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FY14 IPPS Final Rule Overview

Overview

CMS issued a final rule updating payment rates under the Medicare inpatient prospective payment system (IPPS) for operating and capital-related costs of acute care hospitals in fiscal year 2014 (FY14). Some of the proposed changes implement certain statutory provisions contained in the Affordable Care Act (ACA) and other legislation. It also updates annual payment rates for inpatient hospital services provided by long-term care hospitals (LTCHs). These changes are applicable to discharges occurring on or after October 1, 2013. CMS proposes to update the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The final updated rate-of-increase limits would be effective for cost reporting periods beginning on or after October 1, 2013. The final rule establishes new or revised requirements for quality reporting by specific providers that are participating in Medicare. Additionally, CMS updates policies relating to the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program, and a number of changes relating to direct graduate medical education.

Impact Analysis

Federal Register pages: 51021-51022

The table below reflects the impact of the overall percentage change in FY14 IPPS payment rates on different providers. This incorporates the impact of statutory adjustments, budget neutrality adjustments, and provider specific impacts of CMS's various proposed policies.

FY14 IPPS Update Impact Table

	All FY14 Changes (%)
All Hospitals	0.5
Urban Hospitals	0.7
Rural Hospitals	-1.6
Teaching Status	
Non-Teaching	-0.2
Fewer Than 100 Residents	0.5
100 or More Residents	1.4
Special Hospital Types	
Rural Referral Center	-1.0
Sole Community Hospital	-0.2

Extracted from table appearing on pages 51021-51022

FY14 Inpatient Hospital Operating Payment Rate Update

Federal Register pages: 50607 – 50608

CMS will apply the applicable percentage increase to the FY14 operating standardized amount of 1.7 percent (including ACA mandated productivity adjustments). However, with further rate adjustments, the applicable increase to the FY14 operating standardized amount for hospitals that submit quality data is 0.7 percent, as reflected in the following chart:

FY14 Market Basket	Minus MFP Adjustment	Minus ACA Mandate	Minus ATRA Adjustment	Minus Admission & Medical Review Criteria	**FY14 Operating Standardized Amount**
2.5%	0.5%	0.3%	0.8 %	0.2%	**0.7**

For hospitals that do not submit quality data, CMS will reduce the update further by 2.0 percent for a net update of -1.3 percent, as reflected in the following table:

FY14 Market Basket	Minus MFP Adjustment	Minus ACA Mandate	Minus ATRA Adjustment	Minus Admission & Medical Review Criteria	Minus Quality Data Penalty	**FY14 Operating Standardized Amount**
2.5%	0.5%	0.3%	0.8 %	0.2%	2.0	**-1.3 %**

CMS notes that at the time that the impact was prepared, 46 hospitals did not receive the full market basket rate-of-increase for FY13 because they failed the quality data submission process or did not choose to participate.

Standardized Payment Rates

Federal Register pages: 50984-50985

CMS will update the labor-related share under the IPPS for FY14 based on the final FY10-based IPPS market basket, which will result in a labor-related share of **69.6** percent (compared to the FY13 labor-related share of 68.8 percent) or 62 percent, depending on which results in higher payments to the hospital. For all IPPS hospitals whose wage indices are greater than 1.0000, for FY14, CMS will apply the wage index to a labor-related share of **69.6** percent of the national standardized amount. For FY14, for all IPPS hospitals whose wage indices are less than 1.0000, CMS will apply the wage index to a labor-related share of **62** percent of the national standardized amount.

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

Please Note: The labeling for the columns in *Federal Register* tables (replicated below) for the labor and non-labor rates state the update factor is 1.7% (MBU of 2.5% - ACA adjustments (productivity .5% +.3%) = 1.7%). However, the rates listed in the tables include all of the CMS adjustments to arrive at the actual FY14 rates. ***Please see Appendix 1 for a complete table reconciling the FY13 standardized amounts to the final FY14 standardized amounts.***

Final FY14 National Adjusted Standardized Amounts

	Full Update (1.7%) Wage Index >1.0		Full Update (1.7%) Wage Index </=1.0	
	Labor-related	**Non-labor**	**Labor-related**	**Non-labor**
FY14 Rates	**$3,737.71**	**$1,632.57**	**$3,329.57**	**$2,040.71**
Current Rates	$3,679.95	$1,668.81	$3,316.23	$2,032.53

	Reduced Update (-0.3%) Wage Index >1.0		Reduced Update (-0.3%) Wage Index </=1.0	
	Labor-related	**Non-labor**	**Labor-related**	**Non-labor**
FY14 Rates	$3,664.21	$1,600.46	$3,264.10	$2,000.57
Current Rates	$3,607.65	$1,636.02	$3,251.08	$1,992.59

Documentation and Coding

Federal Register page: 51040

Section 631 of the American Taxpayer Relief Act (ATRA) amended section 7(b)(1)(B) of Pub. L. 110-90 to require the Secretary to make a recoupment adjustment totaling $11 billion by FY17. CMS actuaries estimate that if CMS were to fully account for the $11 billion recoupment required by section 631 of ATRA in FY14, a onetime -9.3 percent adjustment to the standardized amount would be necessary. Since it is often CMS's practice to delay or phase-in rate adjustments over more than 1 year in order to moderate the effect on rates in any 1 year, it will apply an -0.8 percent adjustment to the standardized amount in FY14. CMS estimates that this level of adjustment would recover $0.96 billion in FY14, with approximately $10.04 billion remaining to be addressed. CMS is not making any future adjustments at this time but notes that if recoupment adjustments of approximately -0.8 percent are implemented in FY14, FY15, FY16, and FY17, the entire $11 billion will be recovered by the end of the statutory 4-year timeline. CMS also notes that as section 631 of the ATRA instructs it to make a recoupment adjustment only to the standardized amount, this adjustment will not apply to the Puerto Rico-specific rate.

Capital Federal Rate for FY14

Federal Register pages: 50998-50991

CMS will establish a national capital federal rate of $429.31 for FY14 (compared to $425.49 for FY13). This is a result of the 0.9 percent update, the budget neutrality factors, and the 0.2 percent reduction to offset the estimated additional IPPS expenditures projected to result from its policy on admission and medical review criteria for hospital inpatient services. The combined effect of all the changes will increase the national capital federal rate by 1.90 percent compared to the FY13 national capital federal rate. These factors are listed in the chart below.

Comparison of Factors and Adjustments: FY13 Capital Federal Rate and FY14 Capital Federal Rate

	FY13	FY14	Change	Percent Change
Update Factor	1.0120	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor	0.9998	0.9987	0.9987	-0.13
Outlier Adjustment Factor	0.9362	0.9393	1.0033	0.33
Adjustment for admission and medical review criteria	N/A	0.9980	0.9980	-0.20
Capital Federal Rate	**$425.49**	**$429.31**	**1.0190**	**1.90**

Outlier Payments

Federal Register pages: 50977-50984

CMS included estimated uncompensated care payments in the computation of the final outlier fixed-loss cost threshold. Specifically, it used the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the outlier fixed-loss cost threshold methodology. Using this methodology, CMS calculated a final outlier fixed-loss cost threshold for FY14 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$21,748** (compared to FY13 $21,821)**.**

Changes to the Hospital Area Wage Index

Federal Register pages: 50585-50588

The wage index will continue, for FY14, to be calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. CMS defines hospital labor market areas based on the Core-Based Statistical Areas (CBSAs). The FY14 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY10 (the FY13 wage indices were based on data from cost reporting periods beginning during FY09). CMS notes that on February 28, 2013, the Office of Management and Budget issued OMB Bulletin No. 13-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provides guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf. While the revisions OMB published on February 28, 2013, are not as sweeping as the changes OMB announced in 2003, the February 28, 2013, bulletin does contain a number of significant changes.

CMS says it was unable to undertake a lengthy process to adopt OMB's revised delineations before publication of this FY14 proposed rule. CMS says it intends to propose changes to the wage index based on the newest CBSA changes in the FY15 proposed rule. The FY14 national average hourly wage (unadjusted for occupational mix) is **$38.3998**. The FY14 Puerto Rico overall average hourly wage (unadjusted for occupational mix) is **$16.4890**.

Puerto Rico Hospitals

Federal Register pages: 50608, 50595, 50972

Puerto Rico hospitals are paid a blended rate for their inpatient operating costs based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. The update to the Puerto Rico-specific operating standardized amount equals the applicable percentage increase as for all other hospitals subject to the IPPS. Accordingly, CMS proposes an applicable percentage increase to the Puerto Rico-specific operating standardized amount of 1.8 percent for FY14.

The national labor-related share is 62 percent for Puerto Rico hospitals because the national wage index for all Puerto Rico hospitals is less than 1.0. CMS will apply the wage index to a labor-related share of 62 percent for all IPPS hospitals whose wage index values are less than or equal to 1.0000. For all IPPS hospitals whose wage indices are greater than 1.0000, CMS will apply the wage index to a labor-related share of 69.6 percent of the national standardized amount. For FY14, all Puerto Rico hospitals have a wage index less than 1.0 because the average hourly rate of every hospital in Puerto Rico divided by the national average hourly rate (the sum of all salaries and hours for all hospitals in the 50 United States and Puerto Rico) results in a wage index below 1.0000. Therefore, the national labor-related share will be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. The standardized amounts for operating costs appear in Tables 1A, 1B, and 1C that are listed and published in section VI of the Addendum to the final rule and are available via the Internet.

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

Federal Register pages: 51002-51003 & 50991

FY14	Rates Wage Index is </= to 1.0	
	Labor	**Non-Labor**
Full update (1.7%)	$3,329.57	$2,040.71
Reduced Update (-0.3%)	$3,264.10	$2,000.57

Under the capital PPS, CMS computes a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national federal rate for capital-related costs. Beginning with discharges occurring on or after October 1, 2004, capital payments made to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital federal rate. For FY13, the special capital rate for hospitals located in Puerto Rico was $207.25. With the

changes CMS is making to the other factors used to determine the capital federal rate (including the adjustment to account for the estimated additional IPPS expenditures that are projected to result from its policy on admission and medical review criteria for hospital inpatient services under Medicare Part A, discussed in section IX.C of the preamble of the final rule), the FY14 special capital rate for hospitals in Puerto Rico is **$209.82**.

