MEDICARE INPATIENT HOSPITAL OPERATING AND CAPITAL PAYMENT FISCAL YEAR 2014 PROPOSED RULE

SUMMARY

On April 26, 2013, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for federal fiscal year (FY) 2014 changes to Medicare's acute care hospital inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) prospective payment system. The payment rates and policies described in the proposed rule would affect Medicare's operating and capital payments for short-term acute care hospital inpatient services and services provided in long-term care hospitals paid under their respective prospective payment systems as well as payments for inpatient services provided by certain "IPPS-Exempt" providers, such as cancer and children's hospitals, and religious nonmedical health care institutions. The proposed rule is scheduled for publication in the *Federal Register* on May 10, 2013 with a 60-day comment period (from the date of public display) closing on June 25, 2013. The proposed rates and most of the proposed policy changes, as modified by the final rule due to be published by August 1, 2013, will be effective October 1, 2013.

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I. PPS Rate Updates and Impact of the Proposed Rule

CMS estimates that the proposed rule would reduce Medicare's operating payments to the approximately 3,404 acute care hospitals paid under the IPPS by approximately $110 million in FY 2014, a reduction of 0.1 percent, taking into account a rate increase of 0.8 percent for hospitals which successfully report quality measures combined with the other proposed policies affecting payment. IPPS capital payments are projected to increase an estimated $101 million in FY 2014 (a 1.1 percent change) and CMS projects that LTCH payments for about 437 LTCHs will increase by approximately $62 million in FY 2014 relative to FY 2013.

Inpatient Hospital Operating Update for FY 2014

Under the proposed rule, the inpatient hospital "applicable percentage increase" to the payment rates would be 1.8 percent for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program. Hospitals that do not successfully participate in the IQR Program would receive a 2.0 percentage point reduction or a payment rate reduction of 0.2 percent. In FY 2013, 52 hospitals did not receive the full market basket rate-of-increase because they failed the quality data submission process or chose not to participate. The IPPS rate update applies to the national and Puerto Rico operating standardized amounts and to the hospital-specific rates used in payment for sole community hospitals and Medicare-dependent hospitals.

The 1.8 percent "applicable percentage increase" is the net result of a market basket increase projected to be 2.5 percentage points, less an annual multi-factor productivity (MFP) adjustment projected to be -0.4 percentage points[1] and a statutory update reduction of 0.3 percentage points. Both the annual productivity adjustment and the 0.3 percentage point reduction are required by the Affordable Care Act (ACA). Two other changes would affect operating standardized amounts in FY 2014:

- a -0.8 percent adjustment to the IPPS national standardized amounts for the proposed FY 2014 recoupment for documentation and coding as required by the American Taxpayer Relief Act of 2012 (ATRA) and described in section II.D. below; and
- a -0.2 percent adjustment to the IPPS national standardized amount, the Puerto Rico-specific rate and the hospital-specific rate to offset the cost of the proposed policy on admission and medical review criteria for hospital inpatient services under Medicare Part A, as discussed in section V.N. below.

[1] The Bureau of Labor Statistics publishes the official measure of private nonfarm business MFP; historical data on this series are available at http://www.bls.gov/mfp. Projections of MFP for IPPS payment updates are developed by IHS Global Insight, Inc. an economic forecasting firm which also prepares the market basket forecasts, using a methodology described in the proposed rule. More technical information on the MFP is available from BLS: http://www.bls.gov/mfp/mprtech.pdf. The final rule will reflect more recent projections of the market basket and productivity adjustments.

The proposed update to the national standardized amounts is summarized in the table below:

FY 2014 inflation (market basket) update	2.5%
Multifactor productivity adjustment	-0.4%
Additional -0.3 percentage point update adjustment required by the ACA	-0.3%
Subtotal – payment rate inflation update	*1.8%*
Documentation and coding recoupment required by ATRA	-0.8%
Adjustment to offset the cost of the proposed policy on admission and medical review criteria	-0.2%
Net increase in payment rates	*0.8%*

As discussed in section II.D. below, the proposed documentation and coding recoupment adjustment does not apply to the Puerto Rico-specific amount or to the hospital-specific rates of sole community hospitals (SCHs) resulting in a net 1.6 percent increase for these amounts rather than the 0.8 net percentage points adjustment applicable to the national standardized amounts.

Additional Factors Affecting Payment Impacts

Although the proposed FY 2014 standardized amounts increase 0.8 percent compared to FY 2013, the payment impact analysis shows aggregate payments decreasing 0.1 percent. The additional factors affecting the payment impact of the proposed rule are summarized in the table below:

Contributing Factor	**Aggregate National Impact**
Proposed implementation of ACA reduction in disproportionate share payments	-0.9%
Continued implementation of readmissions reduction provision (described in section V.G. below)	-0.2%
Higher SCH hospital-specific rate update (1.6% compared to 0.8% for the national standardized amounts)	+0.1%
Expiration of Medicare-dependent hospital (MDH) provision	-0.1%
Proposed frontier hospital wage index floor	+0.1%
Proposed changes in the MS-DRG relative weights and recalibration and effect of new wage index data and labor change from 68.8% to 69.6%	+0.1%
Effect of geographic reclassification by the Medicare Geographic Classification Review Board (MGCRB)	0.0%
Proposed rural floor, imputed rural floor, and related budget neutrality	0.0%
Section 505 commuting adjustments to the wage index	0.0%
Total	*-0.9%*

In addition, while not modeled in the impact analysis, lower projected outlier payments in FY 2014 compared to FY 2013 will reduce aggregate payments by about -0.1%. CMS currently projects actual outlier payments which will be paid in FY 2013 of 5.2% compared to the 5.1% projected for FY 2014.

Detailed impact estimates are displayed in Table I of the proposed rule (reproduced in the Appendix of this summary). The following table shows the impact by major hospital category.

Hospital Type	All Proposed Rule Changes
All Hospitals	-0.1%
Large Urban	0.5%
Other Urban	-0.4%
Rural	-1.9%
Major Teaching	0.8%

The CMS impact analysis shows significant variation in the net payment change of the proposed rule among hospitals, with an average projected increase of 0.5 percent for hospitals in large urban areas compared to a projected decrease of 1.9 percent for hospitals in rural areas and a decrease of 0.4 percent for hospitals in other urban areas. Rural hospitals' aggregate payments increase 1.7 percent due to geographic reclassification and 1.2 percent for the update factor compared to 0.8 percent for other hospitals (the differential is attributable to the documentation and coding adjustment not applying to the hospital-specific rate), but their payments fall for several other factors. The decreases are: 0.9 percent for implementation of the ACA disproportionate share changes, 0.5 percent for the proposed MS-DRG weights, 0.2 percent for wage index changes, 0.3 percent for the rural floor budget neutrality, 1.2 percent for expiration of the MDH provision, and 0.2 percent for the readmissions reduction program. Hospitals in other urban areas lose 1.1 percent from the ACA disproportionate share provision compared to a loss of 0.7 percent for hospitals in large urban areas, accounting for much of the difference in overall impact between the two categories.

Significant regional variation also is apparent in the impact analysis. Changes in operating payments range from increases of 1.6 percent for urban hospitals in the Middle Atlantic region and 1.2 percent in the Mountain region to a decrease of 1.5 percent for urban hospitals in the Pacific region. Among rural hospitals, decreases range from -3.5 percent in the East South Central region and -2.6 in New England to decreases of 0.3 percent and 0.4 percent in the Pacific and West North Central regions respectively. No rural areas show an increase except Puerto Rico, which has one rural hospital. Regional variation results primarily from differences in the impact of the ACA disproportionate share provision and differential effects of the wage index rural floor and geographic reclassifications (which are budget neutral in the aggregate), but also from geographic variation in the impact of termination of additional payments for MDHs. For example, urban hospitals in the New England region are projected to gain about 4.4 percent in payments primarily due to the application of the proposed rural floor in Massachusetts and Connecticut. The approximately 51 urban hospitals in Puerto Rico would see payments increase about 35.7 percent primarily due to implementation of the ACA disproportionate share provision, which is shown to increase their payments by 34.5 percent.

Proposed IPPS Standardized Amounts for FY 2014

The proposed rule projects the following rates effective October 1, 2013, which reflect all adjustments to the standardized amounts including the adjustment for documentation and coding and the adjustment to offset the cost of the proposed policy on admission and medical review criteria. The net increase in the operating standardized amounts after applying all adjustments is about 0.5 percent.

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

Full Update (1.8 Percent)		Reduced Update (-0.2 Percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,741.72	$1,634.32	$3,668.21	$1,602.21

TABLE 1B.—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)

Full Update (1.8 Percent)		Reduced Update (-0.2 Percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,333.14	$2,042.90	$3,267.66	$2,002.76

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

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
	Labor	**Nonlabor**	**Labor**	**Nonlabor**
National[1]	Not Applicable	Not Applicable	$3,333.14	$2,042.90
Puerto Rico	$1,626.53	$947.09	$1,595.64	$977.98

[1]For FY 2014, there are not CBSAs in Puerto Rico with a proposed national wage index greater than 1.

TABLE 1D.—PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$432.03
Puerto Rico	$212.50

Outlier Payments and Threshold

Hospitals receive additional IPPS payments for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). The sum of these components is referred to as the outlier "fixed-loss cost threshold." To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's cost to charge ratio (CCR) is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is 80 percent of the estimated costs above the fixed-loss cost threshold.

For FY 2014, CMS continues to set the target for total outlier payments at 5.1 percent of total operating DRG payments (including outlier payments but continuing to exclude adjustments for value-based purchasing and the readmissions reduction program). To calculate the proposed FY 2014 outlier threshold, CMS simulated payments by applying proposed FY 2014 payment rates and policies using cases from the FY 2012 MedPAR file, with the hospital charges on the MedPAR claims inflated by 2 years, from FY 2012 to FY 2014. CMS further proposes to establish the proposed FY 2014 outlier threshold using hospital CCRs from the December 2012 update to the Provider-Specific File (PSF) – the most recent available data at the time of the proposed rule. The agency continues to apply an adjustment factor to the CCRs to account for cost and charge inflation using a methodology developed with the Office of Actuary for FY 2007 IPPS final rule (71 FR 48150) and unchanged through FY 2013.

During rulemaking for the FY 2013 IPPS, CMS received numerous suggestions to improve the accuracy of its methodology for setting the outlier threshold. CMS made no changes for FY 2013 but agreed to consider them for FY 2014. The proposed rule includes these changes in the methodology that CMS has used essentially unchanged since FY 2009 (as described in the FY 2009 final rule, 73 FR 48763 through 48766) to calculate a fixed-loss cost threshold consistent with the 5.1 percent target:

1) To improve accuracy, CMS will determine the charge inflation factor using a 1-year period of the most recent charge data instead of comparing periods using only the most recent 6 months of charge data. Specifically, it proposes to compare the second quarter of FY 2011 through the first quarter of FY 2012 (January 1, 2011, through December 31, 2011) to the second quarter of FY 2012 through the first quarter of FY 2013 (January 1, 2012, through December 31, 2012). This rate-of-change was 4.8 percent or 9.9 percent over 2 years. Using the previous 6-month period methodology, the rate of change would be 4.7 percent or 9.6 percent over 2 years.

2) Adopting a simpler methodology which was proposed in FY 2013 comments, CMS proposes to adjust the CCRs from the December 2012 update of the PSF by comparing the percentage change in the national average case-weighted operating CCR and capital CCR from the December 2011 update of the PSF to the national average case-weighted operating CCR and capital CCR from the December 2012 update of the PSF. CMS

calculated a December 2011 operating national average case-weighted CCR of 0.303178 and a December 2012 operating national average case-weighted CCR of 0.295049, resulting in a national operating CCR adjustment factor of 0.973187. Similarly, CMS calculated a December 2011 capital national average case-weighted CCR of 0.025994 and a December 2012 capital national average case-weighted CCR of 0.0249373, resulting in a national capital CCR adjustment factor of 0.959337.

CMS does not propose to make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled when cost reports are settled.

For FY 2014, CMS proposes an outlier fixed-loss cost threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $24,140, which is higher than the FY 2013 final outlier threshold of $21,821. CMS attributes the higher outlier threshold to the decrease in DSH payments due to the ACA, noting that the 75 percent DSH reduction is applied on a per discharge basis while the additional payments made to hospitals receiving Medicare DSH based on uncompensated care are not taken into consideration when determining outlier payments; CMS does not propose to make these payments on a per discharge basis.

CMS projects that the threshold for FY 2014 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.49 percent of capital payments based on the Federal rate and it would adjust the respect payment rates accordingly.

FY 2012 and FY 2013 Outlier Payments

CMS' current estimate, using available FY 2012 claims data, is that actual outlier payments for FY 2012 were approximately 5.47 percent of actual total MS-DRG payments. The agency does not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2012 are equal to 5.1 percent of total MS-DRG payments. Similarly, using the latest CCRs from the March 2013 update of the PSF, CMS currently estimates that actual outlier payments for FY 2013 will be approximately 5.17 percent of actual total MS-DRG payments, approximately 0.1 percentage point higher than the 5.1 percent the agency projected when setting the outlier policies for FY 2013.

II. Proposed Changes to DRG Classifications and Relative Weights

A. to C. MS-DRGs for FY 2014

In the proposed rule for FY 2014, CMS continues to use the Medicare severity diagnosis-related group (MS-DRG) classification system. Proposed changes in specific MS-DRGs are described in section II.G. below. For general information about the MS-DRG system, including yearly reviews and changes to the MS-DRGs, the proposed rule refers readers to previous discussions in these IPPS final rules: FY 2010 (74 FR 43764 through 43766), FY 2011 (75 FR 50053 through 50055), FY 2012 (76 FR 51485 through 51487), and FY 2013 (77 FR 53273). For information on the adoption of the MS-DRGs in FY 2008, CMS refers readers to the FY 2008 IPPS final rule (72 FR 47140 through 47189).

D. FY 2013 Documentation and Coding Adjustment

The FY 2014 proposed rule continues the process of documentation and coding adjustments begun in FY 2008 when the transition to MS-DRGs began. Under this process, CMS has made adjustments in the standardized amounts to the extent the actuaries estimate that increases in the average case-mix index (CMI) are due to improved medical record documentation and more complete and accurate coding that do not reflect real increases in the severity of cases requiring additional hospital resources. A series of adjustments were made in FY 2008 through FY 2012 to eliminate the effects of documentation and coding changes on future payments as well as to recoup overpayments made in FY 2008 and FY 2009 as a result of documentation and coding improvements. In general, adjustments were required by the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Pub. L. 110-90.

The FY 2013 final rule reduced the FY 2013 standardized amounts by 1.9 percentage points, a reduction that completed the adjustments that CMS had determined were necessary to account for coding changes occurring in FY 2008 and FY 2009.

CMS also had proposed to apply a prospective documentation and coding adjustment of -0.8 percent to the FY 2013 rates due to the agency's determination of case-mix change occurring in FY 2010. In the final rule, CMS disagreed with methodological concerns expressed in public comments, including questions raised by MedPAC, but acknowledged that the methodological issues raised are complex and may merit further consideration. Therefore, it did not finalize the proposed -0.8 percent prospective adjustment.

Recoupment or Repayment Adjustment Authorized by Section 631 of the American Taxpayer Relief Act of 2012 (ATRA)

Delaying full implementation of the prospective portion of adjustments related to FY 2008 and FY 2009 case-mix change until FY 2013 resulted in IPPS payments in FY 2010 through FY 2012 being overstated. CMS could not recover these overpayments because its statutory recoupment authority was limited to overpayments made in FY 2008 and FY 2009. Section 631 of the ATRA, however, requires the Secretary to make a recoupment adjustment or adjustments totaling $11 billion, the estimated amount of the increase in aggregate payments as a result of delaying the prospective adjustments, resulting in overstated payment rates in FYs 2010, 2011, and 2012. The adjustment must be completed by FY 2017. The recoupment adjustment required by ATRA is a one-time recovery of prior overpayments, not a permanent reduction to payment rates. Therefore, any adjustment made to reduce rates in one year would eventually be offset by a positive adjustment, once the necessary amount of overpayments is recovered.

CMS actuaries estimate that a -9.3 percent adjustment to the standardized amount would be necessary if CMS were to fully recover the full $11 billion required recoupment in FY 2014. In its March 2013 Report to Congress, MedPAC estimates that a -2.4 percent adjustment made in FY 2014, and not removed until FY 2018, also would recover the required recoupment amount. As it has done in the past, CMS proposes to phase in the adjustment beginning with a -0.8 percent recoupment adjustment to the standardized amount in FY 2014.

The agency estimates that this level of adjustment will recover up to $0.96 billion in FY 2014, with at least $10.04 billion remaining to be recovered by FY 2017. If adjustments of approximately -0.8 percent are implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, CMS estimates that the entire $11 billion would be accounted for by the end of the statutory 4-year timeline. The FY 2014 proposed rule does not, however, propose specific adjustments for FYs 2015, 2016, or 2017.

Additional Prospective Adjustments for the MS-DRG Documentation and Coding Effect through FY 2010 Authorized under Section 1886(d)(3)(A)(vi) of the Act

As noted, for FY 2013 CMS had proposed but did not finalize an additional -0.8 percent prospective adjustment to the standardized amount to account for documentation and coding changes occurring in FY 2010 and agreed that further analysis of public comments, including MedPAC's, was needed. In the FY 2014 proposed rule, CMS does not propose a prospective adjustment in recognition of the impact it would have combined with the 0.8 percent recoupment adjustment. CMS states in the proposed rule that if it were to apply an additional prospective adjustment for the cumulative MS-DRG documentation and coding effect through FY 2010, it believes the most appropriate additional adjustment would be -0.55 percent, as MedPAC and public commenters had urged in FY 2013 rulemaking.

CMS invites public comment concerning whether any portion of the proposed -0.8 percent recoupment adjustment should be reduced and instead applied to a prospective adjustment for the cumulative MS-DRG documentation and coding effect through FY 2010. As an example, CMS says that it could apply a -0.25 percent recoupment adjustment, and a -0.55 prospective adjustment, for a total FY 2014 adjustment of -0.8 percent. Reducing the recoupment adjustment in FY 2014 would require relatively larger recoupment adjustments for FYs 2015, 2016, and/or 2017, but making a prospective adjustment of -0.55 percent would eliminate future payment increases due to MS-DRG documentation and coding that did not reflect real changes in case-mix for discharges occurring through FY 2010. Although CMS does not make this point in the proposed rule, such future payment increases could become a target for legislation requiring recoupment at some point in the future.

The proposed rule notes that the documentation and coding effect through FY 2010 was found for both IPPS hospitals paid with the standardized amount and IPPS hospitals paid under their hospital-specific payment rate. Thus, CMS says that if it were to apply a prospective adjustment to remove this effect, it also would apply the adjustment to the hospital-specific payment rate, using the Secretary's broad authority under section 1886(d)(5)(I)(i) of the Act. Specifically, if it allocated a portion of the -0.8 percent adjustment for FY 2014 to the prospective adjustment, it also would make appropriate adjustments to the hospital-specific payment rates. Puerto Rico-specific rates would not be affected because CMS found no significant additional MS-DRG documentation and coding effect for FY 2010 that would warrant any additional adjustment to the Puerto Rico-specific rate (77 FR 53279).

E. Refinement of the MS-DRG Relative Weight Calculation

Since FY 2009, the relative weights have been fully cost-based and not based directly on hospitals' billed charges. For FY 2013, costs were determined by calculating CCRs for 15 cost centers from hospital cost reports and using national CCRs to convert billed charges to costs. FY 2013 rulemaking again addressed the issue of charge compression affecting the level of charges billed for high cost services and the accuracy of costs determined for these services. CMS did not, however, propose to use the refined cost data available from new cost centers established for Implantable Devices Charged to Patients, Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization as a result of the cost report changes made in recent years. CMS expressed optimism that it would have the necessary data for FY 2014 rulemaking to consider using distinct CCRs for implantable devices, MRIs, CT scans, and cardiac catheterization in the new cost centers.

To calculate the proposed FY 2014 MS-DRG relative weights, CMS proposes to continue the current methodology of using the two most recent data sources: the December 2012 update of the FY 2012 MedPAR file as the claims data source and the December 2012 update of FY 2011 HCRIS as the cost data source. The agency currently has a substantial number of hospitals completing all, or some, of the new cost centers on the FY 2011 Medicare cost reports, compared to prior years. Using the December 2012 update of FY 2011 HCRIS, CMS can calculate a valid implantable device CCR for 2,285 IPPS hospitals, a valid MRI CCR for 1,402 IPPS hospitals, a valid CT scan CCR for 1,470 IPPS hospitals, and a valid cardiac catheterization CCR for 1,022 IPPS hospitals. The preamble of the FY 2013 IPPS final rule stated that prior to proposing to create these CCRs, CMS would first thoroughly analyze and determine the impacts of the data, and that distinct CCRs for these new cost centers would be used in the calculation of the relative weights only if they were first finalized through rulemaking.

For the FY 2014 proposed rule, CMS concludes that there are sufficient data in the FY 2011 cost reports to support a meaningful analysis of using distinct CCRs for implantable devices, MRIs, CT scans, and cardiac catheterization and based on its analyses, and it proposes to create new distinct CCRs for these services. Specifically, rather than having a single CCR for "Supplies and Equipment" which includes low-cost supplies and high-cost implantable devices, a distinct CCR would be carved out of the "Supplies and Equipment" CCR, leaving one CCR for "Supplies" and one CCR for "Implantable Devices." For radiology, which currently is comprised of general radiology ancillary services and MRIs and CT scans, the costs for MRIs and CT scans would be separated from general radiology, creating two distinct CCRs, one for MRIs and one for CT scans, respectively. Finally, by separating the costs of cardiac catheterization out of the CCR for general cardiology, a distinct CCR would be created for cardiac catheterization. Breaking out these 4 additional CCRs would increase the number of CCRs used to calculate the relative weights from 15 to 19.

The table below shows the final FY 2013 CCRs, the potential FY 2014 CCRs computed with the existing 15 cost centers, and the potential FY 2014 CCRs computed with 19 cost centers, with 4 new CCRs for implantable devices, MRIs, CT scans, and cardiac catheterization.

Group	Final FY 2013 15 CCRs	Potential FY 2014 15 CCRs	Potential FY 2014 19 CCRs
Routine days	0.514	0.502	0.502
Intensive days	0.442	0.423	0.423
Drugs	0.199	0.193	0.193
Supplies & Equipment	0.335	0.327	0.293
Implantable Devices	n/a	n/a	0.361
Therapy Services	0.37	0.355	0.355
Laboratory	0.143	0.133	0.133
Operating Room	0.238	0.225	0.225
Cardiology	0.145	0.134	0.132
Cardiac Catheterization	n/a	n/a	0.135
Radiology	0.136	0.128	0.170
MRI	n/a	n/a	0.091
CT Scans	n/a	n/a	0.045
Emergency Room	0.226	0.207	0.207
Blood	0.389	0.371	0.371
Other Services	0.397	0.399	0.399
Labor & Delivery	0.45	0.445	0.445
Inhalation Therapy	0.189	0.187	0.187
Anesthesia	0.109	0.120	0.120

CMS compared a set of relative weights calculated with 15 CCRs and 19 CCRs. Overall, if 19 CCRs were used to calculate the relative weights for FY 2014, relative weights for medical MS-DRGs would decrease by approximately 1.1 percent, and those for surgical MS-DRGs would increase by approximately 1.2 percent. In addition, as shown in the table below, at the MDC level, payments would increase by about 0.39 and 0.25 percent respectively within the orthopedic and cardiac MDCs, with most of the reductions in payment occurring in the medical MSDRGs for the nervous, digestive, and respiratory system MDCs.

MDC	Description	Estimated Percentage Change within MDC
08	Musculoskeletal System and Connective Tissue	0.39%
05	Circulatory System	0.25%
01	Nervous System	-0.16%
06	Digestive System	-0.10%
04	Respiratory System	-0.08%

The largest estimated increases in MS-DRG relative weights are for MS-DRGs associated with cardiac catheterization and implantable cardiac devices and the largest estimated reductions are in MS-DRG relative weights for MS-DRGs associated with traumatic head injury and concussion, which are high users of CT scanning and MRI services. The proposed rule table copied below shows the MS-DRGs that are projected to experience the largest increases and decreases in relative weights if 19 CCRs were used rather than 15 CCRs.

MS-DRGS THAT WOULD EXPERIENCE THE LARGEST DECREASE IN RELATIVE WEIGHT					
MS-DRG	**Type**	**Title**	**Potential Relative Weights with 15 CCRs**	**Potential Relative Weights with 19 CCRs**	**Percentage Change**
90	MED	Concussion without CC/MCC	0.7614	0.7013	-7.90%
84	MED	Traumatic Stupor & Coma, Coma >1 Hour without CC/MCC	0.9137	0.8516	-6.80%
87	MED	Traumatic Stupor & Coma, Coma <1 Hour without CC/MCC	0.7899	0.7369	-6.70%
965	MED	Other Multiple Significant Trauma without CC/MCC	1.045	0.98	-6.10%
185	MED	Major Chest Trauma without CC/MCC	0.7281	0.6845	-6.00%
89	MED	Concussion with CC	0.9959	0.9366	-6.00%
123	MED	Neurological Eye Disorder	0.7355	0.692	-5.90%
343	SURG	Appendectomy without Complicated Principal Diagnosis without CC/MCC	0.988	0.9517	-5.70%
53	MED	Spinal Disorders & Injuries without CC/MCC	0.9355	0.8825	-5.70%
66	MED	Intracranial Hemorrhage or Cerebral Infarction without CC/MCC	0.8034	0.7579	-5.70%
MS-DRGS THAT WOULD EXPERIENCE THE LARGEST INCREASE IN RELATIVE WEIGHT					
454	SURG	Combined Anterior/Posterior Spinal Fusion with CC	7.6399	8.0563	5.50%
455	SURG	Combined Anterior/Posterior Spinal Fusion Without CC/MCC	5.9862	6.3133	5.50%
484	SURG	Major Joint & Limb Reattachment Procedure of Upper Extremity without CC/MCC	2.1211	2.238	5.50%
225	SURG	Cardiac Defibrillator Implant with Cardiac Catheterization without AMI/HF/Shock without MCC	5.6298	5.953	5.70%
223	SURG	Cardiac Defibrillator Implant with Cardiac Catheterization with AMI/HF/Shock without MCC	6.0956	6.4482	5.80%
458	SURG	Spinal Fusion Except Cervical with Spinal Curve/Malignant/Infection OR 9+ Fusion without CC/MCC	4.8794	5.163	5.80%
245	SURG	AICD Generator Procedures	4.4627	4.732	6.00%
849	MED	Radiotherapy	1.3423	1.4258	6.20%
946	MED	Rehabilitation without CC/MCC	1.1295	1.2024	6.50%
227	SURG	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC	5.2193	5.5714	6.70%

CMS finds that the impacts on relative weight and at the MDC level are generally consistent with those estimated by RTI modeling in its July 2008 final report and proposes to calculate the MS-DRG relative weights for FY 2014 using 19 CCRs, creating distinct CCRs from cost report data for implantable devices, MRIs, CT scans, and cardiac catheterization. In conjunction with the proposed rule, the CMS Web site provides Table 5, which lists the proposed MS-DRGs and their relative weights, as proposed using 19 CCRs and a separate Table 5 that lists all MS-DRGs and their relative weights if computed using 15 CCRs. (These tables are available on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp in the section labeled "Acute Inpatient—Files for Download")

F. Preventable Hospital Acquired Conditions (HACs) Including Infections

Section 1886(d)(4)(D) specifies that, by October 1, 2007, the Secretary was required to select at least two conditions that: (a) are high cost, high volume, or both; (b) are assigned to a higher paying MS-DRG when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. Further, effective for discharges occurring on or after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected condition is not present on admission (POA). There are currently 11 categories of HACs and the complete list is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html. CMS is not proposing to add or remove categories of HACs at this time.

The POA indicator reporting requirement currently applies only to IPPS hospitals because they are subject to the HAC provision. Non-IPPS hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's hospitals, hospitals in Maryland operating under waivers, RNHCIs, and the Department of Veterans Affairs/Department of Defense hospitals, are exempt from POA reporting. CMS now believes that it is inappropriate to continue to exempt hospitals in Maryland from the POA indicator reporting requirement although CMS also says that hospitals in Maryland will continue to be exempt from the application of the HAC provision so long as they are not paid under the IPPS. CMS goes on to say that it wants to include Maryland hospitals' POA data and have as complete a dataset as possible when it analyzes trends and makes further payment policy determinations. In sum, CMS proposes that hospitals in Maryland operating under their waiver under section 1814(b)(3) of the Act will no longer be exempted from the POA indicator reporting requirement beginning with claims submitted on or after October 1, 2013, including all claims for discharges on or after October 1, 2013. CMS reminds readers that it treats HACs coded with "N" (Indicates that the condition was not present on admission) and "U" (Indicates that the documentation is insufficient to determine if the condition was present at the time of admission) indicators as Not Present on Admission.

CMS also notes that further information regarding the use of the POA indicator with the ICD-10-CM/ICD-10-PCS classifications as they pertain to the HAC policy will be discussed in future rulemaking. For the moment, the ICD-9-CM HAC list translation to ICD-10-CM and ICD-10-PCS code sets is available at http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html under the link titled "ICD-10-CM/PCS MS-DRG v30

Definitions Manual Table of Contents – Full Titles – HTML Version in Appendix I – Hospital Acquired Conditions (HACs)." CMS encourages the public to submit comments on these translations through the HACs Web page using the CMS ICD-10-CM/PCS HAC Translation Feedback Mailbox ("CMS HAC Feedback" in the Related Links section). CMS adds that the final HAC list translation from ICD-9-CM to ICD-10-CM/ICD-10-PCS will be subject to formal rulemaking.

CMS estimates the HAC payment provision savings for the next 5 fiscal years as follows:

Year	Savings (in millions)
FY 2014	$26
FY 2015	$28
FY 2016	$30
FY 2017	$33
FY 2018	$36

CMS emphasizes that the provision only applies when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment.

G. Changes to Specific DRG Classifications

1. Pre-Major Diagnostic Categories (Pre-MDCs): Heart Transplants and Liver Transplants

CMS acknowledges receiving a request to eliminate the severity levels for the heart and liver transplant MS-DRGs (MS-DRGs 001 and 002, and MS-DRGs 005 and 006, respectively). The commenter stated that there are no "uncomplicated" heart transplants or liver transplants. CMS examined claims data from the FY 2012 MedPAR file and concludes that there are significant differences in average lengths of stay and average costs for the severity level of both heart and liver transplant MS-DRGs. For example, for heart transplants, the average cost for MS-DRG 001 (Heart Transplant or Implant of Heart Assist System with MCC) was $158,556, while the average cost for MS-DRG 002 (Heart Transplant or Implant of Heart Assist System without MCC) was $97,932, with all cases in both DRGs combined having an average cost of $147,310. CMS notes that if it were to combine the heart transplant cases as suggested by the commenter, the payment for the majority of cases with an MCC would be lower. The same would be true for liver transplants. Thus, CMS concludes that it would not be prudent to eliminate the severity levels for the heart and liver transplant MS-DRGs.

2. MDC 1 (Diseases and Disorders of the Nervous System): Tissue Plasminogen Activator (tPA) (rtPA) Administration Within 24 Hours Prior to Admission

CMS acknowledges receipt of a comment asking CMS to conduct an analysis of diagnosis code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility). This is referred to as the "drip-and-ship" issue and reflects a concern that the receiving facilities in such cases may be underpaid. This is because the patients in question do not receive tPA at the second or transfer hospital, which is thus unable to assign the cases to one of the higher-weighted tPA stroke MS-DRGs (MS-DRGs 061, 062, and 063). CMS analyzes MedPAR claims data from FY 2012 and again concludes that moving the subset of cases containing diagnosis code V45.88 as the secondary

diagnosis from MS-DRGs 064, 065, and 066 to MS-DRGs 061, 062, and 063 is not warranted because the differences in the average lengths of stay and the average costs are too small to warrant an assignment to the higher-weighted MS-DRGs. However, for FY 2014, CMS proposes to move cases with diagnosis code V45.88 from MS-DRG 066 (Intracranial Hemorrhage or Cerebral Infarction without CC/MCC) to MS-DRG 065 (Intracranial Hemorrhage or Cerebral Infarction with CC), because the data do reflect that the average costs for cases reporting diagnosis code V45.88 as a secondary diagnosis in MS-DRG 066 are more similar to the average costs of higher severity level cases in MS-DRG 065 ($6,682 vs. $7,414 for all cases in MS-DRG 065). The proposed revised MS-DRG 065 title would be Intracranial Hemorrhage or Cerebral Infarction with CC or tPA in 24 hours.

