Overview

On May 15, the Centers for Medicare and Medicaid Services (CMS) officially published its fiscal year (FY) 2015 proposed rule for the hospital inpatient and long-term care prospective payment systems (PPS). The proposed rule affects inpatient PPS hospitals, critical access hospitals, long-term care hospitals, and PPS-exempt cancer hospitals. While the rule does not directly impact children’s hospitals, Medicare often sets the stage for other public and private programs. Therefore, the Children’s Hospital Association has reviewed the proposed rule and summarized some of its major provisions.

We will work with our colleagues in allied hospital organizations to prepare comments to CMS on the proposed rule (due June 30). We plan to comment specifically on language included throughout the proposed rule regarding the use of a sub-regulatory process when “non-substantive updates” are made to measures used in various program (including “broadening of age ranges”). We will repeat our previous comments, urging CMS to ensure at a minimum that pediatric experts and children’s hospitals are consulted if measures developed for adult settings are expanded to include children. We also plan to comment on CMS’s plans to not include socioeconomic status and other sociodemographic variables in risk adjustment of measures (particularly readmissions measures) in light of a report under review by the National Quality Forum (NQF). The draft NQF report recommended that these variables should be used in risk adjustment for measures used for accountability purposes (e.g., public reporting and pay for performance). NQF is currently considering comments received on the draft report and will make final recommendations later this summer.

We welcome comments from our member hospitals, particularly with regard to the planned inclusion of measures that specifically address children and newborns proposed for the Hospital Value Based Purchasing (VBP) Program (PC-01 – elective delivery prior to 39 weeks gestation) and voluntary electronic reporting under the Hospital Inpatient Quality Reporting (IQR) Program (hearing screening prior to hospital discharge, exclusive breast milk feeding, healthy term newborn, and children’s asthma care document given to patient/caregiver). Although the proposed rule and these programs apply to Medicare programs, note that several of the measures currently included in the programs include all-payer data and apply to children. Examples include the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) health care acquired infection measures and the emergency department throughput measures. In addition, the proposed rule reminds hospitals of a provision in the Affordable Care Act (ACA) that all hospitals must make their list of standard charges public. We would appreciate any feedback or concerns about implementing this provision.

Please send comments or questions to Ellen Schwalenstocker or Liz Parry by Tues., June 24.
**Price Transparency**

As noted above, the ACA requires each hospital to establish, update, and make public a list of its standard charges for items and services it provides. In the proposed rule, CMS reminds hospitals of this obligation and indicates that it will provide hospitals with flexibility to determine how they will make their list of standard charges public. CMS does indicate that hospitals must either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry. CMS also notes that hospitals are expected to update this information at least annually. **While this reminder is included in the IPPS proposed rule, the ACA requires all hospitals operating in the United States to comply with this requirement.**

**Electronic Health Record Incentive Program, Penalty for Failing to Meet Meaningful Use**

Under statute, inpatient PPS hospitals are subject to Medicare payment penalties starting in FY 2015 and subsequent years if they fail to meet EHR meaningful use requirements. In general, hospitals paid under the inpatient PPS are subject to the penalty in FY 2015 if they did not attest to meaningful use in FY 2013. There is, however, a one-time exception for hospitals attesting to meaningful use for the first time in FY 2014. The penalty for failing to meet meaningful use will be applied in future years, and will lead to a 50 percent reduction to the market basket update in FY 2016 and 75 percent in FY 2017 and beyond. **It is important to note that this applies only to the Medicare EHR Incentive Program.**

Other proposed changes to the Medicare EHR Program include a proposal to align the clinical quality measure submissions for the EHR Incentive Program with those of the Inpatient Quality Reporting (IQR) Program. The proposed rule notes that Medicaid only providers would continue to report according to state requirements. The proposed rule also proposes to change its policy with regard to case thresholds for clinical quality measures beginning with reporting periods in 2015 so that, if an eligible hospital or critical access hospital qualifies for an exemption for a particular clinical quality measure due to the case threshold (5 or fewer discharges per quarter or 20 or fewer discharges per year), that exemption will count toward one of the 16 required clinical quality measures.