FY14 Capital Standard Federal Payment Rate

Federal Register page: 50991

	National	Puerto Rico
2014	$429.31	$209.82

FY15 Hospital-Acquired Condition (HAC) Reduction Program

Federal Register pages: 50707-50729

As part of its efforts to promote higher quality of care and improve outcomes for Medicare beneficiaries, CMS in recent years has undertaken a number of initiatives to reduce the number of hospital-acquired conditions (HACs) among Medicare beneficiaries. HACs are conditions that patients acquire while receiving treatment for another condition in an acute care health setting. In the FY11 IPPS/LTCH PPS final rule, CMS adopted 8 HAC measures into the Hospital Inpatient Quality Reporting (IQR) Program for the FY12 payment determination. These quality measures comprise additional efforts to promote quality of care by reducing the number of HACs in an acute care setting. The program applies to IPPS hospitals. Maryland hospitals are excluded but the state is required to submit an annual report to the HHS Secretary describing how a similar program to reduce HACs in that state achieves or surpasses the measured results in terms of health outcomes and cost savings for the HAC Reduction Program.

The ACA establishes an adjustment to hospital payments for HACs, or a HAC Reduction program, under which payments to applicable hospitals are adjusted to provide an incentive to reduce HACs, effective for discharges beginning on October 1, 2014, and for subsequent program years. The amount of payment shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under section 1886(d) or 1814(b)(3) of the Social Security Act (the Act), as applicable. This payment adjustment is calculated and made after payment adjustments under the Hospital VBP Program and the Hospital Readmissions Reduction Program, respectively, are calculated and made. The payment adjustment would apply to an applicable hospital that ranks in the top quartile (25 percent) of all subsection (d) hospitals, relative to the national average, of conditions acquired during the applicable period, as determined by the HHS Secretary.

In section V.I of the preamble of the final rule, CMS establishes measures, scoring, and a risk adjustment methodology to implement the FY15 payment reduction under the HAC Reduction Program. The final rule also establishes the rules governing the payment adjustment under the HAC Reduction Program, and amends existing § 412.150 (the

section that describes the basis and scope of Subpart I of Part 412, which contains the regulations governing adjustments to the base operating DRG payment amounts under the IPPS for inpatient operating costs) to incorporate the basis and scope of §§ 412.170 and 412.172 for the HAC Reduction Program.

In the first year of the program, FY15, CMS will use measures that are part of the IQR program. CMS will group measures into two separate domains (Domain 1 and Domain 2) to calculate a total HAC score in order to determine the payment adjustment. After consideration of the public comments received, CMS is adopting the PSI-90 composite for Domain 1, and the CDC measures for Domain 2. Given that PSI-90 has been both NQF-endorsed and fully supported by the Measures Application Partnership (MAP) for the HAC Reduction Program, CMS believes that it is more suitable. CMS also believes that the PSI-90 measure, as a composite measure of patient safety, appropriately encourages robust hospital attention to patient safety events.

Domain 1

Domain 1 will consist of a composite PSI-90 measure set:

- PSI-6 (Iatrogenic pneumathorax rate)
- PSI-7 (Central venous catheterrelated blood stream infections rate)
- PSI-8 (Postoperative hip fracture rate)
- PSI-12 (Postoperative PE/DVT rate)
- PSI-13 (Postoperative sepsis rate)
- PSI-14 (Wound dehiscence rate)
- PSI-15 (Accidental puncture & laceration rate)

Domain 2

Domain 2 CMS will use the following CDC NHSN measures:

- Central line-associated bloodstream infection CLABSI (FY015 onward)
- Catheter-associated urinary tract infection CAUTI (FY15 onward)
- Surgical Site Infection (SSI):
  - SSI following colon surgery (FY16 onward)
  - SSI following abdominal hysterectomy (FY16 onward)
- Methicillin-resistant staphylococcus aureus (MRSA) bacteremia (FY17 onward)
- Clostridium difficile (FY17 onward)

Performance Scoring

CMS will use a scoring methodology similar to the achievement scoring methodology that is currently used under the Hospital VBP Program. However, in response to public comments, the scoring will begin at the minimum value for each measure rather than the 75th percentile, as originally proposed. The finalized methodology will assess the top quartile of applicable hospitals for HACs based on the Total HAC Score. As provided in the final rule, CMS will calculate a Total HAC Score for each hospital by using the hospital's performance score on each measure within a domain to determine a score for each domain, then multiplying each domain score by the following weights: Domain 1-(AHRQ PSI-90), 35 percent, and Domain 2-(CDC NHSN Measures), 65 percent. It will then combine the weighted domain scores to determine the Total HAC Score. CMS will

use each hospital's Total HAC Score to determine the top quartile of subsection (d) hospitals (applicable hospitals) that will be subject to the payment adjustment beginning with discharges on or after October 1, 2014.

The support for Domain 2 measures in general, coupled with multiple recommendations to provide more weight to Domain 2 measures, specifically those from the Medicare Payment Advisory Commission (MedPAC), has led CMS to conclude that such scoring changes are necessary. With respect to a subsection (d) hospital, CMS will identify as proposed the top quartile of all hospitals that are subsection (d) hospitals with respect to their rate of HACs during the applicable period (§ 412.172(e)(1)). As proposed, CMS will use a Total HAC score to identify applicable hospitals and will identify the 25 percent of hospitals with the highest Total HAC scores as applicable hospitals (§ 412.172(e)(2)). In addition, CMS will calculate the Total HAC score by weighing Domain 1 at 35 percent plus Domain 2 at 65 percent (§ 412.172(e)(3)).

Risk factors such as the patient's age, gender, comorbidities, and complications would be considered in the calculation of the measure rates so that hospitals serving a large proportion of sicker patients would not be unfairly penalized.

Maryland Exemption
Section 1886(p)(2)(c) of the Social Security Act (the Act) specifies that the Secretary may exempt hospitals paid under 1814(b)(3) ''from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the state for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.'' Accordingly, a program established by the state of Maryland that could serve to exempt hospitals in the state from the HAC Reduction Program would focus on hospitals operating under the waiver provided by section 1814(b)(3) of the Act, that is, those hospitals that would otherwise have been paid by Medicare under the IPPS, absent this provision.

CMS will establish criteria for evaluation of Maryland's annual report to the HHS Secretary to determine whether Maryland will be exempted from the application of payment adjustments under this program for a given fiscal year. Maryland's annual report to the Secretary and request for exemption from the Hospital-Acquired Condition Reduction Program must be resubmitted and reconsidered annually. For FY15, Maryland would submit a preliminary report to CMS by January 15, 2014, and a final report by June 1, 2014. The criteria to evaluate Maryland's program is for FY15, the first year of the payment adjustment under the HAC Reduction Program, and CMS's evaluation criteria may change through notice and comment rulemaking as this program evolves.

Hospital Readmissions Reduction Program

Federal Register pages: 50649-50676

The Affordable Care Act establishes the "Hospital Readmissions Reduction Program," effective for discharges from an "applicable hospital" beginning on or after October 1, 2012. The program requires a reduction to a hospital's base operating DRG payments to account for excess readmissions of three hospital risk-standardized readmission measures

endorsed by the NQF for FY13, which are currently in the Hospital IQR Program:

- Acute Myocardial Infarction (AMI) 30-day Risk Standardized Readmission Measure (NQF #0505)
- Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (NQF #0330)
- Pneumonia (PN) 30-day Risk Standardized Readmission Measure (NQF #0506)

Appendix 2 provides a table listing the ICD-9 codes CMS will use to identify each applicable condition.

Refined Readmission Measures
Since the development and implementation of the initial three readmission measures adopted under the Hospital Readmissions Reduction Program, CMS received comments from HFMA and others encouraging it to identify and not count as readmissions a broader range of planned readmissions. In response, CMS worked with experts in the medical community, other stakeholders, and the public to identify planned readmissions for procedures and treatments for exclusion from the readmission measures. Specifically, it developed an expanded "planned readmission algorithm" in the CMS Planned Readmission Algorithm Version 2.1 Report to identify planned readmissions across its readmission measures. CMS will apply the algorithm to the AMI, HF, and PN measures for FY14. Following its ad hoc review, NQF endorsed the revised AMI, HF, and PN measures, as required by statute.

The Planned Readmission Algorithm uses a flow chart and four tables of procedures and conditions to implement these principles and to classify readmissions as planned or unplanned. The flow chart and tables are available in a report, "CMS Planned Readmission Algorithm Version 2.1," which is available on the CMS website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment Instruments/HospitalQualityInits/Measure-Methodology.html. CMS incorporated the algorithm into each condition-specific and procedure-specific readmission measure. For most readmission measures, including the AMI, HF, and PN measures, CMS used one standard version of the algorithm--the CMS Planned Readmission Algorithm Version 2.1. However, for a subset of readmission measures, CMS revised the list of potentially planned procedures or acute primary diagnoses after applying the standard algorithm version because it was clinically indicated. For example, for the Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) readmission measure that will be adopted in this final rule for FY15, 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 also available in the CMS Planned Readmission Algorithm Version 2.1 report.

For the proposed revised AMI, HF, and PN measures, all of which now account for planned readmissions by incorporating the CMS Planned Readmission Algorithm Version 2.1, CMS is proposing 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. 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 readmissions for the index admission. This change in counting practice 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). These changes will be applied to the readmissions measures for the FY14 payment determination and subsequent years.

Expansion of the Applicable Conditions for FY15
Beginning with FY15, the HHS Secretary can expand the applicable conditions beyond the three conditions for which measures have been endorsed, to the additional four conditions that have been identified by MedPAC in its report to Congress in June 2007, and to other conditions and procedures as determined appropriate by the HHS Secretary. Currently, the four conditions and procedures recommended by MedPAC are coronary artery bypass graft (CABG) surgery, chronic obstructive pulmonary disease (COPD), percutaneous coronary intervention (PCI), and other vascular conditions. Effective for the calculation of the readmissions payment adjustment factors in FY15, CMS is finalizing its proposal to include a measure of patients admitted for an acute exacerbation of COPD. Also, although MedPAC did not recommend inclusion of patients admitted for elective THA and TKA, CMS considers this category appropriate for the Hospital Readmissions Reduction Program because it is a high-volume and high-expenditure procedure. CMS is finalizing the adoption of this measure in the final rule also.

CMS notes that at this point, it is not feasible to add readmission measures for three of the conditions identified in MedPAC's 2007 report to Congress (CABG, PCI, and other vascular conditions).

Floor Adjustment Factor and Applicable Period for FY14
CMS is finalizing its proposal that, for FY14, the floor adjustment factor is 0.98. CMS will calculate the excess readmission ratios for payment adjustments for hospitals using data from the 3-year time period from July 1, 2009, to June 30, 2012.

