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FY16 IPPS Proposed Rule Fact Sheet

Overview

The Centers for Medicare & Medicaid Services (CMS) issued a proposed 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 2016 (FY16). Some of these changes implement certain statutory provisions contained in the Affordable Care Act (ACA), the Pathway for Sustainable Growth Reform (SGR) Act of 2013, the Protecting Access to Medicare Act of 2014, and other legislation. Additionally, the proposal updates policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program. CMS also proposes to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY16.

Impact Analysis

Federal Register pages: 24656-24660

Table 1 below reflects the impact of the proposed overall percentage change in FY16 IPPS payment rates on different providers. This incorporates the impact of statutory adjustments, budget neutrality adjustments, and provider specific impacts of CMS' various proposed policies.

FY16 IPPS Proposed Update Impact Table

	All FY16 Proposed Changes (%)
All Hospitals	0.3
Urban Hospitals	0.3
Rural Hospitals	-0.3
Teaching Status	
Non-Teaching	0.2
Fewer Than 100 Residents	0.3
100 or More Residents	0.3
Special Hospital Types	
Rural Referral Center	-0.6
Sole Community Hospital	1.0

FY16 Proposed Inpatient Payment Rate Changes

Federal Register pages: 24661

CMS proposes to make a **1.1** percent update to the national standardized amount after accounting for inflation and other mandatory adjustments. This update accounts for inflation and other mandatory adjustments required by law. Table 2 below reflects these mandatory adjustments in the 1.1 percent update.

Policy	Proposed Impact
Market basket update	2.7%
Multifactor productivity adjustment	-0.6%
ACA mandate	-0.2%
ATRA adjustment	-0.8%
Total	**1.1%**

FY16 Proposed Inpatient Hospital Operating Payment Rate Update

Federal Register pages: 24478, 24652-24653

The applicable percentage increase to the IPPS rates required by the statute, in conjunction with other proposed payment changes in the proposed rule, would result in an estimated $278 million increase in proposed FY16 operating payments (or 0.3 percent change). The operating impact estimate includes the proposed adjustments in Table 2 above.

For FY16, CMS proposes to continue using the FY10-based IPPS operating and capital market baskets and the labor-related share of 69.6 percent, which is based on the FY10-based IPPS market basket.

Based on the most recent data available for the proposed rule CMS has determined four proposed applicable percentage increases to the standardized amount for FY16, as specified in Table 3 below:

PROPOSED FY 2016 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2016	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
Proposed Market Basket Rate-of-Increase	2.7	2.7	2.7	2.7
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	−0.675	−0.675
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	−1.35	0.0	−1.35
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	−0.6	−0.6	−0.6	−0.6
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	−0.2	−0.2	−0.2	−0.2
Proposed Applicable Percentage Increase Applied to Standardized Amount	1.9	0.55	1.225	−0.125

Standardized Payment Rates

Federal Register pages: 24626-24636

For FY16, CMS is proposing to continue to use a labor-related share of 69.6 percent for discharges occurring on or after Oct. 1, 2015. Tables 1A and 1B, which are published in section VI of the addendum to the proposed rule and available via the Internet on the CMS website, reflect this proposed labor-related share. For FY16, for all IPPS hospitals whose wage indexes are less than or equal to 1.0000, CMS is proposing to apply the wage index to a labor-related share of 62 percent of the national standardized amount. For all IPPS hospitals whose wage indexes are greater than 1.0000, for FY16, CMS is proposing to apply the wage index to a proposed labor-related share of 69.6 percent of the national standardized amount.

Table 4 below contains the FY16 proposed national standardized amounts for all hospitals, excluding those hospitals in Puerto Rico.

TABLE 1A—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2016

Hospital submitted quality data and is a meaningful EHR user (update = 1.9 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 1.225 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = 0.55 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = −0.125 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,813.40	$1,665.63	$3,788.14	$1,654.60	$3,762.88	$1,643.56	$3,737.62	$1,632.53

TABLE 1B—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2016

Hospital submitted quality data and is a meaningful EHR user (update = 1.9 percent)		Hospital did not submit quality data and is a meaningful EHR user (update = 1.225 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = 0.55 percent)		Hospital did not submit quality data and is not a meaningful EHR user (update = −0.125 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,397.00	$2,082.03	$3,374.50	$2,068.24	$3,351.99	$2,054.45	$3,329.49	$2,040.66

Documentation and Coding Adjustment

Federal Register pages: 24340-24342

Section 631 of the American Taxpayer Relief Act of 2012 (ATRA) requires the Department of Health and Human Sservices (HHS) 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 in FY14, a onetime -9.3 percent adjustment to the standardized amount would be necessary. Since it is often CMS' practice to delay or phase-in rate adjustments over more than one year in order to moderate the effect on rates in any one year, it applied a -0.8 percent adjustment to the standardized amount in FY14. CMS stated that if adjustments of approximately -0.8 percent are implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, the entire $11 billion will be accounted for by the end of the statutory four-year timeline.

Consistent with the approach discussed in the FY14 IPPS final rule for recouping the $11 billion required by section 631 of the ATRA, in the FY15 IPPS final rule, CMS implemented an additional -0.8 percent recoupment adjustment to the standardized amount for FY15. CMS estimates that this level of adjustment, combined with leaving the -0.8 percent adjustment made for FY14 in place, will recover up to $2 billion in FY15. When combined with the $1 billion adjustment made in FY14, CMS estimated that approximately $8 billion would be left to recover under section 631 of the ATRA.

In the FY16 IPPS proposed rule, CMS proposes to implement a -0.8 percent recoupment adjustment to the standardized amount for FY16. Considering the -0.8 percent adjustments made in FY14 and FY15, CMS estimates that the combined impact of the proposed adjustment for FY16, along with the previous two years, would be to recover up to $3 billion in FY16. Combined with the effects of the -0.8 percent adjustments implemented in FY14 and FY15, CMS estimates that the proposed FY16 -0.8 percent adjustment would result in the recovery of a total of approximately $6 billion of the $11 billion in overpayments required to be recovered by section 631 of the ATRA. Estimates of any future adjustments are subject to slight variations in total savings. Therefore, CMS

has not yet addressed the specific amount of the final adjustment required under section 631 of the ATRA for FY17.

Capital Federal Rate

Federal Register pages: 24638-24641

For FY15, CMS established a capital federal rate of **$434.97**. CMS is proposing to establish an update of **1.3** percent in determining the FY16 capital federal rate for all hospitals. This is then downward adjusted by factors in Table 4 below. As a result of this proposed update and the proposed budget neutrality factors discussed above, CMS is proposing to establish a national capital federal rate of **$438.40** for FY16. The proposed FY16 update factor has the effect of increasing the capital federal rate by 1.3 percent compared to the FY15 capital federal rate. The proposed GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital federal rate by 0.24 percent. The proposed FY16 outlier adjustment factor has the effect of decreasing the capital federal rate by 0.27 percent compared to the FY15 capital federal rate. The combined effect of all the proposed changes would increase the proposed national capital federal rate by 0.79 percent compared to the FY15 national capital federal rate.

These factors are listed in Table 5 below.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2015 CAPITAL FEDERAL RATE AND PROPOSED FY 2016 CAPITAL FEDERAL RATE

	FY 2015	Proposed FY 2016	Change	Percent Change
Update Factor[1]	1.0150	1.0130	1.0130	1.3
GAF/DRG Adjustment Factor[1]	0.9993	0.9976	0.9976	-0.24
Outlier Adjustment Factor[2]	0.9382	0.9357	0.9973	-0.27
Capital Federal Rate	$434.97	$438.40	.0079	0.79

Outlier Payments

Federal Register pages: 24631-24634

Consistent with the methodology used in FYs 2014 and 2015 to calculate the outlier fixed-loss cost threshold, for FY16, CMS is proposing to include estimated FY16 uncompensated care payments in the computation of the proposed outlier fixed-loss cost threshold. Specifically, it is proposing to use the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the proposed outlier fixed-loss cost threshold methodology. Using this methodology, CMS is proposing an outlier fixed-loss cost threshold for FY16 of **$24,485**. It includes Medicare severity diagnosis related group (MS–DRG), plus any Indirect Medical Education (IME) empirically justified Medicare Disproportionate Share Hospital (DSH) payments, estimated uncompensated care payment, and any add-on payments for new technology. CMS notes that the proposed FY16 fixed-loss cost threshold is lower than the FY15 final outlier fixed-loss cost threshold of $24,626.

CMS believes that the decrease in the charge inflation factor (compared to the FY15 charge inflation factor) contributed to a lower proposed outlier fixed-loss threshold for FY16. As charges decrease, so does the amount of outlier payments. As a result, it would be necessary to lower the proposed outlier fixed-loss cost threshold to increase the amount of outlier payments expended in order to reach the 5.1 percent target.

Payment Adjustment for Medicare Disproportionate Share Hospitals

Federal Register pages: 24480-24488

Maryland Hospital Exemption

Maryland hospitals are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the payment methodology of section 1886(r) of the Act, because they are not paid under the IPPS. As discussed in the FY15 IPPS final rule, effective Jan. 1, 2014, the State of Maryland elected to no longer have Medicare pay Maryland hospitals in accordance with section 1814(b)(3) of the Act and entered into an agreement with CMS that Maryland hospitals will be paid under the Maryland All-Payer Model. However, under the Maryland All-Payer Model, Maryland hospitals still are not paid under the IPPS. Therefore, they remain ineligible to receive empirically justified Medicare DSH payments or uncompensated care payments under section 1886(r) of the Act.

Medicare DSH Payment Adjustment Methodology under the ACA

Beginning with discharges in FY14, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments. The other 75 percent is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. This 75 percent will be reduced each year as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. CMS proposes that the 75 percent be further decreased in FY16 to reflect additional decreases in the percentage of uninsured that have occurred since FY15. For each eligible hospital in FY14 and subsequent years, the uncompensated care payment is the product of three factors.

Eligibility for Empirically Justified Medicare DSH and Uncompensated Care Payments

Hospitals must receive empirically justified Medicare DSH payments in a fiscal year in order to receive an additional Medicare uncompensated care payment for that year. The final determination on the hospital's eligibility for uncompensated care payments would be based on the hospital's actual DSH status on the cost report for that payment year. Subsection (d) Puerto Rico hospitals and IPPS hospitals that have elected to participate in the Bundled Payments for Care Improvement initiative are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments. Maryland hospitals, hospitals participating in the Rural Community Hospital Demonstration Program, and sole community hospital (SCHs) that are paid under their hospital-specified rate, are not eligible for Medicare DSH payments.

Empirically Justified Medicare DSH Payments

Since the HHS Secretary pays 25 percent of the amount of the DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Act to a subsection (d) hospital without revising the criteria governing eligibility for DSH payments or the underlying payment methodology, CMS stated in the FY14 IPP final rule that it did not believe it was necessary to develop any new operational mechanisms for making such payments. Therefore, in the FY14 IPPS final rule, CMS implemented this provision simply by revising the claims payment methodologies to adjust the interim claim payments to the requisite 25 percent of what would have otherwise been paid. It also made corresponding changes to the hospital cost report so that these empirically justified Medicare DSH payments can be settled at the appropriate level at the time of cost report settlement. The estimate for empirically justified Medicare DSH payments for FY16 is $3.335 billion (25 percent of the total amount estimated).

Uncompensated Care Payments

For each eligible hospital in FY14 and subsequent years, the uncompensated care payment is the product of three factors. These three factors represent the estimate of 75 percent of the amount of Medicare DSH payments that would otherwise have been paid, an adjustment to this amount for the percent change in the national rate of uninsurance compared to the rate of uninsurance in 2013, and each eligible hospital's estimated uncompensated care amount relative to the estimated uncompensated care amount for all eligible hospitals.

FY16 Proposed Methodology to Calculate Factor 1

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for the fiscal year, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY16. In order to determine Factor 1 in the uncompensated care payment formula for FY16, CMS is proposing to continue the policy established in the FY14 IPPS final rule and in the FY14 IPPS interim final rule with comment period of developing estimates of both the aggregate amount of Medicare DSH payments that would be made in the absence of section 1886(r)(1) of the Act and the aggregate amount of empirically justified Medicare DSH payments to hospitals under 1886(r)(1) of the Act through rulemaking. These estimates will not be revised or updated after it knows the final Medicare DSH payments for FY16.

CMS uses data from the Office of the Actuary's (OACT's) most recently submitted Medicare cost report data to identify current Medicare DSH payments and the most recent DSH payment adjustments provided in the IPPS Impact File, and applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year. Based on the February 2015 estimate, the estimate for empirically justified Medicare DSH payments for FY16 is $3.335 billion (25 percent of the total amount estimated). Since Factor 1 is the difference between the two OACT estimates. In the rule, CMS is proposing that Factor 1 for FY16 is $10,003,425,327.39. Table 6 below shows the factors applied to update this baseline through the current estimate for FY16:

FACTORS APPLIED FOR FY 2013 THROUGH FY 2016 TO ESTIMATE MEDICARE DSH EXPENDITURES USING FY 2012 BASELINE

FY	Update	Discharge	Case-Mix	Other	Total	Estimated DSH payments (in billion)
2013	1.028	0.9844	1.014	1.0139	1.040394	$12.102
2014	1.009	0.9595	1.015	0.9993	0.98197	$11.884
2015	1.014	0.9885	1.005	1.0485	1.056207	$12.552
2016	1.011	1.0012	1.005	1.0446	1.062645	$13.338

FY16 Proposed Methodology to Calculate Factor 2

In the calculation of the uncompensated care payment, Factor 2 for FY 2014, 2015, 2016, and 2017, is a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the ACA, and who are uninsured in the most recent period for which data are available (as so calculated), minus 0.1 percentage point for FY14 and minus 0.2 percentage point for each of FYs 2015, 2016, and 2017. For the proposal, CMS used the Congressional Budget Office's (CBO's) January 2015 estimates of the effects of the ACA on health insurance coverage to calculate the percent of individuals without insurance. The CBO's most recent estimate of the rate of uninsurance in CY15 is 13 percent (that is, 100 percent minus 87 percent.) Similarly, the CBO's January 2015 estimate of individuals under the age of 65 with insurance in CY16 is 89 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY16 available for this proposed rule is 11 percent (that is, 100 percent minus 89 percent.)