3. MDC 4 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat)

a. Endoscopic Placement of a Bronchial Valve

CMS acknowledges receiving a request to move COPD cases that have only a bronchial valve insertion and no other major chest procedure from MS-DRGs 190, 191 and 192 (Chronic Obstructive Pulmonary Disease with MCC, with CC, and without CC/MCC, respectively) to higher-weighted MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively). The request relates to cases involving the use of the Spiration® IBV Valve System, a device intended to control prolonged air leaks following three specific surgical procedures: lobectomy, segmentectomy, or lung volume reduction surgery. A CMS analysis of Medicare claims data found only 2 COPD cases that had bronchial valves inserted in MS-DRGs 190, 191, and 192 (both in MS-DRG 190). The average length of stay for these two cases was about 14 days compared to about 5.07 days for all other cases within MS-DRG 190. Because the additional 10 days cannot be clinically attributed to the bronchial valve insertion, CMS clinical advisers have determined that other factors must have impacted the two cases. These advisers do not support the requested movement of COPD cases with a bronchial valve insertion. Given the limited number of cases for the procedure and the advice from its clinical advisers, CMS is not proposing to change the MS-DRG assignment for procedures involving bronchial valve(s) insertion (procedure codes 33.71 and 33.73) within MS-DRGs 190, 191, and 192.

b. Pulmonary Thromboendarterectomy (PTE) with Full Circulatory Arrest

CMS acknowledges receipt of a request from a university medical center to create a new MS-DRG or to reassign cases reporting a unique approach to pulmonary thromboendarterectomy (PTE) surgery performed with full cardiac arrest and hypothermia. CMS proposes to reject both suggestions.

There is no specific ICD-9-CM procedure code for this unique approach but a subset of existing procedure codes may be used to identify the various components involved. CMS acknowledges that the average length of stay and average costs for these cases are somewhat higher in comparison to the average lengths of stay and average costs of all the other cases in two of the relevant MS-DRGs, MS-DRGs 163 and 164 (Major Chest Procedures with MCC, and with CC, respectively. However, the volume of cases was very low (12 cases in MS-DRG 163 and 4 cases in MS-DRG 164). On this basis, CMS argues that it is not unusual for a

small number of cases in an MS-DRG to demonstrate higher than average costs, nor is it unusual for a small number of cases to demonstrate lower than average costs.

Another aspect of the request involved the evaluation of moving ICD-9-CM diagnosis code 416.2 (Chronic pulmonary embolism) from MDC 4 to MDC 5 (Diseases and Disorders of the Circulatory System). CMS clinical advisers do not support such a move in order to accommodate a rare procedure performed by only a small number of physicians worldwide, especially since the move would impact a large number of patients who do not undergo this procedure.

4. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Discharge/Transfer to Designated Disaster Alternative Care Site

CMS proposes to add new patient discharge status code 69 (Discharged/transferred to a designated disaster alternative care site) to the MS-DRG GROUPER logic for MS-DRGs 280, 281, and 282 (Acute Myocardial Infarction Discharged Alive with MCC, with CC, and without CC/MCC, respectively). CMS says this will identify patients who are discharged or transferred to an alternative site that will provide basic patient care during a disaster response.

b. Discharges/Transfers With a Planned Acute Care Hospital Inpatient Readmission

CMS proposes to add 15 new discharge status codes to the MS-DRG GROUPER logic for MS-DRGs 280, 281, and 282 that will identify patients who are discharged with a planned acute care hospital inpatient readmission. The proposed rule contains a table comparing the current family of discharge status codes and the new, corresponding codes for planned readmission.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Reverse Shoulder Procedures

CMS acknowledges receiving a request to change the MS-DRG assignment for reverse shoulder replacement procedures, captured with procedure code 81.88 (Reverse total shoulder replacement). The reverse shoulder replacement procedure was created to address the clinical needs for patients who would have poor outcomes with a traditional shoulder replacement, and the requestor states that the reverse shoulder replacement procedure is technically more complex. Relevant cases are currently assigned to MS-DRGs 483 and 484 (Major Joint/Limb Reattachment Procedures of Upper Extremities with CC/MCC and without CC/MCC, respectively). CMS analysis of claims data shows that the average costs for reverse total shoulder replacement are about $2,000 higher than the average costs for all other procedures within MS-DRGs 483 and 484. CMS does not consider this inappropriately high compared to the other procedures and concludes that the claims data do not support reassigning the cases or creating a new MS-DRG.

b. Total Ankle Replacement Procedures

CMS acknowledges receipt of a request to develop a new MS-DRG for total ankle replacements, cases captured by procedure code 81.56 (Total ankle replacement). These

cases are currently assigned to MS-DRGs 469 and 470 (Major Joint Replacement or Reattachment of Lower Extremity with MCC and without MCC, respectively). CMS notes that these procedures are higher in average costs than other procedures within these MS-DRGs but points out that cases are grouped together based on similar clinical and resource criteria. CMS further notes that moving all total ankle replacements to MS-DRG 469 would lead to overpayments of about $3,944 per cases. Thus, CMS proposes to maintain the current MS-DRG assignments for total ankle replacements.

6. MDC 15 (Newborns and Neonates with Conditions Originating in the Neonatal Period)

a. Persons Encountering Health Services for Specific Procedures, Not Carried Out

CMS concurs with a commenter that diagnosis codes V64.00 through V64.04, and V64.06 through V64.3 (all of which relate to reasons why vaccination or some surgical or other procedure has not been carried out) should not continue to be assigned to MS-DRG 794 (Neonate with Other Significant Problems), as there is no clinically usable information reported in those codes identifying significant problems. However, CMS clinical advisers recommend that diagnosis codes V64.41, V64.42, and V64.43 (Laparoscopic, thoracoscopic, and arthroscopic surgical procedure converted to open procedure, respectively), continue to be assigned to MS-DRG 794 and CMS proposes to continue doing so. CMS also proposes to add diagnosis codes V64.00 through V64.04, and V64.06 through V64.3 to the "only secondary diagnosis" list for MS-DRG 795 (Normal Newborn).

b. Discharges/Transfers of Neonates with a Planned Acute Care Hospital Inpatient Readmission

CMS proposes to add three patient discharge status codes to the MS-DRG GROUPER logic for MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) to identify neonates that are transferred to a designated facility with a planned acute care hospital inpatient readmission. These are codes 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission), 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission), and 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission).

7. Proposed Medicare Code Editor (MCE) Changes

The Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

a. Age Conflict Edit

CMS proposes to agree with a request to remove diagnosis codes 751.1 (Atresia and stenosis of small intestine), 751.2 (Atresia and stenosis of large intestine, rectum, and anal canal), and 751.61 (Biliary atresia) from the pediatric age conflict edit effective October 1, 2013. CMS

clinical advisers agree that patients described with any one of these codes, although congenital anomalies, may require a revision procedure in adulthood.

b. Discharge Status Code Updates

CMS proposes to add 16 new discharge status codes to the CMS GROUPER and the MCE logic effective October 1, 2013. One code would identify patients being discharged or transferred to an alternative site that will provide basic patient care during a disaster response (69, Discharged/transferred to a designated disaster alternative care site). The other 15 codes correspond with identifying planned acute hospital inpatient readmissions (for example, code 81, Discharged to home or self care with a planned acute care hospital inpatient readmission). A table in the proposed rule lists the existing "base" discharge status codes and the new codes for patients who are discharged with a planned readmission.

8. Surgical Hierarchies

The surgical hierarchy is an ordering of surgical classes from most resource-intensive to least resource-intensive and its application ensures that cases involving multiple surgical procedures are assigned to the MS-DRG associated with the most resource-intensive surgical class. CMS says it did not identify any needed changes to the surgical hierarchy for FY 2014.

9. Complications or Comorbidity (CC) Exclusions List

A substantial complication or comorbidity is defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. CMS created a CC Exclusions List to: (1) preclude coding of CCs for closely related conditions; (2) preclude duplicative or inconsistent coding from being treated as CCs; and (3) ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. In previous years, CMS has made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list. For FY 2014, there are no proposed revisions based on changes to the ICD-9-CM diagnosis codes because no such changes were made due to the partial code freeze.

Suggested Changes to the MS-DRG Diagnosis Codes for FY 2014

a. Coronary Atherosclerosis Due to Calcified Coronary Lesion:

CMS acknowledges receiving a request to change the severity level for diagnosis code 414.4 (Coronary atherosclerosis due to calcified coronary lesion) from a non-CC to an MCC. Based on an analysis of claims data and the advice of its clinical advisers, who do not believe the diagnosis would increase the severity level of patients, CMS proposes to reject the request. CMS adds that its medical advisers point to a similar diagnosis code, 414.2 (Chronic total occlusion of coronary artery), which is a non-CC.

b. Acute Cholecystitis Diagnosis Code:

CMS acknowledges receipt of a comment recommending the addition of diagnosis code 575.0 (Acute cholecystitis) to the CC Exclusion List when reported as a secondary diagnosis code with a principal diagnosis code 574.00 (Calculus of gallbladder with acute cholecystitis

without mention of obstruction). CMS notes that there is an "excludes note" intended to preclude diagnosis codes 575.0 and 574.00 from being reported on the same claims, but adds that the commenter stated that there may be double reporting. CMS clinical advisers agree with the commenter that diagnosis codes 575.0 and 574.00 capture the same clinical content. CMS proposes to accept the commenter's recommendation.

c. Chronic Total Occlusion (CTO) of Artery of the Extremities Diagnosis Code:

CMS acknowledges receipt of a request to remove atherosclerosis and aneurysm codes from the CC Exclusions List for diagnosis code 440.4 (Chronic total occlusion of artery of the extremities). For FY 2013, CMS changed the designation of diagnosis code 440.4 from a non-CC level to a CC level. CMS says its clinical advisers agree with the commenter that the aneurysm and most of the atherosclerosis codes should be removed from the CC Exclusion List for diagnosis code 440.4. However, they do not agree that diagnosis codes 443.81 through 443.89 (other and unspecified peripheral vascular diseases) should be removed from the CC Exclusion List because these cases are more likely related to chronic total occlusion.

In sum, for FY 2014, CMS is proposing changes to Table 6G (Additions to the CC Exclusion List) and Table 6H (Deletions from the CC Exclusion List) and these revised tables are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. A complete updated MCC, CC, and Non-CC Exclusions List is also available there.

CMS notes that there are no new, revised, or deleted diagnosis codes for FY 2014 and hence no Tables 6A, 6C, and 6E published for FY 2014. There are also no proposed additions or deletions to the MS-DRG MCC List or the MS-DRG CC List for FY 2014 and hence no Tables 6I.1 through 6I.2 and 6J.1 through 6J.2 published for FY 2014.

CMS also reminds readers that the complete documentation of the GROUPER logic is available from 3M/Health Information Systems, which, under contract with CMS, is responsible for updating and maintaining the GROUPER program.

10. Review of Procedure Codes in MS DRGs 981 through 983; 984 through 986; and 987 through 989

These MS-DRGs are reserved for those atypical cases in which none of the O.R. procedures performed are related to the principal diagnosis. CMS is not proposing any changes relating to these MS-DRGs for FY 2014. CMS is also not proposing to add any diagnosis or procedure codes to MDCs for FY 2014.

11. Proposed Changes to the ICD-9-CM Coding System, Including Discussion of the Replacement of the ICD-9-CM Coding System with the ICD-10-CM and ICD-10-PCS Systems in FY 2014

a. ICD-9-CM Coding System:

The ICD-9-CM Coordination and Maintenance Committee is responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. There

were no changes to the ICD-9-CM coding system for FY 2014 and no new, revised or deleted diagnosis or procedure codes for FY 2014 resulting from the committee's September 19, 2012 public meeting. CMS adds that there were no requests approved for an expedited April 1, 2013 implementation of an ICD-9-CM code at the September 19, 2012 committee meeting.

The committee held its 2013 meeting on March 5, 2013. CMS says there may be ICD-9-CM coding changes finalized after this proposed rule based on public comments that it receives after the March 5, 2013 meeting. If there are changes, CMS will include them in the final rule.

b. Code Freeze:

CMS reminds readers of the partial code freeze in anticipation of the implementation of ICD-10 codes on October 1, 2014 (the revised compliance date adopted in a final rule published on September 5, 2012). Among other things, under this partial freeze, there will be only limited code updates to ICD-9 code sets on October 1, 2013 to capture new technology and new diseases and no updates to these code sets on October 1, 2014, as the system would no longer be a HIPAA standard and, therefore, no longer used for reporting. Further, on October 1, 2015, regular updates to ICD-10 will begin.

c. Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims

CMS proposes to continue to process up to 25 diagnosis codes and 25 procedure codes when received on the 5010 claims format.

d. ICD-10 MS-DRGs

Information about the ICD-10 version of the MS-DRGs can be found at http://cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html. An updated paper on the hospital payment impact of the conversion of MS-DRGs from ICD-9 to ICD-10 can also be found there under the "Downloads" section. CMS says it will continue to work with the public to explain how it is approaching the conversion of MS-DRGs to ICD-10 and will post drafts of updates as they are developed for public review. CMS adds that the final version of the ICD-10 MS-DRGs will be implemented at the same time as ICD-10 and will be subject to notice and comment rulemaking.

H. Recalibration of MS-DRG Weights

The Secretary is required by statute to revise the DRG groups and weights annually to reflect changes in technology, medical practice, and other factors. In developing relative weights for the FY 2014 proposed rule, CMS used two data sources:

- FY 2012 MedPAR data for discharges occurring on October 1, 2011, through September 30, 2012, based on bills received by CMS through December 31, 2012, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2012 MedPAR file used in calculating the proposed relative weights includes data for approximately 10.4 million Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are

excluded from the analysis. The data also exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken; and

- Medicare cost report data files from HCRIS, principally for FY 2011 cost reporting periods (that is, cost reporting periods beginning on or after October 1, 2010, and before October 1, 2011), using the December 31, 2012 update of the FY 2011 HCRIS.

Adhering to the process used to calculate the relative weights for FY 2013, hospitals' billed charges were converted to costs using national average CCRs. As discussed in section II.E. above, for FY 2014 CMS proposes to convert charges to costs using 19 national average CCRs rather than the 15 CCRs used for FY 2013. The proposed rule CCRs are shown in the table on page 13 of this summary. The proposed rule notes that agency's typical data trims combined with using the 4 additional cost centers allowed CMS to calculate the relative weights using approximately 92.7 percent of the IPPS providers in the MedPAR file compared to the 96 percent of providers that were used in FY 2013.

The new cost-based relative weights were normalized by an adjustment factor of 1.6122128377 so that the average case weight after recalibration is equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

Using data from the FY 2012 MedPAR file, there were 7 MS-DRGs, all pertaining to newborns, which contain fewer than 10 cases, the minimum number CMS has established to assure accurate and stable cost weights. For these 7 newborn MS-DRGs, CMS proposes to compute relative weights by adjusting their FY 2013 weights by the percentage change in the average weight of the cases in other MS-DRGs.

I. Proposed Add-On Payments for New Services and Technologies

1. Background

The regulations at 42 CFR 412.87 specify three criteria for a new medical service or technology to receive add-on payments under the IPPS: (1) the medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. CMS notes that even if a technology receives a new FDA approval, it may not necessarily be considered "new" for purposes of new technology add-on payments if it is "substantially similar" to a technology that was approved by FDA and has been on the market for more than 2 or 3 years. For purposes of the cost criterion, Table 10 that was released with the FY 2013 IPPS/LTCH PPS final rule contains the final thresholds that will be used to evaluate applications for new technology add-on payments for FY 2014.

Under the new technology add-on payment policy, Medicare will make an add-on payment equal to the lesser of: (1) 50 percent of the estimated costs of the new technology (if the

estimated costs for the case including the new technology exceed Medicare's payment); or (2) 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case. Further, unless the discharge qualifies for an outlier payment, the additional Medicare payment is limited to the full MS-DRG payment plus 50 percent of the estimated costs of the new technology. Add-on payment for new medical services or technologies for FY 2005 and later years have not been subjected to budget neutrality.

Applicants for new technology add-on payments must have FDA approval or clearance for their new medical service or technology by July 1 of each year prior to the beginning of the fiscal year that the application is being considered. CMS also notes that for FY 2015, complete application information, along with final deadlines for submitting an application, will be posted as it becomes available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/newtech.html.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

On February 5, 2013, CMS held a town hall meeting at the CMS Headquarters Office in Baltimore, MD for the express purpose of discussing the substantial clinical improvement criterion relating to pending new technology applications. However, CMS says it is considering no longer holding an in-person town hall meeting for this purpose in future years but instead holding a virtual town hall meeting that would be live-streamed on the Internet. **CMS invites comments on the possibility of holding a virtual, rather than an in-person, town hall meeting.**

3. FY 2014 Status of Technologies Approved for FY 2013 Add-On Payments

a. Auto Laser Interstitial Thermal Therapy (AutoLITT™) System

The AutoLITT™ is a minimally invasive, MRI-guided laser tipped catheter designed to destroy malignant brain tumors with interstitial thermal energy causing immediate coagulation and necrosis of diseased tissue. It was first available on May 11, 2010. It is intended only for use in cases of glioblastoma multiforme, and new technology add-on payments have been restricted to cases that map to MS-DRGs 025, 026 and 027. The average cost of the AutoLITT™ is reported as $10,600 per case, and the maximum add-on payment for a case involving this technology is $5,300.

Because the 3-year anniversary date of the AutoLITT™ entry onto the market will expire May 11, 2013, which is prior to the beginning of FY 2014, CMS proposes to discontinue new technology add-on payments for the AutoLITT™ for FY 2014. CMS explains that, in general, it extends add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year.

b. Glucarpidase (Trade Brand Voraxaze®)

Glucarpidase is used in the treatment of patients who have been diagnosed with toxic methotrexate (MTX) concentrations as a result of renal impairment. Its administration causes a rapid and sustained reduction of toxic MTX concentrations. CMS considers Voraxaze® "new" as of April 30, 2012. Relevant cases are identified with ICD-9-CM procedure code

00.95 (Injection or infusion of glucarpidase). The maximum new technology add-on payment for Voraxaze® is $45,000 per case.

CMS proposes to continue new technology add-on payments for Voraxaze® for FY 2014 and estimates the FY 2014 add-on payments for this technology at $6.3 million.

c. DIFICID™ (Fidaxomicin) Tablets

DIFICID™ is an oral antibiotic used in the treatment of *Clostridium difficile*-associated disease. Although CMS initially expressed concern that DIFICID™ might not be eligible for new technology add-on payments because it was not a procedure described by an ICD-9-CM code, the agency ultimately decided to allow the use of National Drug Codes (NDCs) to identify oral medications that have no inpatient procedure for the purposes of new technology add-on payments. CMS established the beginning of the newness period for DIFICID™ to be its FDA approval date of May 27, 2011. Cases are identified with ICD-9-CM diagnosis code 008.45 (Intestinal infection due to *Clostridium difficile*) in combination with NDC code 52015-0080-01. The maximum new technology add-on payment for FY 2013 is $868.

Because the 3-year anniversary date of DIFICID™ will occur in the second half of the fiscal year (after April 1, 2014), CMS proposes to continue new technology add-on payments for DIFICID™ for FY 2014. CMS estimates the FY 2014 add-on payments for DIFICID™ at about $34.8 million.

d. Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft

The Zenith® F. Graft is an implantable device designed to treat patients who have an abdominal aortic aneurysm (AAA) and who are anatomically unsuitable for treatment with currently approved AAA endovascular grafts because of the length of the infrarenal aortic neck. Cases involving the technology are identified by ICD-9-CM procedure code 39.78 (Endovascular implantation of branching or fenestrated graft(s) in aorta). The maximum add-on payment for a case is $8,171.50.

CMS proposes to continue new technology add-on payments for the Zenith® F. Graft and estimates the FY 2014 add-on payments for this technology at about $4.1 million.

4. FY 2014 Applications for New Technology Add-On Payments

CMS received five applications for new technology add-on payments for FY 2014. **CMS invites public comment on whether the five technologies in question (discussed below in more detail) meet the newness, cost and substantial clinical improvement criteria.**

a. Kcentra™

Kcentra™ is a replacement therapy for fresh frozen plasma (FFP) for patients with an acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed. CMS acknowledges that the applicant, CSL Behring, has applied for a new ICD-9-CM procedure code for the technology and notes that any final decisions on new codes approved at the March 5, 2013 ICD-9-CM Coordination and Maintenance Committee meeting will be

included in the ICD-9-CM code addendum posted on the CMS Web site in June 2013 at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/addendum.html

CMS notes that it is concerned that Kcentra™ may be substantially similar to FFP and/or Vitamin K therapy and may, therefore, not be considered "new" for purposes of new technology add-on payments. Nonetheless, CMS acknowledges that FFP needs to thaw for a couple of hours before it can be administered (thus delaying treatment) compared to Kcentra™.

According to the applicant, the technology is eligible to be used across all MS-DRGs. The applicant found 66,749 cases across all MS-DRGs and noted that 18 percent of them would map to MS-DRGs 377, 378 and 379 (Gastrointestinal Hemorrhage with MCC, with CC, and without CC/MCC, respectively), while the top 20 MS-DRGs would account for 41 percent of all cases. The applicant standardized charges for all cases and removed charges for FFP therapy, which equated to a case-weighted average standardized charge per case of $49,748. The applicant calculated a case-weighted threshold of $46,068 across all MS-DRGs and thus asserts that Kcentra™ meets the cost criterion.

With regard to substantial clinical improvement, the applicant notes that Kcentra™ is the first prothrombin complex concentrate (PCC) that will be FDA-approved for rapid warfarin reversal in patients experiencing an acute major bleed. The applicant cited a noninferior, randomized clinical trial in which Kcentra™ was able to reverse the effects of warfarin to a target International Normalized Ratio (INR) of less than or equal to 1.3 within 30 minutes in 62 percent of patients compared to less than 10 percent success for plasma. The applicant also emphasized that Kcentra™ undergoes a dedicated pathogen removal process and plasma does not. The applicant also noted the ability to rapidly prepare and administer the product in an emergency situation. In addition, the applicant explained that high transfusion volumes of treatments such as FFP therapy can lead to transfusion-associated circulatory overload. Finally, the applicant noted that Kcentra™ is the standard of care in the new guidelines issued by the American College of Chest Physicians.

CMS notes that if Kcentra™ were approved for new technology add-on payments, it does not believe that such payments would be available with respect to discharges for which the hospital receives an add-on payment for blood clotting factor administered to a Medicare beneficiary with hemophilia who is a hospital patient. CMS adds that the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and are hospital inpatients are paid separately from the IPPS. CMS believes that that if Kcentra™ is approved by FDA as a blood clotting factor, it may be eligible for separate clotting factor payments when administered to Medicare beneficiaries with hemophilia. Thus, CMS expects that any new technology add-on payments ultimately approved for Kcentra™ would be payable only when the technology is used to treat Medicare beneficiaries who do not have hemophilia. **CMS welcomes public comment on its proposal to only make new technology add-on payments for Kcentra™ in cases when it is included in the operating costs of inpatient hospital services (that is, when no add-on payment is made for clotting factor).**

b. Argus® II Retinal Prosthesis System

The Argus® II System is an active implantable medical device that is intended to provide electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa (RP). It is intended to be implanted in a single eye, typically the worse-seeing eye. It consists of three primary components: (1) an implant which is an epiretinal prosthesis that is fully implanted on and in the eye (that is, there are no percutaneous leads); (2) external components worn by the user; and (3) a "fitting" system for the clinician that is periodically used to perform diagnostic tests with the system and to custom-program the external unit for use by the patient. The stimulation pulses delivered to the retina via the electrode array of the Argus® II Retinal Prosthesis System are intended to mimic the function of degenerated photoreceptor cells in patients with RP.

In terms of the newness criterion, the FDA designated the Argus® II System a Humanitarian Use Device in May 2009 and the applicant, Second Sight Medical Products, Inc., received the Humanitarian Device Exemption approval from the FDA on February 14, 2013. CMS notes that the applicant has applied for three new ICD-9-CM procedure codes for the technology.

With regard to the cost criterion, CMS reports that the applicant noted that the cost of the technology was proprietary information. CMS acknowledges that the device is very costly and that the technology would easily exceed the case-weighted threshold. Further, CMS believes that claims with the device would receive an outlier payment. The relevant MS-DRGs would be 116 and 117 (Intraocular Procedures with CC/MCC and without CC/MCC, respectively). CMS notes that because no procedure code exists for the Argus® II System, cases in these DRGs identified by ICD-9-CM procedure code 14.73 (Anterior vitrectomy) or 14.74 (Posterior vitrectomy) would include patients that are not eligible for or would not otherwise receive this technology.

CMS expresses concern that if new technology add-on payments were to be approved for the Argus® II System, this could serve as a financial incentive to inappropriately shift utilization from an outpatient to an inpatient setting; CMS notes that the types of procedures in question are often performed in the outpatient setting. CMS further expresses concern relating to the descriptions of the medical necessity of performing this procedure on an inpatient basis. **It invites public comments to further its understanding regarding whether approving new technology add-on payments for the Argus® II System would create a financial incentive that would shift utilization inappropriately from an outpatient to an inpatient setting.**

With regard to the substantial clinical improvement criterion, the applicant emphasized that there are no other approved treatments for patients with severe to profound RP. The applicant further submitted the results of a clinical trial involving 30 patients with a median age of 57.9 years. Under the study design, controlled observations could be obtained by performing assessments with the Argus® II System "on" and "off." Tests used in the evaluation included the Square Localization Test, the Direction of Motion Test, the Grating Visual Acuity Test, the ability to recognize large letters and numbers, the ability to read short words, and objectively-scored functional vision tests. Analysis of the Functional Low-vision Observer Rated Assessment (FLORA) results showed that three-quarters of the patients received a positive benefit in terms of well-being and/or functional vision, while none of the patients experienced a negative effect.

CMS, however, expresses concern that the study did not have pre-specified endpoints and changed measurements mid trial. CMS is also concerned about the reliability of the measures used for the tests and the inconsistency of the results across different patients, which leads the agency to question the long-term benefits associated with the device.

CMS acknowledges receipt of two comments supporting the Argus® II System new technology payment application, one from a society of retina specialists and another from a foundation for supporting blindness.

c. Responsive Neurostimulator (RNS®) System

The RNS® is an implantable medical device developed by NeuroPace, Inc. for treating persons with epilepsy whose partial onset seizures have not been adequately controlled with antiepileptic medications. The neurostimulator detects electrographic patterns previously identified by the physician as abnormal, and then provides brief pulses of electrical stimulation through the leads to interrupt those patterns.

With respect to the newness criterion, the applicant anticipates FDA premarket approval in the second quarter of 2013. The following ICD-9-CM procedure codes are used to identify the technology: 01.20 (Cranial implantation or replacement of neurostimulator pulse generator); 01.29 (Removal of cranial neurostimulator pulse generator); and 02.93 (Implantation or replacement of intracranial neurostimulator lead(s).

With respect to the cost criterion, the applicant submitted multiple analyses. The applicant stated that cases eligible for the RNS® System would map to MS-DRG 024 (Craniotomy with Major Device Implant/Acute Complex Central Nervous System Principal Diagnosis without MCC) and extremely rarely to MS-DRG 023 (Craniotomy with Major Device Implant/Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant). With respect to MS-DRG 023, the major complications and/or comorbidities would probably preclude a patient from receiving the RNS® System because it is an elective procedure.

One analysis submitted by the applicant involved an examination of 163 claims from 28 hospitals participating in the RNS® System Pivotal Clinical Investigation (in which the RNS® System was provided at no charge); 5 of the 163 claims had to be excluded because no hospital-specific information regarding standardization was available. For this analysis, the applicant estimated charges for the RNS® System by multiplying the device cost (which it considers to be proprietary information) by an anticipated hospital markup of 100 percent, or conversely by dividing the device cost by a CCR of 0.50. This produced an average standardized charge per case of $121,990 for MS-DRG 024, which exceeds the applicable threshold amount ($78,039). A second "supplementary" analysis of claims for 565 cases assigned to MS-DRG 024, most of which presumably received deep brain stimulation for Parkinson's disease, reached a similar conclusion. For this second analysis, the applicant removed the estimated charges for deep brain stimulation and substituted the estimated charges for the RNS® System.

With respect to the issue of substantial clinical improvement, the applicant argued that the RNS® System clinical trials provide Class I evidence that treatment with the RNS® System substantially reduces disabling seizures in patients with severe epilepsy who have tried and

failed treatment with antiepileptic medications, and in many cases vagus nerve stimulator or epilepsy surgery. However, CMS is concerned that the average age of patients in the applicant's study was 35 years. CMS is also unsure of the extent to which the technology would be used by Medicare beneficiaries. CMS is also concerned that further clarification on how the RNS® System compares to other neurostimulation treatments was not provided by the applicant. CMS also expresses concern that the time period in the clinical trial (3 months) may not be sufficient to confirm durability, and notes that the applicant is currently conducting a 5-year study. **CMS invites public comments on whether the RNS® System meets the substantial clinical improvement criterion, specifically in regard to the degree in which the technology would be used by Medicare beneficiaries, the comparison to other neurostimulation treatments, and its durability.**

CMS acknowledges receipt of two comments supporting the new technology add-on payment application for the RNS® System.

d. Zilver® PTX® Drug Eluting Peripheral Stent

The Zilver® PTX® is intended for use in the treatment of peripheral artery disease (PAD) of the above-the-knee femoropopliteal arteries (superficial femoral arteries). A stent is percutaneously inserted in the artery(s), usually by accessing the common femoral artery in the groin. The stent is self-expanding, made of nitinol (nickel titanium), and is coated with the drug Paclitaxel.

With respect to the newness criterion, the applicant, Cook® Medical, received FDA approval for the technology on November 15, 2012. The technology is currently described by ICD-9-CM procedure code 00.60 (Insertion of drug-eluting stent(s) of the superficial femoral artery).

With respect to the cost criterion, the applicant said that cases would typically map to MS-DRGs 252, 253, and 254 (Other Vascular Procedures with MCC, with CC, and without CC/MCC, respectively). In order to target cases eligible for the Zilver® PTX®, the applicant believed it was only appropriate to target those cases with one or two bare metal stents, because of differences in stent lengths between Zilver® PTX® (80 mm) and bare metal stents (up to 200 mm). Thus, the applicant submitted two cost analyses, one with cases that received one bare metal stent and the other with cases that received one or two bare metal stents. For the first analysis, the applicant assumed that an average of 1.9 Zilver® PTX® stents per case would be used, based on the Zilver® PTX® Global Registry Clinical Study, and noted that the length of a non-drug-eluting peripheral vessel stent typically ranges from 80 mm to 120 mm, while the length of the Zilver® PTX® is 80 mm. For this analysis, the applicant used FY 2010 MedPar data and used an inflation factor of 7 percent to FY 2012. The applicant used the future market price for the Zilver® PTX® (which the applicant considers to be proprietary information). The applicant then converted the cost of the 1.9 stents to a charge by dividing the results by the hospital-specific CCR (from the FY 2010 IPPS impact file). All of this produced a final inflated case-weighted average standardized charge per case of $58,419, compared to the case-weighted threshold for MS-DRGs 252, 253, and 254 (from the FY 2014 Table 10 thresholds) of $54,547. The second, similar analysis, which included cases that used one or two bare metal stents, produced a final inflated case-weighted average standardized charge per case of $62,455. Thus, the applicant argued that the Zilver® PTX® met the cost criterion.

In terms of substantial clinical improvement, the applicant shared several findings from a 479-patient, multicenter, multinational randomized controlled trial that compared the Zilver® PTX® to balloon angioplasty, and a prospective, multicenter, multinational, 787-patient single arm study on the Zilver® PTX®. The applicant argued that these data show that the Zilver® PTX® decreases the recurrence of symptoms arising from restenotic superficial femoral artery lesions, the rate of subsequent diagnostic or therapeutic interventions required to address restenotic lesions, and the number of future hospitalizations. However, CMS is concerned that endpoints such as walking, walking speed, and climbing were not considered as primary endpoints to demonstrate the effectiveness of the Zilver® PTX® in the randomized controlled trial; instead, the primary safety and effectiveness endpoints were "Event-Free Survival" (EFS)[2] and primary patency (defined as a less than 50 percent re-narrowing), respectively. The Zilver® PTX® had an EFS of 90.4 percent at 12 months compared to 83.9 percent for balloon angioplasty, and demonstrated a 50-percent reduction in restenosis rates compared to angioplasty and a 20-percent reduction compared to bare metal stents.

CMS is also concerned that on April 24, 2013, the FDA announced that, based on its investigation into a small number of complaints that the delivery system of the device had separated at the tip of the inner catheter, Cook Medical has initiated a nationwide/global voluntary recall of its Zilver® PTX® Drug Eluting Peripheral Stent. CMS refers readers to http://www.fda.gov/Safety/Recalls/ucm349421.htm?source=govdelivery for more information regarding this announcement.

CMS says it did not receive any public comments on the Zilver® PTX® during the new technology town hall meeting's public comment period.

e. MitraClip® System

The MitraClip® System is a transcatheter mitral valve system that includes a MitraClip® device implant, a Steerable Guide Catheter, and a Clip Delivery System. It is designed to perform reconstruction of the insufficient mitral heart valve for high risk patients who are not candidates for conventional open mitral valve surgery. According to the applicant, Abbott Vascular, the MitraClip mitral valve repair procedure is based on the double-orifice surgical repair technique, under which a portion of the anterior leaflet is sutured to the corresponding portion of the posterior leaflet using standard techniques and forceps and suture, creating a point of permanent coaptation (approximation) of the two leaflets.