Hospital Readmissions Reduction Program Exemption
Section 1886(q)(2)(B)(ii) of the Act allows the Secretary to exempt Maryland 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 established by Congress for the program as applied to ''subsection (d) hospitals.'' Accordingly, a program established by the State of Maryland that could serve to exempt it from the Hospital Readmissions Reduction Program would focus on those ''applicable'' Maryland hospitals operating under the waiver provided by section 1814(b)(3) of the Act; that is, those hospitals that would otherwise have been paid by Medicare under the IPPS absent this provision. According to the final rule, the state of Maryland must submit its preliminary report to CMS no later than January 15 of each year and a final report no later than June 1 of each year for it to consider, through the IPPS/ LTCH PPS proposed and final rules for a federal fiscal year, its exemption from the Hospital Readmissions Reduction Program for the upcoming federal fiscal year. In addition, CMS finalizes the policy to exempt Maryland hospitals paid under section 1814(b)(3) of the Act from the Hospital Readmissions Reduction Program for FY14.

Hospital Quality Reporting Program

Federal Register pages: 50775-50837

Annual payment updates for hospitals that do not participate successfully in the Hospital IQR program are reduced by 2.0 percentage points. Beginning with FY15, hospitals that do not participate will lose one-quarter of the percentage increase in their payment updates.

Impacts Payment Determination	Collection Period	**Measures Listed in Appendix**
FY14	January 1, 2012, through December 31, 2012	• **Adopted Measures 3a** • **Suspended Measures 3b** • **Retired Measures 3c**
FY15	January 1, 2013, through December 31, 2013	• **Adopted Measures 3d** • **Suspended Measures 3e** • **Removed Measures 3f**
FY16	January 1, 2014, through December 31, 2014	• **Previously Adopted and Finalized measures 3g** • **Removed Measures 3h**

Updates to Existing Measures

In the FY13 IPPS/LTCH PPS final rule, CMS finalized 59 measures for the Hospital IQR Program measure set for the FY15 payment determination and subsequent years. CMS will incorporate refinements for several measures that are currently adopted in the Hospital IQR Program. These refinements have either arisen out of the NQF endorsement maintenance process or during its internal efforts to harmonize measurement approaches. Based on the feedback received, CMS will make the following refinements:

- Incorporate the planned readmission algorithm in 30-day readmission measures for AMI, HF, PN, THA/TKA, and Hospital-Wide Readmission to match recent NQF endorsement maintenance decisions beginning in 2013
- Defer the implementation date of the CLABSI/CAUTI expansion to non-ICU settings to January 1, 2015
- Refine SCIP-INF-4 to match refinements made during NQF reendorsement
- Include Railroad Retirement Board beneficiaries in the MSPB measure for future Hospital IQR Program beginning in 2014.

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

CMS will add the following five new risk-adjusted claims-based outcome measures to the Hospital IQR Program for the FY16 payment determination and subsequent years:

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

CMS is finalizing five new claims-based measures for a total of 57 measures for the FY16 payment determination and subsequent years.

Proposed Removal of Hospital IQR Program Measures for the FY16 Payment Determination

For FY16, CMS will remove six chart-abstracted measures and one structural measure. CMS will also suspend the IMM-1 measure from the Hospital IQR Program measure set, beginning with the FY16 payment determination, until further notice.

- PN-3b: Blood Culture Performed in the Emergency Department Prior to First Antibiotic Received in the Hospital Measure
- HF-1: Discharge Instructions Measure
- IMM-1: Immunization for Pneumonia Measure (data collection suspended until the guidelines stabilize and are well-established)
- Participation in a Systematic Clinical Database Registry for Stroke Care
- AMI–2: Aspirin Prescribed at Discharge
- AMI–10: Statin Prescribed at Discharge
- HF–3: ACEI or ARB for LVSD
- SCIP-Inf–10: Surgery Patients with Perioperative Temperature Management

Appendix 3e contains a table showing both previously adopted and new quality measures for FY16 payment determination and subsequent years. This table does not include suspended measures and removed measures.

Electronic Clinical Quality Measures

Hospitals participating in the Hospital IQR Program will have the option to voluntarily report up to four measure sets electronically for the same quarter for the FY16 Hospital IQR Program. Hospitals that choose this option will meet their Hospital IQR reporting requirement with respect to each of these measure sets if they report all the measures in that measure set (with the exception of STK-1, if the hospital chooses that measure set) electronically for one quarter.

1. Stroke (STK)
2. Venous thromboembolism (VTE)

3. Emergency department (ED)
4. Perinatal care (PC)

CMS notes that the STK-1 measure need not be reported as part of the STK measure set for those electronically reporting because no electronic clinical quality measure exists for STK-1. As further detailed in section IX.A.9.d of the preamble of the final rule, hospitals may electronically report one or more of these four measure sets electronically.

CMS will make the electronically reported data public on Hospital Compare if it deems that the data are accurate enough to be publicly reported. In addition, CMS intends to develop and propose a validation strategy for electronically reported quality measure data in future rulemaking. CMS also plans to validate electronic clinical quality measure data as part of the regular Hospital IQR validation program for the FY16 payment determination.

The chart below provides a summary of the finalized reporting periods and electronic submission deadlines for the FY16 Hospital IQR Program:

FY 2016 Hospital IQR Program Electronic Reporting Periods and Submission Deadlines for Eligible Hospitals that are Beyond their First Year of the Medicare EHR Incentive Program	
Discharge Reporting Periods	**Submission Deadlines**
January 1, 2014 - March 31, 2014	November 30, 2014
April 1, 2014 - June 30, 2014	November 30, 2014
July 1, 2014 - September 30, 2014	November 30, 2014
October 1, 2014 - December 31, 2014	Not Applicable

These four measure sets are also already included in the Hospital IQR Program as chart-abstracted measures. The measures in three of these four measure sets—STK, VTE, and ED (15 measures total)—are already included in the Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs. Although electronic reporting is voluntary in FY14, CMS strongly encourages participation in voluntary electronic reporting during CY14 to prepare for required electronic reporting that CMS intends to add to be collected via EHRs in the future. The five new measures listed below were reviewed by the MAP for inclusion in the Hospital IQR Program:

- 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)

CMS notes that it will take comments and suggestions into consideration for future measure selections.

Form, Manner, and Timing of Quality Data Submission

CMS made changes to the procedural requirements in the rule. CMS will align the last date to withdraw from the program with the final measure data submission deadline. The current withdrawal deadline is August 15 of the fiscal year preceding the fiscal year for which a Hospital IQR Program payment determination will be made. CMS will change that deadline to May 15 prior to the start of the payment year affected in order to align with the submission quarter deadline because it is striving to provide more timely feedback to hospitals regarding their annual payment update status. Also, for the FY16 payment determination and subsequent years, submissions to QualityNet will be accepted until 11:59 pm Pacific time.

Data Submission Requirements for Voluntarily Electronically Reported Quality Measures for FY16 Payment Determination

To begin to align quality measure reporting under the Hospital IQR and Medicare EHR Incentive Programs, CMS is proposing that hospitals may choose to either electronically report at least one quarter of CY14 quality measure data for each measure in each of four Hospital IQR measure sets (STK, VTE, ED, and PC) or continue reporting all of these measures using chart abstracted data for all four quarters of CY14. If a hospital chooses to electronically report the four measure sets, all of the quality measures in those four measure sets must be electronically reported for the same reporting quarter(s), although the hospital may choose which quarter(s) to report. If a hospital chooses to report the four measure sets electronically for the Hospital IQR Program, but does not want the data to be used to determine whether the hospital has satisfied the Medicare EHR Incentive Program clinical quality measure reporting requirement, the reporting periods and deadlines are as follows:

Hospital IQR Program Chart-abstracted Measure Reporting Periods and FY16 Deadlines	
Discharge Reporting Periods	**Submission Deadlines**
January 1, 2014–March 31, 2014	August 15, 2014
April 1, 2014–June 30, 2014	November 15, 2014
July 1, 2014–September 30, 2014	February 15, 2015
October 1, 2014–December 31, 2014	May 15, 2015

If a hospital wants CMS to also use the electronically reported data to determine whether it has satisfied the Medicare EHR Incentive Program clinical quality measure reporting requirement, the Medicare EHR Incentive Program reporting periods and deadlines could be used to satisfy the Hospital IQR Program requirements. The Medicare EHR Incentive Program clinical quality measure reporting follows the federal fiscal year, while the Hospital IQR Program follows the calendar year. The table below lists the FY14 Medicare EHR Incentive Program reporting periods and submission deadlines.

Medicare EHR Incentive Program Reporting Periods and Deadlines FY14	
Reporting Periods	**Submission Deadlines**
For eligible hospitals in their first year of the Medicare EHR Incentive Program—Any 90 consecutive days in FY14 prior to July 1, 2014	July 1, 2014
For eligible hospitals that are beyond their first year of the Medicare EHR Incentive Program reporting electronically—Any FY14 quarter, or the entire FY14 (October 1, 2013—	November 30, 2014

September 30, 2014)	

CMS notes that the submission deadline is November 30, 2014, for hospitals that are beyond their first year of the Medicare EHR Incentive Program.

New HAI Measures for Validation Process
For the FY16 payment determination and subsequent years, CMS will validate two new HAI measures: methicillin-resistant staphylococcus aureus (MRSA) bacteremia laboratory-identified (LabID) events and clostridium difficile (CDI) LabID events. MRSA and CDI were finalized for inclusion in the Hospital IQR Program in the FY12 IPPS/LTCH PPS final rule, starting with the FY15 payment determination.

Hospital Value-Based Purchasing (VBP) Program

Federal Register pages: 50676-50707

The Hospital VBP Program applies to payments for hospital discharges occurring on or after October 1, 2012. CMS is required to make value-based incentive payments under the Hospital VBP Program to hospitals that meet or exceed performance standards for a performance period for a fiscal year. The total amount available for value-based incentive payments for a fiscal year will be equal to the total amount of the payment reductions for all participating hospitals for such fiscal year, as estimated by the Secretary. For FY14, the available funding pool is equal to 1.25 percent of the base-operating DRG payments to all participating hospitals. Based on the March 2013 update of the FY12 MedPAR file, CMS estimates that the amount available for value-based incentive payments for FY14 is $1.1 billion. CMS will utilize a linear exchange function to translate this estimated amount available into a value-based incentive payment percentage for each hospital, based on its Total Performance Score (TPS). It will then calculate a value-based incentive payment adjustment factor, which will be applied to the base operating DRG payment amount for each discharge occurring in FY14 on a per-claim basis.