The calculation of the proposed Factor 2 for FY16, employing a weighted average of the CBO projections for CY15 and CY16, is as follows:

- CY15 rate of insurance coverage (January 2015 CBO estimate): 87 percent.
- CY16 rate of insurance coverage (January 2015 CBO estimate): 89 percent.
- FY16 rate of insurance coverage: (87 percent * .25)+(89 percent * .75) = 88.5 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent
- Percent of individuals without insurance for FY16 (weighted average): 11.5 percent
  1- ((0.115-0.18)/0.18) = 1-0.3611 =
  0.6389 (63.89 percent) 0.6389 (63.89 percent) -.002 (0.2 percent for FY16 under section 1886(r)(2)(B)(i) of the Act) = 0.6369 or 63.69 percent
  0.6369 = Factor 2.

Therefore, the proposed Factor 2 for FY16 is 63.69 percent. CMS's proposal for Factor 2 is subject to change if more recent CBO estimates of the insurance rate become available at the time of the preparation of the final rule. The FY16 proposed uncompensated care amount is: $10,003,425,327.39 x 0.6369 = **$6,371,181,591.01**.

FY16 Proposed Methodology to Calculate Factor 3

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY14 and

subsequent fiscal years. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made.

In order to implement the statutory requirements for this factor of the uncompensated care payment formula, it was necessary to determine:

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

CMS proposes that, for FY16, it will continue to base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare (SSI) patients. It still intends to propose through future rulemaking the use of the Worksheet S-10 data for purposes of determining Factor 3 at some point in the future. CMS will publish on its website a table listing Factor 3 for all hospitals that it estimates would receive empirically justified Medicare DSH payments in FY16, and for the remaining subsection (d) hospitals and subsection (d) Puerto Rico hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified Medicare DSH payment for the fiscal year as determined at cost report settlement. Hospitals will have 60 days from the date of public display of the proposed rule to review the table and submit in writing of a change in its subsection (d) hospital status.

To estimate Factor 3 for FY15, CMS used data from the most recently available full-year cost report, the most recent cost report data submitted by Indian Health Service (IHS) hospitals for the Medicaid days, the most recently available SSI ratios, which for FY15 were data obtained from the 2011/2012 cost reports, and the 2010 cost report data submitted by IHS hospitals for the Medicaid days, and the FY12 SSI ratios for the Medicare SSI days. CMS notes that it anticipates using the more recent of the full year 2012 or 2011 data from the March 2015 update of the hospital cost report data in the hospital cost Report information system (HCRIS) database to obtain the Medicaid days and the FY13 SSI ratios to determine the final Factor 3 for FY16.

Impact on Medicare DSH Payment Adjustment of the Continued Implementation of New OMB Labor Market Area Delineations

In the FY15 IPPS PPS final rule, CMS implemented then revised OMB labor market area delineations (which are based on 2010 Decennial Census data) for the FY15 wage index. CMS noted that this implementation would have an impact on the calculation of Medicare DSH payments to certain hospitals. Hospitals that are designated as rural with less than 500 beds and that are not rural referral centers (RRCs) are subject to a maximum DSH payment adjustment of 12 percent. Accordingly, these hospitals that are currently in urban counties that became rural when CMS adopted the new OMB delineations, and that did not become RRCs, are subject to a maximum DSH payment

adjustment of 12 percent. A hospital located in an area that is reclassified from urban to rural, as defined in the regulations, may receive an adjustment to its rural federal payment amount for operating costs for two successive fiscal years. For the purposes of ratesetting, calculating budget neutrality, and modeling payment impacts for this FY16 proposed rule, any hospital that was previously urban but changed to rural status in FY15 as a result of the adoption of the new OMB labor market area delineations will have its DSH payments modeled such that the payment equals the amount of the rural DSH payments plus one-third of the difference between the urban DSH payments and the rural DSH payments.

Changes to the Hospital Area Wage Index

Federal Register pages: 24463-24777

The proposed FY16 national average hourly wage (unadjusted for occupational mix) is **$40.1203**. The proposed FY16 Puerto Rico overall average hourly wage (unadjusted for occupational mix) is $**16.718**.

The wage index will continue, for FY16, 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 proposed FY16 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY12 (the FY15 wage indexes were based on data from cost reporting periods beginning during FY11).

In general, it is CMS's practice to update the CBSA-based labor market area delineations annually based on the most recent updates issued by OMB. At the time of the development of this proposed rule, OMB had not issued any further updates subsequent to OMB Bulletin No. 13–01, which was dated Feb. 28, 2013, and established revised delineations based on 2010 Census Bureau data that were subsequently adopted in the FY15 IPPS final rule. Therefore, for FY16, CMS is proposing to continue to use the CBSA-based labor market area delineations currently used under the LTCH PPS (as adopted in the FY15 IPPS/LTCH PPS final rule.

The proposed national average hourly wage increased 1.02 percent compared to FY15. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 1.02 percent increase in average hourly wage. Of the 3,302 hospitals with wage data for both FYs 2015 and 2016, 1,673 or 50.7 percent would experience an average hourly wage increase of 1.02 percent or more.

Table 7 below, compares the shifts in wage index values for hospitals due to proposed changes in the average hourly wage data for FY16 relative to FY15.

Proposed FY 2016 Percentage Change in Area Wage Index Values	Number of Hospitals	
	Urban	Rural
Increase 10 percent or more	13	0
Increase greater than or equal to 5 percent and less than 10 percent	60	0
Increase or decrease less than 5 percent	2,305	806
Decrease greater than or equal to 5 percent and less than 10 percent	94	9
Decrease 10 percent or more	9	0
Unchanged	6	0

Puerto Rico Hospitals

Federal Register pages: 24475, 24478-24479, 24640- 24641

Table 8 - Proposed Adjusted Operating Standardized Amounts for Puerto Rico (Labor/Nonlabor)

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
Standardized Amount	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
[1]National	Not Applicable	Not Applicable	$3,397.00	$2,082.03
Puerto Rico	$1,638.15	$953.86	$1,607.05	$984.96

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. CMS is proposing an applicable percentage increase to the Puerto Rico-specific operating standardized amount of **1.9** percent for FY16. For the proposed rule, CMS used the first quarter 2015 forecast of the FY10-based IPPS market basket update with historical data through fourth quarter 2014.

CMS notes that, for Puerto Rico hospitals, the national labor-related share is **62** percent because the national wage index for all Puerto Rico hospitals is less than 1.0000.
In the FY14 IPPS, CMS also rebased and revised the labor-related share for the Puerto Rico-specific standardized amounts using FY10 as a base year. For FY15, CMS continued to use a labor-related share for the Puerto Rico-specific standardized amounts of **63.2** percent for discharges occurring on or after Oct. 1, 2014. For FY16, CMS is proposing to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of **63.2** percent for discharges occurring on or after Oct. 1, 2015. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts.

For FY16, CMS is proposing that the labor-related share of a hospital's Puerto Rico-specific rate would be either the Puerto Rico-specific labor-related share of 63.2 percent or 62 percent, depending on which results in higher payments to the hospital. If the hospital has a proposed Puerto Rico-specific wage index greater than 1.000 for FY16,

CMS would set the hospital's rates using a labor-related share of 63.2 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount would result in higher payments. Conversely, a hospital with a proposed Puerto Rico-specific wage index of less than or equal to 1.000 for FY16 would be paid using the Puerto Rico-specific labor-related share of 62 percent of the Puerto Rico-specific rates because the lower labor-related share would result in higher payments.

The proposed Puerto Rico labor-related share of 63.2 percent for FY16 is reflected in Table 1C, which is published in section VI of the Addendum to the proposed rule, which can be found on the on the CMS website.

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

Federal Register pages: 24640-24641

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 Oct. 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 FY15, the special capital rate for hospitals located in Puerto Rico was $209.45.

With the changes CMS is proposing to make to the factors used to determine the proposed capital federal rate, the proposed FY16 special capital rate for hospitals in Puerto Rico is **$213.77**, as seen in Table 9 below**.**

TABLE 1D.—PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATES—FY 2016

	Rate
National	$468.51
Puerto Rico	$230.93

Please note: the number appearing in the table above for the proposed capital standard federal payment rate for hospitals in Puerto Rico differ from the number in the text. We are waiting to hear back from CMS to verify these numbers.

Hospital-Acquired Condition (HAC) Reduction Program

Federal Register pages: 24509-24514

Section 3008 of the ACA added section 1886(p) to the Social Security Act "Act" to provide an incentive for applicable hospitals to reduce the incidence of Healthcare Acquired Conditions (HACs). Section 1886(p) of the Act requires the HHS Secretary adjust payment to "applicable hospitals" effective beginning on Oct. 1, 2014, and for subsequent program years. Section 1886(p)(1) of the Act sets forth the requirements by which payments to "applicable hospitals" will be adjusted to account for HACs with respect to discharges occurring during FY15 or later. The amount of payment shall be

equal to 99 percent of the amount of payment that would otherwise apply to such discharges under section 1886(d) or 1814(b)(3) of the Act, as applicable.

Prior to FY15 and each subsequent fiscal year, the HHS Secretary is required to provide the delivery of confidential reports to applicable hospitals with respect to HACs during the applicable period and make this information available to the public. Hospitals will have the opportunity to review and submit corrections before the information is made public. Once corrected, the HAC information must be posted on the *Hospital Compare* website in a format that is easily understood.

In the FY14 IPPS final rule, CMS presented the general framework for implementation of the HAC Reduction Program for FY15, the first year of the payment adjustment under the HAC Reduction Program. In the proposed rule, CMS proposes three changes to existing HAC reduction program policies:

1. An expansion to the population covered by the central line-associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures to include patients in select non-intensive care unit sites within a hospital
2. An adjustment to the relative contribution of each domain to the total HAC Score, which is used to determine if a hospital will receive the payment adjustment
3. A policy that would align with existing extraordinary circumstance exception policies for other IPPS quality reporting and payment programs and would allow hospitals to request a waiver for use of data from the affected time period.

Under the proposal, CMS would not change policies for the implementation of the HAC Reduction Program for FY16. However, it reminded readers that, in the FY15 IPPS final rule, it finalized the following measures for use in the FY16 program:

- Agency for Healthcare Research and Quality (AHRQ) PSI-90
- Central line-associated bloodstream infection (CLABSI)
- Catheter-Associated Urinary Tract Infection (CAUTI) and
- Colon and Abdominal Hysterectomy Surgical Site Infection (SSI)

CMS is not proposing to add or remove any measures for FY16. CMS is providing an update on National Quality Forum (NQF) proceedings for three of the measures previously finalized for the FY16 program:

- PSI–90 Composite
- CLABSI
- CAUTI

Additional detail for each measure is provided below.

For FY16, CMS is retaining the AHRQ PSI-90 Composite measure (in Domain 1) that it adopted in the FY14 IPPS final rule. As noted in the FY15 IPPS, the AHRQ PSI-90 composite measure is undergoing NQF maintenance review. The PSI-90 Composite measure currently consists of eight component indicators, including:

- PSI-3 Pressure ulcer rate;
- PSI-6 Iatrogenic pneumothorax rate
- PSI-7 Central venous catheter-related blood stream infections rate;
- PSI-8 Postoperative hip fracture rate
- PSI-12 Postoperative pulmonary embolism/Deep vein thrombosis rate
- PSI-13 Postoperative sepsis rate
- PSI-14 Wound dehiscence rate
- PSI-15 Accidental puncture and laceration rate

As part of the NQF maintenance review process, AHRQ is considering the addition of:

- PSI-9 Perioperative hemorrhage rate
- PSI-10 Perioperative physiologic metabolic derangement rate
- PSI-11 Post-operative respiratory failure rate measures

Or a combination of these three measures, to the PSI-90 Composite measure. CMS considers the potential inclusion of additional component measures in the PSI-90 composite measure to be a significant change to the measure, and, if that occurs, it would engage in notice-and-comment rulemaking prior to requiring the reporting of the revised composite for the HAC Reduction Program. At this time, the AHRQ PSI-90 Composite measure is continuing to undergo NQF maintenance review. No changes have been finalized. Therefore, CMS is not proposing any changes to this measure at this time.