**Changes to Graduate Medical Education Payments**

In an effort to streamline timing, CMS is proposing to change the effective date of the full-time equivalent (FTE) resident cap, the three-year rolling average, and the intern-and resident-to-bed (IRB) ratio cap for new programs in teaching hospitals.

- New teaching hospitals currently have a five-year window during which to establish new residency programs before FTE caps take effect. A hospital’s resident cap is then effective beginning with the sixth year of the first new program’s existence.

- Teaching hospitals are paid for GME based on the number of FTE residents it trains over the course of three years. The three year average is the average of the hospital’s FTE resident count in the current Medicare cost reporting period and the counts in the two preceding periods. Under current regulation, when new programs are created, the three-year rolling average begins to be calculated when the period of years the new program is in existence equals the minimum accredited length for the new program. As a result, the three-year rolling average currently takes effect on different dates based on the length of each new program. CMS proposes to make the three-year rolling average effective with each hospital’s
cost reporting period that precedes the start of the sixth program year of the first new program, simultaneous with the effective date of the FTE resident cap.

- The IRB ratio cap caps the individual resident-to-bed ratio on a hospital-specific basis at the level prior to implementation of the FTE cap to prevent a teaching hospital’s IRB ratio, which in part determines indirect medical education payments, from increasing because of a decrease in the hospital’s inpatient bed capacity. Currently, the IRB ratio cap takes effect on different dates based on the length of each new program started during the five-year cap building window. CMS is proposing that the IRB ratio cap become effective with each hospital’s cost-reporting period that precedes the start of the sixth program year of the first new program, simultaneous with the effective date of the FTE resident cap.

**Two-Midnight Policy**

In its FY 2014 inpatient PPS rule, CMS finalized its two-midnight policy. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under inpatient PPS. However, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. While CMS does not propose any changes to this policy, it does seek comments on an alternative payment methodology under the Medicare program for short inpatient stays (i.e. medically necessary inpatient stays that span less than two midnights), which would supplement the two-midnight policy. CMS is also seeking suggestions on exceptions to the two-midnight policy.

**Operating PPS Rate Update**

The market basket is an input price index that measures price changes over a fixed period of time. The proposed rate of increase in the hospital market basket for FY 2015 operating PPS payments is 2.7 percent. CMS also proposes a 0.4 percent point reduction to this market basket update for productivity, as well as an additional 0.2 percentage point reduction. Both are mandated by the ACA. Therefore, CMS is proposing an applicable percentage increase to the FY 2015 operating standardized amount of 2.1 percent. This increase applies to hospitals that submitted quality data and were meaningful users of electronic health records (EHRs) in FY 2013. Hospitals that did not submit quality data or were not meaningful users of EHRs in FY 2013 will be subject to a one-quarter reduction in the initial market basket rate, therefore receiving an update to the standardized amount of 1.425 percent instead of 2.1 percent.

**Medicare Disproportionate Share Hospital Payment Methodology Changes**

The ACA requires that, beginning in FY 2014, hospitals initially receive 25 percent of the Medicare Disproportionate Share Hospital (DSH) funds they would have received under the pre-FY 2014 formula with the remaining 75 percent flowing into a separate funding pool for DSH hospitals. CMS proposes that the amount in the 75 percent pool be further decreased in FY 2015 to reflect additional decreases in the percentage of uninsured that have occurred since FY 2014. It also proposes to continue to use inpatient days of Medicaid beneficiaries and Medicare Supplemental Security Income beneficiaries as an alternative way for measuring uncompensated care. CMS anticipates that DSH payments would decrease by an additional $132 million in FY 2015 compared to FY 2014.

**Wage Index**

The area wage index adjusts payments to reflect differences in labor costs across different geographic areas. The proposed rule would base the FY 2015 wage index on data from FY 2011.
Medicare cost reports. According to CMS, the national average hourly wage increased 1.9 percent compared to FY 2014. As a result, some hospitals may see their wage indices decline relative to last year because, even though their wages rose, they did not rise as quickly as those at other hospitals.