With respect to the newness criterion, the manufacturer submitted a Premarket Approval (PMA) application is support of obtaining FDA approval for the MitraClip System. On March 20, 2013, the Circulatory System Devices Panel of the Medical Devices Advisory Committee of the FDA met to discuss, make recommendations, and vote on information related to this PMA application. CMS refers readers to http://www.fda.gov/AdvisoryCommittees/Calendar/ucm339809.htm for additional detailed information and meeting materials regarding the MitraClip® System. CMS also refers readers

[2] Event-free survival is defined as freedom from the major adverse events of death, target lesion revascularization, target limb ischemia requiring surgical intervention or surgical repair of the target vessel, and freedom from worsening systems as described by the Rutherford classification by 2 classes or to class 5 or 6.

to http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/MedicalDevices/MedicalDevicesAdvisoryCommittee/CirculatorySystemDevicesPanel/UCM345235.pdf for a summary of the March 20, 2013 meeting.

With respect to the cost criterion, the applicant submitted four different analyses (each of which used two different inflation factors), focusing on MS-DRGs 250 and 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI with MCC and without MCC, respectively). Two analyses used the FY 2011 MedPAR file and two analyses used hospital UB-04 claims data from the EVEREST II Continued Access Study that were collected during FY 2012. These produced inflated case-weighted average standardized charges per case for the MitraClip® System ranging from $79,346 to $139,535 (compared to the case-weighted threshold for MS-DRGs 250 and 251, using the FY 2014 Table 10 thresholds, ranging from $61,805 to $63,097). The applicant noted that the cost of the technology was proprietary information. For some of its analyzes, the applicant said it used the European commercial price of the MitraClip® System, and for others, the anticipated U.S. commercial price for the technology.

On the issue of substantial clinical improvement, the applicant argued that clinical studies have consistently shown that the MitraClip® procedure leads to a significant reduction of mitral regurgitation, improvements in left ventricular function including left ventricular volumes and dimensions, improved patient outcomes as measured by improvements in New York Heart Association functional class, health-related quality of life (as measured by the RAND SF-36 health survey, a quality of life instrument), reductions in heart-failure related hospitalizations, and significantly lower mortality than predicted surgical mortality. The applicant cited data from the EVEREST II High Risk Study, the EVEREST II Continued Access Study/Registry (REALISM), a high risk cohort of patients (EVEREST II High Risk Cohort), and from a select number of European centers.

CMS notes that, similar to the FDA, it is concerned that the applicant performed post hoc analyses on a different patient population and revised the initial indication for use for the MitraClip® after learning that the FDA expressed concern regarding the PMA based on insufficient data resulting from the initial indication for use and patient population in the EVEREST II randomized clinical trial. Also, CMS believes that the applicant's retrospective review of registry data resulted in major design flaws and data interpretation limitations. CMS also believes that the appropriate target population for the MitraClip® System is unclear because clinical trials conducted by the applicant included patients with both functional and degenerative mitral regurgitation, which makes it difficult to determine which group of patients may benefit more or less from the technology. **CMS invites public comments on whether the MitraClip® System meets the substantial clinical improvement criterion, specifically in comparison to other surgical therapies such as mitral valve repair or replacement, and also with regard to the appropriate target population for this technology.**

CMS acknowledges receiving nine comments supporting the MitraClip® System's new technology add-on payment application. Several commenters also recommended that the technology be reassigned from MS-DRGs 250 and 251 to MS-DRGs 216 through 221 (Cardiac Valve and Other Major Cardiothoracic Procedure with and without Cardiac

Catheterization with MCC, with CC, and without CC/MCC, respectively), but CMS considers these comments to be outside the scope of the new technology add-on payment application.

CMS says that since it has not yet determined whether any of the above applications will meet the specified criteria for new technology add-on payments for FY 2014, it is premature to estimate the potential payment impact. If any of the five applications are approved, CMS will discuss the estimated payment impact for FY 2014 in the final rule.

III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

A. Proposed Core-Based Statistical Areas for the Hospital Wage Index

CMS proposes to use the same labor market areas in FY 2014 that it used for the FY 2013 wage index notwithstanding that OMB issued Bulletin No. 13-01 on February 28, 2013 which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas based on the OMB 2010 standards and 2010 census data. CMS notes that it requires additional time to review and verify the changes and associated data due to their impact on various hospital reclassifications, the outmigration adjustment, treatment of Lugar counties, etc., and intends to make the requisite changes in the FY 2015 IPPS proposed rule.

B. Proposed FY 2014 Unadjusted Wage Index

The proposed national average hourly wage, unadjusted for occupational mix, is $38.2384 ($16.4873 for Puerto Rico). CMS uses the same methodology it applied for the FY 2012 and FY 2013 wage index in computing the unadjusted wage index for FY 2014. CMS notes that it does not propose to change the use of the employment cost index as its data source for wages, salaries and other price proxies in the IPPS market basket.

C. Proposed Occupational Mix Adjustment to the Proposed FY 2014 Wage Index

The proposed FY 2014 occupational mix-adjusted national average hourly wage is $38.2094; the FY 2014 proposed occupational mix-adjusted Puerto Rico-specific average hourly wage is $16.5300. CMS proposes to use the same methodology it used for FY 2012 and FY 2013.

Section 1886(d)(3)(E) of the Act requires the collection of data every 3 years on the occupational mix of employees for each Medicare participating short-term, acute care hospital to construct an occupational mix adjustment to the wage index. CMS proposes to use data collected on the 2010 Medicare Wage Index Occupational Mix Survey for the FY 2014 hospital wage index as well as for the FY 2015 wage index. CMS notes a new measurement of occupational mix will be required for FY 2016. CMS made what it described as minor editorial changes to the proposed 2013 survey which is available at http://www.cms.hhs.gov/PaperworkReductionActof1995 and is due to fiscal intermediaries/MACs by July 1, 2014. CMS reports a response rate of 91.7 percent and notes it applied proxy data for noncompliant hospitals; CMS requires those hospitals to explain their noncompliance and may consider penalties in the future.

As it did for FY 2013, CMS proposes to apply the occupational mix adjustment to 100 percent of the FY 2014 wage index. The proposed FY 2014 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$37.432
National LPN and Surgical Technician	$21.773
National Nurse Aide, Orderly, and Attendant	$15.327
National Medical Assistant	$17.213
National Nurse Category	$31.811

The proposed wage index values for FY 2014 are included in Tables 4A, 4B, 4C, and 4F of the Addendum to the proposed rule, and include the proposed adjustments for occupational mix, geographic reclassification or redesignation, and the rural, imputed and frontier State floors. Tables 3A (for urban areas) and 3B (for rural areas) list the 3-year average hourly wage for each labor market.

CMS observes that, based on its analysis of the occupational mix data, the national percentage of hospital employees in the nurse category is again approximately 43 percent, and that the proposed wage index values for FY 2014 would increase for two-thirds of rural areas and for slightly more than half of urban areas.

Proposed Rural, Imputed, and Frontier Floors

CMS notes that the rural floor will increase the FY 2014 proposed wage index for 434 hospitals. CMS projects that, in aggregate, rural hospitals will experience a 0.3 percent decrease in payments as a result of the rural floor budget neutrality requirement; hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments; and urban hospitals in the New England region can expect a 4.4 percent increase in payments, primarily due to the application of the proposed rural floor in Massachusetts and Connecticut. CMS expects that all 60 urban providers in Massachusetts will receive a rural floor wage index value, including rural floor budget neutrality, of 1.3108 and will receive approximately a 5.6 percent increase in IPPS payments due to the application of the rural floor. Twenty seven out of 32 hospitals in Connecticut would benefit, increasing payments by $75 million to the state.

CMS proposes to extend for one additional year (through September 30, 2014) its temporary imputed floor program whereby CMS imputes a "floor" for States with no rural counties (i.e., New Jersey and Rhode Island). CMS proposes to continue both the original imputed floor methodology (which benefits New Jersey) and its alternative, temporary methodology for the benefit of Rhode Island, which has only one CBSA in contrast to New Jersey's 10. Under this alternative, the lowest post-reclassified wage index assigned to a hospital in a State with one CBSA (viz. Rhode Island) is increased by a factor equal to the average percentage difference between the post-reclassified, pre-floor area wage index and the post-reclassified, rural floor wage index (absent rural floor budget neutrality). Thirty five hospitals in New Jersey would

benefit from the previously established temporary methodology; CMS estimates an aggregate increase in payments of roughly $15 million in FY 2014. Four hospitals in Rhode Island would benefit from the alternative temporary methodology; CMS estimates an additional $3.5 million in payments in FY 2014. CMS provides in the proposed rule a table showing the payment impact of the proposed rural floor and imputed floor with budget neutrality at the State level.

Forty six hospitals in Montana, North Dakota, South Dakota, and Wyoming would receive the frontier floor value of 1.0000 for FY 2014; though Nevada qualifies as a frontier State, its proposed FY 2014 rural floor value of 1.1503 is greater than the frontier floor. Overall, CMS estimates an increase of approximately $63 million (or 0.1 percent) in IPPS operating payments in FY 2014 by reason of the frontier floor.

D. Proposed Labor-Related Share for the FY 2014 Wage Index

CMS proposes to rebase the labor-related share based on the rebased and revised IPPS market basket using FY 2010 as the base year. Thus, CMS proposes a revised labor-related share of 69.6 percent for discharges occurring on or after October 1, 2013. CMS proposes the revised labor-related share in a budget neutral manner, but in doing so it assumes all hospitals receive the higher labor-related share of the standardized amount. Tables 1A and 1B in section VI of the Addendum to the proposed rule reflect this labor-related share. CMS proposes to apply the wage index to the labor-related share of 62 percent of the national standardized amount for hospitals with wage indices less than 1.0 and 69.6 percent of the national standardized amount for hospitals with wage indices greater than 1.0.

For Puerto Rico hospitals, CMS would also rebase and revise the labor-related share for the Puerto Rico-specific standardized amounts using FY 2010 as the base year. For FY 2014, CMS proposes a labor-related share for the Puerto Rico-specific standardized amounts of 63.2 percent for discharges occurring on or after October 1, 2013. The labor-related share of a hospital's Puerto Rico-specific rate will be either the Puerto Rico-specific labor-related share of 63.2 percent or 62 percent, whichever results in higher payments to the hospital.

E. Proposed Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

CMS notes that 332 hospitals were approved for wage index reclassifications for FY 2014 by the Medicare Geographic Classification Review Board (MGCRB), and, because such reclassifications are effective for 3 years, a total of 773 hospitals are in a reclassification status for FY 2014 (including those initially approved by the MGCRB for FY 2012 and FY 2013). Applications for FY 2015 reclassifications are due to the MGCRB by September 3, 2013 which is also the deadline for canceling a previous wage index reclassification withdrawal or termination. Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals and the CMS review process would be incorporated in the final FY 2014 wage index values.

CMS reminds readers that a "Lugar" hospital may apply to the MGCRB to reclassify to a different area and may compare the impact of any such reclassification in Table 4C of the proposed rule. The hospital would have 45 days from the date of publication of the proposed rule to withdraw from an MGCRB reclassification. Further, an eligible hospital that waives its Lugar status to receive the out-migration adjustment is treated as rural for all purposes (including for the rural DSH adjustment) for each fiscal year for which it receives the out-migration adjustment. CMS permits a Lugar hospital to submit a single notice to automatically waive its deemed urban status for the 3-year period of the out-migration adjustment, though the hospital is permitted before its second or third year of eligibility to notify CMS to return to its deemed urban status.

F. Proposed FY 2014 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

Table 4J (available from the CMS Web site) lists the proposed out-migration wage index adjustments for FY 2014. CMS proposes to use the same policies, procedures and computation that were used for the FY 2012 out-migration adjustment, and estimates increased payments of approximately $17 million in FY 2014 for 210 providers receiving the out-migration adjustment.

G. Worksheet S-3 Wage Data

CMS notes that the proposed wage index values are based on data from FY 2010 submitted cost reports, and include categories of costs paid under the IPPS (and outpatient costs) for salaries and hours from short term, acute care hospitals, home office costs and hours, contract labor costs and hours (including direct and certain indirect patient care, pharmacy, lab, and nonteaching physician Part A services), and wage-related costs (including pension costs). As was done for FY 2013, excluded categories of costs are direct and overhead salaries and hours for services not subject to IPPS payment (e.g., SNF and home health services), GME costs (teaching physicians and residents) and certified registered nurse anesthetists, hospital-based RHCs and FQHCs, and CAHs. CMS also notes this data is used to calculate wage indices for other providers of services as well as for prospective payments to IRFs, IPFs, LTCHs, and hospital outpatient services.

CMS calculates the proposed FY 2014 wage index based on wage data of 3,427 hospitals from Worksheet S-3 of the cost report for cost reporting periods beginning on or after October 1, 2009, and before October 1, 2010. CMS excludes 44 providers due to excessively aberrant data but indicates that, if the data could be corrected in time, it intends to include some of those providers in the final wage index for FY 2014. CMS includes data from IPPS hospitals in 2010 even if they terminated program participation as hospitals, but excludes data from CAHs and from IPPS hospitals that converted to CAH status. CMS removed 4 hospitals that converted to CAH status after February 13, 2012. For a multicampus hospital, CMS uses the same methodology as it did for the FY 2013 wage index to allot wages and hours data among the different labor market areas where the campuses are located. Table 2, available from the CMS Web site, includes separate wage data for multicampus hospitals.

H. Process for Requests for Wage Index Data Correction

CMS describes the process (see table below) by which a hospital may submit to its fiscal intermediary or Medicare Administrative Contractor (FI/MAC) requests to change or revise wage index data, and indicates that June 3, 2013 is a hospital's last opportunity to request a correction to an error the hospital determines was made after review of the CMS final wage index data public use files which will be made available in early May 2013. CMS further indicates that it would only make a change to wage and occupational mix data under very limited circumstances, namely that 1) the error was made by the FI/MAC or CMS; and 2) the hospital could not have known about the error before its review of the final wage index data files. A hospital that can meet these two requirements must send a letter to both its FI/MAC and CMS explaining the error and providing full documentation to support its claim, including when it became aware of the error.

Date/Deadline	Wage Index Data Related Action
October 3, 2012	Preliminary unaudited wage data and occupational mix survey data available on CMS Web site
December 10, 2012	Deadline to submit corrections with detailed explanation to FI/MAC for desk review
Mid-February 2013	FI/MAC notifies hospitals of any changes due to desk review and submits revised data to CMS
February 21, 2013	CMS publishes proposed wage index public use files, including hospital revised wage index data
March 4, 2013	Deadline to submit to FI/MAC request for reconsideration of adjustment made by FI/MAC due to desk review
April 10, 2013	Deadline for FI/MAC to transmit additional revisions due to hospital reconsideration request
April 17, 2013	Deadline for hospital to seek CMS intervention where hospital disagrees with FI/MAC policy interpretation
Early May, 2013	CMS to release final wage index data public use files: only purpose for review is to identify potential CMS or FI/MAC errors in the entry of final wage index data from the correction process (e.g., revisions submitted to CMS by FI/MACs by April 10, 2013)
June 3, 2013	Deadline for receipt of hospital letters to FI/MAC and CMS describing and explaining erroneous wage or occupational mix data (with supporting information)

CMS provides examples of the types of requests that will not be approved: for example, data corrections submitted too late for the April 10, 2013 transmission, or review of fact determinations or policy interpretations by FI/MACs during the wage index correction process.

Verified corrections that are timely received by CMS would be incorporated in the final wage index and be effective October 1, 2013. Hospitals that do not meet the procedural timelines would not be able to appeal to the PRRB any CMS failure to make the requested data revision. However, CMS does reserve the right (not the obligation) to make mid-year corrections to errors that hospitals bring to their attention after the June 3, 2013 deadline under limited circumstances as follows: 1) the FI/MAC or CMS erred in tabulating its data;

and 2) the hospital could not have known about the error, or could not have had an opportunity to correct the error, by the June 3, 2013 deadline. If such a correction would change the wage index value for an area, the revised wage index would be effective prospectively from the correction date.

Only under very limited circumstances would CMS make wage index value changes retroactive to the beginning of the fiscal year involved, as follows: 1) the FI/MAC or CMS erred in tabulating data; 2) the hospital knew and requested a correction before June 3, 2013; and 3) CMS agreed that the error was made and should be corrected. However, this would not apply for a hospital that seeks to revise another hospital's data; nor can the correction be used to revise a prior fiscal year's wage index data. CMS notes that there would also be retroactive effect where a judicial decision reverses a CMS denial of a hospital's wage index revision request.

IV. Proposed Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals

A. Background

Since the inception of the IPPS, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. An explanation of the hospital market basket used to develop the prospective payment rates was published in the *Federal Register* on September 1, 1983 (48 FR 39764). CMS rebases the market basket periodically so that the cost weights in the market basket will reflect recent changes between base periods in the mix of goods and services that hospitals purchase and best available data. CMS last rebased the hospital market basket effective for FY 2010 (74 FR 43843), with FY 2006 cost report data used as the base period for the construction of the market basket cost weights. CMS rebases the market basket every four years to comply with section 404 of P.L. 108-173.

B. Proposed Rebasing and Revising the IPPS Market Basket

For the proposed rebasing, CMS would establish FY 2010 as the base period for determining expenditures by spending category primarily using Medicare cost report data supplemented by other sources. The proportion of total operating costs that each category represents in FY 2010 cost report data would determine the expenditure weight for the respective categories. The FY 2010 Medicare cost reports are for cost reporting periods beginning on and after October 1, 2009 and before October 1, 2010. The "all other" (residual) category derived from the cost report data represents about 31.9 percent of total costs. CMS proposes to use the 2002 Benchmark Input-Output (I-O) Tables created by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce to disaggregate the "all other" (residual) cost category into more detailed hospital expenditure category shares, which allows for use of more appropriate price proxies. The FY 2006-based market basket also used the 2002 BEA data, which remains the most recent BEA data available. For the rebased FY 2010 market basket, CMS proposes to age the 2002 data forward to FY 2010. New BEA data based on 2007 are

due to be released in the summer of 2013. CMS proposes to use the 2007 BEA data if they are available before the final rule with sufficient time to incorporate the data into the final rule.

For the rebased FY 2010 market basket, CMS also reviewed the proxies used to measure price or wage level changes in each of the 25 expenditure categories and it proposes to use the same price proxies that were used in the FY 2006-based IPPS market basket. With the exception of the proxy for professional liability insurance (PLI), all of the proxies would be based on Bureau of Labor Statistics (BLS) data. For example, CMS would use BLS' Employment Cost Indexes (ECIs) to measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. CMS states that, appropriately, they do not reflect shifts in employment mix. This is consistent with the wage and salary cost category in the market basket, which is a single category, not one broken out by type of worker.

The proposed market basket produces an increase of 2.5% for FY 2014, which is the same increase determined using the current market basket. The table below compares results under the current and proposed market baskets and shows no change in any year with the results rounded to the nearest tenth, as they are used for the annual update calculation.

Table IV-04.--FY 2006-Based and Proposed FY 2010-Based Prospective Payment Hospital Operating Index Percent Change, FY 2008 through FY 2016

Fiscal Year (FY)	FY 2006-Based IPPS Market Basket Operating Index Percent Change	Proposed FY 2010-Based IPPS Market Basket Operating Index Percent Change
Historical data:		
FY 2008	4.0	4.0
FY 2009	2.6	2.6
FY 2010	2.1	2.1
FY 2011	2.7	2.7
FY 2012	2.2	2.2
Average FYs 2008-2012	2.7	2.7
Forecast:		
FY 2013	2.2	2.2
FY 2014	2.5	2.5
FY 2015	2.7	2.7
FY 2016	3.0	3.0
Average FYs 2013-2016	2.6	2.6

Source: IHS Global Insight, Inc., 1st Quarter 2013.

C. Proposed Labor-Related Share

Under section 1886(d)(3)(E) of the Act, the Secretary estimates from time to time the proportion of payments that are labor-related and subject to adjustment by the hospital wage index. Based on the updated weights for the cost categories, the proposed rule would increase the labor related-share from 68.8 percent to 69.6 percent, as shown in the table below.

Table IV-05.--Comparison of the Proposed FY 2010-Based Labor-Related Share and the FY 2006-Based Labor-Related Share

	FY 2006-Based Market Basket Cost W	Proposed FY 2010-Based Market Basket Cost Weights
Wages and Salaries	47.213	47.233
Employee Benefits	12.414	13.105
Professional Fees: Labor-Related	5.356	5.5
Administrative and Facilities Support Services	0.626	0.619
All Other: Labor-Related Services	3.193	3.13
Total Labor-Related Share	**68.802**	**69.587**

For Puerto Rico, the proposed rule would increase the labor-related share from 62.1 percent to 63.2 percent using a comparable calculation.

D. Separate Market Basket for Certain Hospitals Presently Excluded from the IPPS

In the FY 2010 IPPS final rule (74 FR 43857), CMS adopted the use of the FY 2006-based IPPS operating market basket to update the target amounts for children's and cancer hospitals and religious nonmedical health care institutions (RNHCIs), which are still reimbursed under the reasonable cost-based system subject to the rate-of-increase limits. The proposed rule for FY 2014 would continue to use the IPPS market basket – with the proposed rebasing – to update the rate-of-increase limits for these hospitals/institutions.

E. Proposed Rebasing and Revising the Capital Input Price Index (CIPI)

The CIPI has been used since FY 1993 to reflect the capital cost structure of the hospital industry. Changes in the CIPI are a significant part of the methodology to update the annual capital Federal rates. The most recent rebasing and revision of the CIPI used FY 2006 as the base year. CMS, as part of the proposed rebasing and revision of the IPPS market basket, is proposing to rebase and revise the CIPI to a FY 2010 base year to better reflect the more current structure of capital costs in hospitals.

As part of the discussion of the proposed changes to the CIPI, CMS includes Chart 9 in the proposed rule (copied below), which shows that the FY 2006-based CIPI would forecast an estimated increase of 1.4 percent in FY 2014 while the proposed FY 2010-based CIPI would forecast an estimated increase of 1.2 percent in FY 2010. The proposed rule indicates that the

0.2 percent difference in the forecasted market basket update for FY 2014 is primarily due to the rebasing of the index to FY 2010 and revising the base year cost weights to incorporate the FY 2010 Medicare cost report data.

Table IV-09.--Comparison of FY 2006-Based and Proposed FY 2010-Based Capital Input Price Index, Percent Change, FY 2008 through FY 2016

Fiscal Year	CIPI, FY 2006-Based	CIPI, Proposed FY 2010-Based
FY 2008	1.5	1.1
FY 2009	1.5	1.2
FY 2010	1.0	0.7
FY 2011	1.2	0.9
FY 2012	1.2	1.0
Forecast:		
FY 2013	1.2	1.0
FY 2014	1.4	1.2
FY 2015	1.5	1.3
FY 2016	1.7	1.5
Average:		
FYs 2008-2012	1.3	1.0
FYs 2013-2016	1.5	1.3

Source: IHS Global Insight, Inc., 1st Quarter 2013 forecast.

V. Other Proposed Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Proposed Changes in the Inpatient Hospital Update

As discussed in section IV of this summary, CMS proposes for FY 2014 to replace the FY 2006-based IPPS operating and capital market baskets with revised and rebased FY 2010-based IPPS operating and capital market baskets. CMS proposes to base its proposed FY 2014 market basket update on IHS Global Insight, Inc. first quarter 2013 forecasts and to use more recent data if available to determine the final market basket update and multifactor productivity (MFP) adjustments.

CMS proposes a 1.8 percent applicable percentage increase to the FY 2014 operating standardized amount for hospitals that submit required quality data, based on an estimated 2.5 percent market basket increase reduced by 0.4 percentage points for the MFP adjustment and further reduced by 0.3 percentage points under the Act. For hospitals that fail to submit the requisite quality data, the applicable percentage increase would be reduced by an additional 2.0 percentage points resulting in a -0.2 percent increase.

For SCHs, CMS proposes the same update of 1.8 percent, or -0.2 percent for an SCH that fails to submit requisite quality data, in FY 2014. Similarly, for Puerto Rico hospitals CMS proposes an applicable percentage increase of 1.8 percent to the Puerto-Rico-specific operating standardized amount in FY 2014. Because the MDH program is set to expire at the end of FY 2013, CMS does not include MDHs in the update to the hospital specific rates.

B. Rural Referral Centers

CMS proposes revised criteria for purposes of determining rural referral center (RRC) status, including updated minimum national and regional case mix index (CMI) values and updated minimum national and regional numbers of discharges. These factors are among those used to determine whether a given hospital qualifies for RRC status.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2013, CMS proposes that a rural hospital with fewer than 275 beds available for use must, among other things:

- Have a CMI value for FY 2012 that is at least 1.5526 or the newly updated median CMI value (not transfer adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located. These proposed median regional CMIs are listed in the proposed rule and will be revised in the final rule to the extent necessary to reflect the updated FY 2012 MedPAR file containing data from bills received through March 2013.
- Have as the number of discharges for its cost reporting period that began in FY 2011 at least 5,000 (3,000 for an osteopathic hospital) or the newly updated median number of discharges for urban hospitals in the census region in which the hospital is located. 5,000 discharges is the minimum criterion for all hospitals (3,000 for osteopathic hospitals) because the proposed median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges.

Due to an ongoing transition in the CMS cost reporting system for cost reporting periods beginning on or after May 1, 2010, CMS proposes to use a combination of FY 2010 and FY 2011 cost report data to create a full fiscal year of data for this analysis. If CMS had a FY 2011 cost report for a hospital in its system, it used that FY 2011 cost report data; if not, it used FY 2010 cost report data.

C. Payment Adjustment for Low-Volume Hospitals

The ACA-revised criteria for the low-volume payment adjustment, as extended for one year by section 605 of ATRA, expires at the end of FY 2013; thus, for discharges occurring during FY 2014, the criteria for this adjustment reverts back to those in effect before FY 2011: the road mileage qualifying criterion reverts to 25 miles from the nearest subsection (d) hospital and the discharge qualifying criterion reverts to no more than 200 total (Medicare and non-Medicare) discharges. The payment adjustment will be an additional 25 percent for discharges occurring during the fiscal year.

A hospital seeking this adjustment must provide sufficient documentation to its FI/MAC that it meets the discharge and distance requirements by not later than September 1, 2013, for the adjustment to apply to discharges made during FY 2014. CMS indicates that a Web-based mapping tool may be used for the mileage criterion. For requests submitted after September 1, 2013 that are approved, the adjustment will apply prospectively to discharges beginning on or after the date that is 30 days after the FI/MAC approval date. CMS proposes to make technical changes to the regulations to reflect the ATRA extension as well as the reversion to the original criteria for FY 2014.

CMS estimates approximately 600 hospitals that qualify as low-volume hospitals for FY 2013 will no longer meet the mileage and discharge criteria to qualify in FY 2014, resulting in a projected reduction in payments of roughly $288 million in FY 2014 compared to the payments that those providers would have otherwise received under the ACA-revised criteria.

D. Indirect Medicare Education (IME) Adjustment

The proposed rule would continue for FY 2014 the IME adjustment factor at 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio. Proposed policy changes affecting GME payment are described below.

E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to PPS hospitals that serve a significantly disproportionate number of low-income patients using either of two methods:

1) Method 1 qualifies a hospital that is located in an urban area, has 100 or more beds and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues is derived from State and local government payments for care furnished to needy patients with low incomes. The DSH add-on adjustment for these hospitals, commonly referred to as "Pickle hospitals," is 35 percent.
2) Method 2 is based on a complex statutory formula under which the level of the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP).

A hospital's DPP is the sum of two fractions: the "Medicare fraction" and the "Medicaid fraction." The Medicare fraction (also known as the "SSI fraction" or "SSI ratio") is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

2. Counting of Patient Days Associated with Patients Enrolled in Medicare Advantage Plans in the Medicare and Medicaid Fractions of the Disproportionate Patient Percentage (DPP) Calculation

In the FY 2005 IPPS final rule (69 FR 49099), CMS determined that Medicare Advantage (MA) patient days should be counted in the Medicare fraction of the DPP calculation (§ 412.106(b)(2)(i) of the regulations). CMS further noted that if the beneficiary is also an SSI recipient, the patient days for that beneficiary will be included in the numerator of the Medicare fraction (as well as in the denominator) and not in the numerator of the Medicaid fraction. The preamble states that the FY 2005 final rule contained an explicit statement to this effect but that due to a clerical error, the corresponding regulation at § 412.106(b)(2)(i) was not amended to reflect the policy until 2007 (72 FR 47384).

On November 15, 2012, the Federal District Court for the District of Columbia ruled in the case of Allina Health Services, et al., v. Sebelius that the final policy of putting MA patient days in the Medicare fraction adopted in the FY 2005 IPPS final rule was not a logical outgrowth of the FY 2004 IPPS proposed rule. Although the government has filed an appeal in the Allina case, the proposed rule seeks comment on a proposal to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP.

3. New Payment Adjustment Methodology for Medicare Disproportionate Share Hospitals (DSHs) under Section 3133 of the Affordable Care Act (§ 412.106)

Section 3133 of the ACA added a new section 1886(r) to the Act changing the methodology for computing the Medicare DSH payment adjustment. Beginning with FY 2014 discharges, hospitals that qualify for Medicare DSH payments will receive two separately calculated payments. The first payment will equal 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments whether the hospital qualifies under section 1886(d)(5)(F)(i)(II) of the Act, the "Pickle hospitals," or under the DPP method. CMS refers to this payment as the "empirically justified Medicare DSH payment." The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is used make additional payments to each hospital that qualifies for Medicare DSH payments and that provides uncompensated care. CMS refers to these additional payments as the "uncompensated care payments."

Eligibility for empirically justified Medicare DSH payments is unchanged by the ACA provision. CMS also notes that the new DSH policies established by the ACA only affect the DSH payment under the operating IPPS. The ACA does not revise or replace the capital IPPS DSH payment provided under the regulations at 42 CFR Part 412, Subpart M, which were established through the exercise of the Secretary's discretion in implementing the capital IPPS under section 1886(g)(1)(A).

The statute precludes all administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care payments, or the periods selected in order to develop such estimates.

Subject to comment, the proposed rule would establish these policies:

- The ACA DSH provisions will apply to hospitals in Puerto Rico and to sole community hospitals paid on the federal rate.[3] They will not apply to hospitals in Maryland (because they are paid under a waiver under Section 1814(b)); sole community hospitals paid based on the hospital-specific rate (because add-on payments, such as outliers, DSH, and IME, do not apply to these hospitals); and hospitals participating in the Rural Community Hospital Demonstration (because these hospitals do not receive DSH payments).
- The proposed rule includes no new operational mechanisms for making empirically justified DSH payments. CMS would implement this provision simply by revising its claims payment methodologies to adjust the interim claim payments to equal 25 percent of what would have otherwise been paid. As currently, final eligibility for Medicare DSH payments and the final amount of these payments for eligible hospitals will be determined at the time of cost report settlement.

Uncompensated Care Payments

The statute provides that the second portion of the DSH payment amount for each DSH hospital – the uncompensated care payment portion – is to be determined as the product of three factors:

1) Factor 1 equals 75 percent of the aggregate DSH payments that would otherwise be made under section 1886(d)(5)(F) without application of the DSH changes made by the ACA;
2) Factor 2 is a ratio of the percent of the population who are insured in the most recent period following implementation of the ACA to the percent of the population who were insured in a base year prior to ACA implementation; and
3) Factor 3 is determined by a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percent.

[3]For SCHs, the fiscal intermediary/MAC determines whether the federal or hospital-specific rate is projected to yield the highest aggregate payment prior to the beginning of the federal fiscal year and automatically makes interim payments at the highest rate using the best data available. Because CMS proposes to make the uncompensated care payments on a periodic rather than per discharge basis, it proposes that these payments would not be accounted for in determining whether the federal or the hospital-specific rate is higher. If the federal rate is higher, SCHs that receive interim empirically justified DSH payments also would receive interim uncompensated care payments. The fiscal intermediary/MAC will make a final adjustment of all payments, including eligibility for DSH payments and the amount of uncompensated care payments, at cost report settlement.

Subject to comment, the proposed rule establishes these policies:

- Consistent with the law, hospitals must receive empirically justified Medicare DSH payments in FY 2014 or a subsequent year to be eligible to receive an additional Medicare uncompensated care payment for that year.
- CMS will make periodic interim uncompensated care payments subject to final determination when the report is settled.

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2014 and subsequent years, in the absence of the ACA payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years, which takes into account the requirement to reduce Medicare DSH payments by 75 percent. The statute gives CMS authority to estimate these amounts recognizing that under a prospective payment system, CMS would not know the precise aggregate Medicare DSH payment amount that would be paid for a Federal fiscal year until cost report settlement for all IPPS hospitals is completed, which occurs several years after the end of the Federal fiscal year.