Year	Measure Domain	Baseline Period	Performance Period	Measures Listed in Appendix:
FY14	Clinical Process of Care	April 1, 2010 – December 31, 2010	April 1, 2012 – December 31, 2012	• **Adopted Measures 4a** • **Performance Standards 4b**
	Patient Experience of Care	April 1, 2010 – December 31, 2010	April 1, 2012 – December 31, 2012	
	Outcome Mortality	July 1, 2009 – June 30, 2010	July 1, 2011 – June 30, 2012	
FY15 (Final)	Clinical Process of Care	January 1, 2011 – December 31, 2011	January 1, 2013 – December 31, 2013	• **Adopted Measures 5a** • **Proposed Performance Standards 5b**
	Patient Experience of Care	January 1, 2011 – December 31, 2011	January 1, 2013 – December 31, 2013	

	Outcome • Mortality • AHRQ • CLABSI	 October 1, 2010 – June 30, 2011 October 15, 2010 – June 30, 2011 January 1, 2011– December 31, 2011	 October 1, 2012 – June 30, 2013 October 15, 2012 – June 30, 2013 February 1, 2013– December 31, 2013	• **Removed Measures 5c**
	Efficiency • Medicare Spending Per Beneficiary -1	May 1, 2011 – December 31, 2011	May 1, 2013 – December 31, 2013	
FY16 (Final)	Clinical Process of Care	January 1, 2012 – December 31, 2012	January 1, 2014 – December 31, 2014	• **Final/Readopted Measures 6a** • **Performance Standards 6b**
	Patient Experience of Care	January 1, 2012 – December 31, 2012	January 1, 2014 – December 31, 2014	
	Efficiency	January 1, 2012 – December 31, 2012	January 1, 2014 – December 31, 2014	
(Final)	Mortality	October 1, 2010– June 30, 2011	October 1, 2012– June 30, 2014	
(Final)	AHRQ PSI	October 15, 2010– June 30, 2011	October 15, 2012– June 30, 2014	

Removed Measures

CMS removed the following measures from the Hospital VBP Program for FY15

- SCIP-Inf-10
- AMI-10
- SCIP-VTE-1

CMS will remove the following measures from the Hospital VBP Program for FY16

- AMI-8a: Primary PCI Received within 90 Minutes of Hospital Arrival
- PN-3b, Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- HF-1, Discharge Instructions
- SCIP-Inf-1
- SCIP-Inf-4

CMS notes that when it published the FY14 IPPS/LTCH PPS proposed rule, it inadvertently did not make FY16 performance and baseline period proposals for CLABSI, CAUTI, and SSI. These periods, included in the CY14 OPPS/ASC proposed rule, are as follows:

Proposed Performance and Baseline Periods for CAUTI/CLABSI/SSI under the FY 2016 Hospital VBP Program		
Domain	**Baseline Period**	**Performance Period**
Outcome • CAUTI / CLABSI / SSI	• January 1, 2012 – December 31, 2012	• January 1, 2014 – December 31, 2014

CMS refers readers to this rule for further discussion, and will consider public comment on the proposal in the CY14 OPPS/ASC final rule with comment period.

New VBP Measures for FY16
CMS is adopting the following new measures for FY16:

- One new clinical process measure
  - IMM-2 influenza immunization
- Two new healthcare-associated infection measures
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI), which is stratified into two separate surgery sites

Future Efficiency Domain Measures
CMS is considering the inclusion of additional measures in the efficiency domain for future years of both the Hospital IQR Program and the Hospital VBP Program through future rulemaking. CMS is considering adding a measure of hospitals' performance on treating Medicare beneficiaries appropriately as a hospital inpatient or a hospital outpatient. Specifically, CMS is considering constructing a measure 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 hospital inpatient claim. CMS notes that it is considering such a measure in light of its recent proposal that when a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was determined not to be reasonable and necessary, or when a hospital determines after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, the hospital may be paid for all Part B services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient, if the beneficiary is enrolled in Medicare Part B. CMS is also considering the addition of Medicare spending measures specific to physician services such as Radiology, Anesthesiology, and Pathology that occur during a hospital stay. CMS received comments on this consideration, and notes that it will take them into consideration as it develops any future measures for the efficiency domain

Performance Standards for the FY16 Hospital VBP Program Measures
CMS has defined the "achievement threshold" as the median, or 50th percentile, of all hospitals' performance on a measure during a baseline period (or during the performance period in the case of the Medicare Spending per Beneficiary (MSPB) measure) with respect to a fiscal year. CMS will revise this definition in order to clarify that, while this is true for the majority of Hospital VBP Program measures, it does not apply to the MSPB. The performance standards for the MSPB measure are based on performance period data, as finalized in the FY12 IPPS/LTCH PPS final rule. Accordingly, CMS will

revise the definition of "achievement threshold" to read: "Achievement threshold (or achievement performance standard) means the median (50th percentile) of hospital performance on a measure during a baseline period with respect to a fiscal year, for Hospital VBP Program measures other than the Medicare Spending per Beneficiary measure, and the median (50th percentile) of hospital performance on a measure during the performance period with respect to a fiscal year, for the MSPB measure."

CMS has defined the "benchmark" as the arithmetic mean of the top decile of all hospitals' performance on a measure during the baseline period. Similar to the definition of "achievement threshold," this definition of "benchmark" does not apply to the MSPB measure. CMS has revised the definition of "benchmark" to read: "Benchmark means the arithmetic mean of the top decile of hospital performance on a measure during the baseline period with respect to a fiscal year, for Hospital VBP Program measures other than the MSPB measure, and the arithmetic mean of the top decile of hospital performance on a measure during the performance period with respect to a fiscal year, for the MSPB measure." CMS continues to believe that the finalized methodology for calculating performance standards is appropriate for the Hospital VBP Program, and recognizes that it has an obligation to calculate the numerical values for each of these standards accurately. However, CMS is also concerned that if it displays the numerical values of the performance standards in a particular rulemaking document, but then discovers a data or calculation error, the result might be that hospitals are held to inaccurate performance standards. CMS will interpret the finalized definitions of "achievement threshold" and "benchmark" to not include the numerical values that result when the performance standards are calculated.

CMS notes that the numerical values for the performance standards displayed represent estimates based on the most recently available data, and will update the numerical values in the FY14 IPPS PPS final rule. Because the MSPB measure's performance standards are based on performance period data, CMS is unable to provide numeric equivalents for the standards at this time. In the proposed rule, CMS provided historical performance standards for information purposes. In the final rule, CMS provides more recent historical performance standards, also for information purposes.

Proposed Domain Weighting for the FY16 Hospital VBP Program for Hospitals that Receive a Score on All Domains

In the FY13 IPPS/LTCH PPS final rule, CMS added the efficiency domain to the Hospital VBP Program beginning with the FY15 Hospital VBP Program. It also finalized its proposal for the domain weights for the FY15 Hospital VBP Program for hospitals that receive a score on all four proposed domains. CMS stated that it believed the domain weighting appropriately reflects its priorities for quality improvement in the inpatient hospital setting and begins aligning with the National Quality Strategy's priorities. CMS believes that the domain weighting will continue to improve the link between Medicare payments to hospitals and patient outcomes, efficiency and cost, and the patient experience. CMS also believes that domains need not be given equal weight, and that over time, scoring methodologies should be weighted more towards outcomes, patient experience of care, and functional status measures (for example, measures assessing physical and mental capacity, capability, well-being and improvement). CMS took these

considerations into account when developing the final domain weighting proposal for the FY16 Hospital VBP Program, displayed in the following table:

Finalized Domain Weights for the FY16 Hospital VBP Program for Hospitals Receiving a Score on All Proposal	
Domain	**Weight**
Clinical Process of Care	10 Percent
Patient Experience of Care	25 Percent
Outcome	40 Percent
Efficiency	25 Percent

CMS believes that the domain weighting will continue to improve the link between Medicare payments to hospitals and patient outcomes, efficiency and cost, and the patient experience. The final domain weighting places the highest relative weight on measures of outcomes and continues to place significant weight on the patient experience and on efficiency, while maintaining clinical processes as an important component of the program's quality measurement.

The following tables contain the final domain weights for FYs 2015 and 2014.

Final Domain Weights for the FY15 Hospital VBP Program for Hospitals Receiving a Score on All Proposed Domains	
Domain	**Weight**
Clinical Process of Care	20%
Patient Experience of Care	30%
Outcome	30%
Efficiency	20%

Finalized Domain Weights for the FY14 Hospital VBP Program for Hospitals Receiving a Score on All Proposed Domains	
Domain	**Weight**
Clinical Process of Care	45%
Patient Experience of Care	30%
Outcome	25%

Domain Weighting for the FY16 Hospital VBP Program for Hospitals Receiving Scores on Fewer than Four Domains

In prior program years, CMS finalized a policy that hospitals must have received domain scores on all finalized domains in order to receive a TPS. However, since the Hospital VBP Program has evolved from its initial two domains to an expanded measure set with additional domains, CMS considered whether it was appropriate to continue this policy. In the FY13 IPPS/LTCH PPS final rule, CMS finalized its proposal for a higher minimum number of cases for the three 30-day mortality measures for the FY15 Hospital VBP Program than was finalized for the FY14 Hospital VBP Program, but was concerned that the relatively higher minimum number of cases could result in a substantially larger number of hospitals being excluded from the Hospital VBP Program.

Therefore, in the FY13 IPPS/LTCH PPS final rule, CMS finalized its proposal that, for the FY15 Hospital VBP Program and subsequent years, hospitals with sufficient data to receive at least two domain scores (that is, sufficient cases and measures to receive a domain score on at least two domains) will receive a TPS. CMS also finalized its proposal that, for hospitals with at least two domain scores, TPSs would be reweighted proportionately to the scored domains to ensure that the TPS is still scored out of a possible 100 points and that the relative weights for the scored domains remain equivalent to the weighting which occurs when there are scores in all four domains.

CMS will continue this approach for the FY16 Hospital VBP Program and subsequent fiscal years for purposes of eligibility for the program. However, as detailed in the rule, CMS will reclassify the Hospital VBP Program's quality measurement domains beginning with the FY17 Hospital VBP Program to align more closely with CMS's National Quality Strategy.