**IPPS Programs Related to Quality Reporting and Payment Adjustments**

The proposed rule addresses several quality reporting programs as well as programs that tie payment to quality performance. These programs include the Hospital Acquired Condition Program, the Hospital Readmissions Reduction Program, the Hospital Value Based Purchasing Program and quality data reporting requirements for specific providers (including hospital quality reporting, PPS-exempt cancer hospitals and long term care hospitals). There is overlap between programs. For example, prior to adoption in the Hospital Value Based Purchasing Program, measures must first be posted through the Inpatient Quality Reporting Program. Additionally, although the payment adjustments are specific to Medicare, many of the measures apply to all-payer data. We outline the programs in general below.

**Hospital Acquired Condition (HAC) Reduction Program**

The ACA required the Secretary to make payment adjustments for applicable hospitals beginning on 10/1/2014. Applicable hospitals are those subsection (d) hospitals that rank in the top quartile of all subsection (d) hospitals relative to the national average of conditions using a total HAC score. Payments for applicable hospitals will be 99 percent of the amount of payment that would otherwise apply.

The framework for the HAC Reduction Program was presented in previous rulemaking. Two general domains are used to calculate the total HAC score: the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator composite measure (PSI-90) and two health care-acquired infection (HAI) measures included in the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). The AHRQ composite measure includes eight AHRQ patient safety indicators (pressure ulcer, iatrogenic pneumothorax, central venous catheter related blood stream infection, postoperative hip fracture, postoperative pulmonary embolism/DVT, postoperative sepsis, wound dehiscence and accidental puncture and laceration). The CDC NHSN measures include catheter-associated urinary tract infection and central line-associated blood stream infection. In the FY 2014 IPPS final rule, additional NHSN measures were included for future years. These included the surgical site infection measure for FY 2016 and subsequent years and hospital-acquired Methicillin-Resistant Staphylococcus aureus and hospital-acquired Clostridium difficile measures for FY 2017 and subsequent years.

The total HAC Score is calculated using two years of data. For FY 2015, the data collection period is 7/1/2011 – 6/30/2013 for the AHRQ PSI-90 measure and calendar years 2012 and 2013 for the NHSN measures. In calculating the total HAC Score, the AHRQ measure is weighted 35 percent and the NHSN measure is weighted 65 percent. Confidential reports will be made available to applicable hospitals, and the scores will be made public on Hospital Compare. For FY 2016, CMS is proposing to weight the Domain 1 (AHRQ PSI) Score by 0.25 and the Domain 2 (NHSN Measures including surgical site infection) by 0.75.

No additional measures are being proposed for the HAC Reduction Program, although the rule notes that both the PSI-90 measure and the NHSN measures are undergoing maintenance review by the NQF. If substantive modifications are made to the measures as a result of NQF review, CMS
will issue notice-and-comment rulemaking. CMS is interested in learning about all-cause harm measures and whether the use of these measures should be considered for the HAC Reduction Program. CMS also is not proposing to add or remove categories of HACs with regard to current policy of not paying for additional costs associated with HACs; however, it is interested in comments regarding previously selected and potential candidate HACs.

**Hospital Readmissions Reduction Program**

The Hospital Readmissions Reduction Program was established as a result of the ACA and was effective with discharges that occurred on or after Oct. 1, 2012. Hospitals with “excess readmissions” receive a payment reduction based on an adjustment described below.

An excess readmission ratio is a hospital-specific calculation defined as the ratio of risk-adjusted actual to risk-adjusted expected readmissions for each applicable condition. The payment adjustment factor is 1 minus the ratio of aggregate payments for excess readmissions to aggregate payments for all discharges, subject to a floor of 0.97 in FY 2015. The adjustment factor is applied to the hospital’s base operating diagnosis-related group (DRG) amount. For FY 2014, the applicable conditions addressed in the Hospital Readmissions Reduction Program include acute myocardial infarction, heart failure and pneumonia. As finalized in the FY 2014 IPPS rule, three additional conditions will be included in the program for FY 2015. These include readmissions following hospitalization for chronic obstructive pulmonary disease (COPD) and total hip arthroscopy (THA) and/or total knee arthroscopy (TKA) procedures.

