposing that a teaching hospital would not be able to claim the time residents are training at a CAH for IME and/or direct GME purposes. A CAH would still be able incur the costs of training residents and would receive payment based on 101% of its Medicare reasonable costs for the time those residents rotate to the CAH.
The proposed rule also outlines an ACA-authorized opportunity for hospitals to add new residency slots due to a hospital closure that occurred in 2012 and provides notice that the legislated freeze applied to hospital-specific per resident amounts (PRAs) that exceed 140% of the locality-adjusted national average PRA expires for FFY 2014.

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

**Inpatient Admission Guidance**

*FR pages 27,644-27,650*

CMS is concerned about recent increases in denials of short-stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs), when it has been determined that the services furnished were reasonable and necessary but should have been furnished as a hospital outpatient, rather than hospital inpatient. Under current rules, when inpatient payment is denied, there are limited circumstances under which a hospital is allowed to re-bill for outpatient payment.

Currently, a physician’s order to admit an individual as an inpatient is made within 24 to 48 hours of observation care. The expectation of an overnight stay may be a factor in the admission decision. CMS has concerns with increases in the length of time for which patients receive observation services as hospitals have sought to avoid the financial risk associated with potential inpatient claims denials. According to CMS, over the last five years Medicare beneficiaries receiving observation services more than 48 hours has increased from 3% to 8%. This trend can cause an increased financial liability for those beneficiaries compared to the liability if they were admitted as an inpatient. In addition to CMS evaluating its policy related to the Medicare Part B re-billing, CMS believes it is important to consider whether more clarity can be made to distinguish the relationship between an inpatient admission and Medicare payment.

To address concerns regarding the requirements for admission as a hospital inpatient, CMS is proposing to clarify the rules governing physician orders of hospital inpatient admissions for payment under Medicare Part A. CMS is proposing to specify in the regulations that an individual becomes an inpatient of a hospital/CAH pursuant to an order for inpatient admission by a physician or other qualified practitioner and, therefore, the order is required for payment of hospital inpatient services under Medicare Part A.

CMS is also proposing to revise guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Medicare Part A. CMS is specifying that hospital inpatient admissions spanning two midnights in the hospital would generally qualify as appropriate for payment under Medicare Part A.

As a result of the proposed admission guidelines, federal claims review contractors (including RACs) would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing two “midnights” threshold). CMS is proposing that claims review efforts going forward would focus on inpatient hospital admissions with lengths of stay crossing only one midnight or less (one Medicare utilization day). According to CMS, these claims have traditionally demonstrated the largest proportion of improper inpatient payments under Medicare Part A. Review contractors would presume that these services should have been provided on an outpatient basis unless there is clear documentation in the medical record supporting the physician’s order. For these claims, medical record documentation and other information would be evaluated to determine if it was reasonable for the physician to expect the individual to require a stay lasting two midnights, even though that did not occur.

CMS has estimated that its proposal would increase inpatient payments by about $220 million. To maintain IPPS budget neutrality, CMS is proposing to use its “exceptions and adjustment authority” to apply a -0.2% reduction to the federal operating and hospital-specific rates.

**Outlier Payments for FFY 2014**

*FR pages 27,566-27,568*
To maintain total outlier payments at 5.1% of total IPPS payments, CMS is proposing an outlier threshold of $24,140 for FFY 2014. The new threshold amount represents a 10.6% increase compared to the current threshold of $21,821. The increased threshold amount would decrease the number of cases eligible for outlier payments.

**HAC MS-DRG Payment Policy for FFY 2014**
*FR pages 27,509-27,512*

CMS is not proposing to expand the categories/conditions under the current HAC MS-DRG payment policy and would continue to recognize 12 HAC categories. As has been the case in prior years, when these defined conditions are not present on admission (POA) and, therefore, considered hospital-acquired, the diagnosis would not be recognized in the assignment of case to a MS-DRG.