Similarly, in the FY15 IPPS final rule, CMS noted that the CDC National Healthcare Safety Network (NHSN) CAUTI and CLABSI measures in Domain 2 that it adopted in the FY14 IPPS final rule for inclusion in FYs 2015, 2016, and 2017 were undergoing NQF maintenance review. CMS stated in the FY15 IPPS final rule that, if there are significant changes to these measures, it would engage in notice-and-comment rulemaking prior to requiring the reporting of the revised measures. These measures have now completed the NQF maintenance review process, and modified versions of the measures were reendorsed by NQF on Nov. 10, 2014. CMS notes that reendorsed versions of the CDC NHSN CLABSI and CAUTI measures included a new statistical option for calculating the measure result, the adjusted ranking metric (ARM), in addition to the standardized infection ratio (SIR) statistical option.

For FY16, CMS will continue use of the CDC NHSN CLABSI and CAUTI measures as previously finalized for the program with use of the SIR. It will be working with CDC in the future to determine if the newly available ARM would be appropriate for use in the HAC Reduction Program. If it is determined at a later time that the ARM is appropriate for use in the HAC Reduction Program and provides an advantage to the existing measure result (the SIR), CMS will propose this change in notice-and-comment rulemaking.

CMS anticipates providing hospitals with their confidential hospital-specific reports and discharge level information used in the calculation of their FY16 Total HAC score in late summer 2015 via the *QualityNet Secure Portal*. In order to have access to their hospital-specific reports, hospitals must register for a *QualityNet Secure Portal* account. CMS did not make any changes to the review and correction policies for FY16. Hospitals have a period of 30 days after the information is posted to the *QualityNet Secure Portal* to

review and submit corrections for the calculation of their HAC Reduction Program measure scores, domain scores, and Total HAC Score for the fiscal year.

Proposed HAC Reduction Program Changes for FY17:

In the FY15 IPPS final rule CMS finalized the following measures for use in the FY17 program: AHRQ PSI-90 Composite and CDC NHSN CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia, and *Clostridium difficile* (CDI). CMS would not change this measure set for FY17. CMS would also not make any changes to the measures from how they were finalized for use in the FY16 program (CAUTI, CLABSI, and Colon and Abdominal Hysterectomy SSI) or FY17 program (MRSA Bacteremia and CDI). However, for FY17, CMS is proposing three changes to existing program policies:

1. Proposed Applicable Time Period for the FY17 HAC Reduction Program

   CMS is proposing to continue similar two-year time periods for the calculation of HAC Reduction Program measure results. For the Domain 1 measure (AHRQ PSI-90 Composite measure), it would use the 24-month period from July 1, 2013, through June 30, 2015. The claims for all Medicare FFS beneficiaries discharged during this period would be included in the calculations of measure results for FY17. For the CDC NHSN measures previously finalized for use in the FY17 HAC Reduction Program (CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI), CMS would use data from CYs 2014 and 2015. CMS is seeking public comment on the proposal to use these updated time periods for calculation of measure results for the FY17 program.

2. Proposed Narrative Rule Used in Calculation of the Domain 2 Score for the FY17 HAC Reduction Program

   In the FY14 IPPS final rule, CMS notes that there will be instances in which applicable hospitals may not have data on all Domain 1 and 2 measures, and, therefore, a set of narrative rules was finalized to determine how to score each Domain For FY17, CMS will follow the rules as previously finalized. CMS is also proposing an additional narrative rule for use beginning in the FY17 program year. This additional narrative rule would be applicable to calculation of the Domain 2 score and would treat each Domain 2 measure independently when determining if a score of 10 (maximal score) should be assigned to the measure for nonsubmission of data without a waiver (if applicable). The current narrative rules for Domain 2 assign a score for each Domain 2 measure and the measure scores are averaged to provide a Domain 2 Score.

   For the FY15 and FY16 HAC Reduction Program, if a hospital reports data for at least one of the Domain 2 measures, its Domain 2 Score is based solely on the measure(s) the hospital reported and the hospital is not assigned the maximum number of points for any nonreported measure(s). This approach was employed for the FY15 and 2016 HAC Reduction Program because the applicable periods for the Domain 2 measures for those program years (Jan. 1, 2012, through Dec. 31, 2013, for FY15, and Jan. 1, 2013, through Dec. 31, 2014, for the FY16) occurred, at least in part, prior to the announcement of the HAC Reduction Program with the publication of the FY14 IPPS final rule. The proposed

applicable period for Domain 2 measures in the FY17 program (CYs 2014 and 2015) occurs in its entirety after the HAC Reduction Program was announced. This means hospitals were notified of the impact that not reporting these data would have on their Total HAC Score before the FY17 reporting period began (that is, before Jan. 1, 2014).

CMS is therefore proposing for FY17 and subsequent program years that each Domain 2 measure be treated independently when determining if a score of 10 (maximal score) should be assigned to the measure for nonsubmission of data without a waiver (if applicable). For instance, if a hospital does not submit data for the Colon and Abdominal Hysterectomy SSI measure and does not have a valid waiver for nonreporting, the measure would receive a score of 10. This score of 10 would then be combined with the measure scores the hospital received for data reported on the other FY17 Domain 2 measures (CLABSI and CAUTI) to calculate the hospital's total Domain 2 score. The rationale for this proposed change in methodology is to encourage hospitals to submit all available data on all measures in the program and to further encourage hospitals to reduce all HACs included in the program. CMS is inviting public comments on its proposal to implement these score calculations in FY17 and subsequent years, as well as its proposal for an additional narrative rule that would treat each Domain 2 measure independently when determining if a score of 10 (maximal score) should be assigned to the measure for nonsubmission of data without a waiver (if applicable).

3. Proposed Domain 1 and Domain 2 Weights for the FY17 HAC Reduction Program

   In the FY15 IPPS final rule, CMS finalized for FY16 a methodology for calculating a Total HAC Score for each hospital by determining a score for each domain, then multiplying each domain score by a weight (Domain 1 – AHRQ Patient Safety Indicators, 25 percent; Domain 2 – CDC NHSN measures, 75 percent), and adding together the weighted domain scores to determine the Total HAC Score. **For FY17, CMS is proposing to adjust the weighting of Domains 1 and 2 so that the weight of Domain 1 would be 15 percent and the weight of Domain 2 would be 85 percent.** CMS is proposing to decrease the Domain 1 weight for two reasons. First, with the implementation of the CDC MRSA Bacteremia and CDI measures in the FY17 program, it believes the weighting of both domains would need to be adjusted to reflect the addition of the fifth and sixth measure in Domain 2. Second, among the public comments on the FY14 and FY15 IPPS final rules that were considered, MedPAC and other stakeholders recommended that Domain 2 should be weighted more than Domain 1, because they believed the CDC NHSN chart-abstracted measures were more reliable and actionable than claims-based measures. CMS invites public comments on this proposal to decrease the Domain 1 weight from 25 percent to 15 percent and increase the Domain 2 weight from 75 percent to 85 percent for FY17.

Select Ward (Non-Intensive Care Unit (ICU)) Locations:

CMS is proposing measure refinements to the CDC NHSN CLABSI and CAUTI measures that were previously adopted for the HAC Reduction Program to include select ward (non-ICU) locations beginning in FY18. In the FY14 IPPS final rule, CMS adopted

the CLABSI and CAUTI measures inclusive of pediatric and adult patients in ICUs for the HAC Reduction Program beginning with FY15.

After considering several options for when to begin using the refined measures in the HAC Reduction Program, CMS is proposing to include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations in addition to data from adult and pediatric ICU locations for the CDC NHSN CLABSI and CAUTI measures, beginning with the FY18 HAC Reduction Program. This option balances its belief that the refinement of the CLABSI and CAUTI measures to include select ward locations results in an improved measure that more accurately captures hospital-wide performance regarding these HACs with the need to provide hospitals with the opportunity to submit data for the full period of performance and the desire to gain experience with the refined measures before incorporating them into the HAC Reduction Program. CMS also believes this measure refinement will allow hospitals that do not have ICU locations to use the tools and resources of the NHSN for quality improvement and public reporting efforts.

Proposed Measure Refinements for the FY18 HAC Reduction Program

CMS proposes measure refinements to the CDC NHSN CLABSI and CAUTI measures that were previously adopted for the HAC Reduction Program to include select ward (non-ICU) locations, beginning in FY18. Specifically, CMS would include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations in addition to data from adult and pediatric ICU locations for the CDC NHSN CLABSI and CAUTI measures, beginning with the FY18 HAC Reduction Program.

Proposed Extraordinary Circumstance Exception Policy for the HAC Reduction Program Beginning in FY16 and for Subsequent Years

In the FY15 IPPS proposed rule, CMS welcomed public comment on whether a potential waiver or exception policy for hospitals located in areas that experience disasters or other extraordinary circumstances should be implemented, and the policy and operational considerations of this exception policy for the HAC Reduction Program. CMS intends to provide relief for a hospital whose ability to accurately collect quality measure data and/or to report those data in a timely manner has been negatively impacted as a direct result of experiencing a significant disaster or other extraordinary circumstance beyond the control of the hospital. Under this proposed policy, a hospital would be able to request a HAC Reduction Program extraordinary circumstance exception. CMS would review each request for an extraordinary circumstance exception on a case-by-case basis. If CMS makes such a determination to grant an extraordinary circumstance exception to hospitals in an affected region or locale, it would convey this decision through routine communication channels, such as e-mails, memos, and notices on the QualityNet web site.

Hospital Readmissions Reduction Program

Federal Register pages: 24488-24498

The ACA establishes the Hospital Readmissions Reduction Program, effective for discharges from an “applicable hospital,” beginning on or after Oct. 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions. Section 1886(q)(1) of the Act sets forth the methodology by which payments to “applicable hospitals” will be adjusted to account for excess readmissions.

Accordingly, payments for discharges from an "applicable hospital" will be an amount equal to the product of the "base operating DRG payment amount" and the adjustment factor for the hospital for the fiscal year. That is, "base operating DRG payments" are reduced by a hospital-specific adjustment factor that accounts for the hospital's excess readmissions.

Refinement of the Readmission Measures

In the proposed rule, for the FY17 payment determination and subsequent years, CMS proposes a refinement of the currently NQF-endorsed CMS Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization measure (NQF #0506), referred to as the CMS 30-Day Pneumonia Readmission Measure (NQF #0506)), which expands the measure cohort to include hospitalizations for patients with a principal discharge diagnosis of aspiration pneumonia and for patients with a principal discharge diagnosis of either sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission. This cohort is the set of hospitalizations that meet all of the inclusion and exclusion criteria, and CMS is proposing an expansion to this set of hospitalizations. CMS believes that measure results derived from refinement of the measure cohort in the manner it is proposing would improve the measure's assessment of avoidable readmissions and more accurately reflect quality and outcome for pneumonia patients. This measure will be submitted to NQF for reendorsement when the appropriate project has its call for measures in 2015.

Floor Adjustment Factor for FY16

For FY15 and subsequent fiscal years, a hospital subject to the Hospital Readmission Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (statutorily the greatest possible reduction).

Proposed Applicable Period for FY16

For FY16, consistent with the definition at § 412.152, CMS is proposing an applicable period for the collection of Hospital Readmissions Reduction Program data to include discharges from the three-year period from July 1, 2011, through June 30, 2014. The base operating DRG payment amount does not include adjustments or add-on payments for IME, DSH, outliers, and low-volume hospitals. The base operating DRG payment amount for Medicare-dependent, small rural hospitals (MDHs) includes the difference between the hospital-specific payment rate and the federal payment rate (as applicable).

Proposed Calculation of Aggregate Payments for Excess Readmissions for FY16

For FY16, CMS is proposing to use Medicare Provider Analysis and Review (MedPAR) data from July 1, 2011, through June 30, 2014. In the rule, CMS is using the March 2012 update of the FY11 MedPAR file to identify claims within FY11 with discharges dates that are on or after July 1, 2011, the March 2013 update of the FY12 MedPAR file to identify claims within FY12, the March 2014 update of the FY13 MedPAR file to identify claims within FY13, and the December 2014, update of the FY14 MedPAR file to identify claims within FY14 with discharge dates no later than June 30, 2014. CMS is proposing to use the same MedPAR files for claims within FY11, FY12, and FY13.

For claims within FY14, CMS would use the March 2015 update of the FY14 MedPAR file. For FY16, CMS is proposing to continue to apply the same exclusions to the claims in the MedPAR file as it applied for FY15 for the current applicable conditions. For FY16, in order to have the same types of admissions to calculate aggregate payments for

excess readmissions as is used to calculate the excess readmissions ratio, CMS is proposing to identify admissions for the AMI, HF, PN, THA/TKA, COPD applicable conditions, for the purposes of calculating aggregate payments for excess readmissions.

The table in ***Appendix 1*** contains the ICD-9-CM codes CMS is proposing to use to identify each applicable condition to calculate the aggregate payments for the excess readmissions proposal for FY16. These ICD-9-CM codes also would be used to identify the applicable conditions to calculate the excess readmissions ratios, consistent with its established policy. ***Appendix 2*** displays the formula to calculate the readmissions adjustment factor for FY16.

Extraordinary Circumstance Exception Policy beginning in FY16
In developing this proposed extraordinary circumstance exception policy for the Hospital Readmissions Reduction Program beginning in FY16 and for subsequent years, CMS considered a policy and process similar to that for the Hospital Inpatient Quality Reporting Program. The request process for an extraordinary circumstance exception would begin with the submission of an extraordinary circumstance exception request form by a hospital within 90 calendar days of the natural disaster or other extraordinary circumstance. Under this proposal, a hospital would be able to request an extraordinary circumstance exception at the same time it may request a similar exception under the Hospital Inpatient Quality Reporting (IQR) Program, the Hospital VBP Program, and the HAC Reduction Program. CMS would review each request for an extraordinary circumstance exception on a case-by-case basis at its discretion. The proposed policy would not preclude CMS from granting extraordinary circumstance exceptions to hospitals that do not request them if it determines that a disaster or other extraordinary circumstance has affected an entire region or locale.