Subject to comment, the proposed rule establishes these policies:

- CMS will develop final estimates of both the aggregate amount of Medicare DSH payments that would be made in the absence of section 1886(r)(1) and the aggregate amount of empirically justified Medicare DSH payments to hospitals under section 1886(r)(1) prior to each fiscal year. CMS will make periodic interim uncompensated care payments subject to final determination when the report is settled. These estimates will determine payments under the final rule; consistent with a prospective payment system, they will not be adjusted based on actual data.
- CMS proposes to use the most recently available projections of Medicare DSH payments for FY 2014 and each subsequent year, as calculated by CMS' Office of the Actuary, to determine Factor 1. OACT projects Medicare DSH payments on a biannual basis, typically in February of each year (based on data from December of the previous year) as part of the President's Budget, and in July (based on data from June) as part of the Midsession Review. If this proposal is finalized, CMS would use the July 2013 Medicare DSH estimates for the FY 2014 IPPS final rule.[4]

The February 2013 OACT estimate for Medicare DSH payments for FY 2014, without regard to the application of section 1886(r)(1), is $12.338 billion (excluding Maryland hospitals, sole community hospitals paid under their hospital-specific payment rate and hospitals participating in the Rural Community Hospital Demonstration). Based on this estimate, the estimate for empirically justified Medicare DSH payments for FY 2014, with the application of section 1886(r)(1), is $3.084 billion (25 percent of the total amount estimated). Factor 1,

[4]For OACT's February 2013 estimate, data are based on the December 2012 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2013 IPPS final rule IPPS Impact file. For the July 2013 estimate, CMS expects that the data will be based on the March 2013 update of the Medicare Hospital Cost Report data and this proposed rule's IPPS Impact file.

which is the difference of these two estimates, is calculated to be $9.2535 billion for modeling the proposed rule. In response to a query, CMS staff confirmed that OACT's estimate of DSH in FY 2014 includes the effect of the ACA expansion of Medicaid on the Medicaid ratio of the DSH formula. CMS did not, however, provide any details concerning the assumptions.

Factor 2 is based on the percent change, essentially since implementation of the ACA, in the percent of individuals under the age of 65 who are uninsured.

- For FYs 2014 through 2017, the statute defines Factor 2 as 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the ACA, minus 0.1 percentage point for FY 2014, and minus 0.2 percentage point for FYs 2015 through 2017.
- For FYs 2014 through 2017, the 2013 baseline for the estimate of the change in the uninsured percentage is fixed by statute to be the most recent estimate of the Congressional Budget Office before the final vote on the Health Care and Education Reconciliation Act of 2010, which is contained in a March 20, 2010 letter from the Director of the Congressional Budget Office to the Speaker of the House.[5]
- In its March 20, 2010 letter, CBO provides two estimates of the "post-policy uninsured population." The first estimate is of the "Insured Share of the Nonelderly Population Including All Residents" (which is 82 percent) and the second estimate is of the "Insured Share of the Nonelderly Population Excluding Unauthorized Immigrants" (83 percent).

Subject to comment, the proposed rule would establish these policies for the calculation of Factor 2:

- CMS proposes to use CBO's estimate that includes all residents, including unauthorized immigrants to establish the 2013 baseline of the percent who are uninsured.
- CMS proposes that, for FYs 2014-2017, the CMS estimate of the uninsurance percentage for 2013 would be 18 percent (calculated from the CBO March 20, 2010 letter reporting an estimate of the "Insured Share of the Nonelderly Population Including All Residents" as 82 percent).
- The CBO estimate excludes Puerto Rico, which is encompassed by the ACA provision on DSH. The proposed rule concludes that the impact of excluding Puerto Rico from the insurance estimate is negligible, but invites public comment.

[5] For FY 2018 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals "who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary" of CMS, and "who are uninsured in the most recent period for which data is available (as so estimated and certified) minus 0.2 percentage points for FYs 2018 and 2019." Thus, for FY 2018 and subsequent years, the statute provides greater flexibility in the choice of the data sources to be used in the estimate of the change in the percent of the uninsured.

- The law requires that CMS compare the 2013 baseline uninsurance rate to the percent of such individuals "who are uninsured in the most recent period for which data is available (as so calculated)." CMS proposes to use the same data source, CBO estimates, to calculate this percent of individuals without insurance for the post-implementation years beginning with 2014.
- CMS proposes to use the most recent estimates available from CBO in order to take into account changes in the environment that can impact insurance rates, such as more recent economic conditions and the Supreme Court's decision in National Federation of Independent Business. v. Sebelius, regarding Medicaid expansions authorized by the ACA.
- For the proposed rule, CMS uses the February 5, 2013, CBO health insurance estimates in order to calculate the percentage of individuals without insurance for 2014. The CBO report projects that the "Insured Share of the Nonelderly Population Including All Residents" for 2014 will be 84 percent. Therefore, CMS proposes that the uninsurance percentage for 2014 would be 16 percent.
- If a more recent CBO estimate becomes available for the FY 2014 IPPS final rule, CMS would use it to calculate Factor 2, but it proposes not to adjust Factor 2 retroactively to account for estimates that become available after publication of the final rule.
- CMS proposes to use this computation for Factor 2 for FY 2014:
  - Percent of individuals without insurance for 2013: 18 percent
  - Percent of individuals without insurance for 2014: 16 percent
  - $1 - |[(0.16 - 0.18)/0.18]| = 1 - 0.111 = 0.889$ (88.9 percent)
  - 0.889 (88.9 percent) - 0.001 (0.1 percentage points) = 0.888 (88.8 percent)
  - Factor 2 = 0.888 = 88.8 percent for FY 2014
- Based on this proposal, CMS further proposes that the amount available for uncompensated care payments for FY 2014 will be $8.217 billion (0.888 times its proposed Factor 1 estimate of $9.2535 billion), subject to changes in the final rule to reflect more recent CBO estimates.

Factor 3 is a hospital-specific value that represents the proportion of the estimated uncompensated care amount attributed to each PPS hospital (including Puerto Rico PPS hospitals) with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. The product of Factors 1 and 2 determine the total pool available for uncompensated care payments. This product multiplied by Factor 3 determines the amount of the uncompensated care payment that each eligible hospital will receive.

The statutory requirements for this factor requires the Secretary to determine: (1) the definition of uncompensated care; (2) the data source(s) for the estimated uncompensated care amount; and (3) the timing and manner of computing the quotient for each hospital estimated to receive DSH payments. The statute instructs the Secretary to estimate the amounts of uncompensated care for a period "based on appropriate data." In addition, it permits the Secretary to use alternative data if the Secretary determines that available alternative data is a better proxy for the costs of PPS hospitals for treating the uninsured.

The preamble includes a lengthy discussion of definitions of uncompensated care, charity care, bad debt, Medicaid payment shortfalls and related issues. The preamble states that Worksheet S-10 is the only national data source that includes data for all Medicare hospitals and is designed to elicit data that are both accurate and consistent with the definition of uncompensated care costs that the agency considered proposing to use, viz. charity care and bad debt. CMS does not propose to use the S-10 data, however, due to data deficiencies. It indicates that it may propose to use data on the Worksheet S-10 to determine uncompensated care costs in the future, once hospitals are submitting accurate and consistent data through this reporting mechanism.

The preamble states that applying a definition of uncompensated care costs based upon information reported on the Worksheet S-10 would require using the 2010/2011 cost reports, which were submitted on or after May 1, 2010, when the new Worksheet S-10 went into effect. These are the most recently available full year of cost reports and the first cost reports with detailed uncompensated care data on Worksheet S-10 that would be available for use in implementing the new methodology for uncompensated care payments for FY 2014. Concerns about the standardization and completeness of the Worksheet S-10 data could be more acute for data collected in the first year of the Worksheet's use. Some stakeholders expressed concern that hospitals have not had enough time to learn how to submit accurate and consistent data through the S-10 reporting mechanism. Other stakeholders have maintained that some instructions for Worksheet S-10 still require clarification in order to ensure standardized and consistent reporting by hospitals.

Subject to comment, the proposed rule would establish these policies for the calculation of Factor 3:

- For FY 2014, CMS proposes to determine Factor 3 using insured low-income patient days from the 2010/2011 cost reports (including the FY 2011 or FY 2010 SSI ratios, whichever represents the most recently available inputs prior to October 1, 2013) as alternative data which are a better proxy for the treatment costs of uninsured patients. It further proposes to define insured low-income patient days as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively.
- The preamble notes that these data are the most recently available full year of Medicare cost report data prior to the beginning of the federal fiscal year and that the data have been historically publicly available, subject to audit, and used for payment purposes. It also compares the advantages of utilization data with the difficulties of collecting consistent cost information.
- CMS further proposes to estimate which hospitals would receive an empirically justified DSH payment in a given federal fiscal year using the most recent data available. The agency will publish a table or tables listing Factor 3 for all hospitals that it estimates would receive empirically justified DSH payments in a fiscal year (that is, hospitals that would receive interim uncompensated care payments during the fiscal year), and for the remaining PPS hospitals that have the potential of receiving a DSH

payment in the event that they receive an empirically justified DSH payment for the fiscal year as determined at cost report settlement.

- With respect to this proposed rule, CMS is posting proposed tables listing Factor 3 for the hospitals that it estimates would receive Medicare DSH payments for FY 2014 on the CMS Website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html. CMS proposes that hospitals have 60 days from the date of display of the IPPS proposed rule (i.e., until June 25) to review these tables and notify CMS in writing of a change in a hospital's PPS hospital status, such as if a hospital has closed or converted to a CAH.

CMS' estimates of eligibility to receive FY 2014 Medicare DSH payments are based on the December 2012 update of the Provider Specific File that lists the most recently available DPP and DSH payment adjustments for hospitals that qualify to receive DSH payments. CMS estimates that 2,349 hospitals, or 68 percent of all applicable hospitals, would be eligible for DSH payments in FY 2014. The proposed Factor 3 is based on the December 2012 update of the Medicare Hospital Cost Report and FY 2010 SSI ratios. CMS used the data from these 2,349 hospitals to determine the denominator for Factor 3. However, it will estimate a Factor 3 numerator for each PPS and PPS Puerto Rico hospital that has the potential of receiving DSH payments for FY 2014 and therefore of qualifying for the uncompensated care payment in FY 2014. In the final rule, CMS will update the list of hospitals that it estimates will be eligible for DSH payments for FY 2014 and its estimate of Factor 3 using more recent data and verified hospital notifications regarding hospital status (for example, closures).

Subject to comment, the proposed rule would establish these additional policies for the uncompensated care payments:

- CMS proposes to make interim uncompensated care payments on the basis of its best available estimates concerning the eligibility of each hospital for empirically justified Medicare DSH payments and its best available calculations concerning the amount of the uncompensated care payments that the hospital is eligible to receive.
- It proposes to make these interim uncompensated care payments on a periodic basis and not on a per discharge basis.
- CMS further proposes that cost report settlement would not include reconciliation of the values of Factors 1, 2, and 3 that were established in the final rule. Reconciliation only would include adjustments for changes in whether the hospital actually was eligible to receive empirically justified DSH payments. The fiscal intermediary/MAC would recoup payments from hospitals that received interim payments but were determined at cost report settlement not to be eligible. Similarly, for a hospital that did not receive interim payments for its empirically justified DSH payments and uncompensated care payments but at cost report settlement is determined to be eligible for DSH payments, the fiscal intermediary/MAC would calculate the uncompensated care payment for such a hospital based on the Factor 3 value determined prospectively for that fiscal year.
- The proposed rule invites public comments concerning whether CMS should include Factor 3 within the reconciliation process. Specifically, should a hospital's final uncompensated care payments be based on Factor 3 numerators and denominators that

are estimated using more recent cost report data (and associated inputs) at the time of cost report settlement.

- CMS proposes to pay the uncompensated care payment on the basis of the federal fiscal year because that is how it is determined, and to reconcile that amount in the cost reporting period that begins in the respective federal fiscal year.

F. Medicare-Dependent, Small Rural Hospital (MDHs)

CMS notes that the one-year extension of the MDH program under section 606 of ATRA will expire at the end of FY 2013, and hospitals will be paid based on the Federal rate beginning October 1, 2013. MDHs may apply for SCH status; applications for FY 2014 are due August 31, 2013, and must request that the SCH status, if granted, be effective October 1, 2013 (immediately after the expiration of the MDH status). Failure to apply before the deadline would mean that the effective date of SCH status, if granted, would be 30 days after CMS' written notice of approval.

CMS estimates that MDHs may expect a 9.9 percent decrease in payments. CMS also estimates that 134 MDHs, which are paid under the blended payment of the federal standardized amount and hospital specific rate, will lose approximately $127 million in payments when switched to payment made only under the Federal standardized amount in FY 2014.

G. Hospital Readmissions Reduction Program

Effective beginning in FY 2013, section 3025 of the ACA reduces payments to Medicare PPS hospitals with readmissions exceeding an expected level. The payment reductions are based on a formula that compares each hospital's payments for actual readmissions (risk-adjusted) to payments based on an estimate of that hospital's expected readmissions (also risk-adjusted). In the FY 2012 final rule, CMS identified three conditions to be used for the Hospital Readmissions Reduction Program: Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN).

In the FY 2012 IPPS final rule (76 FR 51660 through 51676), CMS addressed the portions of the program related to the following provisions:

- Selection of applicable conditions;
- Definition of "readmission";
- Measures for the applicable conditions chosen for readmission;
- Methodology for calculating the excess readmission ratio;
- Definition of "applicable period";
- Index hospitalizations;
- Risk adjustment;
- Risk standardized readmission rate;
- Data sources; and
- Exclusion of certain readmissions.

In the FY 2013 IPPS final rule (77 FR 53374 through 53401), CMS finalized policies that relate to the calculation of the hospital readmission payment adjustment factor and the process by which hospitals can review and correct their data. Specifically, the final rule addressed these provisions:

- Base operating DRG payment amount, including policies for SCHs and MDHs and hospitals paid under section 1814(b) of the Act;
- Adjustment factor (both the ratio and floor adjustment factor);
- Aggregate payments for excess readmissions and aggregate payments for all discharges;
- Applicable hospital;
- Limitations on review; and
- Reporting of hospital-specific information, including the process for hospitals to review readmission information and submit corrections.

The FY 2013 IPPS final rule established a new Subpart I under 42 CFR Part 412 (§§412.150 through 412.154) to codify rules for implementing the Hospital Readmissions Reduction Program.

In the proposed rule for FY 2014 and beyond, CMS proposes to:

- Refine the readmissions measures and related methodology for the current applicable conditions;
- Expand the "applicable conditions" for FY 2015;
- Specify additional policies for hospitals paid under section 1814(b)(3) of the Act (§ 412.154(d)), including the process to be exempted from the Hospital Readmissions Reduction Program and the definition of "base operating DRG payment amount";
- Specify the proposed adjustment factor floor for FY 2014;
- Specify the proposed applicable period for FY 2014;
- Refine the methodology to calculate the aggregate payments for excess readmissions; and
- Clarify the process for reporting hospital-specific information, including the opportunity to review and submit corrections.

Planned Readmissions

During development of the three readmission measures for AMI, HF, and PN, CMS consulted with medical experts to identify readmissions that are typically scheduled as follow-up care for each specific condition within 30 days of discharge. It categorized these readmissions as planned follow-up care and excluded them from being counted as a readmission. The AMI measure included two revascularization procedures (coronary artery bypass graft surgery (CABG) and percutaneous coronary intervention (PCI) that CMS considered to be planned readmissions and excluded them from the readmission calculation as long as the readmissions were not for one of five acute conditions (HF, AMI, other acute/subacute forms of ischemic heart disease, arrhythmia, and cardiac arrest). CMS did not identify any readmissions that were typically planned at the time of the patient's discharge as followup care for the HF and PN readmission measures.

In response to numerous comments from the medical community, other stakeholders, and the general public encouraging the agency to identify and not count as readmissions a broader range of planned readmissions, CMS worked collaboratively to develop an expanded "planned readmission algorithm." The algorithm is part of the CMS Planned Readmission Algorithm Version 2.1 Report that identifies planned readmissions across the readmission measures. For FY 2014, CMS proposes to apply the algorithm to the AMI, HF, and PN measures (The CMS Planned Readmission Algorithm Version 2.1 Report is available on the CMS Web site at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospital QualityInits/Measure-Methodology.html). The proposed rule describes the development of the algorithm, which was developed based on a hospital-wide (not condition-specific) cohort of patients using the Agency for Healthcare Research and Quality's (AHRQ's) Clinical Classification Software (CCS) codes to group thousands of individual procedures and diagnoses codes into clinically coherent, mutually exclusive procedure and diagnosis categories (PROC-CCS categories and Diagnosis-CCS categories, respectively).

CMS sought NQF endorsement of the revised measures for the three current applicable conditions (AMI, HF and PN), as required by the statute. NQF endorsed the revised AMI (NQF #0505) and HF (NQF #0330) measures in January 2013 and the PN measure (NQF #0506) in March 2013.

The Planned Readmission Algorithm uses a flow chart and four tables of procedures and conditions to classify readmissions as planned or unplanned. The flow chart and tables also are available in the report mentioned above.

For most readmission measures, including the AMI, HF, and PN measures, CMS used one standard version of the algorithm, but for a subset of readmission measures, it revised the list of potentially planned procedures or acute primary diagnosis after application of the algorithm based on clinical considerations. For example, for the Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) readmission measures that are proposed for FY 2015, CMS removed diagnostic cardiac catheterization from the potentially planned procedure list because patients in the hip/knee measure are typically well enough to undergo elective surgery and would not be expected to need a catheterization within 30 days of discharge. The details of these adaptations are available in the previously mentioned report.

In addition to the expanded list of planned readmissions through use of the algorithm, CMS proposes that if the first readmission is planned, it will not count as a readmission, nor will any subsequent unplanned readmission within 30 days of the index readmission count as a readmission. In other words, unplanned readmissions that occur after a planned readmission and fall within the 30-day post discharge timeframe would no longer be counted as outcomes for the index admission. This proposed change would affect a very small percentage of readmissions (approximately 0.3 percent of index admissions nationally for AMI, 0.2 percent for HF, and less than 0.1 percent for PN).

Using analyses of discharges between July 2008 and June 2011, CMS modeled the effect that the proposed changes to the measures would have had for FY 2013. Note, however, that the changes are proposed to take effect in FY 2014 and are not retroactive to FY 2013. The 30-day readmission rate (excluding the planned readmissions) would decrease by 1 percentage point for AMI; 1.5 percentage points for HF; and 0.7 percentage point for PN. These and other results of the simulation are shown in the table below.

Table V.G.1.--Comparison of Original AMI/HF/PN Measures Finalized In FY 2013 Relative to Proposed Revised AMI/HF/PN Measures for FY 2014 (Based on July 2008 through June 2011 Discharges from 3,025 Hospitals)

	AMI		PN		HF	
	Proposed Revised Measure	**Original Measure**	**Proposed Revised Measure**	**Original Measure**	**Proposed Revised Measure**	**Original Measure**
Number of Admissions	501,765	501,765	957,854	957,854	1,195,967	1,195,967
Number of Unplanned Readmissions	91,360	96,302	170,396	177,480	276,748	294,260
Readmission Rate	18.20%	19.20%	17.80%	18.50%	23.10%	24.60%
Number of Planned Readmissions	12,811	7,869	7,084	0	17,512	0
Planned Readmission Rate	2.60%	1.60%	0.70%	0.00%	1.50%	0.00%
Percent of Readmissions that are Planned	12.30%	7.60%	4.00%	0.00%	6.00%	0.00%

Proposed Expansion of the Applicable Conditions for FY 2015

As required by section 1886(q)(5)(A), effective for the calculation of the readmissions payment adjustment factors in FY 2015, CMS proposes to expand the applicable conditions and procedures to include: (1) patients admitted for an acute exacerbation of COPD; and (2) patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). The preamble indicates that it is not feasible for CMS to add readmission measures for three of the conditions identified by MedPAC in its 2007 Report to Congress (CABG, PCI, and other vascular conditions). CMS notes that inpatient admissions for PCI and other vascular conditions appear to be decreasing as the procedures are performed more frequently in hospital outpatient departments. The shift in setting may make their future inclusion in the Hospital Readmissions Reduction Program more difficult and impracticable. CMS is exploring how it might address CABG in the readmissions program in the future.

COPD is a leading cause of readmissions to hospitals. In MedPAC's 2007 report to Congress identifying the seven conditions associated with the most costly potentially preventable readmissions, COPD ranked fourth. Evidence also shows variation in readmissions for patients with COPD, supporting a finding that opportunities exist for improving care. The

median, 30-day, risk-standardized readmission rate among Medicare fee-for-service patients aged 65 or older hospitalized for COPD in 2008 was 22.0 percent, and ranged from 18.33 percent to 25.03 percent across 4,546 hospitals.

The COPD readmission measure assesses hospitals' 30-day, all-cause risk-standardized rate of readmission for an acute exacerbation of COPD (AECOPD). The measure uses the same general approach to risk-adjustment and hierarchical logistic modeling (HLM) methodology that is specified for the AMI, HF, and PN readmission measures. This approach accounts for the types of patients a hospital treats (that is, hospital case-mix), the number of patients it treats, and the quality of care it provides. Details on the risk-adjustment statistical model can be found in the 2011 COPD Readmission Measure Methodology Report (note that the link provided in the preamble does not work and the document could not be otherwise located). The preamble also includes a summary of the measure methodology. For detailed information on the cohort definition, CMS refers readers to the 2013 COPD Readmission Measure Updates and Specifications Report, which also is available on the CMS Web site noted above. With respect to calculating the Excess Readmission Ratio for the COPD measure, CMS published a detailed description of how the readmission measures estimate the Excess Readmission Ratio used in the Hospital Readmissions Reduction Program in the FY 2013 IPPS final rule (77 FR 53380 through 53381).

The outcome for the COPD measure is 30-day, all-cause readmission, defined as an unplanned subsequent inpatient admission to any applicable acute care facility from any cause within 30 days of the date of discharge from the index hospitalization. The COPD readmissions measure assesses all-cause unplanned readmissions (excluding planned readmissions) rather than readmissions for acute exacerbations of COPD only. The measure does not count planned readmissions as readmissions. Planned readmissions are identified in claims data using the CMS Planned Readmission
Algorithm Version 2.1 that detects planned readmissions that may occur within 30 days of discharge from the hospital. NQF endorsed the measure (NQF #1891) in March 2013 (http://www.qualityforum.org/QPS/1891).

CMS proposes to adopt the COPD measure in the Hospital Readmissions Reduction Program beginning in FY 2015. It also is proposing the COPD measure for use in the Hospital IQR Program for FY 2014 (discussed in section IX below).

THA and TKA, though not identified in the MedPAC report, also satisfy the statutory criteria of conditions or procedures that are high volume or high expenditures in Medicare. Between 2008 and 2010, over 1.4 million THA and TKA procedures were performed on Medicare FFS patients aged 65 years and older. Combined, THA and TKA procedures account for the largest procedural cost in the Medicare budget. Evidence also shows variation in readmissions of patients with THA/TKA procedures, supporting CMS' finding that opportunities exist for improving care. The median 30-day risk-standardized readmission rate among Medicare FFS patients aged 65 or older undergoing THA/TKA procedures between 2008 and 2010 was 5.7 percent, and ranged from 3.2 percent to 9.9 percent across 3,497 hospitals. The proposed rule also states that including the THA/TKA measure in the Hospital Readmissions Reduction Program is consistent with CMS' priority objectives to promote

successful transitions of care for patients from the acute care inpatient setting to the outpatient setting, and reduces short-term readmission rates.

CMS finalized a hospital-level readmission measure for patients undergoing elective primary THA and/or TKA procedures for use in the Hospital IQR Program in the FY 2013 IPPS final rule (77 FR 53519 through 53521). The agency proposes to include this measure, updated with the CMS Planned Readmission Algorithm Version 2.1 adapted for THA/TKA and excluding transfers, in the Hospital Readmissions Reduction Program beginning in FY 2015. For details of the measure specifications, the preamble refers readers to the FY 2013 IPPS final rule (77 FR 53519 through 53521) as well as the 2013 Hip/Knee Readmission Measures Updates and Specifications Report, which is available on the CMS Web site at: http://www.qualitynet.org/dcs/ContentServer?cid=1219069855841&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page. NQF endorsed the measure (NQF #1551) in January 2012 (http://www/qualityforum.org/QPS/1551).

The proposed rule notes that the set of hospitals for which this measure is calculated for the Hospital Readmissions Reduction Program differs from the set of hospitals used in calculations for the Hospital IQR Program. The Hospital Readmissions Reduction Program includes only PPS hospitals and hospitals paid under section 1814(b)(3) of the Act (that is, Maryland hospitals), while the Hospital IQR Program calculations include non-IPPS hospitals such as CAHs, cancer hospitals, and hospitals in the Territories.

PPS Waiver Hospitals Paid under Section 1814(b)(3) of the Act.

The statute allows the Secretary to exempt Maryland waiver hospitals from the Hospital Readmissions Reduction Program, provided that the State submits an annual report to the Secretary describing how a similar program to reduce hospital readmissions in that State achieves or surpasses the measured results in terms of health outcomes and cost savings. The FY 2013 final rule provided that (1) CMS will not evaluate Maryland's Admission-Readmission Revenue Program (ARR) on measureable health outcomes and cost savings for the first year; (2) beginning in FY 2014, CMS will evaluate whether Maryland's readmissions program can demonstrate similar decreases in potential preventable readmissions and similar cost savings on an annual basis using criteria included in the final rule; (3) Maryland's report to the Secretary and request for exemption from the Hospital Readmissions Reduction Program must be resubmitted and reconsidered annually; and (4) for FY 2013, all acute care hospitals in Maryland paid under the waiver and that absent the waiver would have been paid under the IPPS are exempt from the Hospital Readmissions Reduction Program.

The FY 2014 proposed rule would expand and clarify the requirements for exemption as follows:

- Require that Maryland must submit a preliminary report to CMS no later than January 15 of each year to apply for an exemption for the upcoming federal fiscal year and must submit a final report by June 1.
- Evaluate Maryland's application based on whether, under the state's shared savings approach, it can achieve comparable health outcomes and cost savings to the Hospital

Readmissions Reduction Program. CMS projects that, for FY 2014, the Hospital Readmissions Reduction Program will result in a 0.2 percent decrease, or approximately $175 million, in payments to hospitals.[6]

- Define the "base operating DRG payment amount" for Maryland hospitals, similar to the definition applicable to other hospitals, as the amount equal to the average standardized amount adjusted for resource utilization by the applicable MS-DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index plus new technology payments that would be paid to Maryland hospitals absent section 1814(b)(3).
- "Price" claims submitted by Maryland hospitals under the IPPS payment methodology, and if a Maryland hospital has a readmissions payment adjustment factor, that factor would be applied to that base operating DRG payment amount to determine the payment adjustment.
- Apply the amount of the payment reduction, if any, to the payments made to Maryland hospitals under the waiver.
- If Maryland is not exempt from the Hospital Readmissions Reduction Program in a given year, calculate both the "aggregate payments for excess readmissions" and "aggregate payments for all discharges" (defined at § 412.152) for purposes of determining a hospital's readmission adjustment factor that accounts for excess readmissions under § 412.154(c) using the proposed definition of "base operating DRG payment amount" for Maryland hospitals noted above (that is, the base operating DRG payment amount calculated as if the hospital were paid under the IPPS), and not any payment amount made under the waiver under by section 1814(b)(3).

CMS invites public comments on these proposals.

For FY 2014, CMS has received and evaluated a preliminary report from Maryland describing its readmissions program. Based on this preliminary information, CMS believes that Maryland can achieve savings on readmissions that are tied to hospitals' performance on readmissions, which is comparable to the Hospital Readmissions Reduction Program applied throughout the rest of the country.

Proposed Floor Adjustment Factor for FY 2014 (§ 412.154(c)(2))

Section 1886(q)(3)(A) defines a hospital's readmissions "adjustment factor" for a fiscal year as equal to the greater of the adjustment factor determined based on the hospital's excess readmissions or the floor adjustment factor specified in subparagraph (C). For FY 2013, the floor adjustment factor so specified is 0.99. The proposed rule announces that the floor adjustment factor for FY 2014 will be 0.98. As finalized in the FY 2013 IPPS final rule, CMS

[6] In the FY 2013 IPPS final rule, CMS estimated that, under the Hospital Readmissions Reduction Program, for FY 2013, Medicare IPPS operating payments would decrease by approximately $300 million (or 0.3 percent) of total Medicare IPPS operating payments. Maryland indicated that, for FY 2013, it would achieve comparable savings by reducing the rate update factor for all hospitals by 0.3 percent, regardless of a hospital's performance on readmissions.

rounds the ratio to the fourth decimal place. Thus, for FY 2014, a hospital subject to the Hospital Readmissions Reduction Program would have an adjustment factor that is between 1.0 and 0.9800.

Proposed Applicable Period for FY 2014

In the FY 2013 IPPS final rule (77 FR 53390), CMS codified the definition of "applicable period" in the regulations at 42 CFR 412.152 as the 3-year period from which data are collected in order to calculate excess readmission ratios and adjustments for the fiscal year, which includes aggregate payments for excess readmissions and aggregate payments for all discharges used in the calculation of the payment adjustment.

CMS proposes that the applicable period for FY 2014 under the Hospital Readmissions Reduction Program would be the 3-year period from July 1, 2009, to June 30, 2012.

Proposed Refinements and Specifications of the Methodology to Calculate the Aggregate Payments for Excess Readmissions in FY 2014

For FY 2014, the proposed rule includes and invites comment on these provisions:

- Makes a technical change clarifying that the difference between the applicable hospital-specific payment rate and the federal payment rate for SCHs and MDHs is excluded from the base operating DRG amount for MDHs only for FY 2013 because the MDH program expires at the end of FY 2013.
- Defines the applicable period as July 1, 2009 through June 30, 2012 and proposes to use MedPAR claims with discharge dates that are on or after July 1, 2009, and no later than June 30, 2012. As specified in the FY 2013 IPPS final rule (77 FR 53387), CMS uses the update of the MedPAR file for each federal fiscal year, which is updated 6 months after the end of each federal fiscal year within the applicable period, as the data source (that is, the March updates of the respective federal fiscal year MedPAR files) for the readmissions adjustment determination for the final rule.[7]
- Identifies the admissions for each applicable condition, as was done for FY 2013, based on a list of specific ICD-9-CM codes for that condition. The codes are listed in tables included in the proposed rule (pp. 511-514 of the public display copy of the proposed rule) and also posted on the Web site that can be navigated as follows: http://www.QualityNet.org > Hospital-Inpatient > Claims-Based Measures >Readmission Measures > Measure Methodology. As suggested in public comments, index admissions that are not considered readmissions for the purpose of the readmissions measures, and thus are excluded from the calculation of the excess

[7] Thus, for FY 2014, CMS would use the March 2010 update of the FY 2009 MedPAR file to identify claims within FY 2009 with discharge dates that are on or after July 1, 2009; the March 2011 update of the FY 2010 MedPAR file to identify claims within FY 2010; the March 2012 update of the FY 2011 MedPAR file to identify claims within FY 2010; and the December 2012 update of the FY 2012 MedPAR file to identify claims within FY 2012 with discharge dates no later than June 30, 2012.

readmission ratio, would also not be considered admissions in determining a hospital's aggregate payments for excess readmissions.

- Excludes these admissions, which also were excluded in FY 2013, based on how they were identified in the MedPAR file except as noted below:
  (1) hospitalizations for patients discharged with an in-hospital death;
  (2) hospitalization for patients discharged against medical advice;
  (3) transfers;
  (4) hospitalizations for patients under 65;
  (5) hospitalizations for patients enrolled in Medicare Part C; and
  (6) same day discharges for AMI cases.
- Uses a slightly different methodology for some of the exclusions in FY 2014 than in FY 2013:
  (1) excludes admissions identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis for which the patient was transferred to another acute care hospital (that is, a CAH or an IPPS hospital), as identified through examination of contiguous stays in MedPAR at other hospitals. (In FY 2013, CMS identifies transfers based on discharge destination codes in the MedPAR file);
  (2) excludes admissions identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis for patients who are under the age of 65, as identified by linking the claim information to the information provided in the Medicare Enrollment Database. (In FY 2013, CMS uses claims in the MedPAR file to identify a patient's age); and
  (3) excludes claims paid for patients enrolled in Medicare Advantage as identified in the Enrollment Database, which is consistent with how admissions for Medicare Advantage patients are identified in the calculation of the excess readmission ratios. (In FY 2013, CMS had excluded admissions for Medicare Advantage patients based on whether the claim was identified as a Medicare Advantage claim in the MedPAR file or whether the FFS payment amount on the claim was for an IME payment only).
- Excludes additional admissions from the calculation of aggregate payments for excess readmissions so that the criteria used to identify the admissions excluded for this purpose would be the same as the criteria used to identify admissions for the purpose of calculating the excess readmission ratios. CMS proposes to link MedPAR claims data with the Medicare Enrollment Database to make these additional exclusions:
  (1) admissions for patients who did not have Medicare Parts A and B FFS enrollment in the 12 months prior to the index admission, based on the information provided in the Medicare Enrollment Database;
  (2) admissions for patients without at least 30 days post-discharge enrollment in Medicare Parts A and B FFS, based on the information provided in the Medicare Enrollment Database; and
  (3) all multiple admissions within 30 days of a prior index admission, as identified in the MedPAR file, consistent with how multiple admissions within 30 days of an index admission are excluded from the calculation of the excess readmission ratio.

H. Hospital Value-Based Purchasing (VBP) Program

1. Background

FY 2013 was the first year of payment adjustments under the Hospital VBP Program established by the ACA. Under the program, CMS calculates a VBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. A hospital's VBP incentive payment adjustment factor for a fiscal year combines a uniform contribution to the VBP incentive payment funding pool (a reduction to each hospital's base operating DRG payments), described next, and the hospital-specific incentive payment percentage that results from the hospital's TPS. A hospital's adjustment factor may be positive, negative or result in no change in the payment rate that would apply absent the VBP program.