CMS is not proposing any additional applicable conditions for the Hospital Readmissions Reduction Program for FY 2016 but is proposing to expand the scope of applicable conditions to include isolated coronary artery bypass graft (CABG) for FY 2017. In addition, CMS is proposing use of an updated planned readmission algorithm for FY 2015 and subsequent years as well as additional exclusions for the total hip and total knee arthroscopy measures (to exclude patients with hip fracture coded as either principle or secondary diagnosis).

The applicable period for claims data to calculate the readmissions measures for the FY 2015 Hospital Readmissions Reduction Program will be the three year period from 7/1/2010 to 6/30/2013. CMS is seeking comments on whether or not to include an exceptions process for hospitals experiencing extenuating circumstances (such as natural disasters).

**Hospital Value Based Purchasing Program**

The Hospital Value Based Purchasing Program (VBP) was established as a result of the ACA and began with Medicare discharges occurring on or after Oct. 1, 2012. VBP applies to subsection (d) hospitals. Subsection (d) hospitals do not qualify for the program if they are subject to a payment reduction as a result of not meeting the requirements of the Inpatient Hospital Quality Reporting (IQR) Program, if they have been cited for deficiencies that jeopardize patient health and safety or if they lack data for a minimum number of measures included in the program.

Under the VBP Program, incentive payments are made based on a total performance score (TPS), which is determined by the hospital’s actual achievement or improvement for each measure within a specific domain. The TPS is converted to a per-discharge value-based incentive payment amount, which is applied to the base-operating DRG payment amount for each discharge on a per-claim basis. Performance standards to be used in determining scores must be established at least 60 days
prior to the beginning of a performance period. For FY 2015, the funding pool for the VBP increases to 1.5 percent of base-operating DRG payments.

The measures to be included in the FY 2015 and FY 2016 VBP programs were finalized in previous rulemaking. The proposed rule lists the finalized measures for the FY 2016 program, which include eight clinical process measures (addressing acute myocardial infarction, pneumonia, and surgical care); patient experience with care (Hospital Consumer Assessment of Healthcare Providers and Systems Survey); outcomes and safety measures (including the AHRQ PSI-90 composite measure and CDC NHSN central line-associated blood stream infection, catheter-associated urinary tract infection and surgical site infection measures) and 30-day mortality following AMI, pneumonia and heart failure); and one efficiency measure (Medicare spending per beneficiary). Although the VPB applies to Medicare payment, it is important to note that a majority of the measures used to calculate the total performance score reflect all-payer data. (That is, the measure is reported for all patients included in the measure denominator).

Measures to be used for the VBP must first be reported through the Hospital Inpatient Quality Reporting Program. As a result, the IPPS rule proposes measures to be introduced in future years. The rule proposes additions as well as removal of measures for FY 2017, FY 2018 and FY 2019. For FY 2017, CMS is proposing to remove six clinical process measures because performance is “topped out” (i.e., performance is statistically indistinguishable at 75th and 90th percentiles with little variation in performance). Of interest to children’s hospitals, CMS is proposing to add one measure to the clinical process measure domain (elective delivery prior to 39 completed weeks gestation) and two CDC NHSN HAI measures (Methicillin-resistant Staphylococcus aureus bacteremia and hospital-acquired Clostridium difficile) for FY 2017. CMS is considering a proposal to add a care transition measure to the Patient Experience of Care Domain for FY 2018 and to add measures related to complications following total hip and total knee arthroscopy for FY 2019. In future years, CMS plans to add episode-based payment measures for specific medical conditions and surgical procedures.

The performance and baseline periods to be used for the VBP in FY 2015 were previously finalized. Proposed baseline and performance periods for FY 2017, FY 2019 and FY 2020 are included in this proposed rule.