Hospital Quality Reporting Program

Federal Register pages: 24555- 24590

Annual payment updates for hospitals that do not participate successfully in the Hospital IQR program are reduced by **2.0 percent**.

Removal and Suspension of Hospital IQR Program Measures
CMS generally retains measures from the previous year's Hospital IQR Program measure set for subsequent years' measure sets, except when it specifically proposes to remove or replace them. The FY15 IPPS final rule contains the measures CMS has adopted for the Hospital IQR measure set through the FY17 payment determination and subsequent years. When CMS decides to remove a measure because its performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made, it is considered "topped out."

CMS continues to believe that there are circumstances in which a measure that meets criteria for removal should be retained because the drawbacks of removing a measure could be outweighed by other benefits to retaining the measure. Therefore, because of the continued need to balance benefits and drawbacks as well as the desire to increase transparency, CMS is proposing the additional factors to consider for measure removal and retention contained in the chart in ***Appendix 3***.

Previously Adopted Hospital IQR Program Measures for the FY17 Payment Determination and Subsequent Years

Of the 63 Hospital IQR measures described in the FY15 IPPS final rule, for the FY17 payment determination and subsequent years, 42 were previously finalized measures, 11 were newly adopted that rule final, and 10 were determined to be "topped-out," but retained in the Hospital IQR Program as voluntary electronic clinical quality measures. The table in ***Appendix 4*** shows measures previously adopted for the Hospital IQR Program FY17 payment determination and subsequent years.

NHSN Measures Standard Population Data

The previously adopted NHSN measures include the CAUTI, CLABSI, MRSA Bacteremia, CDI, colon and abdominal hysterectomy SSI measures, and healthcare personnel for the FY17 payment determination and subsequent years. These NHSN measures measure the incidence of hospital acquired infections (HAIs) in hospitals participating in the Hospital IQR Program. The CDC is updating the standard population data to ensure the NHSN measures' number of predicted infections reflect the current state of HAIs in the United States. Beginning in CY16, CDC will use data collected for infection events that occurred in 2015 as the new standard referent population. To do so, CDC will collect HAI data that healthcare facilities are reporting for events that have or will occur in CY15 to use in updating the standard population data for HAI measures. This new CY15 standard population data for HAI measures will hereinafter be referred to as "new standard population data."

Refinements to Existing Hospital IQR Program Measures

CMS is proposing the following refinements to the measure cohorts for:

1. The Hospital 30-day, All-cause, Risk-Standardized Mortality Rate (RSMR) following Pneumonia Hospitalization (NQF #0468) measure
   The proposed measure refinement would expand the measure cohort to include hospitalizations for patients with a principal discharge diagnosis of aspiration pneumonia and for patients with a principal discharge diagnosis of either sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission.

2. Proposed Refinement of Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Pneumonia Hospitalization (NQF #0506)
   This proposed measure refinement would expand the measure cohort to include hospitalizations for patients with a principal discharge diagnosis of aspiration pneumonia and for patients with a principal discharge diagnosis of either sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission. CMS anticipates that this measure will first be publicly reported with the proposed cohort change in CY16.

Clinical Episode-Based Payment Measures

CMS is proposing four clinical episode-based payment measures for inclusion in the Hospital IQR Program, beginning with the FY18 payment determination:

1. Kidney/Urinary Tract Infection Clinical Episode-Based Payment measure
2. Cellulitis Clinical Episode-Based Payment measure
3. Gastrointestinal Hemorrhage Clinical Episode-Based Payment measure

4. Lumbar Spine Fusion/Refusion Clinical Episode-Based Payment measure

The proposed measures evaluate the difference between observed and expected episode cost at the episode level before comparing at the provider level. The measures follow the general construction of the previously adopted, NQF-endorsed, Hospital IQR Program measure, Payment-Standardized Medicare Spending per Beneficiary (MSPB), described in the FY12 IPPS final rule, and include standardized payments for Medicare Part A and Part B services. Similar to the MSPB measure, the episodes are risk adjusted for individual patient characteristics and other factors (for example, attributes of inpatient stays). Unlike the MSPB measure, however, these clinical episode-based measures include only Medicare Part A and B services that are clinically related to the triggering diagnosis or procedure. Mathematically, the methodology first computes the provider's Episode Amount (calculated as the average of the ratios of each episode's observed costs to its expected costs multiplied by the national average observed episode cost) and then divides the provider's Episode Amount by the episode-weighted median of all providers' Episode Amounts. This methodology builds on that which was submitted to the Measure Application Partnership (MAP), in response to MAP feedback, and in order to yield a national episode-weighted measure.

Proposed Removal of Hospital IQR Program Measures for FY18

CMS is proposing to remove the following nine measures included in Table 10, either in their entirety or just the chart-abstracted form, from the Hospital IQR Program measure set for the FY18 payment determination and subsequent years.

Measures Proposed for Removal for the FY 2018 Payment Determination and Subsequent Years
"Topped-out" Measures
• STK-01: Venous Thromboembolism (VTE) Prophylaxis (NQF #0434)
• STK-06: Discharged on Statin Medication* (NQF #0439)
• STK-08: Stroke Education* (NQF endorsement removed)
• VTE-1: Venous Thromboembolism Prophylaxis* (NQF #0371)
• VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis* (NQF #0372)
• VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy* (NQF #0373)
Other Measures Proposed for Removal
• IMM-1 Pneumococcal Immunization (NQF #1653)
• SCIP-Inf-4 Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300)
• AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival* (NQF #0164)

* Proposed for retention as electronic clinical quality measures for the Hospital IQR Program FY 2018 payment determination and subsequent years.

Proposed Additional Hospital IQR Program Measures for the FY18 Payment Determination and Subsequent Years

CMS proposes to add eight new measures to the Hospital IQR Program for the FY18 payment determination and subsequent years. Under the proposal, CMS would adopt the following seven new claims-based measures and one new structural measure:

- Hospital Survey on Patient Safety Culture (structural)
- Kidney/UTI Clinical Episode-Based Payment Measure (claims-based)
- Cellulitis Clinical Episode-Based Payment Measure (claims-based)

- Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure (claims-based)
- Lumbar Spine Fusion/Re-Fusion Clinical Episode-Based Payment Measure (claims-based)
- Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA (claims-based)
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (claims-based)
- Excess Days in Acute Care after Hospitalization for Heart Failure (claims-based)

The table in ***Appendix 5*** outlines the Hospital IQR Program measure set for the FY18 payment determination and subsequent years and includes both previously adopted and proposed measures.

Requirements for Hospitals to Report Electronic Clinical Quality Measures for the FY18 Payment Determination and Subsequent Years

CMS is proposing to expand its electronic clinical quality measure policy in order to make reporting of electronic clinical quality measures required, rather than voluntary, under the Hospital IQR Program. Specifically, it is proposing that, beginning in CY16/FY18 payment determination and subsequent years, it would require hospitals to select and submit 16 electronic clinical quality measures covering three NQS domains from the 28 available electronic clinical quality measures. For the FY18 payment determination and subsequent years, it is proposing that hospitals must submit Q3 and Q4 data for 16 measures chosen by a hospital and reported as electronic clinical quality measures.

Reporting Periods and Electronic Submission Deadlines for the FY18 Payment Determination

In the FY15 IPPS final rule, CMS finalized its policy that hospitals could voluntarily submit electronic clinical quality measure data for one calendar year quarter's data for either CY Q1 (Jan. 1-March 31, 2015), CY Q2 (April 1–June 30, 2015), or CY Q3 (July 1-Sept. 30) by Nov. 30, 2015. In this proposed rule, for the FY18 payment determination, CMS is proposing changes to both the reporting periods and the submission deadlines. For the FY18 payment determination, it is proposing that hospitals must submit both Q3 and Q4 of 2016 data for 16 measures reported as electronic clinical quality measures. It is also proposing that for the FY18 payment determination, hospitals must submit the electronic clinical quality measure data for these two quarters (Q3 and Q4 of 2016) within 2 months after the end of the applicable calendar year quarter. For CY16, these deadlines would be Nov. 30, 2016, for Q3, and Feb. 28, 2017, for Q4. In order to accommodate those hospitals that may require additional time to implement the associated software changes associated with the annual update of electronic clinical quality measure specifications, CMS would delay the required reporting of electronic clinical quality measures to begin with Q3 of 2016, with a reporting deadline of Nov. 30, 2016. Table 11 below shows the required electronic clinical quality measure reporting periods and submission deadlines for CY16:

Proposed CY 2016/FY 2018 Payment Determination Hospital IQR Program Electronic Reporting Periods and Submission Deadlines for Eligible Hospitals	
Discharge Reporting Periods	**Submission Deadline**
January 1, 2016–March 31, 2016	N/A
April 1, 2016–June 30, 2016	N/A
July 1, 2016–September 30, 2016	November 30, 2016
October 1, 2016–December 31, 2016	February 28, 2017

Future Considerations for Electronically Specified Measures

Where feasible, CMS is considering the use of core clinical data elements derived from Electronic Health Records (EHR) for use in future quality measures (for example, risk adjustment of outcome measures), the collection of additional administrative linkage variables to link a patient's episode of care from EHR data with his administrative claim data, and the use of content exchange standards. CMS has identified a set of 21 clinical variables, or core clinical data elements, which it notes are routinely collected on hospitalized adults and feasibly extracted from hospital EHRs. CMS believes that these core clinical data elements can be adapted for future use as part of specific quality measures. In the future, one way in which CMS envisions using core clinical data elements in conjunction with other sources of data, such as administrative claims, is to calculate "hybrid" outcome measures, which are quality measures that utilize more than one source of data. CMS believes that these types of hybrid measures could enhance the current CMS administrative claims-based outcome measures by utilizing patient clinical data captured in the emergency room.

Hospital Value-Based Purchasing Program

Federal Register pages: 24498-24509

The total amount available for value-based incentive payments for a fiscal year will be equal to the total amount of the payment reductions for all participating hospitals for such fiscal year, as estimated by the HHS Secretary. For FY16, the available funding pool will be equal to 1.75 percent.

FY16 Program Year Payment Details

CMS estimates that the total amount available for value-based incentive payments for FY16 is $1.489 billion based on the December 2014 update of the FY14 MedPAR File. CMS intends to update this estimate for the FY16 IPPS final rule, using the March 2015 update of the FY14 MedPAR file. CMS will utilize a linear exchange function to translate this estimated amount available into a value-based incentive payment percentage for each hospital, based on its Total Performance Score (TPS). It will then calculate a value-based incentive payment adjustment factor that will be applied to the base operating DRG payment amount for each discharge occurring in FY16, on a per-claim basis. CMS published proxy value-based incentive payment adjustment factors in Table 16 of the proposed rule (which is available via the CMS website). The proxy factors are based on the TPSs from the FY15 program year. These FY15 performance scores are the most recently available performance scores that hospitals have been given the opportunity to review and correct.

After hospitals have been given an opportunity to review and correct their actual TPSs for FY16, CMS will add Table 16B (which will be available via on the CMS website) to display the actual value-based incentive payment adjustment factors, exchange function slope, and estimated amount available for the FY16 program year. CMS expects that Table 16B will be posted on its website in October 2015.

Retention, Removal, Expansion, and Updating of Quality Measures for the FY18 Program Year

CMS proposes to remove the (1)IMM-2 Influenza Immunization and (2)AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival measures, effective for the FY18 program year. Based on its evaluation of the most recently available data for this measure, CMS believes that IMM-2 is "topped-out." Evaluation of the most recently available data shows that AMI-7a is not widely reported by hospitals and that many hospitals have less than the minimum number of cases required for reporting because most acute myocardial infarction patients receive percutaneous coronary intervention instead of fibrinolytic therapy. Therefore, CMS is proposing to remove this measure because collection of the measure data is burdensome to hospitals and are infrequently reported. CMS believes that removing these measures will continue to ensure that it makes valid statistical comparisons through its finalized scoring methodology, while reducing the reporting burden on participating hospitals.

Removal of Clinical Care—Process Subdomain for the FY18 Program Year and Subsequent Years

CMS previously adopted three measures for the Clinical Care—Process subdomain for the FY17 Hospital VBP Program. However, it is proposing to remove the AMI-7a and IMM-2 measures from the Hospital VBP Program and is not proposing to adopt any additional measures for the Clinical Care—Process subdomain. If the proposals are finalized, only one measure, PC-01 Elective Delivery, which measures the incidence of elective births prior to 39 weeks gestation, would remain in the Clinical Care—Process subdomain for the FY18 program year. If the removal of the IMM–2 and AMI–7a measures are finalized, CMS is proposing to move PC-01 to the Safety domain and to remove the Clinical Care—Process subdomain beginning with the FY18 program year. Also, if CMS finalizes its proposal to remove the Clinical Care—Process subdomain, it is proposing to rename the Clinical Care—Outcomes subdomain as simply the Clinical Care domain.