The total amount available for value-based incentive payments for a fiscal year is specified in statute and estimated by the Secretary. For FY 2013, the available funding pool for value-based incentive payments equals 1.00 percent of the base-operating DRG payments to all participating hospitals, as estimated by the Secretary; the funding pool increases to 1.25 percent of base-operating DRG payments for FY 2014, 1.50 percent for FY 2015, 1.75 percent for FY 2016, and 2.0 percent for FY 2017 and successive fiscal years.

2. VBP in FY 2013

CMS published a final rule in April 2011 (76 FR 26490 through 26547) establishing the VBP program and setting the specific program requirements for FY 2013. That final rule adopted a measure set with 12 clinical process of care measures and 8 dimensions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and categorized them into two domains: a clinical process of care domain with the 12 measures and a patient experience of care domain with 8 dimensions from the HCAHPS survey. The performance period established for these measures began July 1, 2011 and continued through March 31, 2012. CMS assessed a hospital's achievement on each of these measures during the performance period, as well as its improvement during this period compared to its performance during a 3-quarter baseline period running from July 1, 2009 through March 31, 2010.

CMS calculated a FY 2013 TPS for each hospital by summing the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain, weighting each domain score, and adding together the weighted domain scores. For the FY 2013 Hospital VBP Program, the weights are 70 percent for clinical process of care and 30 percent for patient experience of care. CMS converted each hospital's TPS into a value-based incentive payment percentage using a linear exchange function.

3. VBP in FY 2014

In previous rulemaking CMS adopted 17 measures for the Hospital VBP Program for FY 2014. In addition to the 12 clinical process of care measures and the HCAHPS measure that were adopted for the FY 2013 program, measures for FY 2014 include 1 new clinical process of care measure (SCIP-Inf-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2) and 3 mortality outcome measures (Acute Myocardial Infarction (AMI) 30-Day Mortality Rate, Heart Failure (HF) 30-Day Mortality Rate, Pneumonia (PN) 30-Day Mortality Rate). Summary Table H below shows the VBP Program measures for several years, including FY 2014.

Based on the December 2012 update to the MedPAR file, CMS estimates that the 1.25 percent contribution required for the FY 2014 VBP program will total $1.1 billion. This amount will be updated for the final rule using the March 2013 MedPAR file update.

CMS has posted on its website a Table 16 which includes proxy hospital-specific value-based incentive payment adjustment factors for FY 2014. These proxy factors are calculated using each hospital's TPS from the FY 2013 VBP program. CMS will update the amounts and present them in a Table 16A when the final rule is published to reflect more recent MedPAR data, but the updated amounts will continue to reflect FY 2013 TPSs because hospitals will not have been given the opportunity to review and correct the FY 2014 value-based incentive payment adjustment factors until after the final rule is published. Once that review and correction process is complete, CMS will publish a Table 16B which will reflect the actual adjustment factors that will be used in calculating each hospital's FY 2014 payment. CMS expects to post Table 16B on its website in October 2013.

4. VBP Measures for FY 2015

In the FY 2013 IPPS/LTCH final rule, CMS adopted 19 measures for FY 2015 VBP Program. All but one of the measures adopted for FY 2014 are continued, and 3 new measures are added. The measure that is not continued from FY 2014 VBP Program measure set is SCIP-VTE-1, (Surgery patients with venous thromboembolism prophylaxis ordered). The new measures include two outcome measures: AHRQ PSI 90, a composite of eight patient safety and complication measures, and a measure of Central Line-Associated Blood Stream Infection (CLABSI), and a Medicare spending per beneficiary, which is included in a new efficiency domain. Summary Table H below shows the VBP Program measures for several years, including FY 2015.

5. VBP Measures Proposed for FY 2016

CMS proposes to modify the VBP measure set for the FY 2016 payment determination. Previously, all of the FY 2015 measures were adopted for FY 2016, except for CLABSI. In this rule, three measures are proposed for removal, the CLABSI measure is proposed for continuation, and 3 new measures are proposed for addition. Thus, a total of 19 measures are proposed for the FY 2016 VBP program.

- CMS proposes removal of AMI-8, Primary PCI received within 90 minutes of hospital arrival, because it meets the criteria for being "topped out", meaning that national measure data show indistinguishable performance at the 75th and 90th percentiles and a truncated coefficient of variation that is less than 0.10. CMS will continue to analyze data on whether other measures are topped out.
- Removal of PN-3b, Blood cultures performed in the emergency department prior to initial antibiotic received in hospital is proposed because this measure is no longer endorsed by the National Quality Forum (NQF). In review of this measure, an NQF work group concluded that there is insufficient evidence that performing blood cultures prior to initiating antibiotics leads to better outcomes, and significant issues with documentation of this measure were cited.
- Removal of HF-1, discharge planning is similarly proposed because NQF no longer endorses the measure; its review of the measure found insufficient evidence linking it to patient outcomes.
- Addition of IMM-2, Influenza Immunization, as a process of care measure. This is an NQF endorsed measure of whether patients age 6 months and older are screened for influenza immunization status and vaccinated prior to discharge if indicated. Hospitals began reporting this measure under the Hospital Inpatient Quality Reporting (IQR) program with January 1, 2012 discharges.
- Addition of Catheter Associated Urinary Tract Infection (CAUTI) as an outcomes measure. Data collection on this measure, which occurs through the CDC National Healthcare Safety Network (NHSN) began for the IQR program with January 1, 2012 discharges.
- Addition of Surgical Site Infection (SSI), another measure reported through the NHSN that began with January 1, 2012 discharges. Reporting on this measure is currently limited to colon and abdominal hysterectomy procedures. Data collection and public reporting on this measure are currently stratified by surgery site, and CMS proposes that the measure would be scored for VBP purposes as a weighted average of the strata. To have a score the hospital would have to meet the threshold for public display of performance data on this measure, which is that the hospital has at least one predicted infection during the reporting period. The performance standards for this measure would be calculated by equally weighting the measure's strata.
- The CLABSI measure, which is part of the FY 2015 VBP program measure set, is proposed for continuation in FY 2016. CMS did not automatically propose continuation of this measure last year because CDC was planning to submit a revised version of the measure for NQF endorsement that would involve a reliability adjustment. A reliability adjusted measure would better account for differences in patient case-mix, exposures to medical devices or procedures and unmeasured factors that cause variation in outcomes among hospitals. Although CMS will continue to monitor CDC activity on this measure, NQF has not yet endorsed a reliability-adjusted version of CLABSI, and CMS therefore proposes to continue the current CLABSI measure for FY 2016.

With the exception of the removal of the topped out measure AMI-8, CMS notes that each of the proposed deletions and additions are supported by the Measure Application Partnership

(MAP) in its February 2013 report. With respect to CLABSI and CAUTI, the MAP recommended adoption of the reliability- adjusted versions contingent on NQF endorsement, but recommended in each case that the most recent NQF-endorsed measure should be used.

6. Future Measures

CMS announces, and seeks comment on, its intention to propose adding two measures to the FY 2017 VBP program in next year's rulemaking. These are the measures of Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia and the *Clostridium difficile* standardized infection ratio measures that were added to the IQR program measure set for reporting events beginning January 1, 2013.

CMS discusses, and seeks comment on, the possible addition in future rulemaking of two measures to the VBP program efficiency domain. One potential measure would assess appropriateness of inpatient hospital servicers, and the other would consider specific physician services that occur during a hospital stay.

- A measure would be constructed to assess the rate and/or dollar amount of billing hospital inpatient services to Medicare Part B subsequent to the denial of a Part A inpatient hospital claim. CMS describes this as a measure of appropriateness of hospital inpatient services, and notes its recent proposal (78 FR 16632) to pay hospitals for what would have been allowable Part B services in cases where a claim for inpatient hospital services is denied after discharge because the stay was not reasonable or necessary.
- Addition of Medicare spending measures specific to physician services that occur during a hospital stay, such as radiology, anesthesiology and pathology services. CMS is interested in comments on how measures of inpatient physician services could be constructed.

SUMMARY TABLE H. VBP Program Quality Measures for FYs 2014 (Final), 2015 (Final), and 2016 (Proposed)				
Measure ID	**Measure Description**	**2014**	**2015**	**Proposed 2016**
Process of Care Measures				
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	X	X	X
IMM-2	Influenza Immunization			X
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	X	X	Remove
HF-1	Discharge Instructions	X	X	Remove
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	X	X	Remove
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	X	X	X
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	X	X	X

SUMMARY TABLE H. VBP Program Quality Measures for FYs 2014 (Final), 2015 (Final), and 2016 (Proposed)				
Measure ID	**Measure Description**	**2014**	**2015**	**Proposed 2016**
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	X	X	X
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	X	X	X
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	X	X	X
SCIP-Inf-9	Urinary Catheter Removal on Post-Operative Day 1 or 2	X	X	X
SCIP–Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	X	X	X
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	X	Removed	N/A
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	X	X	X
Patient Experience of Care Measures				
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)				
Communication with Nurses		X	X	X
Communication with Doctors		X	X	X
Responsiveness of Hospital Staff		X	X	X
Pain Management		X	X	X
Communication About Medicines		X	X	X
Cleanliness and Quietness of Hospital Environment		X	X	X
Discharge Information		X	X	X
Overall Rating of Hospital		X	X	X
Outcome Measures				
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	X	X	X
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	X	X	X
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	X	X	X
AHRQ PSI 90	Complication/patient safety for selected indicators (composite)		X	X
CLABSI	Central Line-Associated Blood Stream Infection		X	X
CAUTI	Catheter-Associated Urinary Tract Infection			X
SSI	Surgical Site Infection • Colon • Abdominal Hysterectomy			X
Efficiency Measures				
MSPB-1	Medicare spending per beneficiary		X	X

7. Baseline and Performance Periods

In this rule, CMS proposes to adopt a CY 2014 performance period and corresponding CY 2012 baseline period for three domains: clinical process of care, patient experience of care (HCAHPS), and efficiency (Medicare spending per beneficiary). CMS already adopted baseline and performance periods for FY 2016 mortality and AHRQ PSI measures in last year's rulemaking. The following table shows the performance periods for FY 2016; for reference the FY 2015 periods are shown as well. The proposed rule does not propose a performance period for the CLABSI measure for FY 2016, although this measure is proposed for inclusion. The previously adopted performance baseline and performance periods for this measure for FY 2015 are CY 2011 and February 1 through December 31, 2013, respectively.

Domain/Measures	Baseline Period	Performance Period
FY 2016 (Proposed)		
Clinical Process of Care	Jan. 1, 2012 – Dec. 31, 2012	Jan.1, 2014 – Dec. 31, 2014
Patient Experience of Care (HCAHPS)	Jan. 1, 2012 – Dec. 31, 2012	Jan.1, 2014 – Dec. 31, 2014
Efficiency (Medicare spending per beneficiary)	Jan. 1, 2012 – Dec. 31, 2012	Jan.1, 2014 – Dec. 31, 2014
Outcomes		
Mortality	Oct. 1, 2010 – June 30, 2011	Oct. 1, 2012 – June 30, 2014
AHRQ PSI	Oct. 15, 2010 – June 30, 2011	Oct. 15, 2012 – June 30, 2014
CLABSI	(no dates proposed)	(no dates proposed)
FY 2015 (Final)		
Clinical Process of Care	Jan. 1, 2011 – Dec. 31, 2011	Jan.1, 2013 – Dec. 31, 2013
Patient Experience of Care (HCAHPS)	Jan. 1, 2011 – Dec. 31, 2011	Jan.1, 2013 – Dec. 31, 2013
Efficiency (Medicare spending per beneficiary)	May 1, 2011 – Dec. 31, 2011	May 1, 2013 – Dec. 31, 2013
Outcomes		
Mortality	Oct. 1, 2010 – June 30, 2011	Oct. 1 2012 – June 30, 2013
AHRQ PSI	Oct. 15, 2010 – June 30, 2011	Oct. 15, 2012 – June 30, 2013
CLABSI	Jan. 1, 2011 – Dec. 31, 2011	Feb. 1, 2013 – Dec. 31, 2013

For the mortality and AHRQ measures, CMS further proposes the baseline and performance periods for FYs 2017 through 2019 shown in the next table. CMS notes that while the performance periods for the mortality measure would ultimately be 36 months, the AHRQ PSI 90 measure performance period would have a 24 month span, which it says is consistent with the AHRQ recommendation for public reporting on this measure.

Outcome Measure	Proposed Baseline Period	Proposed Performance Period
FY 2017		
Mortality	Oct. 1, 2010 – June 30, 2012	Oct. 1, 2013 – June 30, 2015
AHRQ PSI	Oct. 15, 2010 – June 30, 2012	Oct. 1, 2013 – June 30, 2015
FY 2018		
Mortality	Oct. 1, 2009– June 30, 2012	Oct. 1 2013 – June 30, 2016
AHRQ PSI	July 1, 2010 – June 30, 2012	July 1, 2014- June 30, 2016
FY 2019		
Mortality	July 1, 2009 – June 30, 2012	July 1, 2014- June 30, 2017
AHRQ PSI	July 1, 2010 – June 30, 2012	July 1, 2015- June 30, 2016

8. Performance Standards and Scoring Methodology

The proposed rule includes tables presenting CMS's achievement thresholds and benchmarks for the FY 2016 VBP program, which are not replicated in this summary. The amounts for the mortality and AHRQ measures were finalized in last year's rulemaking; the amounts for the other measures are proposed and will be recalculated for the final rule. Under the VBP scoring methodology, the achievement threshold is the median of all hospital performance during the baseline period and the benchmark is the arithmetic mean of the top decile of all hospitals' performance on the measure during the baseline period. CMS proposes to revise these definitions in the regulatory text to clarify that while these definitions apply to the majority of the VBP measures, they do not apply to the calculation of the threshold and benchmark amounts for the Medicare spending per beneficiary measure. This measure is a ratio of an individual hospital performance to the average, and the achievement threshold and benchmark are calculated after the performance period. CMS reports that for the period May 1, 2011 through December 31, 2011, the achievement threshold for this measure would have been a ratio of 0.99, corresponding to a standardized risk adjusted Medicare spending per beneficiary amount of $18,079. The benchmark ratio would have been 0.82, corresponding to $14,985 adjusted Medicare spending per beneficiary amount.

CMS further discusses its concerns about publishing specific numerical benchmark and performance values during rulemaking, and then subsequently discovering data or calculation errors that could hold hospitals to inaccurate performance standards. CMS understands that hospitals use the published values as targets and proposes to make a single correction to a given measure's performance standards for a fiscal year.

With respect to the VBP scoring methodology, CMS proposes no changes from the methods finalized for the FY 2015 VBP program.

9. Domain Weighting for FY 2016 and Reclassification for FY 2017

As shown in the following table, for FY 2016, CMS proposes to modify the domain weights used to calculate a hospital's total performance score so that clinical process of care measures would receive less weight (10% compared with 20% in FY 2015), HCAHPS would receive less weight (25% v. 30%), while more weight would be given to the outcomes (40% v 30%) and efficiency (25% v 20%) domains.

VBP Program Weighting (Fiscal Year)				
Domain	**2013**	**2014**	**2015**	**2016 (proposed)**
Clinical process of care	70%	45%	20%	10%
Patient experience of care	30%	30%	30%	25%
Outcomes		25%	30%	40%
Efficiency			20%	25%

CMS proposes to continue the current policy for calculating a hospital's performance score when it has scores for fewer than four domains. Beginning in FY 2015, a hospital must have scores for at least two domains in order to have a TPS under the VBP program. (For FYs 13 and 14, a hospital must have scores for all domains in order to receive a total performance score.) Under the proposed rule, a hospital with fewer than four domain scores would continue to have its scores reweighted proportionately to assure that the TPS for each hospital is based on 100 points.

CMS proposes to reclassify the VBP program domains and adjust the weighting for FY 2017. In last year's rulemaking, the proposal to align VBP domains with the National Quality Strategy (NQS) was not finalized in response to concerns of commenters that hospitals had no experience yet with the VBP program. CMS indicates that as a result of hospitals' practical experience with VBP to date and outreach to stakeholders, it believes it is appropriate to again propose reclassification of the domains.

In order to align with the NQS quality priorities, CMS specifically proposes the following VBP program domains and proposed weights for FY 2017. Comments are also sought on whether the case and measure minimums should be maintained if this new domain structure is adopted, or whether CMS should commission analysis of what minimums would be appropriate within the restructured domains.

Proposed FY 2017 Domain	**Proposed FY 2017 Weight**
Patient and Caregiver Centered Experience of Care/Care Coordination	25%
Clinical Care • Clinical Care- Outcomes • Clinical Care –Process	35% • 25% • 10%
Efficiency and Cost Reduction	25%
Safety	15%

As an alternative, if the current domains are maintained, CMS invites comments on domain weights for FY 2017 that are identical to those proposed for FY 2016, as shown in the previous table.

The proposed mapping of FY 2016 VBP program measures into the reclassified domains is show in the following table.

Measure ID	Name (Abbreviated)	Current Domain	Proposed FY 2017 NQS-Based Domain
AMI-7a	Fibrinolytic Therapy W/in 30 Min.	Clin. Process of Care	Clinical Care – Process
IMM-2	Influenza Immunization	Clin. Process of Care	Clinical Care – Process
PN-6	Initial Antibiotic Selection	Clin. Process of Care	Clinical Care – Process
SCIP-Inf-1	Prophylactic Antibiotic W/in 1 Hr.	Clin. Process of Care	Clinical Care – Process
SCIP-Inf-2	Prophylactic Antibiotic Selection	Clin. Process of Care	Clinical Care – Process
SCIP-Inf-3	Prophyl. Antibiotics Discontinued	Clin. Process of Care	Clinical Care – Process
SCIP-Inf-4	Cardiac Surg. Ptnt. Serum Glucose	Clin. Process of Care	Clinical Care – Process
SCIP-Inf-9	Urinary Catheter Removal	Clin. Process of Care	Clinical Care – Process
SCIP–Card-2	Surgery Patients -- Beta Blocker	Clin. Process of Care	Clinical Care – Process
SCIP-VTE-2	Surgery Appropriate VTE Proph.	Clin. Process of Care	Clinical Care – Process
HCAHPS	HCAHPS	Patient Experience of Care	Patient and Caregiver Centered Experience of Care/Care Coordination
MORT-30-AMI	AMI 30-Day Mortality Rate	Outcome	Clin. Care – Outcomes
MORT-30-HF	Heart Failure 30-Day Mortality	Outcome	Clin. Care – Outcomes
MORT-30-PN	Pneumonia 30-Day Mortality Rate	Outcome	Clin. Care – Outcomes
AHRQ PSI 90	Patient safety composite	Outcome	Safety
CLABSI	Central Line-Associated Blood Stream Infection	Outcome	Safety
CAUTI	Catheter-Associated Urinary Tract Infection	Outcome	Safety
SSI	Surgical Site Infection	Outcome	Safety
MSPB-1	Medicare spending per beneficiary	Efficiency	Efficiency and Cost Reduction

10. Disaster/Extraordinary Circumstances Waivers

CMS proposes a process by which a hospital may apply for a waiver from the VBP program due to a significant natural disaster or other extraordinary circumstances. Under existing IQR program policies, a hospital may request a waiver of one or more data submission deadlines in the event of extraordinary circumstances outside the hospital's control. CMS does not believe this process is sufficient with respect to the VBP program because there may be circumstances under which a hospital might continue to report data on VBP quality measures but the performance on the measures is negatively affected by the disaster and therefore the VBP payment adjustment is reduced.

To address this concern, CMS proposes that a hospital may apply for a waiver of all applicable quality measure data for a performance period and effectively be excluded from the VBP program for a fiscal year during which the hospital has experienced a natural disaster or

other extraordinary circumstances. The hospital would note on its IQR program extension/waiver request form that it also seeks a waiver from the VBP program for the fiscal year for which the performance data would be used to calculate the hospital's VBP score. Under current regulations, this application must be filed within 30 days after the occurrence of the disaster or extraordinary circumstance. CMS would notify hospitals of the decisions on the VBP and IQR waiver requests at the same time. CMS states that this process would be needed rarely, and it does not intend to allow hospitals to use this proposed waiver to seek exclusion form the VBP simply due to comparatively poor performance on quality measures.

11. Applicability of the VBP Program to Hospitals

The VBP program applies to all subsection (d) hospitals (i.e., IPPS hospitals), with some exclusions specified in the law with respect to a particular fiscal year: (1) a hospital that is subject to the Hospital IQR payment reduction under section 1886(b)(3)(B)(viii)(I) for the fiscal year; (2) a hospital for which, during the performance period for the fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients; and (3) a hospital for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for the fiscal year involved, or for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for the fiscal year.

CMS is proposing no changes in the minimum number of cases and measures required for a VBP total performance score from the FY 2015 amounts. Under those requirements are that a hospital must have a minimum of 10 cases for a clinical process of care measure score and scores on 4 measures for a clinical process of care domain score. For HCAHPS, a 100-completed survey minimum applies, and for the 30-day mortality measures a 25-case minimum applies for each measure and a minimum of 2 measures is required for an outcomes domain score. For the efficiency measure, a minimum of 25 cases is required for a score. As noted earlier, a hospital must have a score on at least 2 domains to have a total performance score.

Finally, CMS notes that hospitals in Maryland have applied for and been granted an exemption from the VBP program for FY 2014 based on the state's submission of a report describing how a similar state program achieves or surpasses the measured results in terms of patient health outcomes and cost savings under the VBP program.

12. CMS Impact Analysis

In Appendix A to the proposed rule, CMS presents a table showing estimated impacts of the FY 2014 VBP Program, by hospital characteristics. The analysis is based on the TPS that CMS calculated for each hospital for the FY 2013 VBP Program. As required by law, VBP Program payments overall would be budget neutral. CMS estimates that 44 percent of hospitals would have a change in base operating DRG payment amounts that is between -0.2 percent and +0.2 percent. The estimated effects shown in the Appendix table by hospital type all fall within that range, with the largest effects for high DSH hospitals (-0.19 percent) and small urban bed size (+.15 percent).

I. Proposed Implementation of Hospital-Acquired Condition (HAC) Reduction Program for FY 2015

CMS proposes a methodology for implementing section 3008 of the ACA, which requires the Secretary to implement a HAC payment adjustment beginning in FY 2015. The regulations would appear in proposed 42 CFR 412.170 and 412.172. In presenting background on his section, CMS reviews how various other policies address concerns regarding HACs, including the adjustment to the MS-DRG payment that is made when specified preventable HACs are present as a secondary diagnosis (discussed in section II.F. earlier in this summary), the National Coverage Decisions regarding never events issued in 2009, and the public reporting of data on certain HACs on the *Hospital Compare* website.

1. Background and Proposed Definitions

Under section 3008 of the ACA, the Secretary must make an adjustment to payments of "applicable hospitals" to account for HACs with respect to discharges occurring in FY 2015 and later. The payment adjustment will result in the applicable hospitals receiving 99 percent of the payment that would otherwise apply (i.e., a 1 percent payment reduction). The Secretary is required to provide applicable hospitals with confidential reports with respect to HACs for the "applicable period"; hospitals are to be given an opportunity to review and correct this information before it is made public on the *Hospital Compare* website. The statute provides that there may be no administrative or judicial review with respect to what qualifies as an applicable hospital, the specifications of a HAC, the determination of an applicable period, and what information is reported to hospitals and the public.

CMS proposes definitions for the terms "HAC", "applicable hospital" and "applicable time period" for purposes of the HAC Reduction Program created under section 3008. HAC would be defined as in section 3008, to include any condition described in section 1886(d)(4)(D)(iv), which refers to the HACs identified for the current MS-DRG payment adjustment, and any other condition determined appropriate by Secretary that an individual acquires during a stay in an applicable hospital.

As required by section 3008, "applicable hospital" would be defined as a subsection (d) hospital that, relative to the national average, is in the top quartile of all subsection (d) hospitals of HACs during the applicable period, as determined by the Secretary. CMS proposes to include Maryland hospitals that absent the state's Medicare payment waiver would be paid under the IPPS, although a process is proposed under which the Secretary could determine whether to exempt Maryland hospitals from the HAC Reduction Program. CMS reviews what a subsection (d) hospital is, noting that hospitals and units excluded from the IPPS are not included, nor are critical access hospitals or hospitals in Puerto Rico (or otherwise outside the 50 states). However, sole community hospitals are subsection (d) hospitals, and an Indian Health Service hospital that is enrolled as a Medicare provider and meets the definition of subsection (d) would be included as an applicable hospital.

The definition of "applicable time period" is proposed to be, with respect to a fiscal year, the two- year period specified by the Secretary from which data are collected in order to calculate a Total HAC Score for purposes of the HAC Reduction Program.

2. Payment Adjustment

The payment adjustment specified in section 3008, under which applicable hospitals would receive payment equal to 99 percent of the amount that would otherwise apply under the IPPS (or the Maryland payment waiver). The HAC Reduction Program adjustment must be applied after the adjustments made under the Hospital VBP Program and the Readmissions Reduction Program. (The proposed rule does not offer any numerical examples of this calculation.)

3. Measure Selection

CMS proposes to adopt eight measures for the FY 2015 HAC Payment Reduction Program grouped into two domains as shown in the following table. Proposed Domain 1 includes six Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures, which are claims-based measures calculated by AHRQ. Proposed Domain 2 includes two Centers for Disease Control and Prevention (CDC) healthcare associated infection (HAI) measures. Hospitals report on these measures through CDC's National Healthcare Safety Network (NHSN).

Additional CDC HAI measures are proposed for inclusion in the measure sets for FY 2016 and FY 2017, as noted in the table. While CMS believes that its proposed approach would be simpler to interpret, it seeks comment on an alternative Domain 1 in which instead of the proposed six AHRQ Patient Safety Indicators, the AHRQ measure PSI 90 would be used. AHRQ PSI 90 is a composite of eight component AHRQ PSI indicators. The eight components overlap partly but not completely with the proposed six measures. PSI 90 is included in the IQR program and is part of the VBP program measure set beginning with the FY 2015 payment determination.

Proposed Measures for the HAC Reduction Program			
	FY 2015	**FY 2016**	**FY 2017**
Domain 1: AHRQ Patient Safety Indicators*			
PSI-3 (Pressure ulcer rate)	X	X	X
PSI-5 (Foreign object left in body)	X	X	X
PSI-6 (Iatrogenic pneumothorax rate)	X	X	X
PSI-10 (Postoperative physiologic and metabolic derangement rate)	X	X	X
PSI-12 (Postoperative PE/DVT rate)	X	X	X
PSI-15 (Accidental puncture & laceration rate)	X	X	X
Domain 2: CDC HAI Measures			
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X
Surgical Site Infection (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X
Methicillin-resistant Staphylococcus aureus (MRSA)			X
Clostridium difficile			X
***** CMS seeks comment on an alternative Domain 1 measure set consisting solely of the AHRQ PSI-90 composite measure. PSI-90 is a composite of eight PSI measures: PSI-3, PSI-6, PSI-12, PSI-15 and PSI-7 (Central venous catheter related blood stream infections rate), PSI-8 (Postoperative hip fracture rate), PSI-13 (Postoperative sepsis rate) and PSI-14 (Wound dehiscence rate).			

The reason CMS offers for proposing two separate domains for the purpose of calculating a Total HAC Score is the many differences between the AHRQ and CDC HAI measures, summarized in the following table. CMS believes that because of these differences, the HAC scoring calculations need to begin with separate scoring on these two types of measures in order to provide for a more reliable scoring model.

AHRQ Measures (Proposed Domain 1)	CDC HAI Measures (Proposed Domain 2)
Medicare FFS claims data	Chart-abstracted data
Adverse events among Medicare discharges	Adverse events among all patients
Risk-adjusted and reliability adjusted for a 24-month period	Quarterly Standardized Infection Ratio
Adverse events across the facility	Adverse events at the unit level*
Risk adjusted at patient level	Risk adjusted at the hospital and patient-care unit level
*Currently, CAUTI and CLABSI are inclusive of intensive care unit patients only, although elsewhere in this rule, CMS proposes to expand these measure populations to include medical and surgical wards.	

CMS states that the statute (section 1886(p)) does not require that the HAC scoring methodologies be subject to notice and comment rulemaking, but that it has elected to do so in order for the public to understand the HAC Payment Reduction Program.

4. Proposed Applicable Time Period for FY 2015

The proposed applicable time period for collecting data to calculate the total HAC score for FY 2015 would be the 24-month period from July 1, 2011 through June 30, 2013 for the AHRQ measures and CYs 2012 and 2013 for the CDC HAI measures, which are collected and calculated on a quarterly basis. CMS notes that for the AHRQ measures, analysis by Mathematica Policy Research shows that 50 to 90 percent of hospitals attain a moderate or high level of reliability on the measures over a 24-month period. In addition, CMS states that the 24-month period would allow time to complete the complex calculations, perform comprehensive quality assurance to enhance the accuracy of results and disseminate the required confidential hospital-level reports prior to public reporting.

5. Measure Calculations

In order for a hospital to receive a score on an individual AHRQ PSI measure, CMS proposes that for the Domain 1 measures other than PSI-5 (foreign object left in body) the measure would be excluded from a hospital's score if the hospital had fewer than three eligible discharges in the denominator. PSI-5 would always be included in the hospital's score. CMS states that the three eligible discharge criteria is the approach taken with respect to whether the AHRQ PSI measures are calculated for a hospital in the IQR program. Also following the IQR program criteria, if the alternative Domain1 PSI-90 measure is used, CMS proposes that the national rate would be substituted for any PSI-90 component measure for which the hospital has few than three eligible discharges. However, if a hospital has fewer than three eligible discharges for all eight of the PSI-90 components, no score would be calculated for the composite measure.

Similarly, for the Domain 2 CDC HAI measures, CMS proposes to use the same inclusion criteria that apply for these measures under the hospital IQR program. For these measures, CDC calculates a standard infection rate (SIR) which compares the number of HAIs at a facility to a national baseline. The number of observed infections is divided by the number of expected infections, which is calculated using event rates from a standard population during a baseline period. (CMS provides the following link for more information on the SIR calculation: http://www.cdc.gov/HAI/surveillance/QA_stateSummary.html#a6)

6. Risk Adjustment

Section 3008 requires that the Secretary to establish and apply appropriate risk adjustment methodology when determining the hospitals subject to the 1 percent payment reduction. CMS proposes to use the existing measure-level risk adjustments for this purpose, noting that all the proposed measures are risk-adjusted and reliability-adjusted except for PSI-5, for which it argues risk adjustment is not needed because it is a "never event."

7. Performance Scoring

CMS proposes a scoring methodology similar to that used in the Hospital VBP Program. The methodology would first score each hospital on each individual measure, then sum the hospital's scores on each measure within a domain to calculate a score for the domain and then multiply each domain score by a weight to calculate the Total HAC Score. It is the Total HAC Score that would be used to identify which hospitals fall in the top quartile and therefore subject to the payment adjustment. (As described further below, the two proposed domains would be weighted equally in calculating the Total HAC Score.)

Under the proposed approach Domain 1 would include six measures, and because a hospital may not have complete data for each of these measures (meaning it may not have enough cases to calculate the risk-adjusted and reliability-adjusted rate for an AHRQ PSI), CMS proposes to use a similar methodology to the one used in the VBP program to determine which measures are included in the calculation of a hospital's score for Domain 1. Specifically, if the hospital has:

- fewer than 3 Domain 1 measures with complete data, no Domain 1 score would be calculated for the hospital*; or
- from 3 to 5 Domain 1 measures with complete data, the missing measures would be excluded from the calculation of a Domain score and the remaining measures with complete data would be weighted equally; or
- all 6 PSIs, the Domain 1 score would reflect all measures, weighted equally.

(*A table in the proposed rule indicates that no Total HAC Score would be calculated for a hospital with fewer than 3 Domain 1 measures. However, this conflicts with discussion elsewhere in the text indicating that the Domain 2 score would be used to determine the Total HAC Score.)

With respect to Domain 2 (the CDC HAI measures), calculation of an SIR for a measure requires that the facility have one or more predicted HAI events. The predicted HAI events are

calculated using the national HAI rate and observed number of specific HAIs. If an SIR cannot be calculated for at least one measure because the facility does not meet this threshold, Domain 1 scores alone will be used to calculate the hospital's Total HAC Score.

CMS proposes to make the measure scores more meaningful by assigning points to hospital performance on each measure. While the use of points is similar to the VBP program, CMS points out that in the case of the HAC score, having more points indicates a poorer performance, which is the opposite of VBP program scoring.

The points assigned to a measure would vary based on the specific measure construct, and are summarized in the following table. In the case of PSI-5 (foreign object left in the body), only two scores are possible. Any occurrence of this measure would result in a full 10 points, while no occurrence would result in zero points. (Again, zero points is the most desirable score.) For the five proposed PSI measures and the CDC measures which are all rates, hospitals with rates below the top quartile for the measure would receive zero points on that measure, while those in the top quartile would receive between 1 and 10 points. The assignment of points from 1 to 10 would be determined by taking all the hospitals in the top quartile and assigning them to deciles –increments of 10—with points assigned to each decile. For example, as shown in the table, a hospital in the eighth percentile for a measure (between the 70th and 80th percentile) would receive 8 points on the measure.

