2013 Medicare Inpatient Prospective Payment System/Long Term Care Hospital Final Rule

This Member Briefing summarizes the Fiscal Year 2013 Inpatient Prospective Payment System (IPPS).¹

The editors of this Member Briefing, Barbara J. Vimont, RHIA (Akron General Health System, Akron, OH), and Daniel J. Hettich, Esquire (King & Spalding LLP, Washington, DC), want to sincerely thank the contributors below for their efforts in the production of this Member Briefing. This project would not have been possible without the help and support of each of them.

¹ Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals’ Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers.
Contributors

Marie A. Connelly, Esquire
Cause of Action
Washington, DC

Lauren B. Jacques, Esquire
Bradley Arant Boult Cummings LLP
Nashville, TN

Kelly R. Anderson, Esquire
Baptist Healthcare System Inc.
Louisville, KY

Juliet M. McBride, Esquire
Christopher Kenny, Esquire
Susan Banks, Esquire
King & Spalding LLP
Houston, TX, and Washington, DC
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introduction</td>
<td>12</td>
</tr>
<tr>
<td>II. Changes to Medicare Severity Diagnosis Related Group (MS-DRG)</td>
<td>12</td>
</tr>
<tr>
<td>Classifications and Relative Weights (77 Fed. Reg. 53273-53283 and</td>
<td></td>
</tr>
<tr>
<td>53303-53365)</td>
<td></td>
</tr>
<tr>
<td>Recoupment or Repayment Adjustment</td>
<td>13</td>
</tr>
<tr>
<td>Refinement of the MS-DRG Relative Weight Calculation</td>
<td>14</td>
</tr>
<tr>
<td>Transition to ICD-10</td>
<td>14</td>
</tr>
<tr>
<td>Changes to Specific MS-DRG Classifications</td>
<td>14</td>
</tr>
<tr>
<td>Pre-Major Diagnostic Categories (Pre-MDCs)</td>
<td>14</td>
</tr>
<tr>
<td>Major Diagnostic Categories (MDCs)</td>
<td>15</td>
</tr>
<tr>
<td>Medicare Code Editor (MCE) Changes</td>
<td>15</td>
</tr>
<tr>
<td>Complications or Comorbidity (CC) Exclusion List</td>
<td>15</td>
</tr>
<tr>
<td>Changes to ICD-9</td>
<td>16</td>
</tr>
<tr>
<td>Recalibration of MS-DRG Weights</td>
<td>16</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement Initiative</td>
<td>17</td>
</tr>
<tr>
<td>Add on payments for New Services and Technologies</td>
<td>17</td>
</tr>
<tr>
<td>Preventable Hospital-Acquired Conditions (HACs), Including Infections</td>
<td>18</td>
</tr>
<tr>
<td>Addition of Diagnosis Codes to the Vascular Catheter-</td>
<td></td>
</tr>
<tr>
<td>Associated Infection HAC Category</td>
<td>19</td>
</tr>
<tr>
<td>Addition of a Sub-HAC Condition within the Surgical Site</td>
<td>19</td>
</tr>
<tr>
<td>Infection (SSI) HAC Category</td>
<td></td>
</tr>
</tbody>
</table>
Addition of Iatrogenic Pneumothorax with Venus Catheterization as a HAC Category ................................................................. 19

III. Changes to Hospital Wage Index for Acute Care Hospitals (77 Fed. Reg. 53365-53374) .................................................................................................................. 20
   Method for Computing the FY 2013 Unadjusted Wage Index .......... 20

IV. Other Decisions and Changes to the IPPS for Operating Costs and Graduate Medical Education (GME Costs) (77 Fed. Reg. 53374-53455) .......... 22
   Hospital Readmissions Reduction Program .......................................................... 22
      Applicable Hospitals ....................................................................................... 22
      Base Operating DRG Payment Amount .......................................................... 23
      Adjustment Factor ........................................................................................ 23
      Aggregate Payments for Excess Readmissions and Aggregate Payments for All Discharges ................................................................. 24
      Limitations on Review .................................................................................... 24
      Reporting of Hospital-Specific Information ................................................ 25