Modifications to the Existing Processes for Validation of Hospital IQR Program Data

In the proposed rule, CMS is proposing modifications to existing processes for validation of chart-abstracted measures, specifically for the Influenza Immunization (NQF #1659) measure. Since CMS is proposing to remove the IMM-2 Influenza Immunization measure from the Hospital VBP Program, it is no longer necessary to ensure validation of this topic area by including a separate stratum for the Influenza measure. As a result, in the proposal, for the Hospital IQR Program, beginning with the FY18 payment determination and for subsequent years, CMS is proposing to remove the separate immunization validation stratum and include the Influenza Immunization measure in the clinical process of care measure validation stratum. Table 12 below shows the proposed effect on topic area weighting of the proposal to remove the immunization measure validation stratum and to move the Influenza Immunization measure to the clinical process of care validation stratum.

Proposed Topic Area Weighting for Validation for the FY 2018 Payment Determination and Subsequent Years	
Topic Area	**Weight (Percent)**
Healthcare-associated infection (HAI)	66.7
Other/Clinical Process of Care	33.3
Total	**100.0**

New Measure for the FY18 Program Year: 3-Item Care Transition Measure (CTM-3) (NQF #0228)

The 3-Item Care Transition Measure (CTM-3) is an NQF-endorsed measure, adopted in the Hospital IQR Program in the FY13 IPPS final rule. In the FY15 IPPS final rule, CMS stated that it was considering proposing to add the CTM-3 measure from the HCAHPS Survey to the Patient and Caregiver Centered Experience of Care/Care Coordination domain of the FY18 Hospital VBP Program. CMS is proposing this measure for the Hospital VBP Program based on the MAP recommendation, its adoption of the measure in the Hospital IQR Program, and its posting of measure data on *Hospital Compare* for at least one year before the beginning of the performance period for that measure.

NHSN Measures Standard Population Data

The NHSN measures are calculated by the CDC and currently include the CAUTI, CLABSI, MRSA bacteremia, CDI, and Colon and Abdominal Hysterectomy SSI measures in the FY17 program year and subsequent program years. They measure the occurrence of these HAIs in hospitals participating in the Hospital VBP Program. As part of routine measure maintenance, CDC is updating the "standard population data" to ensure the NHSN measures' number of predicted infections reflect the current state of HAIs in the United States. Beginning in 2015, CDC will collect data in order to update the standard population data for all of the NHSN measures.

Summary of Previously Adopted and Newly Proposed Measures for the FY18 Program Year

For the FY18 program, CMS is proposing the following measure set contained in Table 13 below:

FY 2018 PREVIOUSLY ADOPTED AND NEWLY PROPOSED MEASURES

Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey.
CTM–3*	3-Item Care Transitions Measure.
Clinical Care Domain	
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization.
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization.
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.
Safety Domain	
CAUTI	National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure.
CLABSI	National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure.
Colon and Abdominal Hysterectomy SSI.	Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure: • Colon • Abdominal Hysterectomy.
MRSA bacteremia	National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* Bacteremia Outcome Measure.
CDI	National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection Outcome Measure.
PSI–90	Patient Safety for Selected Indicators (Composite).
PC–01**	Elective Delivery.
Efficiency and Cost Reduction Domain	
MSPB–1	Payment-Standardized Medicare Spending Per Beneficiary

*Proposed new measure.
**Proposed to be moved from the Clinical Care—Process subdomain to the Safety domain.

Previously Adopted and Newly Proposed Measures for the FY19, FY21, and Subsequent Program Years

In the proposal, CMS intends to include additional data in certain NHSN measures, beginning with the FY19 program year, adopt a new measure beginning with the FY21 program year, and summarize all previously adopted and newly proposed measures. Under the rule, CMS would include the selected ward (non-ICU) locations in the CAUTI and CLABSI measures, beginning with the FY19 program year in future rulemaking. CMS also intends to propose to adopt a baseline period of Jan, 1, 2015, through Dec. 31, 2015, and a performance period of Jan. 1, 2017, through Dec. 31, 2017, for these measures. CMS believes this expansion of the measures will allow hospitals that do not have ICU locations to use the tools and resources of the NHSN for quality improvement and public reporting efforts.

CMS is proposing the adoption of the Hospital 30-Day, All-Cause, Risk-standardized Mortality Rate following COPD Hospitalization (NQF #1893) (MORT–30–COPD) measure for the Hospital VBP Program based on the MAP recommendation, its adoption of the measure in the Hospital IQR Program, and its posting of measure data on *Hospital Compare* for at least one year prior to the start of the performance period. The measure aligns with the CMS Quality Strategy Goal of Effective Prevention and Treatment. Based on the continued high risk of mortality after COPD hospitalizations, CMS is proposing to add it to the Clinical Care domain for the FY21 Hospital VBP Program and subsequent years.

Previously Adopted and Newly Proposed Baseline and Performance Periods for the FY18 Program Year

- FY18 Baseline and Performance Periods for the Patient and Caregiver Centered Experience of Care/Care Coordination (PCCEC/CC)
  For the FY18 program year, CMS would adopt a 12-month performance period of Jan. 1, 2016, through Dec. 31, 2016, for the PCCEC/CC domain. CMS would also adopt a corresponding 12-month baseline period of Jan. 1, 2014, through Dec. 31, 2014, for purposes of calculating improvement points and calculating performance standards.

- FY18 Baseline and Performance Periods for NHSN Measures and PC–01 in the Safety Domain
  Since the FY16 program year, CMS has adopted a 12-month baseline period and 12-month performance period for NHSN measures. In addition, CMS adopted the PC–01 measure for the FY17 program year with a 12-month baseline period and performance period. Since 12-month baseline and performance periods are consistent with those used for these measures under the Hospital IQR Program for the FY18 program year, CMS is proposing to adopt a performance period of Jan. 1, 2016, through Dec. 31, 2016, for the NHSN measures and the PC–01 measure in the Safety domain. CMS would adopt a corresponding baseline period of Jan. 1, 2014, through Dec. 31, 2014, for purposes of calculating improvement performance standards.

FY18 Baseline and Performance Periods for the Efficiency and Cost Reduction Domain for the FY18 Program Year

- For the FY18 program year, CMS is proposing to adopt a 12-month performance period of Jan. 1, 2016, through Dec. 31, 2016, for the MSPB–1 measure in the Efficiency and Cost Reduction domain. CMS is proposing to adopt a corresponding baseline period of Jan. 1, 2014, through Dec. 31, 2014. These proposed baseline and performance periods align with the baseline and performance periods for the PCCEC/CC domain and all measures in the Safety domain with the exception of PSI–90.

Appendix 6 summarizes previously adopted and proposed baseline and performance periods for the FY18 program year (with previously adopted baseline and performance periods for the mortality and PSI composite (PSI–90) measures noted). ***Appendix 7*** summarizes previously adopted baseline and performance periods for the Clinical Care domain and PSI–90 measures for the FY19 program year, previously adopted and proposed baseline and performance periods for the FY20 program year, and proposed baseline and performance periods for the clinical care domain for the FY21 program year.

FY18 Proposed Performance Standards for the Hospital VBP Program

In accordance with its finalized methodology for calculating performance standards, CMS is proposing to adopt additional performance standards for the FY18 program year. CMS notes that the numerical values for the performance standards displayed below represent estimates based on the most recently available data, and it intends to update the numerical values in the FY16 IPPS final rule. CMS notes further that the MSPB–1 measure's performance standards are based on performance period data; therefore, it is unable to provide numerical equivalents for the standards at this time. Also, the performance standards for the NHSN measures, the PSI–90 measure, and the MSPB–1 measure are calculated with lower values representing better performance. This distinction is made in contrast to other measures for which higher values indicate better performance. The numerical values for the previously adopted performance standards for FY18 are listed in ***Appendix 8*** of this document. The available numerical values for the performance standards for FY19, FY20, and FY21 are included in this appendix also.

FY18 Program Year Scoring Methodology

In the FY15 IPPS/LTCH PPS final rule, CMS adopted the following domains contained below in Table 14:

DOMAIN WEIGHTS FOR THE FY 2017 PROGRAM YEAR FOR HOSPITALS RECEIVING A SCORE ON ALL DOMAINS

Domain	Weight
Safety	20 percent.
Clinical Care	30 percent.
• Clinical Care—Outcomes	• 25 percent.
• Clinical Care—Process	• 5 percent.
Efficiency and Cost Reduction	25 percent.
Patient and Caregiver-Centered Experience of Care/Care Coordination	25 percent.

For the FY18 program year, CMS is proposing to remove two ''topped-out'' measures from the Clinical Care— Process subdomain. In addition, it is proposing to move one measure (PC–01) from the Clinical Care—Process subdomain to the Safety domain and remove the Clinical Care—Process subdomain. If these proposals are adopted, the Safety domain will include seven measures for the FY18 program year, including PC–01, which

would be new to that domain. Because CMS is proposing to move one measure to the Safety domain, and because it continues to believe that hospitals should be provided strong incentives to perform well on measures of patient safety, it is proposing to increase the Safety domain's weight by 5 percent. Table 15 contains the FY18 program year domain weighting for hospitals receiving a score on all proposed newly-aligned domains that CMS is proposing to adopt:

PROPOSED DOMAIN WEIGHTS FOR THE FY 2018 PROGRAM YEAR FOR HOSPITALS RECEIVING A SCORE ON ALL DOMAINS

Domain	Weight
Safety	25 percent.
Clinical Care	25 percent.
Efficiency and Cost Reduction	25 percent.
Patient and Caregiver-Centered Experience of Care/Care Coordination	25 percent.

Proposed Domain Weighting for the FY18 Program Year for Hospitals Receiving Scores on Fewer Than Four Domains

In the FY15 IPPS final rule, CMS adopted a policy that, for the FY17 program year and subsequent years, hospitals must receive domain scores on at least three quality domains in order to receive a TPS. Hospitals with sufficient data on at least three of four domains for FY17 will have their TPSs proportionately reweighted. In that final rule, CMS also adopted case minimums for the FY16 program year and subsequent years. At this time, CMS is not proposing any changes to the minimum numbers of cases and measures that it adopted previously. However, because it is proposing to remove the Clinical Care—Process subdomain from the Hospital VBP Program effective with the FY18 program year, it considered whether it should revisit the requirement that hospitals must receive scores on at least three domains in order to receive a TPS. CMS continues to believe that this requirement appropriately balances its desire to enable as many hospitals as possible to participate in the Hospital VBP Program and the need for TPSs to be sufficiently reliable to provide meaningful distinctions between hospitals' performance on quality measures. CMS is not proposing to change this requirement at this time, but welcomes public comments on whether it should consider adopting a different policy on this topic.

Short Inpatient Hospital Stays

Federal Register pages: 24523

In the FY14 IPPS final rule CMS, discussed modifications and clarifications to its longstanding policy on how Medicare contractors review inpatient hospital and critical access hospital (CAH) admissions for payment purposes. Under that final rule, CMS established a two midnight benchmark for determining the appropriateness of an inpatient hospital admission versus treatment on an outpatient basis. The FY14 policy responded to both hospital calls for more guidance about when an inpatient admission and Part A payment are appropriate, and beneficiaries' concerns about increasingly long stays as outpatients due to hospital uncertainties about payment.

Although CMS does not propose any changes to this policy, it notes that hospitals and physicians continue to voice their concern with parts of the two-midnight rule. Therefore, it is considering this feedback carefully, as well as recent MedPAC recommendations, and expects to include a further discussion of the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the CY16 hospital outpatient prospective payment system proposed rule that will be published this summer.

Expanding the Bundled Payments for Care Improvement (BPCI) Initiative

Federal Register pages: 24414-24418

The Bundled Payment for Care Improvement (BPCI) initiative, developed under the authority of section 3021 of the Affordable Care Act (codified at section 1115A of the Act),comprises four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. All four models pay a discounted bundled payment for a single episode of care as an alternative approach to payment for service delivery under traditional Medicare fee-for-service. Each of the four models in the BPCI initiative tests bundled payments for a different episode of care. Under this initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care.

CMS is currently testing the BPCI initiative. For FY16, CMS is proposing to continue to include all applicable data from subsection (d) hospitals participating in BPCI Models 1, 2, and 4 in its IPPS payment modeling and ratesetting calculations. Evaluation of the BPCI initiative for expansion is expected to include analyses based on a combination of qualitative and quantitative sources, including Medicare claims, patient surveys, awardee reports, interviews, and site visits. Given that further evaluation of the BPCI initiative is needed to determine its impact on both Medicare cost and quality of care, CMS is not proposing an expansion of any models within the initiative or any policy changes associated with it. Instead, it requests public comments on issues surrounding a potential expansion of the BPCI initiative so that it can be prepared in the event that the HHS Secretary determines that findings from the evaluation of the initiative demonstrate that it meets all criteria for expansion, consistent with the requirements of section 1115A(c) of the Act, and that, based on these findings and other pertinent factors, expansion is warranted.

CMS is seeking public comments on the following issues:

- *Breadth and scope of an expansion* - Whether model expansion should focus on one or more of the four models or one or more specific episodes, or should target specific geographic regions of the country.
- *Episode definitions* - The current BPCI initiative episode definitions as part of an expansion, including the MS-DRGs, other bundled services (such as hospital readmissions), exclusions, and the duration of the episodes.
- *Models for expansion* - Whether one or more of the current BPCI initiative models should be considered as the first candidates for expansion.
- *Roles of organizations and relationships necessary or beneficial to care transformation* - The roles that organizations, including whether health care providers and suppliers and other entities, should serve under an expanded model.
- *Setting bundled payment amounts* - Approaches to setting bundled payments under model expansion. For participants in the BPCI initiative, bundled payments are related to the historical episode experience of episode initiators based on data from 2009 through 2012.
- *Mitigating risk of high-cost cases* - Depending on the breadth and scope of an expansion, the potential financial impact of high-cost episode cases could be an

issue for some providers. CMS seeks comments on strategies to mitigate the risk of high-cost cases to ensure appropriate payment for these episodes under model expansion, such as through outlier or other policies, while encouraging high-value, coordinated care for these cases as well.