After consideration of the public comments it received, CMS is finalizing its proposal to adopt new quality measurement domains based on the CMS National Quality Strategy (NQS) for the FY17 Hospital VBP Program as proposed. CMS intend to propose more details about this policy in future rulemaking. Therefore, CMS will adopt the following domains and domain weights for the FY17 Hospital VBP Program:

Proposed Domains and Domain Weights for the FY 2017 Hospital VBP Program for Hospitals Receiving a Score on All Proposed Domains	
Domain	**Weight**
Safety	15 percent
Clinical Care • Clinical Care – Outcomes • Clinical Care – Process	35 percent • 25 percent • 10 percent
Efficiency and Cost Reduction	25 percent
Patient and Caregiver Centered Experience of Care/Care Coordination	25 percent

CMS sought comment on how it should address minimum numbers of cases and measures under sections 1886(o)(1)(C)(ii)(III) and (IV) of the Act if it finalizes this domain structure for the FY17 Hospital VBP Program. If it adopted the NQS-based domains solely for purposes of constructing the TPS, it could retain the general case and measure minimums structure adopted for prior program years. However, given the requirement in section 1886(o)(1)(C)(iii) of the Act that the Secretary conduct an independent analysis of what numbers are appropriate, it is also considering if it should commission such an analysis for the NQS domains, as modified. CMS intends to address this issue in future rulemaking.

Disaster/Extraordinary Circumstance Exception under the Hospital VBP Program
Out of concern that hospital performance under the Hospital VBP Program might be adversely impacted as a direct result of a significant natural disaster or other extraordinary circumstance, CMS proposed to adopt a Hospital VBP Program extraordinary circumstances exception process. In developing its proposed approach, it

considered the feasibility of adopting an exception that would allow a hospital to not have the measure data submitted during the affected time period included in its measure scores. Essentially, this policy could prevent the possibility that a hospital's TPS is significantly and negatively affected by a natural disaster or other extraordinary circumstance, which CMS believed would alleviate the hospital's concerns.

After consideration of the public comments received, CMS is finalizing a policy under which it will consider, upon a hospital's request and after its review, providing an exception from a Hospital VBP Program year to hospitals affected by natural disasters or other extraordinary circumstances. CMS is not, however, finalizing its proposal that these exception requests must be made at the same time as waiver requests under the Hospital IQR Program. CMS will require that disaster exception requests be submitted within 90 calendar days of the date that the natural disaster or other extraordinary circumstance occurred. It believes that this extended timeline for disaster exception requests is responsive to the concerns expressed by commenters, and enables hospitals to evaluate fully the impacts of natural disasters or other extraordinary circumstances on their performance under the Hospital VBP Program.

Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A

Federal Register pages: 50746-50747

CMS clarifies the rules governing physician orders of hospital inpatient admissions for payment under Medicare Part A. CMS clarifies and specifies in the regulations that an individual becomes an inpatient of a hospital, including a critical access hospital (CAH), when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A. In the CY13 OPPS/ASC proposed rule and final rule with comment period, CMS expressed concern about recent increases in the length of time that Medicare beneficiaries spend as hospital outpatients receiving observation services. CMS also solicited and summarized public comments on potential policy changes it could make to improve clarity and consensus among providers, Medicare, and other stakeholders regarding the relationship between admissions decisions and appropriate Medicare payment, such as when a Medicare beneficiary is appropriately admitted to a hospital as an inpatient.

In the Part B Inpatient Billing proposed rule, CMS proposed that when a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was deemed not to be reasonable and necessary, or when a hospital determines after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, a hospital may be paid for all Medicare Part B services (except for those that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient, if the beneficiary is enrolled in Medicare Part B. This policy would apply when CMS or a Medicare review contractor determines that the hospital admission was not reasonable and necessary, or when a hospital determines after a beneficiary has been discharged that the beneficiary should have received hospital outpatient services rather than hospital inpatient services. CMS also proposed to continue applying the timely filing

restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within one year from the date of service.

In addition to evaluating its policy related to Medicare Part B inpatient billing following denials of Medicare Part A inpatient claims on the basis that the inpatient admission was not reasonable and necessary or following a hospital self-audit, CMS also believes it is important to consider whether it can provide more clarity regarding the relationship between inpatient admission decisions and Medicare payment. In the CY13 OPPS/ASC final rule with comment period, CMS discussed revising hospital inpatient status criteria as one of several policy clarifications or changes suggested by stakeholders to improve policies governing when a Medicare beneficiary should be admitted as an inpatient, and how hospitals should be paid by Medicare for the associated costs they incur.
In the final rule CMS clarifies that a beneficiary becomes a hospital inpatient if a physician (or other qualified practitioner as provided in the regulations) orders inpatient admission in accordance with the hospital conditions of participation, and that Medicare pays under Part A for such an admission if the order is documented in the medical record. However, the order must be supported by objective medical information for purposes of the Part A payment determinations. Under its final policy, Medicare's external review contractors will presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing two "midnights") in the hospital receiving medically necessary services. In the final rule, CMS clarifies its longstanding policy on how Medicare review contractors review inpatient hospital admissions for payment under Medicare Part A. CMS also clarifies how it will instruct contractors to review inpatient stays spanning less than 2 midnights after admission.

Medical Review Criteria for Payment of Inpatient Hospital Admissions under Part A
Under the final policy, Medicare's external review contractors will presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing 2 "midnights") in the hospital receiving medically necessary services. Similarly, CMS will presume that generally services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required an inpatient level of care.

Payment Adjustment
CMS actuaries estimate that the final policy including a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing 2 "midnights") would increase IPPS expenditures by approximately $220 million.

CMS actuaries examined FY09 through FY11 Medicare claims data for extended hospital outpatient encounters and shorter stay hospital inpatient encounters, and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters, which represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under the IPPS. Since

shorter stay hospital inpatient encounters currently represent approximately 17 percent of the IPPS expenditures, CMS actuaries estimated that 17 percent of IPPS expenditures will increase by 1.2 percent under this policy. After consideration of the comments received, CMS is finalizing a reduction to the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount of -0.2 percent to offset the additional $220 million in expenditures.

LTCH PPS Payment Rates for FY14

Federal Register pages: 50760-50768

CMS is establishing an update to the LTCH PPS standard federal rate for FY14 based on the full LTCH PPS market basket increase estimate (for this final rule, estimated to be 2.5 percent), subject to an adjustment based on changes in economy-wide productivity and any additional reductions.

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	**FY15 Payment Rate Update**
2.5	0.5%	0.3%	**1.7%**

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	Minus Quality Data Penalty	**FY15 Payment Rate Update**
2.5	0.5%	0.3%	2.0%	**-0.3%**

The standard federal rate for FY14 will be further adjusted by an adjustment factor of 0.98734 (or approximately -1.3 percent) under the second year of the 3-year phase-in of the one-time prospective adjustment of 0.9625 (a permanent reduction of approximately 3.75 percent) to account for the estimated difference between projected aggregate FY03 LTCH PPS payments and the projected aggregate payments that would have been made in FY03 under the Tax Equity and Fiscal Responsibility Act of 1982 payment system if the LTCH PPS had not been implemented. As a result, LTCHs will experience an increase in estimated aggregate payments of $72 million (1.1 percent) in FY14 relative to FY13.This impact does not include an estimate effect of the 2.0 percent reduction to the proposed annual update to the LTCH PPS standard federal rate for LTCHs that fail to submit quality data.

Additionally, CMS will apply an area wage level budget neutrality factor of 1.0010531 to the standard federal rate to ensure that any changes to the area wage level adjustment (that is, the annual update of the wage index values and labor-related share) would not result in any change (increase or decrease) in estimated aggregate LTCH PPS payments. Accordingly, CMS will establish a standard federal rate for FY14 of **$40,607.31** (calculated as $40,397.96 × 1.017 × 0.98734 × 1.0010531) for discharges occurring on or after October 1, 2013, and on or before September 30, 2014, provided the LTCH submits quality reporting data. The current rate is $40,397.96. For LTCHs that fail to submit quality reporting data for FY14, CMS is establishing a standard federal rate for FY14 of $39,808.74 (calculated as $40,397.96 × 0.997 × 0.98734 × 1.0010531) for discharges occurring on or after October 1, 2013. The labor-related share that CMS is adopting to

use for LTCH PPS in FY14 would be **62.537** percent, down from the current value 63.096 percent. CMS is proposing a fixed-loss amount of **$13,314** for FY14. The current amount is $15,408.

Twenty-Five Percent Patient Threshold Rule
Under the 25-percent patient threshold policy, if an LTCH admits more than 25 percent of its patients from a single acute care hospital, Medicare will pay it at a rate comparable to IPPS hospitals for those patients above the 25-percent threshold. CMS placed a statutory moratorium on application of the 25-percent rule from December 2007, through December 2012. CMS is not extending the regulatory moratorium; therefore, it will expire for certain LTCHs for cost reporting periods beginning on or after October 1, 2013. CMS estimates that the expiration of the moratorium will result in a reduction of approximately $90 million in LTCHs' PPS payments in FY14. CMS notes that its current estimate of the impact of the expiration of the moratorium on the full application of the 25-percent threshold payment adjustment policy is significantly lower than its estimate presented in the FY14 IPPS/LTCH PPS proposed rule, which was approximately $190 million.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)

Federal Register pages: 50613- 50647

Section 3133 of the ACA modified the Medicare DSH payment methodology beginning in FY14. Currently, Medicare DSHs qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income benefits and their Medicaid utilization. Under section 1886(r) of the Act, which was added by section 3133i, starting in FY14, DSHs will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments. The remaining amount, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, will be paid as additional payments after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive its additional amount based on its share of the total amount of uncompensated care for all Medicare DSH hospitals for a given time period.

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 uninsured population under age 65, will become available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. In addition to the reduced DSH payment, for FY14 and each subsequent fiscal year, the HHS Secretary shall pay an additional amount equal to the product of three factors to subsection (d) hospitals.

The first factor is the difference between CMS's estimates of: (1) The amount that would have been paid in Medicare DSH payments for FY14 and subsequent years, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY14 and subsequent years, which takes into account the requirement to reduce Medicare DSH payments by 75 percent. The second

factor is, for FY14 through FY17, 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of those individuals who are uninsured in 2013, the last year before coverage expansion under the ACA, minus 0.1 percent for FY14, and minus 0.2 percent for FY15 through FY17. For FY14 through FY17, the baseline for the estimate of the change in uninsurance is fixed by the most recent estimate of the Congressional Budget Office before the final vote on the Health Care and Education Reconciliation Act of 2010. For FY18 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals ''who are uninsured in 2013 minus 0.2 percent for FY18 and FY19.'"