Proposed Scoring of Measures for HAC Reduction Program

Measure	Measure unit	Performance	Measure Score
PSI-5 (foreign object left in body)	Frequency count	No occurrence	0 points
		At least 1 occurrence	10 points
Other PSI measures and CDC HAI measures	Rates or Standard Infection Ratio	Within worst performing quartile	1-10 points*
		Not within worst performing quartile	0 points

*** Assignment of points by percentile within worst performing quartile:**

Percentile	Points
1st – 10th	1
11th – 20th	2
21st - 30th	3
31st - 40th	4
41st - 50th	5
51st - 60th	6
61st - 70th	7
71st - 80th	8
81 - 90th	9
91st - 100th	10

With respect to Domain 2, CMS proposes to use measure results that hospitals submitted to the CDC NHSN for the IQR program. Because the current measures capture HAIs in the ICU only, a hospital that participates in the IQR program but has no ICU beds can apply for an ICU waiver so that they are not penalized for not reporting on these measures. CMS reports

that 377 hospitals have an ICU waiver, or 10 percent of the 3,321 hospitals participating in the IQR program. A small number of IQR participating hospitals that do not have a waiver failed to report data on these measures (4 failed to report CLABSI and 8 failed to report CAUTI.)

CMS proposes that for those hospitals with an ICU waiver from reporting on the CDC HAI measures for the IQR program, the Total HAC Score will be calculated based entirely on the Domain 1 measures. CMS proposes that a hospital that is eligible to report HAIs, does not have a zero ICU beds waiver and fails to report to NHSN, would receive the maximum score of 10 points for Domain 2. The Total HAC Score for these hospitals would equal a 50-50 weighted average of the hospital's Domain 1 score and the 10-points given for Domain 2.

As noted earlier, if data are sufficient to calculate an SIR for at least one of the CDC HAI measures, a Domain 2 score will be calculated and the Total HAC Score will be a 50-50 weighted average of the Domain 1 and Domain 2 scores. If data are not sufficient to calculate an SIR, the Total HAC Score will be the Domain 1 score alone. If there are data sufficient to calculate a Domain 2 score but there are data for fewer than three Domain 1 measures, the Total HAC Score would equal the Domain 2 score. (As noted earlier, a table in the proposed rule indicates that in this case no Total HAC Score would be calculated.) No Total HAC Score would be calculated if a hospital had data for fewer than three Domain 1 measures and no measures in Domain 2.

CMS seeks comments on alternative scoring approaches in addition to its proposal that would identify hospitals in the top quartile for all the HACs combined. For example, instead of awarding points only to those hospitals in the top quartile on each measure, points could be awarded to all hospitals by deciles of measure performance. Or, points could be awarded by decile for all hospitals with scores that fall below the median for a measure.

8. Reporting of Hospital-Specific Information, Including Review and Correction of Information

In accordance with section 3008, CMS proposes to make information available to the public regarding the Total HAC Score of all subsection (d) hospitals (including hospitals in Maryland). Before the information is made public, CMS proposes to provide each hospital with a confidential hospital-specific report that contains certain information related to claims-based measure data for the PSI measures, the domain scores for each domain, and the Total HAC Score.

Hospitals would be given 30 days to review and correct the following information: the claims-based AHRQ PSI measures in Domain 1; the point allocations for the measures in each domain; the domain scores; and the Total HAC Score.

For the Domain 1 claims-based AHRQ PSI measures, CMS proposes that the data for calculating the scores would be extracted approximately 90 days after the last discharge data in the applicable period. (For FY 2015, CMS proposes that the applicable period span from July 1, 2011 through June 30, 2013.)

CMS would deliver confidential reports and accompanying discharge level information to hospitals' secure QualityNet accounts. In addition to the Domain 1 PSI measure rates, information provided would include dates of admission and discharge, discharge

characteristics, and other information relevant to the measure exclusions and calculations and calculation of the Total HAC Score.

The data correction process would permit hospitals to correct calculations of the Domain 1 PSI measures but would not permit them to submit corrections to underlying claims data or to submit additional claims, although CMS notes that hospitals have up to one year after the date of discharge to submit a claim. CMS argues that this is important in providing timely data that is useful for quality improvement purposes. Because it take several months to calculate measure rates and produce the confidential level files after the data set is extracted, CMS argues that if it delayed data extraction until one year after discharge, hospitals would receive calculations 18 to 24 months after the last discharge.

For the Domain 2 CDC HAI chart-abstracted measures proposed for inclusion in the FY 2015 HAC Reduction Program, CMS proposes that the hospital IQR program data review and correction process be used rather than creating a separate process for the HAC Reduction Program. Under the hospital IQR program, chart-abstracted data are submitted for a calendar quarter and hospitals have an opportunity to submit, review, and correct any chart-abstracted measure during the calendar quarter and for 4 ½ months following the end of the calendar quarter.

The 30-day review and corrections period would begin when the hospitals' confidential reports and accompanying discharge-level information are posted to their QualityNet accounts. During the review and correction period, hospitals would notify CMS of any errors in their Total HAC Score using the technical assistance contact information provided in their confidential reports. In addition, a hospital could notify CMS if it suspects that discrepancies exist in the application of the HAC scoring methodology (assignment of points to measures, domain scoring, domain weighting). If CMS confirms that it made an error in creating the data extract or in calculating the Total HAC Score, the calculations would be corrected and new confidential reports provided to affected subsection hospitals.

In the case of errors that take more time than anticipated to correct, CMS would notify hospitals that corrected HAC Scores will be made available through delivery of confidential reports followed by a second 30-day review and correction period, subsequent publication, and posting on Hospital Compare Web site. CMS also proposes that any corrections to a hospital's Total HAC Score would then be used to recalculate a hospital's quartile in order to determine the correct HAC Reduction Program adjustment factor.

9. Impact Analysis

The regulatory impact analysis presented in Appendix A of the proposed rule includes a discussion of the estimated effects of the proposed HAC Reduction Program for FY 2015. CMS used data for the period July 1, 2009 through June 30, 2011 to estimate a Total HAC Score for hospitals under the proposed rule and also for the alternative under which the Domain 1 score is based on the AHRQ PSI 90 composite measure. CMS calculated results for 3,435 hospitals. Domain 1 scores were calculated for all these hospitals under both the proposed and alternative measures. Domain 2 scores were calculated for about half the hospitals. For only 10 of the hospitals was the data insufficient to calculate a Total HAC Score.

The results are displayed in Appendix in three tables that show, by type of hospital, the number of hospitals in and out of the top quartile for 1) the estimated Domain 1 scores, 2) Domain 2 scores, and 3) Total HAC Score. A fourth final table shows the completeness of data for calculating each domain score.

The table shown below summarizes the results of CMS' analysis for the Total HAC Score, using the Domain 1 measures as proposed. (The Appendix A table is more detailed, including results by region and for the Domain 1 alternative measure.)

Large bed size, urban, and especially teaching hospitals stand out as disproportionately represented in the top quartile, the group that would be subject to the 1 percent payment reduction in FY 2015. More than half the teaching hospitals in the analysis are estimated to be in the top quartile. (If results did not vary by type of hospital, all groups would be expected to have about 25 percent of hospitals in the top quartile.) However, the analysis includes only 270 teaching hospitals – 8 percent of all the hospitals in the analysis. By contrast, teaching hospitals represent one-third (971) of the hospitals in the VBP Program impact analysis also presented in Appendix A. CMS does not offer an explanation for the low number of teaching hospitals in the HAC Reduction Program analysis.

CMS Analysis of Total HAC Scores under Proposed Rule, by type of hospital				
Hospital Type	Number of Hospitals In Analysis	Number of Hospitals in Worst Performing Quartile (Total = 858)	Percent of Hospital Type	Percent of Hospitals in Worst Performing Quartile
Urban	2461	731	29.7%	85.2%
Rural	964	127	13.2%	14.8%
Teaching	270	153	56.7%	17.8%
Nonteaching	3037	691	22.8%	80.5%
DSH	2641	713	27.0%	83.1%
Non-DSH	740	140	18.9%	16.3%
< 50 beds	656	47	7.2%	5.5%
50-99 beds	678	105	15.5%	12.2%
100-199 beds	884	237	26.8%	27.6%
200-299 beds	499	186	37.3%	21.7%
300-399 beds	263	105	39.9%	12.2%
400-499 beds	124	59	47.6%	6.9%
500 beds or more	203	105	51.7%	12.2%
For-profit	754	166	22.0%	19.3%
Government	558	136	24.4%	15.9%
Nonprofit	1995	542	27.2%	63.2%

J. Payment for Graduate Medical Education (GME) Costs

Proposed Inclusion of Labor and Delivery Days

In the FY 2013 IPPS/LTCH PPS final rule, CMS included labor and delivery patient days in the disproportionate patient percentage of the DSH payment adjustment for purposes of IME and DSH payment adjustments. CMS notes that some commenters observed that if these days are considered inpatient days, they should also be counted as patient days in allocating direct GME payments. CMS proposes that patient days associated with maternity patients admitted as inpatients who receive ancillary labor and delivery services when the inpatient routine census is taken shall be included in the Medicare utilization calculation. This applies regardless of whether the patient actually occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a maternity suite (i.e., where labor, delivery recovery, and postpartum care all occur in the same room).

Thus for cost reporting periods beginning on or after October 1, 2013, CMS would include Medicare labor and delivery inpatient days in the numerator and all labor and delivery inpatient days in the denominator of the Medicare utilization ratio; CMS understands this would likely reduce direct GME payments. CMS notes this proposal would also impact other Medicare policies where the number of patient days or a ratio of Medicare inpatient days to total inpatient days is used to determine eligibility or payment; however, it does not impact reasonable cost payments for routine inpatient services. CMS estimates this proposal saves $15 million for FY 2014.

Notice of Closure of Teaching Hospital; Opportunity to Apply for Available Slots

CMS uses the proposed rule to serve notice to the public of the closure on April 9, 2012, of a teaching hospital in Far Rockaway, NY (the Peninsula Hospital Center) as part of round 4 of the application and selection process under section 5506 of the ACA for the redistribution of residency cap slots. Hospitals that seek to apply for and receive slots from such teaching hospital must submit their applications to the CMS Central Office (not the relevant CMS Regional Office) no later than July 25, 2013. CMS must have actually received the applications by the due date; a postmark will not suffice. CMS encourages applicants to notify it by email (ACA5506application@cms.hhs.gov) indicating that a hard copy of the application has been mailed.

Payments for Residents Training in Approved Residency Programs at CAHs

CMS posits that the changes made by section 5504 of the ACA to the Act, as they relate to the counting of resident time in non-provider settings, require a change in its policy for payment of residency training occurring in a CAH. Before the ACA, CMS had determined that CAHs could be paid directly for those costs under their 101 percent reasonable cost reimbursement methodology or that hospitals may be paid for those costs insofar as the CAH was functioning as a nonhospital setting. One rationale for this treatment of a CAH as a nonhospital setting was due to the definition of hospital which indicates that, generally, a CAH is not a hospital.

After the ACA section 5504 changes, CMS now believes the relevant distinction is whether a CAH is a provider or non-provider. CMS notes that a CAH is included in the definition of the term "provider of services" under section 1861(u) of the Act; being a provider under that definition, CMS reasons a CAH may not be treated as a non-provider and therefor a hospital may not claim the time FTE residents are training at a CAH for purposes of IME, direct GME, or both. CAHs may however continue to be paid for the time FTE residents rotate to the CAH at the CAH reimbursement rate. CMS notes that the CAH may not include as allowable costs the portion of any training costs when the resident is not training at the CAH and its provider-based facilities. CMS does not believe there is any financial impact to the proposed policy.

Expiration of Inflation Update Freeze for High Per Resident Amounts

CMS notifies readers that the statutory freeze (imposed under the MMA) of the annual CPI-U updates to certain hospital-specific per resident amounts expires at the end of FY 2013. Thus, for cost reporting periods beginning on or after October 1, 2013, CMS will calculate and apply the full CPI-U update for all per resident amounts for purposes of direct GME payments.

K. Rural Community Hospital Demonstration Program

For the 23 hospitals participating in the budget neutral, rural community hospital demonstration program in FY 2014, CMS proposes to continue the 3-step methodology it adopted in the FY 2013 final rule to calculate the budget neutrality offset amount that is applied across aggregate IPPS payments. Under the proposal, CMS would calculate the budget neutrality offset amount by subtracting the sum of estimated aggregate amount of payments to all 23 hospitals participating in the demonstration program for covered inpatient hospital services, including the costs of swing bed services (if any), that would otherwise be made in the absence of the demonstration (calculated under Step 2 of the methodology) from the aggregate reasonable cost amount payments to all 23 hospitals for those services estimated to be made under the demonstration (calculated under Step 1 of the methodology).

Under the proposed methodology, CMS would:

1. Use hospital data for all participating hospitals from "as submitted" cost reports for the hospitals' cost reporting periods ending in CY 2011.
2. Update the estimated reasonable cost amounts for all 23 hospitals under the demonstration by the IPPS market basket percentage increases for FYs 2012 through 2014, multiplied by a 3-percent annual volume adjustment (Step 1).
3. Update the estimated payments that would otherwise be made to those 23 hospitals absent the demonstration by the applicable percentage increase for FYs 2012 through 2014, multiplied by a 3-percent annual volume adjustment (Step 2).

CMS estimates that the amount of the adjustment to the national IPPS rates during FY 2014 is $46,515,865, and notes that it would use updated data for the final rule if available. CMS also notes that if settled cost reports are available for all hospitals participating in FY 2007 through 2010 before the FY 2014 final rule, it would include in the budget neutrality offset for FY 2014 any additional amounts by which the final settled cost reports for one or more of those

fiscal years exceeded the budget neutrality offset amount for fiscal year involved. The estimate does not account for differences between the cost of the demonstration for participating in FYs 2007 through 2010 and the amounts that were offset by the budget neutrality adjustment for those years; this is because the numeric value for that component of the adjustment to the national IPPS rates was not known at the time of publication of the proposed rule.

L. Proposed Technical Change to the Regulations for Hospital Emergency Services under EMTALA

CMS proposes a technical change to the heading of the regulation at 42 CFR 489.24(f) from "Beneficiary hospital responsibilities" to "Recipient hospital responsibilities" to properly reflect that the duties under that section of the regulations relate to a hospital with specialized capabilities that receives an appropriate transfer of an EMTALA patient.

M. Hospital Services Furnished under Arrangements

In the FY 2012 IPPS/LTCH PPS final rule, CMS revised its policy under which a hospital may furnish services under arrangements stating that only therapeutic and diagnostic services may be furnished under arrangements. Routine services (bed and board, or nursing services and other related services) may not be provided under arrangements. CMS had delayed by one year the implementation date of its revised policy, effective for cost reporting periods beginning on or after October 1, 2013. CMS proposes a further delay of the implementation date to services furnished on or after January 1, 2015. CMS expects hospitals to be full compliance at that time. CMS believes the financial impact of the proposed additional delay would be negligible.

N. Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services

Related to concerns about increases in the length of time that Medicare beneficiaries spend as hospital outpatients receiving observation services, CMS proposes to clarify requirements for physician or other qualified practitioner orders of inpatient admissions which would apply to hospitals and CAHs for purposes of Part A payment by adding a new §412.3 to the regulations. A patient must be formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner who has admitting privileges at the hospital or CAH and who is responsible for the inpatient care of the patient at the hospital or CAH. The order must be present in the medical record and be supported by the physician admission and progress notes. The physician/qualified practitioner may not delegate the order to another individual who 1) is not responsible for the care of the patient; 2) is not State-authorized to admit patients; or 3) has not been granted admitting privileges applicable to the patient by the hospital's medical staff. CMS also notes that all orders must be authenticated promptly by the ordering practitioner or other practitioner responsible for the patient's care, and that verbal orders should be used infrequently.

CMS proposes changes to how Medicare review contractors (MAC, RAC, and CERT contractors) review inpatient hospital admissions for Part A payment; however, CMS does not propose any change to either coding review strategies for hospital claims or the practice of using clinicians to review practitioner documentation for procedures in complex medical reviews. CMS proposes to codify what it describes as a longstanding requirement that medical documentation must support the physician's order and certification. CMS underscores that no presumptive weight currently is assigned to an order or certification alone; rather the medical review determination of the order or certification is based on the documentation contained in the medical record.

CMS proposes to establish the following guidelines for when physicians should order an inpatient admission. It would create presumptions used in the medical necessity reviews of inpatient admissions based on how long the beneficiary spent, or was expected to spend, in the hospital as an inpatient. Medicare review contractors would be instructed to

1. presume that the inpatient admission is reasonable and necessary for a beneficiary who requires
    a. more than one Medicare utilization day (meaning an encounter that crosses 2 "midnights") in the hospital receiving medically necessary services; or
    b. a procedure specified as inpatient only under 42 CFR 419.22; and
2. presume generally that services spanning less than 2 "midnights" should have been provided on an outpatient basis, absent clear physician documentation in the medical record specifying the relevant factors that support the physician's order and expectation that the beneficiary required an inpatient level of care.

CMS proposes that the starting point for the time-based instruction is when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services will be provided, but it specifically solicits comments on calculating the length of stay. The physician would be required to clearly and completely document in the medical record the clinical factors supporting the admission and his or her expectation that the patient stay would cross 2 midnights, regardless of the actual length of stay, which may be shorter due to death or transfer of the patient. CMS identifies certain factors as potentially instructive or persuasive, such as patient history, comorbidities, severity of signs and symptoms, current medical needs, and risk of adverse events; CMS does not believe convenience to the beneficiary or family is a compelling factor unless it affects the beneficiary's health.

CMS also notes that medical review activities would focus on potential practices by providers to unduly delay care in order to meet the 2-midnight threshold or if reviewers suspect a provider is using the presumption to systematically game the system. CMS proposes to focus medical review efforts on inpatient admissions with lengths of stay less than or equal to 1 "midnight" which would not benefit from the presumption of medical necessity; however, it notes that if the medical record reflects complex medical factors (described above), Part A payment for the admission may still be made.

CMS proposes a rare exercise of its general authority to provide for exceptions and adjustments to IPPS payments under section 1886(d)(5)(I)(i) of the Act to offset the estimated additional costs of the proposed new admissions policies ($220 million) in FY 2014. CMS

proposes to reduce the national standardized amount, the Puerto Rico-specific standardized amount, and the hospital-specific rates by 0.2 percent.

VI. Proposed Changes to the IPPS for Capital-Related Costs

Capital Standard Rate for FY 2014. CMS proposes an update factor to the capital federal rate for FY 2014 equal to 0.9 percent based on the capital input price index (CIPI) of 1.2 percent, adjusted for FY 2012 forecast error and other factors as detailed in the table below.

Proposed CMS FY 2014 Update Factor to the Capital Federal Rate

Capital Input Price Index*	1.2
Intensity:	0
Case-Mix Adjustment Factors:	
Real Across DRG Change	-0.5
Projected Case-Mix Change	0.5
Subtotal	1.2
Effect of FY 2012 Reclassification and Recalibration	0
Forecast Error Correction**	-0.3
Total Update	0.9

*The capital input price index is based on the proposed revised and rebased FY 2010-based CIPI described in section IV.D. above.
** Current historical data indicate that the forecasted FY 2012 rate-of-increase of the FY 2006-based CIPI (1.5 percent) used in calculating the FY 2012 update factor slightly overstated the actual realized FY 2012 price increases of the FY 2006-based CIPI (1.2 percent) by 0.3 percentage point because the prices associated with both the depreciation and interest cost categories grew more slowly than anticipated.

CMS proposes to reduce the capital federal rate by 0.2 percentage points to offset the estimated additional IPPS expenditures projected to result from the proposed policy on admission and medical review criteria for hospital inpatient services. This is the same as the adjustment proposed to apply to the operating rates, which is discussed in section V.N. above.

The proposed FY 2014 budget neutrality adjustment factor that is applied to the proposed capital Federal rate for proposed changes in the MS-DRG classifications and relative weights and proposed changes in the GAFs is 0.9988. The proposed FY 2014 outlier adjustment factor is 0.9451.

Consistent with its decision not to propose a prospective documentation and coding adjustment to the FY 2014 operating rates to reflect coding changes which occurred in FY 2010, CMS does not propose an adjustment to the capital federal rate. As discussed in section II.D. above, the proposed rule indicates that the prospective adjustment would be -0.55 percent if it were to make one. The proposed rule also notes that if, in response to public comments, the agency decides to reduce the recoupment adjustment to the operating rates and apply a prospective adjustment, it would apply the same prospective adjustment to the capital

federal rate. The proposed rule also notes that the recoupment adjustment applies only to the operating rate.

Considering all adjustments, CMS proposes a national capital federal rate for FY 2014 of $432.03, representing a 1.54 percent increase over the FY 2013 rate of $425.49, as shown in the table below:

Comparison of Factors and Adjustments:
FY 2013 Capital Federal Rate and Proposed FY 2014 Capital Federal Rate

	Final FY 2013	**Proposed FY 2014**	**Change**	**Percent Change**
Update Factor[1]	1.012	1.009	1.009	0.9
GAF/DRG Adjustment Factor[1]	0.9998	0.9988	0.9988	-0.12
Outlier Adjustment Factor[2]	0.9362	0.9451	1.0095	0.95
Adjustment for admission and medical review criteria[3]	N/A	0.998	0.998	-0.2
Capital Federal Rate	$425.49	$432.03	1.0154	1.54

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2013 to FY 2014 resulting from the application of the proposed 0.9988 GAF/DRG budget neutrality adjustment factor for FY 2014 is a net change of 0.9988 (or -0.12 percent).
[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the proposed FY 2014 outlier adjustment factor is 0.9451/0.9362, or 1.0095 (or 0.95 percent).
[3] The proposed adjustment to account for the estimated additional IPPS expenditures that are projected to result from the policy proposal on admission and medical review criteria for hospital inpatient services under Medicare Part A (discussed in section V.N. above).

For Puerto Rico hospitals, the proposed FY 2014 special capital rate is $212.50 compared to the final FY 2013 special capital rate of $207.25.

Exception Payments. The regulations continue the provision under which a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control.

New Hospitals. Medicare defines a "new hospital" as a hospital that has operated for less than 2 years. CMS notes that a new hospital beginning on or after October 1, 2002 is paid 85% of its Medicare allowable capital-related reasonable costs through the first 2 years of operation unless the new hospital elects to receive full prospective payment based on 100 percent of the federal rate.

VII. Proposed Changes to the IPPS for Hospitals Excluded from the IPPS

A. Proposed Changes for Hospitals Excluded from the IPPS

CMS proposes a 2.5 rate-of-increase percentage to the target amount for cancer hospitals, children's hospitals, and religious nonmedical health care institutions (RNHCIs), unless more recent data is available for the final rule. As noted earlier, CMS proposes to revise and rebase the IPPS operating market basket to a FY 2010 base year. CMS proposes to use the percentage increase in the IPPS operating market basket because the number of cancer hospitals, children's hospitals, and RNHCIs is too small and cost report data too limited to create a market basket for them. These hospitals and institutions are not subject to the ACA-mandated percentage point reductions for the MFP or the statutory 0.3 percentage point reduction applicable to IPPS hospitals for FY 2014. CMS notes that the annual updates for IRF PPS and IPF PPS are issued separately.

B. Proposed Changes to Conditions of Participation (CoPs) for CAHs Relating to Payment for Inpatient Services

CMS proposes to revise its regulatory requirements for CAHs to specify that CAHs must, as a condition of participation, furnish inpatient services. Noting that roughly 99 percent of CAHs already furnish inpatient services, CMS believes the cost to implement this proposal would be minimal and that most CAHs will welcome this proposal, which CMS describes as a clarification. CMS notes that CAHs were established in large part to afford critically needed access to acute care inpatient services for those beneficiaries who reside in rural areas. CMS also proposes a technical change to eliminate the effective date for the increased acute care inpatient bed limit made under the MMA.

VIII. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2014

CMS proposes updates for LTCHs using a process generally consistent with prior regulatory policy, including changes finalized in last year's rulemaking for FY 2013. CMS proposes several changes for FY 2014:

- Implementation of the 2 percent withhold for LTCHs not reporting quality data (see section IX of the summary for information on the quality reporting);
- Expiration of the moratorium on full implementation of the "25 percent threshold" payment adjustment.

Finally, **CMS sets out, for comment, an extensive review of research and policy development on a potential change to a patient-criteria based payment adjustment that it is considering for FY 2015, focusing LTCH care and higher payment on a selected group of chronically critically ill and medically complex (CCI/MC) patients.**

Summary of Changes to LTCH PPS for FY 2014*	
Standard Federal Rate, FY 2013	$40,397.96
Proposed update factors	
Market basket change	+2.5%
Multi-factor productivity adjustment	-0.4%
Additional adjustment required by statute	-0.3%
Penalty for hospitals not reporting quality data	-2.0%
Net update, hospitals reporting quality data	+1.8% (1.018)
Net update for hospitals not reporting quality data	-0.2% (0.9980)
Proposed Adjustments	
2nd year proposed of 3-year phase-in of on-time budget-neutrality adjustment for base year estimates that started for discharges on or after 12/29/2012 (adjustment of 0.98734 per year for three years)	0.98734
Average wage index budget neutrality adjustment	1.000433
Proposed Standard Federal Rate, FY2014	
LTCHs reporting quality data ($40,397.96∗1.018∗0.98734∗1.000433)	$40,622.06
LTCHs not reporting quality data ($40,397.96∗0.998∗0.98734∗1.000433)	$39,823.99
Estimated percent change in payments per discharge*	
All LTCH providers (423 LTCH providers)	+1.1%
Rural (27 LTCH providers)	+0.7%
Urban (396 LTCH providers)	+1.1%
Voluntary (78 LTCH providers)	+1.5%
Proprietary (327 LTCH providers)	+1.1%
Government (18 LTCH providers)	+0.9%
*More detail is available in Table IV of "L. Effects of Proposed Payment Rate Changes and Policy Changes to LTCH PPS Payments for 2014". Estimated effects of payment rate and policy changes only, not estimated changes in use; does not include $190 million in estimated savings from the expiration of the moratorium on the 25% rule.	

Proposed Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2014

Patient Classification into MS-LTC-DRGs

CMS continues to use the same Medicare Severity Diagnosis-Related Groups (MS-DRG) classification system used for the IPPS payments for the LTCH PPS (MS-LTC-DRG). As noted elsewhere in this summary, CMS is not proposing to add or delete any MS-DRGs for FY 2014, retaining the 751 that were in place for FY 2012 and 2013. The other updates to the MS-DRG system described elsewhere in this summary would be reflected in the MS-LTC-DRG system since it is the same classification system.

Volume-related adjustments

CMS proposes to continue to account for low-volume MS-LTC-DRG cases in updating the MS-LTC-DRG relative weights as follows:

- If a proposed MS-LTC-DRG has at least 25 cases, it is assigned its own proposed relative weight (there are 234 such MS-LTC-DRGs).
- If a proposed MS-LTC-DRG has 1-24 cases, it is assigned to one of five quintiles (56 MS-LTC-DRGs in each quintile) based on average charges (CMS finds that there are 280 such MS-LTC-DRGs). CMS then determines a proposed relative weight and average length of stay of the MS-LTC-DRGs in the quintile and applies those weights to each MS-LTC-DRGs assigned to the quintile. (See Table 13A at the Table link provided below for these low-volume MS-LTC-DRGs.)
- If a proposed MS-LTC-DRG has zero cases (CMS finds that there are 236 such MS-LTC-DRGs), it is cross-walked to another proposed MS-LTC-DRG based on clinical similarities in intensity of use and costliness of resources, in order to assign an appropriate proposed relative weight. If the MS-LTC-DRG that is similar is a low-volume DRG that has been assigned to one of the five quintiles noted above, then the zero volume MS-LTC-DRG would be assigned to that same quintile. CMS further notes that it will assign a 0.0 relative weight for eight transplant MS-LTC-DRGs because Medicare coverage policy covers these procedures only in a certified hospital, and no LTCH has been so certified. (See Table 13B at the Table link provided below for these zero-volume MS-LTC-DRGs.)

Determining relative weights in the MS-LTC-DRGs

In computing the relative weights, CMS proposes to continue its prior policy to exclude data on 14 all-inclusive rate providers, 2 LTCHs that are paid in demonstration projects, and all Medicare Advantage claims.

CMS proposes to continue two long-standing policies for setting the relative weights of the MS-LTC-DRGs in a manner different from the IPPS.

- CMS proposes to continue to calculate the relative weights based on LTCH facilities alone (rather than using the IPPS relative weights) to reflect the different resource use and costs of such patients compared with the broader IPPS system.
- CMS proposes to continue to set the relative weights based on a hospital-specific relative-value (HSRV) methodology, because CMS finds that LTC facilities often specialize in certain services that have the potential to distort charge differences among facilities.

CMS proposes to continue its policy of calculating the relative weights by first removing statistical outliers (charges and length of stay outside of 3.0 standard deviations from the mean) and cases with a length of stay of 7 days or less.

CMS proposes to continue to adjust for the effect of short-stay outlier (SSO) cases (cases with a length of stay of five-sixths or less of the average for that MS-LTC-DRG) by counting an

SSO as a fraction of a discharge based on the ratio of the length of stay of the SSO case to the average length of stay for the MS-LTC-DRG for non-SSO cases.

CMS proposes to continue to adjust in cases where it finds that relative weights within an MS-LTC-DRG decrease as severity increases within the DRG (a "nonmonotonic" relative weight). CMS proposes, in such cases, to combine severity levels within such a base MS-LTC-DRG for purposes of computing a proposed relative weight to assure that monotonicity is maintained.

Budget Neutrality Factor

Consistent with prior policy, CMS proposes a two-step budget neutrality adjuster for the annual update to the MS-LTC-DRG classifications and relative weights. That adjuster first includes a normalization adjustment (proposed at 1.11546) that CMS applies to the recalculated relative weights to ensure that the recalibration does not change the average case mix index. CMS then proposes a budget neutrality adjustment of 0.9953277.

Proposed Changes to the LTCH Payment Rates for FY 2014 and Other Proposed Changes to the LTCH PPS for FY 2014

Proposed Annual Market Basket Update

Using the LTCH-specific market basket first finalized for FY 2013, CMS projects a market basket update of 2.5 percent based on the IHS Global Insight first quarter 2013 forecast (this is the same firm that forecasts components of other market baskets for CMS). CMS notes that, consistent with current policy, if more recent data become available it would use such data for the FY 2014 update in the final rule.

CMS proposes a full market basket update of 2.50 percent, with several adjustments.

- CMS proposes a 0.4 percent decrease for the multi-factor productivity adjustment called for under the ACA.
- CMS proposes to subtract the additional adjustment of 0.3 percentage point called for under sections 1886(m)(3)(A)(ii) and 1866(m)(4)(C).

That yields a proposed update of 1.8 percent for FY 2014.

Proposed adjustment for LTCHs not reporting quality data

CMS proposes implementation of the 2 percentage point reduction for LTCHs not reporting required quality data (see section IX).

- Hospitals reporting the required quality data would receive the 1.8 percent update noted above;
- Hospitals not reporting the required quality data would receive a -0.2 percent update (1.8 percent minus 2.0 percent).

CMS indicates that it has no estimate of the number of LTCHs that will not be able to report the quality data.

Area wage levels and wage index

On February 28, 2013, the Office of Management and Budget (OMB) announced in OMB Bulletin No. 13-01 (www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf) revisions to its delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, based on the 2010 Census data and standards it had announced in 2010. CMS notes that by the time these changes were issued, the FY 2014 IPPS/LTCH PPS was in the advanced stages of development. To allow time to assess the changes, consistent with its proposal for the IPPS discussed in section III of this summary, CMS intends to propose adoptions of the newest designations and resulting changes in the wage index for FY 2015 notice and comment rulemaking. For FY 2014, CMS proposes to continue to use the same labor market areas that were used for the LTCH PPS for FY 2013.

CMS sets out a proposed labor-related share of 62.717 percent based on the most recent IHS Global Insight first quarter 2013 projection for the LTCH-specific market basket that was established for FY 2013 for purposes of applying the area wage index. The components of the labor-related share are as follows:

Proposed FY 2014 Relative Importance Labor-Related Share	
Wages and Salaries	45.130
Employee Benefits	8.134
Professional Fees: Labor-Related	2.214
Administrative and Business Support Services	0.502
All Other: Labor-Related Services	2.515
Subtotal	58.495
Labor-Related Portion of Capital Costs (46%)	4.222
Total Labor-Related Share	**62.717**

CMS proposes to compute the wage index in a manner consistent with prior years. Further, CMS proposes a budget neutrality adjustment, computed as in prior years, of 1.000433 for FY 2014.

Proposed Second Year of the One-Time Prospective Adjustment to the Standard Federal Rate

In the August 2002 Final Rule, CMS set LTCH PPS rates to achieve budget neutrality for FY 2003 with the prior TEFRA-based system, and also stated its intent to provide for a prospective, one-time adjustment if future data indicated that the original budget neutrality calculation for payments in FY 2003 yielded rates that were too high or too low. The original deadline for that adjustment was extended, and subsequently the Congress set and then extended a moratorium on implementing the adjustment. The moratorium expired on December 28, 2012.