- *Administering bundled payments* - Issues related to prospective or retrospective payment under model expansion. The feasibility of different payment approaches under the various models, including the administrative capacity and feasibility for some organizations to pay others for care during episodes or to share payments at reconciliation.
- *Data needs* - The types of data and functionality needed in the marketplace in order to expand this type of model (for example, EHRs and quality measurement, among others).
- *Use of health information technology* - How the use of health information technology can be used and encouraged in coordinating care across care settings, including postacute care.
- *Quality measurement and payment for value* - Which quality measures could be applied to episodes and approaches to incorporating value-based payment in the BPCI initiative.
- *Transition from Medicare FFS payments to bundled payments* - The need for and parameters of a transition period from Medicare FFS payment to bundled payment under an expanded model.
- *Other issues* - Other issues the public believes are important to consider.

LTCH PPS Payment Rates

Federal Register pages: 24677-24683**,** 24686**,** 24688

In the proposed rule, CMS presents its proposals related to the annual update to the LTCH PPS standard federal payment rate for FY16, which includes the proposed annual market basket update. Consistent with its historical practice of using the best data available, it also is proposing to use more recent data, if available, to determine the FY16 annual market basket update to the LTCH PPS standard federal payment rate in the final rule. CMS is proposing that, beginning with FY 16, only LTCH discharges that meet the criteria for exclusion from the site neutral payment rate would be paid based on the LTCH PPS standard federal payment rate specified at § 412.523.

CMS is proposing to establish an annual update for FY16 to the LTCH PPS standard Federal rate of **1.9** percent (that is, the current FY16 estimate of the market basket rate-of-increase of 2.7 percent, less a proposed adjustment of 0.6 percent for multifactor productivity (MFP), and less the 0.2 percent mandated by the ACA). The update for the FY16 LTCH is contained in Tables 16 and Table 17.

Table 16

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	**FY16 Payment Rate Update**
2.7%	0.6%	0.2%	**1.9 %**

Table 17

Market Basket Estimate	Minus MFP Adjustment	Minus ACA Mandate	Minus Quality Data Penalty	**FY16 Payment Rate Update**
2.7%	0.6%	0.2%	2.0%	**-0.1%**

FY16 LTCH PPS Standard Federal Payment Rate

For FY16, CMS is proposing to apply the annual update to the LTCH PPS standard federal rate from the previous year. Therefore, it would apply a factor of 1.019 to the FY15 standard federal rate of $41,043.71 to determine the proposed FY16 LTCH PPS standard federal payment rate. CMS is also proposing to apply a proposed area wage level budget neutrality factor to the FY16 standard federal rate of 1.001444. CMS would apply this area wage level budget neutrality factor to ensure that any changes to the area wage level adjustment will not result in any change (increase or decrease) in estimated aggregate LTCH PPS standard federal payment rate payments. Accordingly, CMS is proposing to establish a LTCH PPS standard federal payment rate of **$41,883.93** (calculated as $41,043.71× 1.019 × 1.001444) for FY16.

The proposed standard federal rate would apply in determining the payments for FY16 discharges from LTCHs that submit quality reporting data for FY16 in accordance with the requirements of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. The current rate is $41,043.71. For LTCHs that fail to submit quality reporting data for FY16 in accordance with the requirements of the LTCHQRP under section 1886(m)(5) of the Act, CMS is proposing to establish a LTCH PPS standard Federal payment rate of **$41,061.87** (calculated as $41,043.71× 0.999 × 1.001444) for FY16.

For FY16, CMS is proposing to establish a labor-related share for the LTCH PPS standard federal payment rate payments based on IHS Global Insight, Inc. (IGI's) first quarter 2015 forecast of the FY09-based LTCH-specific market basket. CMS is proposing to establish a labor-related share under the LTCH PPS for FY16 of **62.2** percent. This proposed labor-related share is determined using the same methodology as used in calculating all previous fiscal years LTCH labor-related shares.

CMS is proposing a fixed-loss amount of **$18,768** for LTCH PPS standard federal payment rate cases for FY16 and also to continue to make an additional high-cost outlier (HCO) payment for the cost of an LTCH PPS standard federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard federal payment rate payment and the proposed fixed-loss amount for LTCH PPS standard federal payment rate cases of $18,768). The current amount is $14,972 for FY15.

Site Neutral Payment Rate

Section 1206 of Pub. L. 113-67 mandates significant changes to the payment system for LTCHs beginning with LTCH discharges occurring in cost reporting periods beginning on or after Oct. 1, 2015. Under the current LTCH PPS, all discharges are paid under the LTCH PPS standard federal payment rate. Section 1206 requires the establishment of an alternate "site neutral" payment rate for Medicare inpatient discharges from an LTCH that fail to meet certain statutorily defined criteria. All LTCH discharges that meet the

criteria for exclusion from the site neutral payment rate will continue to be paid the LTCH PPS standard federal payment rate. Discharges that do not meet the statutory criteria will be paid at a new site neutral payment rate. The criteria for exclusion from the site neutral payment rate are:

- The discharge from the LTCH does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation
- Admission to the LTCH was immediately preceded by discharge from a subsection (d) hospital
- The immediately preceding stay in a subsection (d) hospital included at least three days in an intensive care unit (ICU) (referred to in this proposed rule as the ICU criterion) or the discharge from the LTCH is assigned to a MS-LTC-DRG based on the patient's receipt of ventilator services of at least 96 hours (referred to in this proposed rule as the ventilator criterion).

Rural Community Hospital Demonstration Program Adjustment

Federal Register pages: 24631

The Medicare Modernization Act of 2003 required the HHS Secretary to establish a demonstration program that modifies reimbursement for inpatient services for up to 15 small rural hospitals. Under this demonstration program, the HHS Secretary ensures that the aggregate payments made to participants do not exceed the amount that would have been paid if the demonstration program was not implemented. The ACA extended the demonstration program for an additional five-year period and allowed up to 30 hospitals to participate in 20 states with low population densities. In previous final rules, CMS adjusted the national IPPS payment rates by an amount sufficient to account for the added costs of this demonstration program. In other words, CMS has applied budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration program.

For FY16, CMS is proposing to adjust the national IPPS payment rates according to the proposed methodology detailed in section IV.I. Of the preamble of the proposed rule to account for the estimated additional costs of the demonstration program for FY16. Included also in the rule is CMS' proposal to subtract from the budget neutrality offset amount for FY16 the amount by which the budget neutrality offset amount finalized in the FY09 IPPS final rule exceeds the actual costs of the demonstration for FY09. The proposed total budget neutrality offset amount that CMS is proposing to be applied to the FY16 IPPS rates is **$17,738,497**. Accordingly, using the most recent data available to account for the estimated costs of the demonstration program, for F16, CMS computed a proposed factor of **0.999808** for the rural community hospital demonstration program budget neutrality adjustment that will be applied to the IPPS standard federal payment rate.

Long Term Care Hospital Quality Reporting Program

Federal Register pages: 24595- 24611

Section 3004(a) of the ACA amended section 1886(m)(5) of the Act, requiring the HHS Secretary to establish the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). This program applies to all hospitals certified by Medicare as LTCHs. Beginning

with the FY14 payment determination and subsequent years, the HHS Secretary is required to reduce any annual update to the standard federal rate for discharges occurring during such fiscal year by two percent for any LTCH that does not comply with the established requirements. The IMPACT Act of 2014 amended the Act in ways that affect the LTCH QRP.

In the FY16 rule, CMS is proposing three previously finalized quality measures. One measure proposal establishes the newly NQF-endorsed status of that quality measure; two other measure proposals are for the purpose of establishing the cross-setting use of the previously finalized quality measures, in order to satisfy the IMPACT Act of 2014 requirement of adopting quality measures under the domains of skin integrity and falls with major injury. CMS is proposing to adopt an ''application of'' a fourth previously finalized LTCH functional status measure in order to meet the requirement of the IMPACT Act of 2014 to adopt a cross-setting measure under the domain of functional status, such as self-care or mobility. All four measure proposals effect the FY18 annual payment update determination and beyond. These proposed measures are:

- All-Cause Unplanned Readmission Measure for 30 Days Post- Discharge from LTCHs (NQF #2512) to reflect NQF endorsement
- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) to meet the requirements of the IMPACT Act of 2014
- An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) to meet the requirements of the IMPACT Act of 2014;
- An application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under NQF review) to meet the requirements of the IMPACT Act of 2014.

In addition to proposing a process-based measure for the domain in the IMPACT Act of 2014 of ''Functional status, cognitive function, and changes in function and cognitive function,'' which is included in this year's proposed rule, CMS also intends to develop outcomes-based quality measures, including functional status and other quality outcome measures to further satisfy this domain. These measures will be proposed in future rulemaking in order to assess functional change for each care setting, as well as across care settings.

CMS is also proposing to publicly report LTCH quality data beginning in fall 2016, on a CMS website, such as *Hospital Compare*. CMS would initially publicly report quality data on four quality measures. CMS is proposing to lengthen its quarterly data submission deadlines from 45 days to 135 days beyond the end of each calendar year quarter beginning with quarter four (4) 2015 quality data. It is proposing this change in order to align with other quality reporting programs and to allow an appropriate amount of time for LTCHs to review and correct quality data prior to the public posting of that data.

General Considerations Used for Selection of Quality, Resource Use, and Other Measures for the LTCH QRP

CMS would apply the same considerations to the selection of quality, resource use, and other measures required under section 1899B of the Act for the LTCH QRP, in addition to the considerations discussed in the rule. The totality of the measures considered to

meet the requirements of the IMPACT Act of 2014 will evolve, and additional measures will be proposed over time as they become available.

Previously Adopted Quality Measures

Set out in Table 18 below are the quality measures, both previously adopted measures retained in the LTCH QRP and measures adopted in FY13 and FY14 IPPS/LTCH PPS final rules, for the FY15 and FY16 payment determinations and subsequent years.

LTCH QRP Quality Measures Previously Adopted for the FY 2015 and FY 2016 Payment Determinations and Subsequent Years

NQF Measure ID	Measure title	Payment determination
NQF #0138	National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	FY 2015 and Subsequent Fiscal Years.
NQF #0139	National Health Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure.	FY 2015 and Subsequent Fiscal Years.
NQF #0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay).	FY 2015 and Subsequent Fiscal Years.
NQF #0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay).	FY 2016 and Subsequent Fiscal Years.
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel	FY 2016 and Subsequent Fiscal Years.

Previously Adopted Quality Measures for the FY17 and FY18 Payment Determinations and Subsequent Years

In the FY14 IPPS final rule, CMS adopted three additional measures for the FY17 payment determination and subsequent years and one additional measure for the FY18 payment determination and subsequent years. In the FY15 IPPS final rule, CMS revised the data collection and submission period for the application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) measure (NQF #0674); and adopted three new quality measures for the FY17 payment determination and subsequent years. These measures are set out in Table 19 below.

LTCH QRP Quality Measures Previously Adopted for the FY 2017 and FY 2018 Payment Determinations and Subsequent Years

NQF Measure ID	Measure title	Payment determination
NQF #1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	FY 2017 and Subsequent Years.
NQF #1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure.	FY 2017 and Subsequent Years.
NQF #2512	All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals.	FY 2017 and Subsequent Years.
Application of NQF #0674.	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) ...	FY 2018 and Subsequent Years.
NQF #2631*	Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.	FY 2018 and Subsequent Years.
NQF #2632*	Functional Outcome Measure: Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support.	FY 2018 and Subsequent Years.
Not NQF endorsed	National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure.	FY 2018 and Subsequent Years.

*Under review at NQF. We refer readers to: *http://www.qualityforum.org/ProjectMeasures.aspx?projectID=73867*, NQF #2631 and NQF #2632.

Proposed Timing for New LTCHs to Begin Reporting Data to CMS for the FY17 Payment Determination and Subsequent Years

Beginning with the FY17 payment determination, CMS is proposing that a new LTCH be required to begin reporting quality data under the LTCH QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. The LTCH would be required to begin collecting quality data on the first day of the quarter subsequent to quarter two, which is quarter three, or July 1. The collection of quality data would begin on the first day of the calendar year quarter identified as the start date and would include all LTCH admissions and subsequent discharges beginning on, and subsequent to, that day; however, submission of

quality data would be required by previously finalized or newly proposed quarterly deadlines. CMS is proposing to adopt new deadlines that allow 4.5 months (approximately 135 days) after the end of each calendar year quarter for quality data submission, beginning with quarter four 2015 (October 2015 through December 2015).

Under this new policy, LTCHs will have approximately 135 days following the end of each calendar year quarter, during which to submit, review, and correct their quality data for that CY quarter. CMS is also proposing data collection and data submission timelines for quality measures that it is proposing for the FY18 payment determination and subsequent years. For three measures proposed in this rule, including Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), The application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), and The application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), data collection and data submission timelines would align with the proposed data collection and data submission timelines for each respective measure starting with April 1, 2016. Since measure (NQF #2512) is a Medicare FFS claims-based measure, the data collection and submission timelines are not applicable to this measure.