The methodology for determining the total performance score (including how the different domains are weighted in determining the score) for FY 2015 and for FY 2016 was finalized in the Final FY 2013 and FY 2014 IPPS rules respectively. In the FY 2015 proposed rule, CMS is proposing to change the weighting of the domains. Specifically, CMS is proposing to reduce the weight for the clinical care process measures from 10 percent to 5 percent of the score and to increase the weight of the safety measures from 15 percent to 20 percent.

Finally, minimum numbers of cases (or surveys for the patient experience domain) for FY 2015 were previously finalized in the FY 2013 IPPS rule. CMS is proposing to adopt the same minimum numbers for FY 2016 and subsequent years. In addition, CMS is proposing that hospitals must have data for at least three of the measures in the safety domain, two measures in the clinical care outcome measure group and one measure in the clinical care process group in order to receive a score for the domain for FY 2017. For FY 2015 and FY 2016, hospitals must have scores for at least two domains in order to receive a total performance score as finalized in previous rulemaking. CMS is proposing to increase this to three domains for FY 2017 and subsequent years.
Quality Data Reporting Requirements for Specific Providers and Suppliers

Hospital Inpatient Quality Reporting (IQR) Program
The IQR Program was initiated as a result of the Medicare Prescription Drug, Improvement and Modernization Act. Measures to be included in the IQR Program through FY 2016 were finalized in the FY 2014 IPPS Final Rule.

The FY 2015 proposed rule proposes the removal of five clinical process measures for FY 2017 and subsequent years. CMS has identified another 15 measures for removal, but proposes to retain electronic clinical reporting for 10 of these measures in order to continue to monitor the clinical topic covered by the measure to ensure hospitals are maintaining high levels of performance. Measures are proposed for removal because performance is “topped out” and include four measures related to AMI, one measure related to heart failure, one measure related to pneumonia, eight surgical care measures, four stroke measures, and one measure related to venous thromboembolism. In addition, CMS proposes to remove one measure (participation in a systematic data base for cardiac surgery) based on recommendations made by the Measures Application Partnership.

The proposed rule re-summarizes measures adopted for FY 2016 and proposes to use three years of data to calculate the mortality and readmissions measures and the total hip/total knee arthroscopy complication rate. In addition, the rule proposes refinements to the algorithms for identifying planned readmissions for the risk-standardized readmission rate measures and refinements to the hip and knee readmissions and complications measures to exclude index admissions with a secondary diagnosis of fracture as well as complications coded as present on admission. These refinements would apply to FY 2015 and subsequent years.

CMS proposes to add 11 measures to the IQR Program for FY 2017 and subsequent years. These include 30 day all-cause readmission and mortality following isolated coronary artery bypass graft, 30 day episode-of-care cost measures for pneumonia and heart failure and a severe sepsis and septic shock management bundle process measure. CMS is proposing to re-adopt two previously removed AMI measures for voluntary reporting in order to align with the EHR Incentive Program. CMS also proposes to include several electronic measures for voluntary reporting that apply to children and/or newborns. These include hearing screening prior to hospital discharge, exclusive breast milk feeding, healthy term newborn and the children’s asthma care measure on home management plan of care (CAC-3).

For FY 2017, CMS is proposing to expand its policy to allow hospitals to electronically submit data. CMS is proposing that providers can select to voluntarily report any 16 of the 28 IQR electronic clinical quality measures that align with the Medicare EHR Incentive Program as long as the measures cover at least three National Quality Strategy domains for FY 2017. In addition, CMS is proposing that hospitals be required to submit a full year of data (vs. a minimum of one quarter). As an incentive for hospitals to voluntarily submit electronically-specified clinical quality measures, CMS is proposing that hospitals successfully submitting these measures will not have to submit chart-abstracted data for validation. CMS indicates its intent to require reporting of electronic CQMS for the Hospital IQR program beginning for the CY 2016 reporting period (for FY 2018 determination). In addition, if the proposal to align reporting under the Hospital IQR and the Medicare EHR Incentive program is finalized, CMS proposes to adopt four CQMs (including...
Hepatitis B vaccine coverage for live newborns prior to discharge with data collection beginning with 10/1/2016 discharges.