**Expiration of the More Inclusive Low-Volume Adjustment Criteria for FFY 2014**
*FR pages 27,574-27,577*

For FFYs 2011-2013, the ACA and ATRA mandated changes to the low-volume hospital adjustment criteria that allowed more hospitals to qualify for the adjustment and modified the amount of those adjustments. Absent legislation, beginning FFY 2014, the low-volume adjustment criteria will revert to the more restrictive requirements previously in effect (25-mile/800 discharge criteria and 25% payment adjustment). Potentially eligible hospitals seeking to achieve the 25% adjustment beginning October 1, 2013 (FFY 2014) must make a request in writing to their fiscal intermediary (FI)/Medicare Administrative Contractor (MAC) by September 1, 2013. Hospitals that request the status after September 1 and qualify will be eligible for the adjustment effective prospectively within 30 days of the date of the FI/MAC determination.

**Expiration of MDH Status for FFY 2014**
*FR pages 27,592-27,593*

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

**RRC Status for FFY 2014**
*FR pages 27,573-27,574*

Hospitals that meet certain criteria can be classified as a Rural Referral Center (RRC). This special status allows exemption from the 12% cap on traditional per-discharge DSH payments and special treatment under the geographic reclassification rules. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The FFY 2014 proposed minimum case-mix and discharge values by region are available on FR page 27,574.

**Quality-Based Payment Policy Proposals—FFYs 2015 and Beyond**

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

- **VBP Program – FFYs 2016-2019 Policy Proposals (FR pages 27,608-27,622)**: CMS is proposing changes to how the VBP Program would function in future years (FFYs 2016-2019). CMS has already adopted program rules through FFY 2015. CMS is proposing:
  - Measure additions/deletions for FFY 2016. These changes would retain the patient experience of care and efficiency measures, add 1 and eliminate 3 process of care measures, and add 3 patient outcomes measures;
New data collection time periods for FFY 2016 for all measures and through FFY 2019 for a subset of measures; 
National performance standards for FFY 2016 for all measures and through FFY 2019 for a subset of measures; and 
New measure weighting formulas for FFYs 2016 and 2017 that are used for calculating each hospital’s VBP Total Performance Score (TPS). The new weighting formulas would assign greater weight to the patient outcomes and efficiency measures and lesser weight to the process of care and patient experience of care measures.

Details and CMS tables on the newly proposed measures, collection time periods, performance standards and measure weighting is available on the FR pages listed above. Other details and information on the program currently in place and on the programs in place for FFYs 2014 and 2015 are available on CMS’ QualityNet Web site at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

CMS notes in the proposed rule that it is considering expanding the use of efficiency measures for future VBP Program years. The FFY 2014 VBP Program will evaluate efficiency using one measure of Medicare spending per beneficiary. According to CMS, the expansion may include a measure that evaluates the rate and/or dollar amount of hospital inpatient services billed to Medicare Part B subsequent to the denial of a Part A hospital inpatient claim and the addition of Medicare spending measures specific to physician services such as Radiology, Anesthesiology, and Pathology that occur during a hospital stay.

CMS is also proposing a waiver process to recognize the effect that natural disasters might have on a hospital’s performance under VBP. Under the proposal, hospitals would be required to submit the waiver request at the same time it requests an extraordinary circumstance waiver under the Inpatient Quality Reporting (IQR) Program (within 30 days of the date that the extraordinary circumstance occurred).

• **Readmissions Reduction Program – FFY 2015 Policy Proposals (FR pages 27,596-27,601):** For FFY 2015, CMS is proposing to add two readmissions measures for evaluation under the Readmissions Reduction Program. In addition to the current AMI, HF, and PN measures, CMS is proposing to evaluate readmissions for patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD) and patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). CMS has the authority to expand the policy to additional conditions, including coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA), but is not proposing to do so at this time. Detailed policies related to how this payment program functions were adopted in prior rulemaking.