The table in **Appendix 9** presents the data collection period and data submission timelines for quality measures affecting the FY17 payment determination, and the table in **Appendix 10** contains revisions to the data collection period and data submission timelines for quality measures for the FY18 payment determination and subsequent years.

Indirect Medical Education (IME) Payment Adjustment Factor

Federal Register pages: 24480

For discharges occurring during FY16, the formula multiplier is 1.35. CMS estimates that application of this formula multiplier for the FY16 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10 percent increase in the hospital's resident to bed ratio.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Federal Register pages: 24590-24595

The ACA mandated a quality reporting program for PPS-exempt cancer hospitals (PCHs) that specifically applies to PCHs that meet the requirements under 42 CFR 412.23(f). For FY14 and each subsequent fiscal year, a PCH must submit data to the HHS Secretary. CMS is proposing to remove six Surgical Care Improvement Project (SCIP) measures from the PPS-exempt cancer hospital quality reporting program, beginning with fourth quarter (Q4) 2015 discharges and for subsequent years. Under this proposal, PCHs will meet reporting requirements for the FY16 and FY17 programs by submitting first quarter (Q1) through third quarter (Q3) 2015 data for the following measures:

- Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)

- Urinary Catheter Removed on Post-Operative Day One (POD1) or Post-Operative Day Two (POD2) with Day of Surgery Being Day Zero (NQF#0453)
- Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (NQF #0527)
- Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
- Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time (NQF #0529)
- Surgery Patients on Beta-Blocker Therapy Prior to Admission who Received a Beta-Blocker During the Perioperative Period (NQF #0284)

CMS first adopted the six SCIP measures in the FY14 IPPS final rule. As described in the FY15 IPPS final rule, these measures have been determined to be topped-out in the Hospital IQR Program and have been removed. To meet FY16 and FY17 program requirements, CMS proposes that PCHs would continue to submit these six measures for first quarter (Q1) 2015 through third quarter (Q3) 2015 discharges in accordance with the submission timeline it finalized in the FY15 IPPS final rule. Under the proposal, these measures were removed from the PCHQR Program because CMS removed them from the Hospital IQR Program and, also, because they have been removed from that program, it is no longer operationally feasible to collect these measures under the PCHQR Program. By removing these measures, CMS believes that it would alleviate the maintenance costs and administrative burden for PCHs associated with reporting them

New Quality Measures Beginning With the FY18 Program

CMS is proposing to adopt the following three new quality measures for the FY18 PCHQR Program:

- National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717) (CDC NHSN CDI Measure)
- CDC NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716) (CDC NHSN MRSA Measure)
- CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel (HCP) Measure (NQF #0431) (CDC NHSN HCP Measure)

In conjunction with this proposal to remove the six SCIP measures from the PCHQR Program beginning with Q4 2015 discharges, the PCHQR measure set would consist of 16 measures beginning with the FY18 program. Consistent with other HAI measures in the PCHQR, CMS would require PCHs to submit measure data using the CDC's NHSN.

The table below lists all previously adopted measures as well as the proposed new measures for the PCHQR Program, beginning with the FY18 program. Please note that it does not include the measures CMS is proposing to remove the measures as contained in Table 20 which follows.

Topic	Summary of finalized and proposed PCHQR Program measures beginning with the FY 2018 program
Safety and Healthcare-Associated Infection—HAI.	• CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139).*
	• CDC NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure (NQF #0138).*
	• Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure* [currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery] (NQF #0753).*
	• CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717).**
	• CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716).**
	• CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel [HCP] (NQF #0431).**
Clinical Process/Cancer-Specific Treatments.	• Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer (NQF #0223).*
	• Combination Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer (NQF #0559).*
	• Adjuvant Hormonal Therapy (NQF #0220).*
Clinical Process/Oncology Care Measures.	• Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382).*
	• Oncology: Plan of Care for Pain (NQF #0383).*
	• Oncology: Pain Intensity Quantified (NQF #0384).*
	• Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients (NQF #0390).*
	• Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients (NQF #0389).*
Patient Engagement/Experience of Care.	• HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems Survey] (NQF #0166).*
Clinical Effectiveness Measure.	• External Beam Radiotherapy for Bone Metastases (NQF #1822).*

*Previously finalized measures.
**Proposed for the FY 2018 program and subsequent years in this proposed rule.

Possible New Quality Measure Topics for Future Years

Quality measure domain areas are discussed in the FY15 IPPS final rule. CMS welcomes public comment and specific suggestions for measure topics addressing the following CMS Quality Strategy domains: making care affordable; communication and coordination; and working with communities to promote best practices of healthy living.

More Information

The proposed rule was published in the April 30, 2015, *Federal Register*, and comments on the rule are due on June 29, 2015.

Appendix 1 – ICD-9-CM Codes for Excess Readmission Calculation for FY16

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

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

Appendix 1 – ICD-9-CM Codes for Excess Readmission Calculation for FY16 – Cont.

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 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CASES

ICD-9-CM Code	Description of Code
491.21	Obstructive chronic bronchitis; With (acute) exacerbation; acute exacerbation of COPD, decompensated COPD, decompensated COPD with exacerbation
491.22	Obstructive chronic bronchitis; with acute bronchitis
491.8	Other chronic bronchitis. Chronic: tracheitis, tracheobronchitis.
491.9	Unspecified chronic bronchitis
492.8	Other emphysema; emphysema (lung or pulmonary): NOS, centriacinar, centrilobular, obstructive, panacinar, panlobular, unilateral, vesicular. MacLeod's syndrome; Swyer-James syndrome; unilateral hyperlucent lung
493.20	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, unspecified
493.21	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with status asthmaticus
493.22	Chronic obstructive asthma; asthma with COPD, chronic asthmatic bronchitis, with (acute) exacerbation
496	Chronic: nonspecific lung disease, obstructive lung disease, obstructive pulmonary disease (COPD) NOS. NOTE: This code is not to be used with any code from categories 491-493.
518.81*	Other diseases of lung; acute respiratory failure; respiratory failure NOS
518.82*	Other diseases of lung; acute respiratory failure; other pulmonary insufficiency, acute respiratory distress
518.84*	Other diseases of lung; acute respiratory failure; acute and chronic respiratory failure
799.1*	Other ill-defined and unknown causes of morbidity and mortality; respiratory arrest, cardiorespiratory failure
**Principal diagnosis when combined with a secondary diagnosis of AECOPD (491.21, 491.22, 493.21, or 493.22)*	

ICD-9-CM CODES TO IDENTIFY TOTAL HIP ARTHROPLASTY/TOTAL KNEE ARTHROPLATY (THA/TKA) CASES

ICD-9-CM Code	Description of Code
81.51	Total hip arthroplasty
81.54	Total knee arthroplasty

Appendix 2 – Aggregate Payment for Excess Readmission Calculation

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (Excess Readmissions Ratio for THA/TKA-1)].

*We note that if a hospital's excess readmissions ratio for a condition is less than/equal to 1, there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = 1-(Aggregate payments for excess readmissions/Aggregate payments for all discharges).

Proposed Readmissions Adjustment Factor for FY 2016 is the higher of the ratio or 0.9700.

*Based on claims data from July 1, 2011 to June 30, 2014 for FY 2016.

Appendix 3 – Factors for Removal and Retaining IQR Measures

FACTORS CMS CONSIDERS IN REMOVING OR RETAINING MEASURES

Measure Removal Factors
1. Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped-out" measures).
2. A measure does not align with current clinical guidelines or practice.
3. The availability of a more broadly applicable measure (across settings, populations, or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic).
4. Performance or improvement on a measure does not result in better patient outcomes.
5. The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.
6. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
7. It is not feasible to implement the measure specifications*.

FACTORS CMS CONSIDERS IN REMOVING OR RETAINING MEASURES—Continued

"Topped-Out" Criteria
1.• Statistically indistinguishable performance at the 75th and 90th percentiles; and • Truncated coefficient of variation ≤0.10.
Measure Retention Factors
1. Measure aligns with other CMS and HHS policy goals.*
2. Measure aligns with other CMS programs, including other quality reporting programs, or the EHR Incentive Program.
3. Measure supports efforts to move facilities towards reporting electronic measures.

*Consideration proposed in this FY 2016 IPPS/LTCH PPS proposed rule.

Appendix 4 - Hospital IQR Program Measures for FY17 and Subsequent Years

PREVIOUSLY ADOPTED HOSPITAL IQR PROGRAM MEASURES FOR THE FY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

Short name	Measure name	NQF No.
	NHSN	
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure.	0139
Colon and Abdominal Hysterectomy SSI.	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.	0753
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.	0138
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.	1717
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
	Chart-abstracted	
AMI–7a *	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0164
ED–1 *	Median Time from ED Arrival to ED Departure for patients Admitted ED Patients	0495
ED–2 *	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Imm-2	Influenza Immunization	1659
PC–01 *	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	0469
SCIP-Inf-4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	0300
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
STK–01	Venous Thromboembolism (VTE) Prophylaxis	0434
STK–04 *	Thrombolytic Therapy	0437
STK–06 *	Discharged on Statin Medication	0439
STK–08 *	Stroke Education	N/A
VTE–1 *	Venous Thromboembolism Prophylaxis	0371
VTE–2 *	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372

Appendix 4 - Hospital IQR Program Measures for FY17 and Subsequent Years – Cont.

Short name	Measure name	NQF No.
VTE–5*	Venous Thromboembolism Discharge Instructions	N/A
VTE–6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A
	Claims	
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization for Patients 18 and Older.	0230
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization for Patients 18 and Older.	0229
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0468
MORT–30–COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	1893
STK Mortality	Stroke 30-day Mortality Rate	N/A
CABG Mortality	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery.	2558
READM–30–AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0505
READM–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization.	0330
READM–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization.	0506
READM–30–THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	1551
READM–30–HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
COPD READMIT	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	1891
STK READMIT	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	N/A
CABG READMIT	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery.	2515
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158
AMI payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI).	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF).	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia.	2579
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	1550
PSI 4 (PSI/NSI)	Death among Surgical Inpatients with Serious, Treatable Complications	0351
PSI 90	Patient Safety for Selected Indicators (Composite Measure)	0531
	Electronic Clinical Quality Measures	
AMI–2	Aspirin Prescribed at Discharge for AMI	0142
AMI–7a*	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0164
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
AMI–10	Statin Prescribed at Discharge	N/A
CAC–3	Home Management Plan of Care Document Given to Patient/Caregiver	N/A
EHDI–1a	Hearing Screening Prior to Hospital Discharge	1354
ED–1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED–2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
HTN	Healthy Term Newborn	0716
PC–01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	0469
PC–05	Exclusive Breast Milk Feeding and the Subset Measure PC–05a Exclusive Breast Milk Feeding Considering Mother's Choice.	0480
PN–6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients.	0147
SCIP-Inf-1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0527
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients	0528
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero.	N/A
STK–02	Discharged on Antithrombotic Therapy	0435
STK–03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK–04*	Thrombolytic Therapy	0437
STK–05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK–06*	Discharged on Statin Medication	0439
STK–08*	Stroke Education	N/A
STK–10	Assessed for Rehabilitation	0441
VTE–1*	Venous Thromboembolism Prophylaxis	0371

Appendix 4 - Hospital IQR Program Measures for FY17 and Subsequent Years – Cont.

PREVIOUSLY ADOPTED HOSPITAL IQR PROGRAM MEASURES FOR THE FY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEARS—Continued

Short name	Measure name	NQF No.
VTE–2*	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
VTE–3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	0373
VTE–4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram.	N/A
VTE–5*	Venous Thromboembolism Discharge Instructions	N/A
VTE–6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A
Patient Survey		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM–3)	0166 0228
Structural		
Registry for Nursing Sensitive Care.	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	N/A
Registry for General Surgery	Participation in a Systematic Clinical Database Registry for General Surgery	N/A
Safe Surgery Checklist	Safe Surgery Checklist Use	N/A

*Measure is listed twice, as both chart-abstracted and electronic clinical quality measure.

Appendix 5: Previously Adopted and Proposed 2018 IQR Program Measures

HOSPITAL IQR PROGRAM MEASURES FOR THE FY 2018 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

Short name	Measure name	NQF #
	NHSN	
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure.	0139
Colon and Abdominal Hysterectomy SSI.	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure • Colon Procedures • Hysterectomy Procedures.	0753
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.	0138
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.	1717
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
	Chart-abstracted	
ED–1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED–2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Imm–2	Influenza Immunization	1659
PC–01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
STK–04*	Thrombolytic Therapy	0437
VTE–5*	Venous Thromboembolism Discharge Instructions	N/A
VTE–6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A

Short name	Measure name	NQF #
	Claims	
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0230
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization.	0229
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.	0468
MORT–30–COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	1893
STK Mortality	Stroke 30-day Mortality Rate	N/A
CABG Mortality	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery.	2558
READM–30–AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0505
READM–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization.	0330
READM–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization.	0506
READM–30–THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	1551
READM–30–HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
COPD READMIT	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	1891
STK READMIT	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	N/A
CABG READMIT	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery.	2515
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI).	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF).	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia.	2579
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	1550
PSI 4 (PSI/NSI)	Death among Surgical Inpatients with Serious, Treatable Complications	0351
PSI 90	Patient Safety for Selected Indicators (Composite Measure)	0531
THA/TKA Payment**	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty.	N/A
Kidney/UTI Payment**	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	N/A
Spine Fusion/Refusion Payment**.	Spine Fusion/Refusion Clinical Episode-Based Payment Measure	N/A
Cellulitis Payment**	Cellulitis Clinical Episode-Based Payment Measure	N/A
GI Payment**	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	N/A
AMI Excess Days**	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	N/A
HF Excess Days**	Excess Days in Acute Care after Hospitalization for Heart Failure	N/A

Appendix 5: Previously Adopted and Proposed 2018 IQR Program Measures – Cont.