The applicable percentage increase is reduced by 2 percentage points for hospitals that fail to meet the IQR requirements, including data collection, submission and validation requirements. Beginning with FY2015, the penalty will be one quarter of the applicable percentage increase. The proposed rule clarifies that the NHSN HAI measures must include all required data elements. CMS is proposing to reduce the number of charts to be submitted for validation of chart abstracted IQR data with greater weight placed on the HAI and immunization measures.

**PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program**

The ACA required the Department of Health and Human Services to create a hospital reporting program for PPS-Exempt Cancer Hospitals. The PCHQR Program was initiated in FY 2014 and applies only to PPS-excluded cancer hospitals. The measures selected for this program for FY 2015 and FY 2016 were finalized in previous rulemaking. For FY 2016, these measures address healthcare-acquired infections (central-line associated blood stream infection, catheter associated urinary tract infection, surgical site infections for colon and abdominal hysterectomy surgery) and process measures for cancer-specific treatments and surgical care. In addition, PPS-exempt hospitals will be required to report on hospital inpatient experience of care (HCAHPS) beginning in FY 2016.

CMS is not proposing to remove or replace any of the previously finalized measures for FY 2017 and subsequent years. However, CMS is proposing that PPS-exempt cancer hospitals must report all-patient data for each of the clinical process/oncology care measures beginning with the FY 2016 program. In addition, CMS is proposing a clinical effectiveness measure (external beam radiotherapy for bone metastases) to be added for FY 2017 and subsequent years. CMS outlines and seeks comment on proposed new quality measure topics for future years including measures that assess safety and efficiency of diagnosis and treatment, measures that take into account novel diagnostic and treatment modalities, measures that assess symptoms and functional status and measures of appropriate disease management. In addition, CMS is interested in including measures related to patient-centered care planning and care coordination, disease management, complications and quality of life outcomes.

CMS is proposing to add one measure (adjuvant hormonal therapy) to the measures selected for public display in FY 2014. In addition, CMS is proposing to modify the data submission requirements, including allowing two mechanisms for data submission and requiring annual vs. quarterly submission deadlines and is proposing a new sampling methodology for certain process measures allowing for different numbers of cases to be reported depending on patient population size. CMS notes that it will consider developing criteria to determine whether or not to remove or replace measures and the need to align measures across reporting programs in future rulemaking. In addition, CMS will consider requiring PCHs to report specified clinical quality measures electronically.

**Long-Term Care Hospital Quality Reporting (LTCHQR) Program**

The LTCHQR was established in accordance with the ACA. Beginning with rate year 2014 any annual update for discharges occurring during the rate year is reduced by 2 percent for long-term care hospitals that fail to meet the reporting requirements under the Program.
For FY 2015, three measures were previously finalized for this program (percent of new or worsened pressure ulcers for short term stay patients, catheter associated urinary tract infection, and central line-associated blood stream infection). Additional measures were finalized for subsequent years in previous rulemaking.

CMS is not proposing to remove or revise any of the measures previously finalized, but is proposing to revise data collection timelines and submission deadlines for two measures (percent of short stay residents assessed and appropriately given seasonal influenza vaccine and percent of residents experiencing one or more falls with major injury). In addition, CMS is proposing to add new measures for FY 2018 consistent with its goal of moving toward collection of more outcomes measures. Proposed measures include the percent of long-term care hospital patients with an admission and discharge functional assessment and care plan, change in mobility among long-term care residents requiring ventilator support and ventilator associated events. CMS also is seeking comments on measures and concepts under consideration for future years. As with the hospital IQR Program, CMS is proposing to revise the timeline for data submission for the influenza vaccination measure.

The proposed rule includes proposed data collection and timelines for FY 2019 payment determination. Additionally, data completion thresholds and data validation processes for measures affecting FY 2016 and subsequent years are proposed. CMS indicates its intent to expand the data validation process to additional measures for FY 2017 through future rulemaking.