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

• **HAC Reduction Program – FFY 2015 Policy Proposals (FR pages 27,622-27,636):** CMS is proposing policies for the implementation of the ACA-mandated HAC Reduction Program. By law, hospitals with historic risk-adjusted HAC scores in the top quartile (worse performing quartile) will be subject to 1.0% reduction in IPPS payments. This program is expected to reduce IPPS payments by about $300 million per year. For the FFY 2015 program, CMS is proposing:

- Measures, domains, and timeframes for the evaluation of HAC rates—CMS is proposing to evaluate risk-adjusted HAC rates from all or portions of care provided in 2011, 2012, and 2013 on a total of 8 measures across 2 domains. The first domain would include 6 individual Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) calculated from Medicare claims data. The second domain would include 2 Center for Disease Control and Prevention (CDC) Healthcare Associated Infection (HAI) measures collected via the National Healthcare Safety Network.
CMS notes that the two different domains were proposed to separate the AHRQ and CDC HAI measures due to notable differences between the measure sources, risk-adjustments, and calculation methodologies.

CMS is considering an alternative for the first domain for FFY 2015 that would replace the 6 individual AHRQ measures with the PSI-90 composite measure. This composite measure includes 8 individual complication and patient safety measures, 4 of which are included in the primary proposal. For the second domain, CMS is proposing the use of additional measures in future program years; 2 additions for FFY 2016 and 2 additions for FFY 2017.

- Scoring methodology—
  CMS is proposing a scoring methodology that would calculate a Total HAC Score for each eligible hospital. The proposed methodology would score each individual risk-adjusted HAC measure on a scale from 0 to 10 points; a measure score of 0 would represent the best performers and a measure score of 10 would represent the worst performers.

  Specifically, scores for individual HAC measures would be determined based on the hospital’s HAC occurrence rate relative to the top quartile HAC occurrence range (worse performing quartile range). A score between 1 and 10 would be applied to each measure rate within top quartile range (a score of 1 would indicate the best performance within the top quartile range and score of 10 would indicate the worst performance within the top quartile range). A score of 0 would be applied to each measure rate below the top quartile range.

  Once all useable measures are scored, CMS would calculate domain scores for each of the proposed domains by averaging the useable measure scores within the domain. CMS would then combine the domain scores by weighting them. For FFY 2015, CMS is proposing to weight the domains equally at 50% each.

  The result of the combined domain score would be the hospital’s Total HAC Score. CMS would use the Total HAC Score to determine the top quartile (worse performing) hospitals subject to the 1.0% payment penalty.

  CMS notes that it is proposing the points scoring methodology rather than adding the measure results together due to differences between the proposed measures and the distribution of measure results.

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

Updates to the IQR Program and Voluntary EHR-Based Reporting Under the Program
FR pages 27,677-27-710

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

For FFY 2015 and FFY 2016 payment determinations, CMS is proposing to refine and make specification changes to several previously adopted program measures. For FFY 2016 payment determinations specifically, CMS is proposing several measure additions and deletions to the program reporting requirements. Of note, CMS is proposing to collect and publicly report data on 30-day stroke and COPD readmission and mortality rates. CMS is also proposing to collect and publicly report payment per episode of care data for AMI patients.
These and other refinements not only update the IQR Program but also remove and/or potentially put in place measures for use under the VBP Program, Readmissions Reduction Program, and HAC Reduction Program. The updates also maintain a level of alignment with the quality measures used under the EHR incentive program.

A table that lists the 59 measures CMS will collect for FFY 2015 payment determinations is available on FR pages 27,681-27,683.

A table that lists the 57 measures CMS is proposing to collect for FFY 2016 payment determinations is available on FR pages 27,693-27,694 (a table that lists the 8 measures CMS is proposing to remove from the IQR Program for FFY 2016 payment determinations is available on FR pages 27,680-27,681).

As it does each year, CMS is using the proposed rule to update the IQR Program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes. Complete detail on these updates is available on FR pages 27,695-27,710.

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

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