CMS found that the initial budget neutrality adjustment built into the FY 2003 payment rates was not adequate, and determined that it would need to apply an adjustment factor of 0.9625 (a reduction of about 3.75 percent) to payments in FY 2013 to assure that the original miscalculation is not retained in future payment rates.

Given the magnitude of the adjustment required, CMS, in its final rule for FY 2013, decided to implement this adjustment over a three year period by applying a factor of 0.98734 for each of three years (0.98734*0.98734*0.98734 = 0.9625). It applied a factor of 0.98734 for FY 2013, (a reduction of about 1.3 percent) for discharges occurring on or after December 29, 2012, and proposes the second year of that adjustment (another 0.98734 adjustment) for FY 2014, with a final adjustment of 0.98734 assumed for FY 2015.

Proposed Adjustment for High Cost Outlier (HCO) Cases

CMS proposes to continue payments for high cost outlier (HCO) cases if the estimated cost of a case exceeds a threshold amount, which is the adjusted LTCH PPS payment for the MS-LTC-DRG plus a fixed-loss amount. In such cases, CMS makes a payment that is 80 percent of the difference between the estimated cost of the case and that threshold amount.

CMS proposes to continue to compute the fixed-loss amount so that projected outlier payments are 8 percent of projected total LTCH PPS payments. CMS proposes a fixed loss amount of $14,139 for FY 2014. CMS notes that it is lower than the $15,408 fixed loss amount for FY 2013 in order to maintain the existing requirement that estimated outlier payments equal 8 percent of total LTCH PPS payments.

CMS proposes to continue to calculate the estimated cost of the case by multiplying the Medicare allowable covered charge by the hospital's overall cost-to-charge ratio (CCR). The CCR methodology is also used in determining payments for SSO cases. In general, CMS uses the hospital's CCR, but if the hospital's CCR is in excess of a CCR ceiling, CMS uses the statewide average CCR instead. For FY 2014, CMS proposes a CCR ceiling of 1.259. The statewide average is also used if CMS is unable to determine a CCR for a hospital (for example, new LTCHs, hospitals with missing or faulty data.). CMS proposes in Table 8C (see Table link provided below) the statewide average CCRs for urban and rural hospitals for FY 2014.

Proposed COLA Updates for Alaska and Hawaii

CMS proposes to implement in FY 2014, with updates every four years, updated cost-of-living adjustments (COLAs) for LTCHs in Alaska and Hawaii based on a comparison of the growth in the CPIs for Anchorage, Alaska and Honolulu, Hawaii with the growth in the CPI for the average U.S. city. The proposed approach would continue to use the statutorily mandated cap of 25 percent on the adjustments.

Proposed Cost-of-Living Adjustment Factors for Alaska and Hawaii Hospitals for the LTCH PPS for FY 2014	
Alaska	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Proposed expiration of moratorium on the 25 Percent Payment Adjustment Threshold

CMS extended the moratorium on full implementation of the 25 percent payment adjustment threshold for FY 2013, but proposes allowing that moratorium to expire for FY 2014 (for cost reporting periods beginning on or after October 1, 2013). In brief, the previously finalized regulatory policy would, with some exceptions, adjust payments if more than 25 percent of the discharges from an LTCH that is either a "hospital within a hospital" or a satellite that is co-located with a host hospital are admitted from that host hospital. Payment for discharges in excess of that 25 percent threshold would be the lesser of the payment for the MS-LTC-DRG or the amount that Medicare would have paid under the IPPS. CMS notes that the threshold was put in place because research revealed a strong correlation between growing numbers of discharges from IPPS hospitals, after short-stays, to onsite or neighboring LTCHs, yielding costs to Medicare.

CMS estimates that implementation of this adjustment will save $190 million in FY 2014.

Research on the development of a patient criteria-based payment adjustment

CMS notes an extensive history of research and policy development for patient and/or facility level criteria for treatment of medically appropriate patients in LTCHs, starting with MedPAC recommendations for the development of such criteria in its June 2004 Report. In its FY 2013 IPS/LTCH proposed rule, CMS noted that research projects underway could result in revisions to payment policies that could render the 25 percent threshold policy unnecessary.

CMS reviews the history of MedPAC reports and CMS-sponsored research, some of which is still underway by Kennel and Associates and its subcontractor, RTI. **CMS emphasizes that it is not proposing new payment policy at this time, but is interested in receiving feedback on the findings of the studies and on the potential impact of its framework on hospital markets, with the expectation of formulating a proposal for a patient-criteria based payment adjustment for FY 2015.**

CMS reviews the research and growth in the LTCH field. CMS believes that the preliminary findings suggest that certain types of patients – those who are chronically, critically ill (CCI) and considered medically complex (MC) - are more appropriate candidates for high-cost

treatment at a LTCH. CMS believes that the research is identifying specific factors that can be used to identify the CCI/MC patient population, and that research can be used to provide a definition for the core group of patients appropriate for treatment at LTCHs and payment under the LTCH PPS. CMS believes that the non-CCI/MC patients may not receive cost-effective care at an LTCH.

Specifically, CMS notes that the research suggests that a patient would be identified as a CCI/MC patient based on having one or more of the five clinical factors listed below, combined with a stay of 8 or more days in an ICU/CCU at an IPPS hospital. CMS suggests that the CCI/MC definition could be used to identify patients as they are discharged from an IPPS hospital and transferred to a LTCH. The five CCI/MC status clinical factors are:

- Prolonged Mechanical Ventilation (PMV)
- Tracheotomy
- Multiple Organ Failure/Stroke/Intercerebral Hemmorrhage/TBI
- Sepsis and Other Severe Infections
- Severe Wounds

CMS describes this patient population as having intensive service needs, high costs, and negative margins at IPPS hospitals. These patients typically have a predictable and consistent need for extended hospital-level care that can be met either from continued stays in the IPPS hospital in a step-down unit after ICU or CCU treatment, or through transfer to a LTCH. CMS data indicate that LTCHs are already revising practices by admitting more critically ill patients.

CMS describes a potential framework for payment under which a full LTCH-PPS payment could be made for patients meeting this CCI/MC definition, and an "IPPS comparable amount" could be paid for patients not meeting these criteria.

Again, CMS is not formally proposing policy changes for FY 2014, but is soliciting comments on this important potential change to LTCH policy, including comments on whether it would obviate the need for the 25 percent threshold policy. CMS notes that it will post final reports on the RTI follow-up research as soon as it is completed.

Tables

The complete set of tables providing detail on the proposed LTCH PPS for FY 2014 is at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1599-P.html?DLPage=4&DLSort=0&DLSortDir=ascending.

The information at that link provides:

- Table 11: Proposed MS-LTC-DRGs, relative weights, geometric average length of stay, SSO threshold, and IPPS comparable threshold for FY 2014.
- Tables 12A and 12B: Proposed LTCH PPS wage index for urban (Table 12A) and rural (Table 12B) areas for FY 2014

- Table 13A: Composition of proposed low-volume quintiles for MS-LTC-DRGs for FY 2014
- Table 13B: Proposed no volume MS-LTC-DRG crosswalk for FY 2014
- Table 8C: Proposed statewide average cost-to-charge ratios (CCRs) for LTCHs (Urban and Rural)
- LTCH PPS FY 2014 hospital-specific proposed rule data

IX. Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers

In this section of the proposed rule, CMS sets forth proposed changes to quality reporting programs for inpatient hospital stays, PPS-exempt cancer hospitals, long-term care hospitals, and inpatient psychiatric facilities.

A. Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes a number of changes to the IQR Program, including proposed removals and additions to the measure set, voluntary electronic reporting of certain measures, and modifications to the validation process. An IPPS hospital that chooses not to participate in the IQR program or one that fails to meet the requirements of the program for a fiscal year will receive an update factor reduction of 2.0 percentage points; CMS reports in the impact analysis presented in Appendix A to the proposed rule that for FY 2013, 66 hospitals did not receive the full update factor. CMS also estimates that this number may increase to 200 due to increased reporting requirements for new measure topics.

1. Proposed Public Display of Quality Measures

CMS proposes to continue its policy of publicly reporting data from the Hospital IQR Program as soon as it is feasible on the *Hospital Compare* or *Medicare.gov* websites.

CMS specifically discusses public reporting regarding the AHRQ public safety indicators, in particular PSI-90, which is a composite measure of eight individual indicators. Based on feedback from consumer advocates and large purchasers, CMS proposes to make publicly available hospital level data for the individual indicators as well as the composite. According to CMS, data on the individual component indicators are highly relevant to consumers of healthcare.

In addition to welcoming comments on this proposal, CMS invites comments on what additional quality measures and information may be useful to patients and other consumers of healthcare. In particular, CMS indicates that it has considered aggregating measures in a graphical display, such as star ratings.

2. Removal and Suspension of Hospital IQR Program Measures

After reviewing a list of measures previously removed from the Hospital IQR Program measure set, CMS proposes to remove eight additional measures from the Hospital IQR Program for the FY 2016 payment determination and subsequent years. They are shown in the following table.

Measure	CMS Reasons for Proposed Removal
PN-3b: Blood culture performed in the emergency department prior to first antibiotic received in hospital.	No longer NQF endorsed, MAP recommended removal; MAP believes it is topped out, and there is inadequate link to patient outcomes.
HF-1: Discharge planning.	No longer NQF endorsed, MAP recommended removal, challenges in validating efficacy.
IMM-1: Immunization for pneumonia	Cannot feasibly implement the measure to incorporate new Advisory Committee on Immunization Practices guidelines on pneumococcal vaccination
Participation in Stroke Registry	Stroke measure set more meaningful
AMI–2: Aspirin prescribed at discharge	Either recommended for removal by MAP or "topped out"
AMI–10: Statin prescribed at discharge	Either recommended for removal by MAP or "topped out"
HF–3: ACEI or ARB for LVSD	Either recommended for removal by MAP or "topped out"
SCIP-Inf–10: Surgery Patients with perioperative temperature	Either recommended for removal by MAP or "topped out"

In addition, CMS proposes to continue the suspension of data collection on four measures unless there is evidence that performance on the measures is in danger of declining. These are AMI-1: Aspirin at arrival; AMI-3: ACEI/ARB for left ventricular systolic dysfunction; AMI-5: Beta-blocker prescribed at discharge; and SCIP INF-6 Appropriate Hair Removal.

3. Proposed Refinements to Hospital IQR Program Measures

CMS proposes to make refinements to several IQR program measures. In all but one case the refinements are the result of the NQF measure maintenance process. The proposed measure refinements are:

- Modification of the various 30-day readmission measures (for AMI, HF, PN, THA/TKA, and Hospital-Wide Readmission) to incorporate an algorithm identifying planned readmissions, beginning in 2013. The algorithm was endorsed by NQF during its review of the readmission measures.
- Expansion of the CLABSI and CAUTI measures to select non-ICU locations beginning with infections occurring on or after January 1, 2014. The locations are medical wards, surgical wards, and medical/surgical wards. CMS believes this expansion is consistent with the NQF update of these measures allowing for their application beyond ICUs.
- Adoption of revised specifications of the measure SCIP Inf 4: Controlled 6AM Glucose for Cardiac Surgery Patients to incorporate recent NQF endorsement maintenance decisions, beginning with January 1, 2014 discharges. The NQF changed the measure from controlled glucose at 6AM to a more comprehensive measure of controlled glucose 18-24 hours post-cardiac surgery, and requires that corrective action be documented if post-operative glucose if over 180mg/dl.

- Revisions to the Medicare spending per beneficiary (MSPB) measure to include Railroad Retirement Board beneficiaries for the FY 2016 payment determinations. CMS is also considering how best to incorporate Maryland waiver hospitals into the MSPB measure.

4. Additional Hospital IQR Program Measures for the FY 2016 Payment Determination and Subsequent Years

CMS proposes to add five new measures to the Hospital IQR Program measure set for the FY 2016 payment determination and subsequent years. Combined with the proposed removal of eight measures, the proposed measure set consists of 57 total measures. Summary Table IX at the end of this section shows the proposed measures for FY 2016, compared with the IQR program measure sets for the FY 2014 and FY 2015 payment determinations.

For each of the five proposed new measures, CMS provides an overview and discusses data sources, clinical cohort, inclusion and exclusion criteria, risk adjustment and measure calculations. These details are not summarized here. For each of the five proposed risk-standardized measures, the information displayed on *Hospital Compare* would not be a point estimate, but would indicate whether hospital performance was higher than expected, as expected, or lower than expected. CMS has posted information on the methodologies for these proposed measures and others at:

http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

The proposed new measures are:

- Hospital 30-day All-Cause Risk Standardized Readmission Rate following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891)
- Hospital 30-day All-Cause Risk Standardized Mortality Rate following COPD Hospitalization risk (NQF #1893)
- Hospital 30-day All-Cause Risk Standardized Rate of Readmission Following Acute Ischemic Stroke
- Hospital 30-day All-Cause Risk Standardized Rate of Mortality Following an Admission for Acute Ischemic Stroke
- Hospital Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI)

The proposed readmission and mortality measures for Chronic Obstructive Pulmonary Disease are NQF-endorsed measures that were supported for addition to the IQR program by the MAP. In discussing these measures, CMS notes the high incidence of COPD, which has been identified by AHRQ as an ambulatory-care-sensitive condition for which hospitalization can potentially be prevented. CMS also believes that data on variation in hospital mortality rates for these patients suggest opportunities for improving care.

With respect to the proposed readmission and mortality measures for acute ischemic stroke, CMS acknowledges that these measures are not NQF endorsed or supported for inclusion by the MAP. Nonetheless, CMS believes that adoption of the measure is imperative because it aims to address a prevalent and costly health problem, and because it aligns with priority quality improvement objectives.

The proposed measure of risk-adjusted payment per episode of care for AMI patients is not NQF endorsed, and MAP support was made contingent on NQF endorsement. CMS however believes that this measure would provide valuable information on the substantial variation in the cost of care for AMI patients and would be paired with the current 30-day AMI mortality and readmission measures.

Summary Table IX
Hospital IQR Program Measures for Payment Determinations for FYs 2014, 2015 and 2016
'X' indicates measure adopted in prior rulemaking

	2014	2015	2016
Acute Myocardial Infarction (AMI) Measures			
AMI-2 Aspirin prescribed at discharge	X	X	**REMOVAL PROPOSED**
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X	X
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)	X	X	X
AMI-10 Statin Prescribed at Discharge	X	X	**REMOVAL PROPOSED**
Heart Failure (HF) Measures			
HF-1 Discharge instructions	X	X	**REMOVAL PROPOSED**
HF-2 Evaluation of left ventricular systolic function	X	X	X
HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction	X	X	**REMOVAL PROPOSED**
Stroke (STK) Measure Set			
STK-1 VTE prophylaxis*		X	X
STK-2 Antithrombotic therapy for ischemic stroke*		X	X
STK-3 Anticoagulation therapy for Afib/flutter*		X	X
STK-4 Thrombolytic therapy for acute ischemic stroke*		X	X
STK-5 Antithrombotic therapy by the end of hospital day 2*		X	X
STK-6 Discharged on Statin*		X	X
STK-8 Stroke education*		X	X
STK-10 Assessed for rehabilitation services*		X	X
Venous Thromboembolism (VTE) Measure Set			
VTE-1 VTE prophylaxis*		X	X
VTE-2 ICU VTE prophylaxis*		X	X
VTE-3 VTE patients with anticoagulation overlap therapy*		X	X
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol*		X	X

Summary Table IX **Hospital IQR Program Measures for Payment Determinations for FYs 2014, 2015 and 2016** 'X' indicates measure adopted in prior rulemaking			
	2014	**2015**	**2016**
VTE-5 VTE discharge instructions*		X	X
VTE-6 Incidence of potentially preventable VTE*		X	X
Pneumonia (PN) Measures			
PN-3b Blood culture performed before first antibiotic received in hospital	X	X	**REMOVAL PROPOSED**
PN-6 Appropriate initial antibiotic selection	X	X	X
Surgical Care Improvement Project (SCIP) Measures			
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	X	X	X
SCIP-INF-2: Prophylactic antibiotic selection for surgical patients	X	X	X
SCIP-INF 3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	X	X	X
SCIP-INF-4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	X	X	X
SCIP–INF-9: Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero	X	X	X
SCIP-INF-10: Surgery patients with perioperative temperature management	X	X	**REMOVAL PROPOSED**
SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period	X	X	X
SCIP-VTE-1: Surgery patients with Venous thromboembolism (VTE) prophylaxis ordered	X	Previously Removed	
SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery	X	X	X
Mortality Measures (Medicare Patients)			
AMI 30-day mortality rate	X	X	X
Heart Failure 30-day mortality rate	X	X	X
Pneumonia 30-day mortality rate	X	X	X
Stroke 30-day mortality rate			**PROPOSED**
COPD 30-day mortality rate			**PROPOSED**
Patients' Experience of Care Measures			
HCAHPS survey	X	X	X
Readmission Measures (Medicare Patients)			
AMI 30-Day Risk Standardized Readmission	X	X	X
Heart Failure 30-Day Risk Standardized Readmission	X	X	X
Pneumonia 30-Day Risk Standardized Readmission	X	X	X
30-Day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty		X	X
Hospital-Wide All Cause Unplanned Readmission		X	X
Stroke 30-day Risk Standardized Readmission			**PROPOSED**
COPD 30-day Risk Standardized Readmission			**PROPOSED**

Summary Table IX Hospital IQR Program Measures for Payment Determinations for FYs 2014, 2015 and 2016 'X' indicates measure adopted in prior rulemaking			
	2014	**2015**	**2016**
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs).Composite Measures a Nursing Sensitive Care			
PSI 06: Iatrogenic pneumothorax, adult	X	Previously Removed	
PSI 11: Post Operative Respiratory Failure	X	Previously Removed	
PSI 12: Post Operative PE or DVT	X	Previously Removed	
PSI 14: Postoperative wound dehiscence	X	Previously Removed	
PSI 15: Accidental puncture or laceration	X	Previously Removed	
IQI 11: Abdominal aortic aneurysm (AAA) mortality rate	X	Previously Removed	
IQI 19: Hip fracture mortality rate	X	Previously Removed	
Complication/patient safety for selected indicators (composite)	X	X	X
Mortality for selected medical conditions (composite)	X	Previously Removed	
PSI 04 Death among surgical inpatients with serious, treatable complications	X	X	X
Structural Measures			
Participation in a Systematic Database for Cardiac Surgery	X	X	X
Participation in a Systematic Clinical Database Registry for Stroke Care	X	X	**REMOVAL PROPOSED**
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	X	X	X
Participation in a Systematic Clinical Database Registry for General Surgery	X	X	X
Safe Surgery Checklist Use			X
Healthcare-Associated Infections Measures			
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X
Surgical Site Infection	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X
MRSA Bacteremia		X	X
Clostridium Difficile (C.Diff)		X	X
Healthcare Personnel Influenza Vaccination		X	X
Surgical Complications			
Hip/Knee Complication: Hospital-Level Risk Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty		X	X
Hospital Acquired Condition (HAC) Measures			
Foreign Object Retained After Surgery	X	Previously Removed	
Air Embolism	X	Previously Removed	
Blood Incompatibility	X	Previously Removed	
Pressure Ulcer Stages III & IV	X	Previously Removed	
Falls and Trauma (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock	X	Previously Removed	
Vascular Catheter-Associated Infection	X	Previously Removed	
Catheter-Associated Urinary Tract Infection (UTI)	X	Previously Removed	
Manifestations of Poor Glycemic Control	X	Previously Removed	

Summary Table IX Hospital IQR Program Measures for Payment Determinations for FYs 2014, 2015 and 2016 'X' indicates measure adopted in prior rulemaking			
	2014	**2015**	**2016**
Emergency Department (ED) Throughput Measures			
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital*	X	X	X
ED-2 – Median time from admit decision to time of departure from the ED for ED patients admitted to the inpatient status	X	X	X
Prevention			
Immunization for Influenza	X	X	X
Immunization for Pneumonia	X	X	**REMOVAL PROPOSED**
Cost Efficiency			
Medicare Spending per Beneficiary	X	X	X
AMI Payment per Episode of Care			**PROPOSED**
Perinatal Care			
Elective delivery < 39 completed weeks gestation*		X	X
* Measure proposed for voluntary electronic reporting in CY 2014			

5. Electronic Clinical Quality Measures

CMS proposes that hospitals may voluntarily report 16 of the FY 2016 IQR program measures electronically during CY 2014. The 16 selected measures are the complete measure sets for stroke (8 measures), venous thromboembolism (6 measures), and perinatal care (1 measure) plus one of the two emergency department measures. Except for the perinatal care measure, all these measures are also included in the Medicare Electronic Health Record (EHR) Program Electronic Reporting Pilot for Eligible Hospitals and CAHs. CMS believes that the perinatal care measure is highly burdensome for hospitals to report via chart abstraction, and that the electronic specifications for all these measures are not substantively different than the chart-abstraction specifications.

CMS strongly urges participation in this voluntary reporting program, as it intends to propose a requirement for electronic reporting for some measures beginning in CY 2015. CMS is proposing voluntary electronic reporting for CY 2014 rather than a requirement for electronic reporting based on comments it received in response to the January 3, 2013 "Request for Information on Hospital and Vendor Readiness for Electronic Health Records Hospital Inpatient Quality Data Reporting." Those comments led to concerns that hospitals and vendors might not be able to comply with a requirement in CY 2014.

Specific data submission requirements for voluntary reporting are discussed further below. A hospital may choose to electronically report at least one quarter of CY 2014 quality measure data for each of the 16 measures.

6. Possible Future Quality Measures and Topics

CMS emphasizes its interest in moving to electronic reporting for all chart-abstracted and HAI measures in the IQR program, and indicates its intention to propose five measures that would be collected via EHRs for addition to the IQR program in future rulemaking. CMS notes that these measures were considered by the MAP. The measures and CMS' indication of MAP support are:

- Severe Sepsis and Septic Shock Management Bundle NQF #0500 (MAP supported)
- PC-02 Cesarean Section NQF #0471 (MAP supported)
- PC-05 Exclusive Breast Milk Feeding NQF #0480 (MAP supported)
- Healthy Term Newborn NQF #0716 (MAP supported the direction of this measure)
- Hearing Screening Prior to Hospital Discharge NQF #1354 (MAP supported).

7. Form, Manner, and Timing of Quality Data Submission

CMS proposes the following IQR Program procedural requirements.

- The deadline for a hospital to withdraw from participation in the IQR Program for a fiscal year would be changed from August 15 of the preceding fiscal year to May 15 of the prior year (e.g., May 15, 2014 for the FY 2016 payment determination).
- The quarterly data submission deadline time would be clarified from 11:59 pm to mean 11:59 pm Pacific time.
- Data submission requirements for HCAHPS would be continued for FY 2017 with no changes.
- The deadline for submission of data on the previously adopted Healthcare Provider Influenza Vaccination measure is proposed to be May 15th of the calendar year when the flu season ends. For example, May 15, 2014 for vaccinations given between October 1, 2013 (or when they become available) and March 31, 2014.
- The Medicare Beneficiary ID number would be reported to the NHSN system for all events reported for Medicare beneficiaries for the FY 2016 payment determination and subsequent years. CMS believes this will increase confidence that records will be appropriately matched during data validation.
- The date of submission of the annual Data Accuracy and Completeness Acknowledgement would be changed from the final submission quarter for each fiscal year to the third quarter submission deadline. For example, instead of the current May 15, 2014 deadline for FY 2015, the acknowledgement deadline would be between January 1, 2014 and February 15, 2014 with respect to data for the CY 2013 reporting period.
- Beginning with the FY 2015 payment determination, hospitals with a quarterly overall validation result of <75 percent could no longer appeal mismatched data elements to state quality improvement organization (QIO). CMS believes this process is redundant because a hospital can request reconsideration of a determination that it has not met the IQR Program requirements.

- The forms for extraordinary circumstances waivers or extensions could be signed by hospital-designated personnel other than the CEO. In addition the forms could be submitted online via the QualityNet website. Further, CMS proposes that a waiver or extension may be granted if a problem with the CMS data collection system directly affected the ability of a hospital to submit data.

8. Proposed Requirements for Voluntary Electronic Submission of IQR Program Measures in CY 2014

Proposed data submission requirements for hospitals that are voluntarily electronically reporting measures in CY 2014 are described. In order to incentivize participation, CMS proposes to use the electronically reported IQR Program data to determine whether a hospital has satisfied the Medicare EHR Incentive Program clinical quality measure reporting requirement. CMS notes that a hospital must also satisfy all the other requirements of that program.

The proposed data submission schedule varies depending on whether or not a hospital elects to use the electronically reported IQR Program data to satisfy the EHR Incentive Program. The quarterly data submission deadlines for IQR Program chart-abstracted measures are 4 ½ months after the end of the reporting quarter (i.e., August 15, 2014 for the discharges occurring during the calendar quarter ending on March 31, 2014). These deadlines would apply for electronic submission if a hospital does not want the data to be used to satisfy the EHR Program clinical quality data reporting requirement. However, a hospital choosing to use the IQR Program reporting also for the EHR Incentive Program may use that program's reporting periods and deadlines instead. For an eligible hospital beyond its first year of EHR Incentive Program electronic reporting, the data submission deadline for any FY 2014 quarter or the entire FY 2014 period is November 30, 2014. (The deadline for a hospital in its first year is July 1, 2014 for reporting on any 90-day consecutive period that ends prior to July 1, 2014.)

CMS notes that a hospital choosing to electronically report data for the third quarter of CY 2014 under the IQR Program would need to submit that data by November 30, 2014 rather than the February 15, 2015 deadline that generally applies for chart-abstracted data in the IQR Program. Further, because the EHR Incentive Program is fiscal-year based, CMS will not be able to use electronic submission of IQR Program data for the fourth quarter of CY 2014 to determine whether a hospital has satisfied the EHR Incentive Program clinical quality reporting requirement.

The Medicare EHR Incentive Program process would be used to submit data electronically, following submission requirements finalized in the Stage 2 final rule (77 FR 54080). Specific procedures will be posted on the QualityNet website. The case threshold exemption would apply for IQR Program data submission. For hospitals choosing voluntary electronic reporting of the 16 proposed measures, the data would be extracted from the from the Certified Electronic Health Record Technology (CEHRT) and submitted to CMS using the Health Level Seven (HL7) Quality Reporting Document Architecture (QRDA) Category I Revision 2 standard.

CMS proposes that data submitted through the voluntary electronic submission in CY 2014 will not be publicly reported. Noting comments received in response to the January RFI, CMS believes there may be abnormalities in the data or submission process during the first year of reporting. CMS seeks comment on how to acknowledge hospitals electing voluntary electronic submission, such as through a "Pioneer" designation on the *Hospital Compare* website.

Data submitted electronically for the FY 2016 IQR Program would not be validated. CMS intends to develop and propose a validation strategy for electronically reported quality measure data in next year's rulemaking, and seeks comments on potential validation methodologies.

9. Modifications to the Validation Process for Chart-Abstracted and HAI Measures

CMS proposes several changes to the validation process for chart-abstracted measures in the IQR Program, and proposes new procedures for validation of the CDC HAI measures.

- Timing and Number of Quarters Included in Validation. For the FY 2015 payment determination and future years, CMS proposes to modify the data validation time period so that the determination of whether a hospital has met the requirements of the IQR Program and therefore will be included in the VBP Program for a fiscal year can be made by July 1st prior to the start of the fiscal year. The proposed rule includes a chart illustrating the proposed time frames. For example, for the FY 2015 determination, the validation period would include the 4th quarter of CY 2012 through the 2nd quarter of CY 2013 (October 1, 2012 through June 30, 2013). For FY 2016 and later, the validation period would include the 3rd and 4th quarters of the year 2 years prior to the payment determination and the 1st and 2nd quarters of the subsequent year (e.g., for FY 2016 the dates would be July 1, 2013 – June 30, 2014). However, for FY 2016, data validation for the CDC HAI measures could not begin until the 4th quarter of CY 2013 because CMS would not have the infrastructure ready in time.
- Selection of Measures. For FY 2015, the previously finalized data validation process includes 21 chart-abstracted clinical process of care measures and three CDC HAI measures. In this rule, CMS proposes to continue validation of 12 clinical process of care measures, and add validation of the two new HAI measures (MRSA and C.diff). Validation would be suspended for nine process of care measures: seven that CMS proposes to remove from the IQR Program measure set, and the two ED measures, for which CMS states it does not have the ability to validate electronically reported versions. CMS believes that it would be inequitable to continue validation for the ED measures only when they are submitted by chart abstraction.
- Sampling of Charts for Process of Care Measures. The validation sample would continue to include three records each sampled from the heart attack, heart failure, pneumonia, and surgical infection measure sets. For the immunization measures, three records will be sampled from among principal diagnoses and procedures not already included in the four topic areas separately sampled, and the other 12 charts selected for the four identified measure sets will be sampled for immunizations as well.
- Validation Templates for CLABSI and CAUTI. Changes are proposed with respect to the validation templates developed for the CLABSI and CAUTI measures to align with

NHSN definitions and remain up-to-date. In the future, CMS proposes to notify hospitals of changes in definitions of HAI events though HAI validation guidance posted annually on QualityNet. It believes that very detailed specifications are better handled through subregulatory process than through rulemaking. In addition, CMS proposes to require that hospitals submit data to the Validation Template posted on QualityNet without modifying the formatting.

- Exclusion of Long-Stay Cases. CMS proposes to exclude from HAI validation all patient episodes of care with lengths of stay of more than 120 days. This would align the length of stay maximum with the IQR Program specifications and reduce the burden of validation when medical records may be tens of thousands of pages.
- Validation MRSA and C.Diff (CDI) For validation of the new HAI measures, CMS proposes to use processes similar to those developed for the CLABSI and CAUTI measures. Sampled hospitals would be required to provide a list of final blood cultures positive for MRSA and a second list of all final stool specimens toxin positive for CDI. Both hospital and community-onset cases would be reported. Only hospital-onset infections are publicly reported, but community-onset cases are used by NHSN in risk adjustment. The proposed rule specifies the information that would be collected on the Validation Templates, and draft versions are available at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021
- Selection of Hospitals for HAI Measures. To limit the burden associated with validation of HAI measures, CMS proposes half the hospital validation sample would be assigned to submit templates for CLABSI and CAUTI validation and half for MRSA and CDI validation. (Validation of the SSI measure would continue for all sampled hospitals.)
- Stratification of Sampling by HAI. For the FY 2016 payment determination and subsequent years, CMS proposes to target separate sampling strata for each type of HAI, and these are displayed in a table published in the proposed rule. For FY 2016, for hospitals submitting the CLABSI and CAUTI templates, the proposed quarterly sample sizes are 2 for SSI, 5 for CLABSI and 5 for CAUTI. Similarly, for hospitals submitting the MRSA and CDI templates, the proposed quarterly sample sizes are 2 for SSI, 5 for MRSA and 5 for CDI. Cases would be randomly selected from among patient episodes of care with at least one candidate event. If there are insufficient cases in any stratum, these would be reallocated to any stratum that have enough cases to meet sample size targets. Because for FY 2017 and later, there will be validation data drawn from four quarters instead of three, CMS proposes to reduce the total quarterly sample size from 12 to 9, with a configuration of 3, 3, and 1 for CLABSI, CAUTI and SSI or MRSA, CDI and SSI, and 2 additional cases randomly drawn.
- Scoring of CLABSI, CAUTI and SSI. For FY 2016 and later, CMS proposes to score each case sampled for the infection for which it was sampled. For CLABSI, CAUTI and SSI, cases will be scored with a 1 if the medical record matches the hospital reporting and zero if there is a mismatch.
- Scoring of MRSA and CDI. For MRSA and CDI, CMS proposes to score two components, with a 1 for a match and a zero for a mismatch. First, whether an event should have been reported to NHSN and was reported, and second whether the correct dates of admission and event were reported so that NHSN correctly classified the infection as hospital or community onset. No more than four events could be validated for an

episode of care. Hospitals would not be credited or penalized with respect to certain events that are automatically excluded by NHSN.

- Combining Scores. CMS proposes no changes to the calculation of the total score, which weights the clinical process of care and HAI validation scores by the number of measures in each group. For FY 2016, this would be 12/17 for clinical process of care measures and 5/17 for the HAI measures. The determination of whether a hospital passes validation would not change. As has been CMS' practice, specific formulas would be posted on QualityNet at least one year prior to computation.
- Targeting of Hospitals for validation. CMS proposes to continue drawing a random validation sample of 400 hospitals annually, with up to 200 hospitals selected for more targeted validation. CMS proposes to add one additional criterion for targeting, which is that any hospital which failed to report to NHSN at least half of actual HAI events detected as determined during the previous year's validation efforts. CMS is concerned that the VBP Program might give hospitals an unintended incentive to underreport HAI events.
- Procedures for Submitting Records for Data Validation. CMS proposes that for validation of the MRSA and CDI measures for FY 2016 and later, hospitals would be required to submit only those parts of the medical record needed to validate those measures, namely all final positive blood culture and toxin positive CDI specimens and documentation of dates of admission, transfer and discharge. CMS also proposed that a hospital selected for validation would meet the current requirement for submission of patient charts either through paper charts (the only option currently available) or, beginning with the FY 2016 payment determination, through secure transmission of electronic medical information. The specific guidelines for electronic transmission will be posted on QualityNet. Hospitals, which are reimbursed 12 cents per page plus shipping for paper medical records, would be reimbursed for the labor and supply costs of electronic transmission, although CMS does not indicate what the reimbursement would be.