Short name	Measure name	NQF #
Electronic Clinical Quality Measure		
AMI–2	Aspirin Prescribed at Discharge for AMI	0142
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0164
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
AMI–10	Statin Prescribed at Discharge	N/A
CAC–3	Home Management Plan of Care Document Given to Patient/Caregiver	N/A
ED–1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED–2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI–1a	Hearing Screening Prior to Hospital Discharge	1354
HTN	Healthy Term Newborn	0716
PC–01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure).	0469
PC–05	Exclusive Breast Milk Feeding and the Subset Measure PC–05a Exclusive Breast Milk Feeding Considering Mother's Choice.	0480
PN–6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients.	0147
SCIP–Inf–1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0527
SCIP–Inf–2a	Prophylactic Antibiotic Selection for Surgical Patients	0528
SCIP–Inf–9	Urinary catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero.	N/A
STK–02	Discharged on Antithrombotic Therapy	0435
STK–03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK–04*	Thrombolytic Therapy	0437
STK–05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK–06	Discharged on Statin Medication	0439
STK–08	Stroke Education	N/A
STK–10	Assessed for Rehabilitation	0441
VTE–1	Venous Thromboembolism Prophylaxis	0371
VTE–2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
VTE–3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	0373
VTE–4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram.	N/A
VTE–5*	Venous Thromboembolism Discharge Instructions	N/A
VTE–6*	Incidence of Potentially Preventable Venous Thromboembolism	N/A
Patient Survey		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM-3)	0166 0228
Structural		
Patient Safety Culture**	Hospital Survey on Patient Safety Culture	N/A
Registry for Nursing Sensitive Care.	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	N/A
Registry for General Surgery	Participation in a Systematic Clinical Database Registry for Registry for General Surgery	N/A
Safe Surgery Checklist	Safe Surgery Checklist Use	N/A

*Measure is listed twice, as both chart-abstracted and electronic clinical quality measure.
**Measures we are proposing beginning with FY 2018 and for subsequent years.

Appendix 6 - FY18 Adopted and Proposed Baseline and Performance Periods

PREVIOUSLY ADOPTED AND PROPOSED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2018 PROGRAM YEAR

Domain	Baseline period	Performance period
PCCEC/CC: • HCAHPS Survey • CTM–3.	January 1, 2014–December 31, 2014	January 1, 2016–December 31, 2016.

Domain	Baseline period	Performance period
Clinical Care: Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–PN)*.	October 1, 2009–June 30, 2012	October 1, 2013–June 30, 2016.
Safety: • PSI–90*	• July 1, 2010–June 30, 2012	• July 1, 2014–June 30, 2016.
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2014–December 31, 2014	• January 1, 2016–December 31, 2016.
Efficiency and Cost Reduction: MSPB–1	January 1, 2014–December 31, 2014	January 1, 2016–December 31, 2016.

*Previously adopted baseline and performance periods.

Appendix 7 – FY19, FY20, and FY21 Baseline and Performance Periods

PREVIOUSLY ADOPTED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2019 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care: Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–PN).	• July 1, 2009–June 30, 2012	• July 1, 2014–June 30, 2017.
• THA/TKA	• July 1, 2010–June 30, 2013	• July 1, 2015–June 30, 2017.
Safety: • PSI–90	• July 1, 2011–June 30, 2013	• July 1, 2015–June 30, 2017.

PREVIOUSLY ADOPTED AND NEWLY PROPOSED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2020 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care: • Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–PN)*.	July 1, 2010–June 30, 2013	July 1, 2015–June 30, 2018.
• THA/TKA*.		
Safety: PSI (PSI–90) Measure	July 1, 2012–June 30, 2014	July 1, 2016–June 30, 2018.

*Previously adopted baseline and performance periods.

PROPOSED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2021 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care: • Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–PN, MORT–30–COPD).	• July 1, 2011–June 30, 2014	• July 1, 2016–June 30, 2019.
• THA/TKA	• April 1, 2011–March 31, 2014	• April 1, 2016–March 31, 2019.

Appendix 8 –Previously Adopted and Proposed Performance Standards

FY18

PREVIOUSLY ADOPTED AND PROPOSED PERFORMANCE STANDARDS FOR THE FY 2018 PROGRAM YEAR: SAFETY, CLINICAL CARE, AND EFFICIENCY AND COST REDUCTION MEASURES

Measure ID	Description	Achievement threshold	Benchmark
Safety Measures			
CAUTI*	National Healthcare Safety Network Catheter-associated Urinary Tract Infection Outcome Measure.	0.916	0.000.
CLABSI*	National Healthcare Safety Network Central line-associated Bloodstream Infection Outcome Measure.	0.401	0.000.
CDI*	National Healthcare Safety Network Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure.	0.776	0.000.
MRSA bacteremia*	National Healthcare Safety Network Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* Bacteremia Outcome Measure.	0.766	0.000.
PSI–90±*	Patient safety for selected indicators (composite)	0.577321	0.397051.
Colon and Abdominal Hysterectomy SSI*.	American College of Surgeons—Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure.		
	• Colon	• 0.801	• 0.000.
	• Abdominal Hysterectomy	• 0.745	• 0.000.
PC–01	Elective Delivery	0.022989	0.000.
Clinical Care Measures			
MORT–30–AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization*.	0.851458*	0.871669.*
MORT–30–HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure*.	0.881794*	0.903985.*
MORT–30–PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization*.	0.882986*	0.908124.*
Efficiency and Cost Reduction Measure			
MSPB–1*	Payment-Standardized 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.

*Lower values represent better performance.
±Previously adopted performance standards.

PROPOSED PERFORMANCE STANDARDS FOR THE FY 2018 PROGRAM YEAR PATIENT AND CAREGIVER-CENTERED EXPERIENCE OF CARE/CARE COORDINATION DOMAIN

HCAHPS Survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	52.85	78.45	86.70
Communication with Doctors	59.48	80.56	88.59
Responsiveness of Hospital Staff	37.91	65.22	80.35
Pain Management	50.17	70.26	78.44
Communication about Medicines	45.50	63.38	73.61
Hospital Cleanliness & Quietness	43.43	65.58	79.25
Discharge Information	62.00	86.50	91.58
3-Item Care Transition*	27.28	51.33	62.18
Overall Rating of Hospital	36.94	70.15	84.72

*Newly proposed measure.

Appendix 8 - Previously Adopted and Proposed Performance Standards - Cont.

FY19

PREVIOUSLY ADOPTED PERFORMANCE STANDARDS FOR CERTAIN SAFETY AND CLINICAL CARE DOMAIN MEASURES FOR THE FY 2019 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Safety Measures			
PSI–90*	Patient Safety for Selected Indicators (Composite)	0.853715	0.589462
Clinical Care Measures			
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization.	0.850671	0.873263
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization.	0.883472	0.908094
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.	0.882334	0.909460
THA/TKA*	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty.	0.032229	0.023178

*Lower values represent better performance.

FY20

PREVIOUSLY ADOPTED AND PROPOSED PERFORMANCE STANDARDS FOR CERTAIN CLINICAL CARE DOMAIN AND SAFETY DOMAIN MEASURES FOR THE FY 2020 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Safety Domain			
PSI–90*	Patient Safety for Selected Indicators (Composite)	0.778761	0.545903
Clinical Care Domain			
MORT–30–AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization.	0.853715	0.875869
MORT–30–HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization.	0.881090	0.906068
MORT–30–PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.	0.882266	0.909532
THA/TKA*±	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty.	0.032229	0.023178

*Lower values represent better performance.
±Previously adopted performance standards.

FY21

PROPOSED PERFORMANCE STANDARDS FOR CLINICAL CARE DOMAIN MEASURES FOR THE FY 2021 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Clinical Care Measures			
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Hospitalization.	0.860355	0.879714
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization.	0.883803	0.906144
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.	0.886443	0.91067
MORT–30–COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease Hospitalization.	0.860355	0.879714
THA/TKA*	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty.	0.03089	0.022304

*Lower values represent better performance.

Appendix 9 – FY17 Data Collection Period and Data Submission Timeline for LTCH QRP Quality Measures

DETAILS ON DATA COLLECTION PERIOD AND DATA SUBMISSION TIMELINE FOR QUALITY MEASURES AFFECTING THE FY 2017 PAYMENT DETERMINATION

Quality measure	NQF ID#	Submission method	Data collection period	Proposed data submission deadlines	APU determination affected
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay).	#0678	LTCH CARE Data Set/ QIES ASAP.	1/1/15–3/31/15, 4/1/15–6/30/15, 7/1/15–9/30/15, 10/01/15–12/31/15.	5/15/15 (Q1), 8/15/15 (Q2), 11/15/15 (Q3), Proposed 5/15/16 (Q4).	FY 2017.
NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	#0138	CDC NHSN.			
NHSN Central-Line Associated Bloodstream Infections (CLABSI) Outcome Measure.	#0139.				

DETAILS ON DATA COLLECTION PERIOD AND DATA SUBMISSION TIMELINE FOR QUALITY MEASURES AFFECTING THE FY 2017 PAYMENT DETERMINATION—Continued

Quality measure	NQF ID#	Submission method	Data collection period	Proposed data submission deadlines	APU determination affected
NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	#1716.				
NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.	#1717.				
All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long Term Care Hospitals*.	#2512	Medicare FFS Claims Data.	N/A	N/A	For future public reporting.

* This measure will not be used in determining compliance for the LTCH QRP because it is a claims-based measure and LTCHs do not report additional data to CMS.

Appendix 10 - Revised Data Collection Period and Data Submission Timelines for LTCH QRP Measures for FY18 Payment Determination and Subsequent Years

DETAILS ON DATA COLLECTION AND SUBMISSION TIMELINE FOR QUALITY MEASURES AFFECTING THE FY 2018 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

Quality measure	NQF ID#	Submission method	Data collection period	Proposed data submission deadlines	APU determination affected
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay).	#0678	LTCH CARE Data Set/ QIES ASAP.	1/1/16–3/31/16, 4/1/16–6/30/16, 7/1/16–9/30/16, 10/01/16–12/31/16; Quarterly for each subsequent calendar year.	8/15/16 (Q1), 11/15/16 (Q2), 2/15/17 (Q3), 5/15/17 (Q4); Approximately 135 days after the end of each quarter.	FY 2018; Subsequent Years.
NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	#0138	CDC NHSN.			
NHSN Central-Line Associated Bloodstream Infections (CLABSI) Outcome Measure.	#0139.				
NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	#1716.				
NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.	#1717.				
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine.	#0680	LTCH CARE Data Set/ QIES ASAP.	10/1/15–12/31/15, 1/1/16–3/31/16, 10/1–12/31, 1/1–3/31 for subsequent years.	5/15/16, 8/15/16, 5/15, 8/15 for subsequent years.	FY 2018; Subsequent Years.
Influenza Vaccination Coverage among Healthcare Personnel.	#0431	CDC NHSN	10/1/15 (or when vaccine becomes available)–3/31/16, 10/1 (or when vaccine becomes available)–3/31.	8/15/16, 8/15 for subsequent years.	FY 2018; Subsequent Years.
All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long Term Care Hospitals.*	#2512	Medicare FFS Claims Data.	N/A	N/A	For future public reporting.
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).	#0674	LTCH CARE Data Set/ QIES ASAP.	4/1/16–6/30/16, 7/1/16–9/30/16, 10/1/16–12/31/16; Quarterly for each subsequent calendar year.	11/15/16 (Q2), 2/15/17 (Q3), 5/15/17 (Q4).	FY 2018; Subsequent Years.
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.	#2631 (Under NQF review).				
Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support.	#2632 (Under NQF review).			Quarterly approximately 135 days after the end of each quarter for subsequent years.	
Ventilator Associated Event	N/A	CDC NHSN	1/1/16–3/31/16, 4/1/16–6/30/16, 7/1/16–9/30/16, 10/1/16–12/31/16; Quarterly for each subsequent calendar year.	8/15/16 (Q1), 11/15/16 (Q2), 2/15/17 (Q3), 5/15/17 (Q4); Quarterly approximately 135 days after the end of each quarter for each subsequent year.	FY 2018; Subsequent Years.

Quality measure	NQF ID#	Submission method	Data collection period	Proposed data submission deadlines	APU determination affected
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.	#2631 (Under NQF review).	LTCH CARE Data Set/ QIES ASAP.	4/1/16–6/30/16, 7/1/16–9/30/16, 10/1/16–12/31/16; Quarterly for each subsequent calendar year.	11/15/16 (Q2), 2/15/17 (Q3), 5/15/17 (Q4); Quarterly approximately 135 days after the end of each quarter for subsequent years.	FY 2018; Subsequent Years.

* This measure will not be used in determining compliance for the LTCH QRP because it is a claims-based measure and LTCHs do not report additional data to CMS.