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

Eligibility
Hospitals that are not eligible to receive empirically justified Medicare DSH payments in FY14 and subsequent years would not receive uncompensated care payments for those respective years. CMS will make a determination concerning eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for FY14 or the applicable year (using the most recent data that are available). CMS currently has a system for interim payment and final settlement of DSH payments. Payments will be made on a per claim basis instead of a pass-through basis as originally proposed. Specifically, interim payments are made for each claim based on the best available data concerning each hospital's eligibility for DSH payments and the appropriate level of such payments. Final determination of eligibility for Medicare DSH payments and the final empirically justified payment adjustments for eligible hospitals will be settled on the cost report. CMS will provide more detailed operational instructions and cost report instructions following display of this final rule in the *Federal Register.*

Methodology to Calculate Factor 1
In order to determine Factor 1 in the uncompensated care payment formula, CMS developed 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 to which the new provision applies. For the final rule, the Office of the Actuary has used the July 2013 Medicare DSH estimates, based on the March 2013 update of the Medicare Hospital Cost Report data and the proposed rule's IPPS Impact file, to determine Factor 1. The July 2013 Office of the Actuary estimate for Medicare DSH payments for FY14, without regard to the application of section 1886(r)(1) of the Act, is approximately $12.772 billion (for purposes of the proposed rule, CMS estimated this amount to be approximately $12.338 billion).

This estimate excludes Maryland hospitals, SCHs paid under their hospital-specific payment rate, and hospitals participating in the Rural Community Hospital Demonstration program. Therefore, based on this estimate, the estimate for empirically justified Medicare DSH payments for FY14, with the application of section 1886(r)(1) of the Act, is approximately $3.193 billion (25 percent of the total amount estimated). Under CMS's proposal, Factor 1 is the difference of these two estimates of the Office of the Actuary. Therefore, for the purpose of this final rule, CMS calculates Factor 1 to be approximately **$9.579 billion** (for purposes of the proposed rule, Factor 1 was estimated to be approximately $9.2535).

Methodology to Calculate Factor 2
Section 1886(r)(2)(B)(i) of the Act states that Factor 2 for FY14 is equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals without insurance in the baseline and in the most recent period for which CMS has data (minus 0.1 percent for FY14). CMS finalizes its proposal to employ the most recent CBO estimates of the rates of insurance for FY14 and subsequent payment years. CMS agreed with the commenters' recommendation that it should normalize the estimate of uninsurance for FY14 by calculating a weighted average of the CBO estimates for CY13 and CY14, respectively. CMS believes that normalizing the estimate to cover FY14 rather than CY14 will more accurately reflect the actual rate of uninsurance that hospitals will experience during the FY14 payment year. CMS uses the most recent available estimate, specifically CBO's May 2013 estimates of the effects of the ACA on health insurance coverage.

The calculation of Factor 2 for FY14, employing a weighted average of the CBO projections for CY13 and CY14, is as follows:

- **CY13 rate of insurance coverage (May 2013 CBO estimate): 80 percent**

- **CY14 rate of insurance coverage (May 2013 CBO estimate, updated with July 2013 CBO estimate): 84 percent**

- **FY14 rate of insurance coverage: (80 percent * .25) + (84 percent * .75) = 83 percent**

- **Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent**

- **Percent of individuals without insurance for FY 2014 (weighted average): 17 percent**
- **1 – |[(0.17 - 0.18)/0.18]| = 1 - 0.056 = 0.944 (94.4 percent)**
  0.944 (94.4 percent) - 0.001 (0.1 percentage points) = 0.943 (94.3 percent)
  0.943 = Factor 2

CMS notes that as a result of this change, it will reduce the total amount of uncompensated care payments by a smaller amount than the reductions that would have resulted from CMS's proposed methodology for Factor 2. Therefore, in the final rule,

CMS is adopting 0.943 as the final determination of Factor 2 for FY14. In conjunction with this determination, it has also determined, for the purpose of the final rule, that the amount available for uncompensated care payments for FY14 will be approximately $9.033 billion (0.943 times its Factor 1 estimate of $9.579 billion).

Proposed Methodology to Calculate Factor 3
Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY14 and subsequent years. Factor 3 is a hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and subsection (d) Puerto Rico hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY14 and subsequent years. In order to implement the statutory requirements for this factor of the uncompensated care payment formula, CMS must determine the following:

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

For FY14, CMS will adopt as proposed that the denominator for Factor 3 reflect the estimated Medicaid and Medicare SSI patient days based on data from the 2010/2011 Medicare cost report (including the most recently available data that may be used to update the SSI ratios) for all hospitals that CMS estimates will receive an empirically justified Medicare DSH payment in FY14. The numerator of Factor 3 will be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data (including the most recently available data that may be used to update the SSI ratios).

The most recent SSI fraction is the FY11 SSI fraction. CMS posted the FY11 SSI fractions for each subsection (d) hospital on the CMS DSH website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html on June 27, 2013. The most recently available Medicaid fraction is that reported on the March 2013 update of the Provider Specific File.

CMS will calculate Factor 3 for all hospitals that are eligible for empirically justified Medicare DSH payment adjustments under its revised methodology based on their proportion of low-income insured days relative to the low-income insured days for all hospitals projected to receive DSH payments, and the hospital will receive uncompensated care payments on an interim basis. Hospitals that receive uncompensated care payments on an interim basis but are not eligible for Medicare DSH payments at the time of cost report settlement would no longer be eligible to receive an uncompensated care payment and would need to repay those interim payments.

For the final rule, CMS finalizes its method to identify hospitals eligible for empirically justified Medicare DSH payment adjustments and, therefore, eligible to receive interim uncompensated care payments based on its projections of whether the hospital would receive Medicare DSH payments for FY14. CMS will identify those subsection (d) and Puerto Rico subsection (d) hospitals that it projects to have a disproportionate patient percentage (DPP) of at least 15 percent, which is the minimum required DPP to be eligible for Medicare DSH payments.

CMS, as stated in the proposed rule, remains convinced that the Worksheet S–10 is a better source of uncompensated care data and could ultimately serve as an appropriate source of more direct data regarding uncompensated care costs once technical issues are resolved. Therefore, CMS will review Worksheet S–10 in order to determine what revisions or clarifications may be necessary so that it can yield accurate and consistent data revisions and clarifications as it does so. CMS notes that it intends to propose introducing use of the Worksheet S–10 to determine Factor 3 within a reasonable amount of time.

Direct Graduate Medical Education (GME)

Federal Register pages: 50729-50733

CMS proposes to revise the GME policy addressing inpatient labor and delivery days in the inpatient Medicare utilization calculation. CMS also proposes, for portions of cost reporting periods beginning on or after October 1, 2013, that a hospital may not claim full-time equivalent residents training at a CAH for indirect medical education (IME) and/or direct GME purposes.

However, if a CAH itself incurs the costs of training the full-time equivalent residents when these residents rotate to the CAH, the CAH may receive payment based on 101 percent of those Medicare reasonable costs under the regulations. Finally, in accordance with ACA Section 5506, which redistributes residency slots from closed hospitals, CMS is notifying the public of the closure of a hospital and initiating another application and selection process to redistribute the closed hospital's GME full-time equivalent caps.

Inclusion of Labor and Delivery Days in the Calculation of Medicare Utilization for Direct GME Purposes and for Other Medicare Purposes

CMS stated that because labor and delivery days are considered inpatient days for DSH purposes, they also should be considered inpatient days for purposes of determining the Medicare share for direct GME payments. CMS believes that the best way to calculate a hospital's Medicare patient load or the ''Medicare utilization'' is to include *all* of the hospital's inpatient days. As such, CMS finalized its proposal to include patient days associated with maternity patients who have been admitted as inpatients and are receiving ancillary labor and delivery services at the time the inpatient routine census is taken, 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'' in which labor, delivery, recovery, and postpartum care all take place in the same room, in the Medicare utilization calculation for cost reporting periods beginning on or after October 1, 2013. CMS notes that this final policy does not impact

Medicare payments calculated on a reasonable cost basis for routine inpatient services, which are apportioned in accordance with 42 CFR 413.53(a)(1).

More Information

The final rule is published in the May 19, 2013, *Federal Register*, and is effective on October 1, 2013.

Appendix 1

COMPARISON OF FY 2013 STANDARDIZED AMOUNTS TO THE FY 2014 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE

	Full Update (1.7 percent); Wage index is greater than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)	**Full Update (1.7 percent); Wage index is less than or equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)**	**Reduced Update (-0.3 percent); Wage index is greater than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)**	**Reduced Update (-0.3 percent); Wage index is less than or equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)**
FY 2013 Base Rate after removing: 1. FY 2013 Geographic Reclassification Budget Neutrality (0.991276) 2. FY 2013 Rural Community Hospital Demonstration Program Budget Neutrality (0.999677) 3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 (0.9478) 4. FY 2013 Operating Outlier Offset (0.948999)	Labor: $4,176.63 Nonlabor: $1,824.27	Labor: $3,720.56 Nonlabor: $2,280.34	Labor: $4,176.63 Nonlabor: $1,824.27	Labor: $3,720.56 Nonlabor: $2,280.34
FY 2014 Update Factor	1.017	1.017	0.997	0.997

FY 2014 MS-DRG Recalibration and Wage Index Budget Neutrality Factor	0.997936	0.997936	0.997936	0.997936
FY 2014 Reclassification Budget Neutrality Factor	0.990718	0.990718	0.990718	0.990718
FY 2014 Rural Community Demonstration Program Budget Neutrality Factor	0.999415	0.999415	0.999415	0.999415
FY 2014 Operating Outlier Factor	0.948995	0.948995	0.948995	0.948995
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A	0.998	0.998	0.998	0.998
Cumulative Factor: FY 2008, FY 2009, FY 2012,and FY 2013 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012	0.9403	0.9403	0.9403	0.9403
Final National Standardized Amount for FY 2014	Labor: $3,737.71 Nonlabor: $1,632.57	Labor: $3,329.57 Nonlabor: $2,040.71	Labor: $3,664.21 Nonlabor: $1,600.46	Labor: $3,264.10 Nonlabor: $2,000.57

Appendix 2 – ICD-9-CM Codes for Excess Readmission Calculation for FY14

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

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

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

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

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

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

Appendix 3a – Hospital IQR Program Adopted Measures for FY14 Payment Determination