B. PPS Exempt Cancer Hospital Quality Reporting (PCHQR) Program

In the FY 2013 IPPS/LTCH final rule, CMS established a quality reporting program beginning in FY 2014 for PPS- exempt cancer hospitals (PCHs), as required under section 1866(k) of the Act, as added by section 3005 of the ACA. The PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. No policy was adopted on the consequences if a PCH fails to meet the quality reporting requirements; CMS indicated its intention to address the issue in future rulemaking. No discussion of this issue is included in this proposed rule. Five measures were adopted for the new cancer hospital quality reporting program for FY 2014. Existing and proposed measures are shown in the table below.

PCHQR Program Measures. In this rule, CMS proposes to adopt one new measure for the PCHQR Program in FY 2015 and 13 new measures beginning in FY 2016. The measures, listed below, include the NHSN measure of surgical site infections following colon surgeries and abdominal hysterectomies, six surgical care improvement project (SCIP) measures, six clinical process/oncology measures, and the HCAHPS. With the exception of the oncology

measures, all the measures proposed for the PCHQR Program are already included in the Hospital IQR Program. In addition, all 14 proposed measures are NQF endorsed and CMS reports that all but one were supported for inclusion in the PCHQR Program by the MAP. The exception is the HCAHPS measure, for which the MAP thought additional experience was needed to apply the survey questions to the PCH setting. However, CMS indicates that 27 percent of PCHs are currently administering the HCAHPS to their patients.

Current and Proposed PCHQR Program Measures
Measures Previously Adopted Beginning in FY 2014
NHSN CLABSI outcome measure (NQF #0139)
NHSN CAUTI outcome measure (NQF #0138)
Adjuvant chemotherapy is considered or administered with 4 months (120 days) of surgery to patients < 80 with AJCC T1c (lymph node positive) colon cancer (NQF #0223)
Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis to women < 70 with AJCC T1c or Stage II or III hormone receptor negative breast cancer. (NQF #0559)
Adjuvant hormonal therapy (Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year of diagnosis to women > 18 with AJCC T1cN0M0, or Stage II or III hormone receptor positive breast cancer.) (NQF #0220)
Measures Proposed for Adoption Beginning in FY 2015
Surgical Site Infection (SSI) (NQF #0753)
Measures Proposed for Adoption Beginning in FY 2016
Surgical Care Improvement Project (SCIP)
SCIP-Inf-1: Prophylactic Antibiotic Received Within 1 Hr Prior to Surgical Incision (NQF#0527)
SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-3: Prophylactic Antibiotic Discontinued Within 24 Hrs After Surgery End Time (NQF #0529)
SCIP-Inf-9: Urinary Catheter Removed on Post-Operative Day 1 or Post-Operative Day 2 with Day of Surgery Being Day Zero (NQF #0453)
SCIP-Card 2: Surgery Patients on Beta Blocker Therapy Prior to Admission who Received a Beta Blocker During the Perioperative Period (NQF #0284)
SCIP- VTE 2: Surgery Patients who Received Appropriate VTE Prophylaxis within 24 Hrs Prior to Surgery to 24 Hrs After Surgery End Time (NQF #0218)
Clinical Process/Oncology Care Measures
Multiple Myeloma-Treatment with Bisphosphonates (NQF #0380)
Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382)
Oncology: Plan of Care for Pain (NQF #0383)
Oncology: Pain Intensity Quantified (NQF #0384)
Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389)
Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)
Patient Experience of Care
HCAHPS

Detailed specifications of the proposed oncology measures can be found in Appendix A of the NQF Cancer Endorsement Maintenance 2011 report using the following link. (The link provided in the proposed rule appears to be broken.)

http://www.qualityforum.org/Publications/2012/12/Cancer_Endorsement_Maintenance_2011.aspx

Public Display. CMS proposes to publicly display in 2014 data for two of the five previously adopted measures. They are the measures involving adjuvant chemotherapy for colon cancer (NQF #0223) and combination chemotherapy for breast cancer (NQF #0559). CMS proposes to defer public reporting of the other measures while it engages in testing and assessing data quality, including reliability and validity of the measure rates.

Data Submission and Other Procedures. CMS proposes procedures for data submission under the PCHQR Program beginning with the FY 2015 program year. These involve 1) a proposal for granting waivers from program requirements under extraordinary circumstances similar to other quality reporting programs, 2) specified reporting periods and data submission timelines for the proposed new measures. PCHs would report on the proposed SSI measure beginning with January 1, 2014 events. HCAHPS reporting would begin with discharges occurring on April 1, 2014. The proposed SCIP and oncology process measures would be reported beginning with January 1, 2015 discharges.

C. Long-Term Care Hospital Quality Reporting (LTCHQR) Program

In the FY 2012 IPPS/LTCH final rule, CMS established a quality reporting program beginning in FY 2014 for LTCHs, as required under section 1886(m) of the Act as added by section 3004 of the ACA. Further developed in the FY 2013 IPPS/LTCH rulemaking, the LTCHQR Program follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. An LTCH that does not meet the requirements of participation in the LTCHQR for a rate year is subject to 2.0 percentage point reduction in the update factor for that year. Initial reporting under the LTCHQR Program began in October 2012, and in the impact analysis presented in Appendix A to the proposed rule, CMS reports that a majority of certified-LTCHs are submitting quality data to CMS. The impact analysis also discusses modifications to previous CMS estimates of the burden of reporting based on LTCH initial reporting experience.

LTCHQR Program Measures. Three measures were previously adopted for LTCHQR Program for the FY 2014 and FY 2015 payment determinations, and two measures were added beginning with the FY 2016 payment determination. Existing and proposed measures are shown in the table below.

Current and Proposed LTCHQR Program Measures					
NQF Measure	**Measure Title**	**FYs 2014 and 2015**	**FY 2016**	**FY 2017**	**FY 2018**
NQF #0138	National Health Safety Network (NHSN) Catheter- associated Urinary Tract Infection (CAUTI) Outcomes Measure	X	X	X	X
NQF #0139	NHSN Central line-associated Blood Stream Infection (CLABSI) Outcomes Measure	X	X	X	X

Current and Proposed LTCHQR Program Measures					
NQF Measure	**Measure Title**	**FYs 2014 and 2015**	**FY 2016**	**FY 2017**	**FY 2018**
NQF #0678	Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short-Stay)	X	X	X	X
NQF #0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)		X	X	X
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel		X	X	X
NQF #1716	NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure			Proposed	Proposed
NQF #1717	NHSN Facility-Wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure			Proposed	Proposed
	All-cause Unplanned Readmission Measure for 30-days Post Discharge from LTCHs			Proposed	Proposed
Application of NQF #0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)				Proposed

CMS proposes modifications to three of the previously adopted measures.

- The deadline for submission of data on the Influenza Vaccination Coverage among Healthcare Personnel measure would be modified to align with the flu vaccination season, which is defined by the CDC as October 1 (or when the vaccine becomes available) through March 31. LTCHs must report on this measure for the entire influenza season. This can be done once at the end of the season, although data can be entered at any point in the season.
- The start date for reporting on the Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine would be delayed from January 1, 2014 to April 1, 2014 to allow time for LTCHs and vendors to participate in CMS-sponsored training activities and incorporate changes into their data collection systems. The data reporting periods for the FY 2016 payment determination would be shortened to reflect this change. While data collection would be on a calendar year basis, CMS proposes that public reporting on this measure would be based on the influenza vaccination season (e.g., October 1, 2014-March 15, 2015).
- CMS notes that the measure Percent of Residents with Pressure Ulcers that are New or Worsened (Short-Stay) was originally adopted for the LTCHQR as an application of a measure that was NQF-endorsed only for the skilled nursing facility and short stay nursing home settings. Subsequently, the NQF has expanded the measure to the LTCH and IRF patient populations and changed the name of the measure. No changes in the data elements, technical specifications or data submission requirements were made by NQF.

Three measures are proposed for addition to the LTCHQR beginning with the FY 2017 payment determination: 1) the NHSN MRSA measure previously adopted for the IQR

Program, 2) the NHSN *C.Difficile* infection (CDI) measure also previously adopted for the IQR Program, and 3) a risk-adjusted measure of readmission rates, All-cause Unplanned Readmission Measure for 30-days Post-Discharge form LTCHs.

The proposed readmissions measure is not NQF endorsed but is modeled after the Hospital-Wide Risk-Adjusted All-Cause Unplanned Readmission Measure (NQF #1789) which is NQF-endorsed and previously adopted for the IQR Program. CMS states that it would use the same statistical approach, the same time window and a similar set of patient characteristics for the proposed LTCH measure, and intends to seek NQF endorsement for it. The patient population would include LTCH patients who were discharged alive from the LTCH; had Medicare Part A fee-for-service coverage for 12 months prior to the LTCH stay and for 30 days after discharge; had an IPPS stay within the 30 days prior to the LTCH stay, and who were age 18 or older when admitted to the LTCH. The proposed rule reviews certain exclusions and other specification details of this proposed measure. CMS intends to propose details with respect to public reporting and LTCH preview of performance results in future rulemaking. For FY 2016, CMS would calculate this measure using CYs 2013 and 2014 claims data.

One more measure is proposed for addition to the LTCHQR Program beginning with the FY 2018 payment determination, specifically CMS proposes application of NQF #0674, Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay). This measure is NQF endorsed for long stay nursing home residents. CMS discusses evidence regarding fall-related injuries in people age 65 and older, and its relevance to the LTCH setting. CMS proposes that data on this measure would be reported through the existing infrastructure of the LTCH CARE Data set.

The proposed rule presents a list, not reproduced in this summary, of additional potential measure topics under consideration for future LTCHQR. CMS welcomes comments on the list, specifically regarding clinical importance, feasibility of data collection and implementation, current use, and usability of data to inform quality improvements in the LTCH setting.

Public Display. CMS is developing plans for implementing the statutory requirement that it publicly display quality data reported under the LTCHQR Program, and intends to propose procedures and timeframes in future rulemaking. Public comments on considerations that CMS should take into account regarding public display of these data are welcomed.

Data Submission and Other Procedures. CMS also proposes specific data submission deadlines under the LTCHQR Program for FYs 2017 and 2018, which in general involve reporting periods of CY 2015 and 2016 respectively. Other procedural issues are proposed involving 1) granting waivers from program requirements under extraordinary circumstances similar to other quality reporting programs, and 2) a process to allow LTCHs to request reconsiderations pertaining to their payment determinations for FY 2015 and later.

D. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

In the FY 2013 IPPS/LTCH final rule, CMS established a quality reporting program beginning in FY 2014 for inpatient psychiatric facilities (IPFs), as required under section 1886(s) of the Act as added and amended by sections 3401(f) and 10322(a) of the ACA. An IPF that does not meet the requirements of participation in the IPFQR for a fiscal year is subject to a 2.0 percentage point reduction in the update factor for that year, and may result in a negative annual update for that year.

IPFQR Measures. Six measures were previously adopted for the FY 2014 payment determination and subsequent years. In this rule, CMS proposes to add three measures beginning with the FY 2016 payment determination. A table showing current and proposed measures follows.

Current and Proposed IPFQR Program Measures			
Measure ID	**Description**	**FYs 2014 and 2015**	**FY 2016**
NQF 0640/HBIPS-2	Hours of Physical Restraint Use	X	X
NQF 0641/HBIPS-3	Hours of Seclusion Use	X	X
NQF #0552/ HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications (HBIPS-4)	X	X
NQF #0560/HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	X	X
NQF #0557/HBIPS-6	Post-Discharge Continuing Care Plan	X	X
NQF #0558/HBIPS-7	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	X	X
	SUB-1: Alcohol Use Screening		Proposed
	SUB-4: Alcohol & Drug Use: Assessing Status After Discharge		Proposed
NQF# 0576	Follow-Up After Hospitalization for Mental Illness		Proposed

Of the three proposed measures, one is an NQF-endorsed measure of outpatient visits subsequent to an inpatient discharge and the other are substance use measures developed by The Joint Commission which have been submitted to the NQF for endorsement. One assesses whether patients are screened for unhealthy drinking using a validated screening questionnaire, and the other assesses whether patients are contacted between 7 and 30 days after discharge to collect follow-up information on alcohol or drug use status. The MAP supports the addition of all three measures, although support for the substance use measures is contingent on NQF endorsement. CMS indicates that dates for NQF review of the two Joint Commission measures have not been established. Technical specifications on the two substance use measures developed by The Joint Commission are included in the Specifications Manual for National Hospital Inpatient Quality Measures for 2013 available at: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

CMS indicates that it intends to pursue adoption of a standardized measure of patient experience of care in the IPFQR in the near future, and is requesting information from IPFs. Specifically, CMS would like to know yes/no whether the IPFs participating in the IPFQR assess patient experience of inpatient behavioral health services using a standardized instrument, and if yes, the name of the survey they administer. Submission of this information through a web-based tool and is completely voluntary and will not affect the FY 2016 payment determination. CMS reports they considered proposing inclusion of the HCAHPS in the IPFQR for FY 2016, but did not propose this due to concerns about reporting burdens in a new program and compatibility with the content and format of other similar CMS beneficiary surveys.

Comments are sought on possible future measures for inclusion in the IPFQR, and CMS is particularly interested in recommendations concerning (1) inpatient psychiatric treatment and quality of care of geriatric patients and other adults, adolescents, and children; (2) quality of prescribing for antipsychotics and antidepressants; (3) readmissions; (4) access to care; (5) screening for suicide and violence; and (6) screening and treatment for nonpsychiatric, comorbid conditions for which patients with mental or substance use disorders are at higher risk.

Public Display. CMS proposes to change the timing of public display of IPFQR data in order to better align with the IQR Program. In last year's rulemaking CMS finalized policies to make the IPFQR data publicly available on its website beginning in the first quarter of the calendar year following the payment determination year. For example, data for the FY 2014 payment determination year will be displayed during the first quarter of CY 2014. IPFs will have the opportunity to preview the data between September 20 and October 19 of the payment determination year before it is publicly displayed (for example, between September 20, 2013 and October 19, 2013 for the FY 2014 payment determination year).

In this rule, CMS proposes instead that for the FY 2014 payment determination and subsequent years, submitted data would be displayed publicly on CMS website in April of each calendar year following the start of the respective payment determination year (e.g., public display for the FY 2014 payment determination would begin April 2014.) Hospitals would preview the data for a 30 day period approximately 12 weeks prior to public display; this would align with the preview and display periods for the IQR Program.

Data Submission and other Procedures. CMS reviews procedures for IPF participation in the IPFQR Program, and presents the following chart regarding data reporting periods, submission deadlines, deadlines for the Data Accuracy and Completeness Acknowledgement (DACA), and public display periods.

Proposed IPFQR Program Time Frames				
Payment Determination Year	**Reporting Period for Services Provided**	**Data Submission Time Frame**	**DACA Deadline**	**Public Display Begins**
FY 2014	Q4 2012 – Q1 2013 (October 1, 2012 – March 31, 2013)	July 1, 2013- August 15, 2013	August 15, 2013	April 2014
FY 2015	Q2 2013- Q4 2013 (April 1, 2013 – December 31 2013)	July 1, 2014- August 1 2014	August 15, 2014	April 2015
FY 2016	Q1-Q4 2014 (January 1, 2013 – December 31, 2013)	July 1, 2015- August 1 2015	August 15, 2015	April 2016

X. Proposed Change to Hospital CoPs for Administration of Pneumococcal Vaccines

42 CFR 482.23(c)(3) contains the Medicare hospital condition of participation related to preparation and administration of influenza and pneumococcal *polysaccharide* vaccines. CMS had intended to establish a policy under which hospitals had the flexibility to administer these vaccines without prior practitioner order and only after assessing patients for contraindications to the vaccine administration; it had not intended to exclude other pneumococcal vaccines available currently or in the future. Thus, it proposes to delete "*polysaccharide*" from the text of the regulation to clarify its policy that a hospital may include any type of pneumococcal vaccine in its physician-approved policy for administration by nurses without prior practitioner order, if the vaccine has been FDA-approved for the patient population involved. CMS indicates it cannot estimate costs (or savings) for this proposal; it notes benefits of improved patient access to pneumococcal vaccines as well as the benefit of having more than one supply of vaccine, especially in the case of a shortage.

XI. MedPAC Recommendations

In the March 2013 MedPAC Report to Congress, MedPAC recommended an update to the hospital inpatient rates equal to 1.0 percent. While it expects Medicare margins to remain low in 2013, MedPAC's analysis finds that efficient hospitals can maintain positive Medicare margins while maintaining a relatively high quality of care. It also recommended that Congress should require the Secretary to use the difference between the increase of the applicable percentage increase under the IPPS for FY 2014 and MedPAC's recommendation of a 1.0 percent update to gradually recover past overpayments due to documentation and coding changes.

CMS responds that section 1886(b)(3)(B) of the Act, as amended by the ACA, sets the requirements for the FY 2014 applicable percentage increase, including for example reductions for failure to submit quality data, the MFP adjustment and the statutory percentage point reduction for the year involved. With respect to overpayments due to documentation and coding changes, CMS notes that ATRA section 631 requires the Secretary to make a recoupment totaling $11 billion by 2017; were CMS to fully account for that recoupment in FY 2014, a -9.3 percent adjustment to the standardized amount would have been required.

CMS often delays or phases in rate adjustments over more than 1 year, in order to moderate the effect on rates in any one year. CMS also observes that it continues to use separate updates for operating and capital payments because the respective prospective payment systems remain separate.

Appendix: Regulatory Impact Analysis Table

TABLE I.— IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2014

	No. of Hospitals1 (1)	Proposed Hospital Rate Update and Documentation and Coding Adjustment 2 (2)	Proposed FY 2014 Weights and DRG Changes with Application of Recalibration Budget Neutrality3 (3)	Proposed FY 2014 Wage Data with Application of Wage Budget Neutrality4 (4)	Proposed FY 2014 DRG, Rel. Wts., Wage Index Changes with Wage and Recalibration Budget Neutrality5 (5)	Proposed FY 2014 MGCRB Reclassifications6 (6)	Proposed Rural Floor and Imputed Floor with Application of National Rural Floor Budget Neutrality7 (7)	Proposed Application of the Frontier Wage Index8 (8)	Proposed FY 2014 Out-Migration Adjustment9 (9)	Expiration of MDH Status10 (10)	Proposed Hospital Readmissions Reduction Program11 (11)	Proposed Changes to Medicare DSH12 (12)	All Proposed FY 2014 Changes 13 (13)
All Hospitals	3,404	0.8	0	0	0.1	0	0	0.1	0	-0.1	-0.2	-0.9	-0.1
By Geographic Location:													
Urban hospitals	2481	0.8	0	0	0.1	-0.2	0	0.1	0	0	-0.2	-0.8	0.1
Large urban areas	1367	0.8	0	0.1	0.2	-0.3	0	0	0	0	-0.2	-0.7	0.5
Other urban areas	1114	0.8	0.1	-0.1	0	-0.1	0.1	0.2	0	-0.1	-0.1	-1.1	-0.4
Rural hospitals	923	1.2	-0.5	-0.2	-0.6	1.7	-0.3	0.1	0.1	-1.2	-0.2	-0.9	-1.9
Bed Size (Urban):													
0-99 beds	622	0.8	0.3	0	0.3	-0.4	0.1	0.2	0	-0.4	-0.1	0.6	0.9
100-199 beds	762	0.8	-0.1	0	-0.1	-0.1	0.3	0.1	0	0	-0.2	-1.1	-0.5
200-299 beds	464	0.8	-0.1	0	0	0	0	0.1	0	0	-0.2	-0.7	-0.1
300-499 beds	418	0.8	0.1	0	0.1	-0.2	0	0.1	0	0	-0.2	-0.8	0.1
500 or more beds	215	0.8	0.2	0.1	0.4	-0.2	-0.1	0	0	0	-0.2	-1	0.4
Bed Size (Rural):													
0-49 beds	339	1.1	-0.8	-0.3	-1	0.5	-0.3	0.1	0.2	-2	-0.3	0.3	-2.4
50-99 beds	328	1.2	-0.7	-0.2	-0.8	1.2	-0.3	0	0.2	-3.3	-0.3	-0.1	-3.3
100-149 beds	151	1.2	-0.6	-0.3	-0.7	1.9	-0.3	0.1	0	-0.3	-0.3	-1	-1.1
150-199 beds	59	1.1	-0.2	-0.2	-0.3	2.2	-0.4	0.1	0	0	-0.2	-1.5	-1.1
200 or more beds	46	1.2	-0.1	-0.3	-0.2	2.4	-0.3	0	0	0	-0.2	-1.9	-1.2
Urban by Region:													

	No. of Hospitals1 (1)	Proposed Hospital Rate Update and Documentation and Coding Adjustment 2 (2)	Proposed FY 2014 Weights and DRG Changes with Application of Recalibration Budget Neutrality3 (3)	Proposed FY 2014 Wage Data with Application of Wage Budget Neutrality4 (4)	Proposed FY 2014 DRG, Rel. Wts., Wage Index Changes with Wage and Recalibration Budget Neutrality5 (5)	Proposed FY 2014 MGCRB Reclassifications6 (6)	Proposed Rural Floor and Imputed Floor with Application of National Rural Floor Budget Neutrality7 (7)	Proposed Application of the Frontier Wage Index8 (8)	Proposed FY 2014 Out-Migration Adjustment9 (9)	Expiration of MDH Status10 (10)	Proposed Hospital Readmissions Reduction Program11 (11)	Proposed Changes to Medicare DSH12 (12)	All Proposed FY 2014 Changes 13 (13)
New England	120	0.8	-0.1	0.4	0.4	0.7	4.4	0	0	0	-0.2	-1.5	0.2
Middle Atlantic	318	0.8	0	0.7	0.7	0.3	-0.3	0	0	0	-0.3	-0.1	1.6
South Atlantic	375	0.8	0	-0.4	-0.3	-0.4	-0.4	0	0	-0.1	-0.1	-0.4	0
East North Central	395	0.8	0	-0.2	-0.1	-0.2	-0.5	0	0	0	-0.2	-0.7	-0.2
East South Central	149	0.8	0.1	-0.5	-0.2	-0.3	-0.4	0	0	0	-0.2	-0.9	-0.3
West North Central	165	0.8	0.2	-0.2	0	-0.7	-0.5	0.8	0	-0.1	-0.1	-0.8	-0.2
West South Central	371	0.8	0.1	-0.3	0	-0.6	-0.5	0	0	0	-0.1	-0.8	-0.1
Mountain	156	0.9	0.2	-0.1	0.1	-0.1	0	0.2	0	0	-0.1	0.8	1.2
Pacific	381	0.8	0	0.5	0.5	-0.1	0.7	0	0	0	-0.1	-3.2	-1.5
Puerto Rico	51	1	-0.1	0.2	0.5	-0.8	0	0	0	0	0	34.5	35.7
Rural by Region:													
New England	23	1	-0.3	0.2	-0.1	3.2	-0.5	0	0	-3.9	0	-0.8	-2.9
Middle Atlantic	69	1.2	-0.5	-0.2	-0.6	1.6	-0.3	0	0.1	-2.1	-0.2	0.3	-1.2
South Atlantic	165	1.1	-0.5	-0.3	-0.7	2.1	-0.4	0	0.1	-1	-0.3	-0.9	-1.8
East North Central	119	1.2	-0.3	-0.3	-0.6	1.3	-0.3	0	0.1	-2.1	-0.2	-0.3	-1.6
East South Central	171	0.9	-0.4	-0.5	-0.7	2.5	-0.5	0	0.1	-0.6	-0.4	-2	-3.5

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West North Central	100	1.4	-0.3	0.1	-0.2	0.4	-0.1	0.3	0.1	-0.8	-0.1	-0.7	-0.4
West South Central	181	1	-0.6	-0.5	-0.9	2.2	-0.4	0	0.1	-0.4	-0.4	-1.2	-2.7
Mountain	65	1.5	-0.4	-0.1	-0.4	0.2	-0.1	0.4	0	-0.1	-0.1	-0.9	0
Pacific	29	1.4	-0.6	0.2	-0.4	1.1	-0.2	0	0	-0.1	-0.1	-0.7	-0.3
Puerto Rico	1	1	3.3	-0.5	3.4	-0.9	-0.4	0	0	0	0	0	4.6
By Payment Classification:													
Urban hospitals	2495	0.8	0	0	0.1	-0.2	0	0	0	0	-0.2	-0.8	0.1
Large urban areas	1377	0.8	0	0.1	0.2	-0.2	0	0	0	0	-0.2	-0.7	0.5
Other urban areas	1118	0.8	0.1	-0.1	0	0	0.1	0.1	0	0	-0.1	-1.1	-0.4
Rural areas	909	1.2	-0.4	-0.2	-0.6	1.4	-0.3	0.2	0.1	-1.2	-0.2	-0.9	-1.9
Teaching Status:													
Nonteaching	2378	0.9	-0.1	-0.1	-0.2	0.2	0	0	0	-0.3	-0.2	-0.9	-0.8
Fewer than 100 residents	782	0.8	0	0	0	-0.1	0	0.1	0	0	-0.1	-0.9	-0.1
100 or more residents	244	0.8	0.2	0.2	0.5	-0.2	0	0	0	0	-0.2	-0.7	0.8
Urban DSH:													
Non-DSH	706	0.8	0	0	0.1	0.1	0	0	0	-0.2	-0.2	0	0.2
100 or more beds	1562	0.8	0.1	0	0.1	-0.2	0	0	0	0	-0.2	-1	0

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Less than 100 beds	330	0.9	-0.4	0.1	-0.3	0.2	0.1	0.2	0	-0.5	-0.2	1.1	1.2
Rural DSH:													
SCH	260	1.5	-0.8	0	-0.8	0.1	-0.1	0	0	-0.2	-0.2	-0.1	-1.3
RRC	223	1.2	-0.3	-0.2	-0.4	2	-0.3	0.4	0	-0.3	-0.2	-1.9	-1.6
100 or more beds	29	0.8	-0.5	-0.3	-0.6	1.2	-0.4	0	0.1	-1.5	-0.3	1.5	0.2
Less than 100 beds	294	0.8	-0.7	-0.5	-0.9	0.8	-0.5	0	0.4	-4.9	-0.4	1.1	-3.6
Urban teaching and DSH:													
Both teaching and DSH	826	0.8	0.1	0.1	0.3	-0.3	0	0.1	0	0	-0.2	-0.9	0.4
Teaching and no DSH	135	0.8	0	0.2	0.2	0.3	0.1	0	0	0	-0.2	0	0.7
No teaching and DSH	1066	0.8	-0.1	-0.1	-0.1	0	0.2	0	0	0	-0.2	-1.2	-0.6
No teaching and no DSH	468	0.8	0.1	0	0.1	-0.2	-0.1	0.1	0	0	-0.2	0	0.3
Special Hospital Types:													
RRC	207	0.8	-0.1	-0.1	-0.1	2.9	-0.4	0.5	0.1	-0.5	-0.2	-1.9	-1.4
SCH	329	1.5	-0.6	0	-0.6	0	-0.1	0	0	-0.1	-0.2	-0.2	-0.5
Former MDH	192	0.8	-0.7	-0.6	-1.1	1.1	-0.4	0	0.3	-9.9	-0.5	0.3	-8.5
SCH and RRC	124	1.5	-0.3	0	-0.3	0.5	-0.1	0	0	0	-0.2	-1.1	-0.1

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Former MDH and RRC	11	0.8	-0.4	0.3	0	2	-0.6	0	0.1	-15.7	-0.2	-0.8	-12.4
Type of Ownership:													
Voluntary	1944	0.8	0	0.1	0.1	0	0	0.1	0	-0.1	-0.2	-0.9	-0.1
Proprietary	895	0.8	0.1	-0.1	0	0.1	0	0.1	0	-0.1	-0.2	-1.4	-0.9
Government	546	0.9	0	-0.2	-0.1	-0.1	-0.1	0	0	-0.1	-0.1	0.3	1.1
Medicare Utilization as a Percent of Inpatient Days:													
0-25	368	0.8	0.2	0.3	0.5	-0.3	-0.1	0	0	0	-0.1	4.4	6
25-50	1807	0.8	0.1	0	0.1	-0.2	0	0.1	0	0	-0.2	-1.5	-0.6
50-65	967	0.9	-0.2	-0.1	-0.2	0.6	0.1	0	0	-0.4	-0.2	-0.9	-0.8
Over 65	171	1	-0.4	-0.3	-0.7	0.8	-0.3	0	0.1	-1.6	-0.4	-0.6	-1.9
FY 2014 Reclassifications by the Medicare Geographic Classification Review Board:													
All Reclassified Hospitals	762	0.9	-0.1	0	0	2.1	0.2	0	0	-0.2	-0.2	-1.2	-0.5
Non-Reclassified Hospitals	2642	0.8	0	0	0.1	-0.7	-0.1	0.1	0	-0.1	-0.2	-0.7	0
Urban Hospitals Reclassified	451	0.8	0	0.1	0.1	1.9	0.4	0	0	0	-0.2	-1.1	-0.2
Urban Nonreclassified Hospitals, FY 2014	1990	0.8	0.1	0	0.2	-0.7	-0.1	0.1	0	0	-0.2	-0.8	0.2

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All Rural Hospitals Reclassified FY 2014	311	1.1	-0.3	-0.3	-0.5	2.7	-0.3	0	0	-0.8	-0.2	-1.6	-1.7
Rural Nonreclassified Hospitals FY 2014	552	1.2	-0.6	-0.2	-0.8	-0.2	-0.3	0.1	0.2	-1.7	-0.3	0.2	-2.2
All Section 401 Reclassified Hospitals	47	1.3	-0.4	-0.3	-0.6	-0.3	0	2.1	0	-2.4	-0.2	-0.2	-1.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	1	-0.8	-0.7	-1.3	4.1	-0.4	0	0	-3.9	-0.2	0	-2.6
Specialty Hospitals Cardiac specialty Hospitals	15	0.8	1.1	0.3	1.5	-0.8	-0.2	0.7	0	0	-0.1	-0.1	1.4

1 Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2012, and hospital cost report data are from reporting periods beginning in FY 2010 and FY 2009.

2 This column displays the payment impact of the proposed hospital rate update, the documentation and coding adjustment and the adjustment to offset the costs of the proposed inpatient status policy including the 1.8 percent adjustment to the national standardized amount (the estimated 2.5 percent market basket update

reduced by the proposed 0.4 percentage point for the multifactor productivity adjustment and the 0.3 percentage point reduction under the Affordable Care Act) and the 0.8 percent documentation and coding adjustment to the national standardized amount and the 0.2 percent adjustment for the policy proposal on admission and medical review criteria applied to the national standardized amount, hospital-specific rate and the Puerto Rico-specific amount.

3 This column displays the payment impact of the proposed changes to the Version 31.0 GROUPER, the proposed changes to the relative weight methodology that uses 19 CCRs as opposed to 15 CCRs, and the proposed recalibration of the MS-DRG weights based on FY 2012 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the proposed recalibration budget neutrality factor of 0.997583 in accordance with section 1886(d)(4)(C)(iii) of the Act.

4 This column displays the payment impact of the proposed update to wage index data using FY 2010 cost report data and proposed changes to the labor-related share. This column displays the payment impact of the proposed application of the wage budget neutrality factor, which is calculated separately from the recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The proposed wage budget neutrality factor is

5 This column displays the combined payment impact of the proposed changes in Columns 3 through 4 and the proposed cumulative budget neutrality factor for MS-DRG and wage changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act. The proposed cumulative wage and recalibration budget neutrality factor of 0.99783 is the product of the proposed wage budget neutrality factor and the proposed recalibration budget neutrality factor.

6 Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the proposed FY 2014 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2014. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the proposed geographic budget neutrality factor of 0.990971.

7 This column displays the effects of the proposed rural floor and imputed floor. The Affordable Care Act requires the rural floor budget neutrality adjustment to be 100 percent national level adjustment. The proposed rural floor budget neutrality factor (which includes the proposed imputed floor) applied to the wage index is 0.990189.

8 This column shows the impact of the policy required under section 10324 of the Affordable Care Act that hospitals located in frontier States have a wage index no less than 1.0.

9 This column displays the impact of section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

10 This column displays the impact of the expiration of MDH status for FY 2014, a non-budget neutral payment provision.

11 This column displays the impact of the implementation of the Hospital Readmissions Reduction Program, section 3025 of the Affordable Care Act, a nonbudget neutral provision that adjusts a hospital’s payment for excess readmissions.

12 This column displays the impact of the implementation of section 3133 of the Affordable Care Act that reduces Medicare DSH payments by 75 percent and establishes an additional uncompensated care payment.

13 This column shows the proposed changes in payments from FY 2013 to FY 2014. It reflects the impact of the proposed FY 2014 hospital update, the proposed

adjustment for documentation and coding, and the proposed adjustment for the policy proposal on admission and medical review criteria. It also reflects proposed changes in hospitals' reclassification status in FY 2014 compared to FY 2013. It incorporates all of the proposed changes displayed in Columns 2, 5, 6, 7, 8, 9, 10, 11 and 12 (the proposed changes displayed in Columns 3 and 4 are included in Column 5). The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.