Topic	Hospital IQR Program Measures for FY 14 Payment Determination
Acute Myocardial Infarction (AMI)	• AMI–2 Aspirin prescribed at discharge. • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival. • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI). • AMI–10 Statin Prescribed at Discharge.
Heart Failure (HF)	• HF–1 Discharge instructions. • HF–2 Evaluation of left ventricular systolic function. • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.
Pneumonia (PN)	• PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital. • PN–6 Appropriate initial antibiotic selection.
Surgical Care Improvement Project (SCIP)	• SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision. • SCIP INF–2: Prophylactic antibiotic selection for surgical patients. • SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery). • SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose. • SCIP INF–9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero. • SCIP INF–10: Surgery patients with perioperative temperature management. • SCIP Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period. • SCIP INF—VTE-1: Surgery patients with recommended Venous Thromboembolism (VTE) prophylaxis ordered. • SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery.
Mortality Measures (Medicare Patients)	• Acute Myocardial Infarction (AMI) 30-day mortality rate. • Heart Failure (HF) 30-day mortality rate. • Pneumonia (PN) 30-day mortality rate.
Patients' Experience of Care	• HCAHPS survey
Readmission Measure (Medicare Patients)	• Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure. • Heart Failure 30-day Risk Standardized Readmission Measure. • Pneumonia 30-day Risk Standardized Readmission Measure.
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	• PSI 06: Iatrogenic pneumothorax, adult. • PSI 11: Post Operative Respiratory Failure. • PSI 12: Post Operative PE or DVT. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
AHRQ PSI and Nursing	• PSI 04 Death among surgical in patients with serious treatable

Sensitive Care	complications.
Structural measures	• Participation in a Systematic Database for Cardiac Surgery. • Participation in a Systematic Clinical Database Registry for Stroke Care. • Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. • Participation in a Systematic Clinical Database Registry for General Surgery.**

Appendix 3b - Hospital IQR Program Suspended Measures for FY14 Payment Determination

• AMI–1 Aspirin at arrival
• AMI–3 ACEI/ARB for left ventricular systolic dysfunction
• AMI–5 Beta-blocker prescribed at discharge
• SCIP INF–6 Appropriate Hair Removal

Appendix 3c – *Hospital IQR Program Retired Measures for FY14 Payment Determination*

AMI-4 Adult smoking cessation advice/counseling
HF-4 Adult smoking cessation advice/counseling
PN-4 Adult smoking cessation advice/counseling
PN-5c Timing of receipt of initial antibiotic following hospital arrival

Appendix 3d – ***Hospital IQR Program Adopted Measures for FY15 Payment Determination***

Topic	Hospital IQR Program Measures for FY 2015 Payment Determination
Acute Myocardial Infarction (AMI) Measures	• AMI–2 Aspirin prescribed at discharge. • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival. • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI). • AMI–10 Statin Prescribed at Discharge.
Heart Failure (HF) Measures	• HF–1 Discharge instructions. • HF–2 Evaluation of left ventricular systolic function. • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.
Stroke Measure Set	• STK–1 VTE prophylaxis.** • STK–2 Antithrombotic therapy for ischemic stroke.**STK–3 Anticoagulation therapy for Afib/flutter.** • STK–4 Thrombolytic therapy for acute ischemic stroke.** • STK–5 Antithrombotic therapy by the end of hospital day.** • STK–6 Discharged on Statin.** • STK–8 Stroke education.** • STK–10 Assessed for rehab.**
VTE Measure Set	VTE–1 VTE prophylaxis.** • VTE–2 ICU VTE prophylaxis.** • VTE–3 VTE patients with anticoagulation overlap therapy.** • VTE–4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol.** • VTE–5 VTE discharge instructions.** • VTE–6 Incidence of potentially preventable VTE.**
Pneumonia (PN) Measures	• PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital. • PN–6 Appropriate initial antibiotic selection.
Surgical Care Improvement Project (SCIP) Measures	• SCIP INF–1: Prophylactic antibiotic received within 1 hour prior to surgical incision. • SCIP INF–2: Prophylactic antibiotic selection for surgical patients. • SCIP INF–3: Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery). • SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose. • SCIP INF–6: Appropriate Hair Removal [SUSPENDED]. • SCIP INF–9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero. • SCIP INF–10: Surgery patients with perioperative temperature management. • SCIP Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period. • SCIP INF–VTE-1: Surgery patients with recommended Venous Thromboembolism (VTE) prophylaxis ordered. • SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery.

Mortality Measures (Medicare Patients)	• Acute Myocardial Infarction (AMI) 30-day mortality rate. • Heart Failure (HF) 30-day mortality rate. • Pneumonia (PN) 30-day mortality rate.
Patients' Experience of Care Measure	HCAHPS survey.
Readmission Measures (Medicare Patients)	• Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure. • Heart Failure 30-day Risk Standardized Readmission Measure. • Pneumonia 30-day Risk Standardized Readmission Measure.
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	• PSI 06: Iatrogenic pneumothorax, adult. • PSI 11: Post Operative Respiratory Failure. • PSI 12: Post Operative PE or DVT. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
AHRQ PSI and Nursing Sensitive Care	• PSI–4 Death among surgical inpatients with serious treatable complications.
Structural Measures	• Participation in a Systematic Database for Cardiac Surgery. • Participation in a Systematic Clinical Database Registry for Stroke Care. • Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. • Participation in a Systematic Clinical Database Registry for General Surgery.*
Healthcare-Associated Infections Measures	• Central Line Associated Bloodstream Infection. • Surgical Site Infection. • Catheter-Associated Urinary Tract Infection.* • MRSA Bacteremia.** • Clostridium difficile (C. difficile).** • Healthcare Provider Influenza Vaccination.**
Hospital Acquired Condition Measures	• Foreign Object Retained After Surgery. • Air Embolism • Blood Incompatibility. • Pressure Ulcer Stages III & IV. • Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock). • Vascular Catheter-Associated Infection. • Catheter-Associated Urinary Tract Infection (UTI). • Manifestations of Poor Glycemic Control.
Emergency Department Throughput Measures	• ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital. • ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status.
Prevention: Global Immunization Measures	• Immunization for Influenza. • Immunization for Pneumonia.
Cost Efficiency	Medicare Spending per Beneficiary.*

Appendix 3e ***Hospital IQR Program Suspended Measures for FY15 Payment Determination***

• AMI–1 Aspirin at arrival
• AMI–3 ACEI/ARB for left ventricular systolic dysfunction
• AMI–5 Beta-blocker prescribed at discharge
• SCIP INF–6: Appropriate Hair Removal

Appendix 3f – Hospital IQR Program Removed Measures for FY15 Payment Determination

Topic	17 Measures Removed from Hospital IQR Program Measure Set for the FY 2015 Payment Determination and Subsequent Years
Surgical Care Improvement Project (SCIP) Measure	
	• SCIP INF -VTE-1: Surgery patients with recommended Venous Thromboembolism (VTE) prophylaxis ordered*
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult**
	• PSI 11: Post Operative Respiratory Failure**
	• PSI 12: Post Operative PE or DVT**
	• PSI 14: Postoperative wound dehiscence**
	• PSI 15: Accidental puncture or laceration**
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume) **
	• IQI 19: Hip fracture mortality rate**
	• IQI 91: Mortality for selected medical conditions (composite) **
Hospital Acquired Condition Measures	
	• Foreign Object Retained After Surgery**
	• Air Embolism **
	• Blood Incompatibility**
	• Pressure Ulcer Stages III & IV**
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock) **
	• Vascular Catheter-Associated Infection**
	• Catheter-Associated Urinary Tract Infection (UTI)**
	• Manifestations of Poor Glycemic Control**

Appendix 3g – Hospital IQR Program Previously Adopted and Finalized Quality Measures Finalized for FY16 Payment Determination

Topic	Previously Adopted Hospital IQR Program Measures and Measures Finalized in this Final Rule for the FY 2016 Payment Determination and Subsequent Years
Acute Myocardial Infarction (AMI) Measures	
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF) Measures	
	• HF-2 Evaluation of left ventricular systolic function
Stroke Measure (STK) Set	
	• STK-1 VTE prophylaxis
	• STK-2 Antithrombotic therapy for ischemic stroke†
	• STK-3 Anticoagulation therapy for Afib/flutter†
	• STK-4 Thrombolytic therapy for acute ischemic stroke†
	• STK-5 Antithrombotic therapy by the end of hospital day 2†
	• STK-6 Discharged on Statin†
	• STK-8 Stroke education†
	• STK-10 Assessed for rehab†
VTE Measure Set	
	• VTE-1 VTE prophylaxis†
	• VTE-2 ICU VTE prophylaxis†
	• VTE-3 VTE patients with anticoagulation overlap therapy†
	• VTE-4 Patients receiving un-fractionated Heparin with doses/labs monitored by protocol†
	• VTE-5 VTE discharge instructions†
	• VTE-6 Incidence of potentially preventable VTE†
Pneumonia (PN) Measures	
	• PN-6 Appropriate initial antibiotic selection
Surgical Care Improvement Project (SCIP) Measures	
	• SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP INF-2: Prophylactic antibiotic selection for surgical patients
	• SCIP INF-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)
	• SCIP INF-4: Cardiac surgery patients with controlled 6AM postoperative serum glucose
	• SCIP INF-9: Postoperative urinary catheter removal on post operative day 1 or 2 with day of surgery being day zero
	• SCIP Cardiovascular-2: Surgery Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period
	• SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery

Mortality Measures (Medicare Patients)	
	• Acute Myocardial Infarction (AMI) 30-day mortality rate
	• Heart Failure (HF) 30-day mortality rate
	• Pneumonia (PN) 30-day mortality rate
	• Stroke 30-day mortality rate***
	• COPD 30-day mortality rate***
Patients' Experience of Care Measures	
	• HCAHPS survey (expanded to include one 3-item care transition set* and two new "About You" items)*
Readmission Measures (Medicare Patients)	
	• Acute Myocardial Infarction (AMI) 30-day Risk Standardized Readmission Measure
	• Heart Failure (HF) 30-day Risk Standardized Readmission Measure
	• Pneumonia (PN) 30-day Risk Standardized Readmission Measure
	• 30-day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty*
	• Hospital-Wide All-Cause Unplanned Readmission (HWR)*
	• Stroke 30-day Risk Standardized Readmission***
	• COPD 30-day Risk Standardized Readmission***
AHRQ Patient Safety Indicators (PSIs) Composite Measures	
	• Complication/patient safety for selected indicators (composite)
AHRQ PSI and Nursing Sensitive Care	
	• PSI-4 Death among surgical inpatients with serious treatable complications
Structural Measures	
	• Participation in a Systematic Database for Cardiac Surgery
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
	• Participation in a Systematic Clinical Database Registry for General Surgery
	• Safe Surgery Checklist Use**
Healthcare-Associated Infections Measures	
	• Central Line Associated Bloodstream Infection
	• Surgical Site Infection - SSI following Colon Surgery - SSI following Abdominal Hysterectomy
	• Catheter-Associated Urinary Tract Infection
	• MRSA Bacteremia
	• Clostridium difficile (C. difficile)
	• Healthcare Personnel Influenza Vaccination

Surgical Complications	
	• Hip/Knee Complication: Hospital-level Risk-Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty*
Emergency Department (ED) Throughput Measures	
	• ED-1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital†
	• ED-2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status†
Prevention: Global Immunization (IMM) Measures	
	• Immunization for Influenza
Cost Efficiency	
	• Medicare Spending per Beneficiary
	• AMI Payment per Episode of Care***
Perinatal Care	
	• Elective delivery prior to 39 completed weeks of gestation*/†

Appendix 3h – Hospital IQR Program Removed Measures for FY16 Payment Determination

Topic	Hospital IQR Program Measures Removed in this Final Rule Beginning with the FY 2016 Payment Determination
Acute Myocardial Infarction	
	• AMI-2 Aspirin prescribed at discharge
	• AMI-10 Statin prescribed at discharge
Pneumonia	
	• PN-3b Blood culture performed in the emergency department prior to first antibiotic received in hospital
Heart Failure	
	• HF-1 Discharge instructions
	• HF-3 ACEI or ARB for LVSD
Surgical Care Improvement Project	
	• SCIP-Inf-10 Surgery patients with perioperative temperature management
Structural Measure	
	• Participation in a systematic clinical database registry for stroke care

Topic	Hospital IQR Program Measures Suspended in this Final Rule Beginning with the FY 2016 Payment Determination.
Immunization	
	• IMM-1 Immunization for pneumonia

Appendix 4a – FY14 Hospital VBP Measures

Finalized Quality Measures for the FY 2014 Hospital VBP Program	
Clinical Process of Care Measures	
Measure ID	**Measure Description**
Acute myocardial infarction	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	
HF-1	Discharge Instructions
Pneumonia	
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
Healthcare-associated infections	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
Surgeries	
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience of Care Measures	
Measure ID	**Measure Description**
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey*
Outcome Measures	
Measure ID	**Measure Description**
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate
MORT-30 PN	Pneumonia (PN) 30-Day Mortality Rate

Appendix 4b – FY14 Performance Standards

FY 2014 Achievement Performance Standards for Clinical Process of Care Measures			
Measure ID	**Measure Description**	**Performance Standard (Achievement Threshold)**	**Benchmark**
Process of Care Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.8066	0.9630
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9344	1.0000
HF-1	Discharge Instructions	0.9266	1.0000
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9730	1.0000
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9446	1.0000
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9807	1.0000
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9813	1.0000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9663	0.9996

Appendix 4b cont. – FY14 Performance Standards

FY 2014 Achievement Performance Standards for Clinical Process of Care Measures			
Measure ID	**Measure Description**	**Performance Standard (Achievement Threshold)**	**Benchmark**
Process of Care Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.8066	0.9630
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9344	1.0000
HF-1	Discharge Instructions	0.9266	1.0000
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9730	1.0000
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9446	1.0000
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9807	1.0000
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9813	1.0000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9663	0.9996

Appendix 4b cont. – FY14 Performance Standards

FY 2014 Achievement Performance Standards for Patient Experience of Care Measures				
Measure ID	**Measure Description**	**Performance Standard (Achievement Threshold)**	**Benchmark**	**Floor**
Patient Experience of Care Measure				
HCAHPS				
	Communication with Nurses	75.79%	84.99%	42.84%
	Communication with Doctors	79.57%	88.45%	55.49%
	Responsiveness of Hospital Staff	62.21%	78.08%	32.15%
	Pain Management	68.99%	77.92%	40.79%
	Communication about Medicines	59.85%	71.54%	36.01%
	Hospital Cleanliness & Quietness	63.54%	78.10%	38.52%
	Discharge Information	82.72%	89.24%	54.73%
	Overall Rating of Hospital	67.33%	82.55%	30.91%

Appendix 5a – Final FY15 Hospital VBP Measures

Finalized Quality Measures for FY 2015 Hospital VBP Program	
Clinical Process of Care Measures	
Measure ID	**Measure Description**
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Finalized Quality Measures for FY 2015 Hospital VBP Program	
HF-1	Discharge Instructions
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience Measures	
HCAHPS*	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
Outcome Measures	
AHRQ PSI composite	Complication/patient safety for selected indicators (composite)
CLABSI	Central Line-Associated Blood Stream Infection
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate
MORT-30-HF	Heart Failure (HF) 30-day mortality rate
MORT-30-PN	Pneumonia (PN) 30-day mortality rate
Efficiency Measures	
MSPB-1	Medicare Spending per Beneficiary

Appendix 5b - FY15 Performance Standards

Proposed Performance Standards for the FY15 Hospital VBP Program Clinical Process of Care and Outcome Domains, and the Medicare Spending Per Beneficiary Measure

[Corrected]

Measure ID	Description	Achievement threshold	Benchmark
Clinical Process of Care Measures			
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.	0.72727	1.00000.
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival.	0.92857	1.00000.
AMI–10	Statin Prescribed at Discharge	0.90474	1.00000.
HF–1	Discharge Instructions	0.92090	1.00000.
PN–3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.	0.97129	1.00000.
PN–6	Initial Antibiotic Selection for CAP in Immunocompetent Patient.	0.93671	0.99832.
SCIP–Card–2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period.	0.95122	1.00000.
SCIP–Inf–1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.	0.97872	1.00000.
SCIP–Inf–2	Prophylactic Antibiotic Selection for Surgical Patients.	0.97882	1.00000.
SCIP–Inf–3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.	0.96154	0.99905.
SCIP–Inf–4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.	0.94799	0.99824.
SCIP–Inf–9	Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2.	0.93333	1.00000.
SCIP–VTE–2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery.	0.94118	0.99938.
Outcome Measures			
MORT–30–AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate.	0.8477	0.8673.
MORT–30–HF	Heart Failure (HF) 30-Day Mortality Rate	0.8861	0.9042.
MORT–30–PN	Pneumonia (PN) 30-Day Mortality Rate	0.8818	0.9021.
PSI–90	Patient safety for selected indicators (composite).	0.4006	0.2754.
CLABSI	Central Line-Associated Blood Stream Infection.	0.442	0.000.
Efficiency Measures			
MSPB–1	Medicare Spending per Beneficiary	Median Medicare spending per beneficiary ratio. across all hospitals during the performance period.	Mean of the lowest decile of Medicare spending per beneficiary ratios across all hospitals during the performance period.

Proposed Performance Standards for the FY15 Hospital VBP Program Patient Experience of Care Domain

HCAHPS Survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	49.23	76.28	85.56
Communication with Doctors	57.31	79.61	88.72
Responsiveness of Hospital Staff	34.83	62.75	78.59

Pain Management	43.05	69.24	78.24
Communication about Medicines	28.11	60.46	71.72
Hospital Cleanliness & Quietness	40.35	63.79	78.46
Discharge Information	55.10	83.29	89.60
Overall Rating of Hospital	29.26	67.73	83.13

Appendix 5c - FY15 Removed Measures

- SCIP–VTE–1: Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
- SCIP-Inf-10: Surgery Patients with Perioperative Temperature Management (‘‘topped-out.’’)

Appendix 6a: FY 16 New Final VBP Measures

Newly Finalized and Readopted Measures for the FY 2016 Hospital VBP Program Clinical Process of Care Measures	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
IMM-2**	Influenza Immunization
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arriva Who Received a Beta-Blocker During the Perioperative Period
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience Measures	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey
Outcome Measures	
CAUTI**	Catheter-Associated Urinary Tract Infection
CLABSI***	Central Line-Associated Blood Stream Infection
MORT-30-AMI*	Acute Myocardial Infarction (AMI) 30-day mortality rate
MORT-30-HF*	Heart Failure (HF) 30-day mortality rate
MORT-30-PN*	Pneumonia (PN) 30-day mortality rate
PSI-90*	Complication/patient safety for selected indicators (composite)
SSI**	Surgical Site Infection ● Colon ● Abdominal Hysterectomy
Efficiency Measures	
MSPB-1	Medicare Spending per Beneficiary

Appendix 6b: FY16 Final Performance Standards for Certain Outcome Domain Measures

FINALIZED PERFORMANCE STANDARDS FOR THE FY 2016 HOSPITAL VBP PROGRAM CLINICAL PROCESS OF CARE, OUTCOME, AND EFFICIENCY DOMAIN MEASURES

Measure ID	Description	Achievement threshold	Benchmark
Clinical Process of Care Measures			
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.	0.91154	1.00000
IMM–2	Influenza Immunization	0.90607	0.98875
PN–6	Initial Antibiotic Selection for CAP in Immunocompetent Patient.	0.96552	1.00000
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients.	0.99074	1.00000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.	0.98086	1.00000
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2.	0.97059	1.00000
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period.	0.97727	1.00000
SCIP–VTE–2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery.	0.98225	1.00000
Outcome Measures			
CAUTI	Catheter-Associated Urinary Tract Infection.	0.801	0.000
CLABSI	Central Line-Associated Blood Stream Infection.	0.465	0.000
SSI	Surgical Site Infection. • Colon • Abdominal Hysterectomy	 • 0.668 • 0.752	 • 0.000 • 0.000
Efficiency Measures			
MSPB–1	Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

FINALIZED PERFORMANCE STANDARDS FOR THE FY 2016 HOSPITAL VBP PROGRAM PATIENT EXPERIENCE OF CARE DOMAIN

HCAHPS Survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	53.99	77.67	86.07
Communication with Doctors	57.01	80.40	88.56

FINALIZED PERFORMANCE STANDARDS FOR THE FY 2016 HOSPITAL VBP PROGRAM PATIENT EXPERIENCE OF CARE DOMAIN—Continued

HCAHPS Survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Responsiveness of Hospital Staff	38.21	64.71	79.76
Pain Management	48.96	70.18	78.16
Communication about Medicines	34.61	62.33	72.77
Hospital Cleanliness & Quietness	43.08	64.95	79.10
Discharge Information	61.36	84.70	90.39
Overall Rating of Hospital	34.95	69.32	83.97