Changes to Sole Community Hospital (SCH) and Medicare-Dependent Hospital (MDH) Status ......................................................................................... 26

Rural Referral Centers (RRCs): Annual Update to Case-Mix Index (CMI) and Discharge Criteria .............................................................................. 27
   Payment Adjustment for Low-Volume Hospitals ........................................ 28
   IME Payment Adjustment ............................................................................. 29

Changes in Medicare DSH and IME ................................................................. 29

MDH Discussion Included with IV.B ............................................................. 30
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in the Inpatient Hospital Update</td>
<td>30</td>
</tr>
<tr>
<td>Payment for GME and IME Costs</td>
<td>30</td>
</tr>
<tr>
<td>Changes to the Reporting Requirements for Pension Costs for Medicare</td>
<td>31</td>
</tr>
<tr>
<td>Cost-Finding Purposes</td>
<td>31</td>
</tr>
<tr>
<td>Rural Community Hospital Demonstration Program</td>
<td>31</td>
</tr>
<tr>
<td>Hospital Routine Services Furnished under Arrangements</td>
<td>32</td>
</tr>
<tr>
<td>Teaching Hospitals</td>
<td>32</td>
</tr>
<tr>
<td>Redistribution of FTE resident caps under the ACA</td>
<td>33</td>
</tr>
<tr>
<td>Preservation of Resident Cap Positions from Closed Hospitals</td>
<td>36</td>
</tr>
<tr>
<td>(Section 5506 of the ACA)</td>
<td></td>
</tr>
<tr>
<td>V. Changes to IPPS Capital-Related Costs (77 Fed. Reg. 53455-53457)</td>
<td>39</td>
</tr>
<tr>
<td>Adjustments for Documentation &amp; Coding Effect</td>
<td>40</td>
</tr>
<tr>
<td>VI. Changes for Hospitals Excluded from the IPPS (77 Fed. Reg. 53457-53458)</td>
<td>41</td>
</tr>
<tr>
<td>Excluded Hospitals</td>
<td>41</td>
</tr>
<tr>
<td>Report on Adjustment (Exception) Payments</td>
<td>42</td>
</tr>
<tr>
<td>VII. Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2013 (77 Fed. Reg. 53458-53502)</td>
<td>42</td>
</tr>
<tr>
<td>Background of the LTCH PPS</td>
<td>42</td>
</tr>
<tr>
<td>MS-LTC-DRG Classifications and Relative Weights for FY 2013</td>
<td>44</td>
</tr>
<tr>
<td>Changes to the MS-LTC-DRG Relative Weights</td>
<td>44</td>
</tr>
<tr>
<td>Use of LTCH-Specific Market Basket under the LTCH PPS</td>
<td>44</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>Page</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Changes to the LTCH Payment Rates for FY 2013 and other</td>
<td></td>
</tr>
<tr>
<td>Changes to the LTCH PPS for FY 2013</td>
<td>45</td>
</tr>
<tr>
<td>Expiration of Certain Payment Rules for LTCH Services and the Moratorium on the Establishment of Certain Hospitals and Facilities and the Increase in Number of Beds in LTCHs and LTCH Satellite Facilities</td>
<td>45</td>
</tr>
<tr>
<td>The 25 percent Payment Adjustment Threshold</td>
<td>45</td>
</tr>
<tr>
<td>One-Time Prospective Adjustment to the Standard Federal Rate under § 412.523(d)(3)</td>
<td>46</td>
</tr>
</tbody>
</table>
| VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers
(77 Fed. Reg. 53502-53660)                                 | 47   |
| Hospital Inpatient Quality Reporting (IQR) Program         | 47   |
| Maintenance of Technical Specifications for Quality Measures | 47   |
| Removal and Suspension of Hospital IQR Program Measures    | 48   |
| Hospital IQR Program Measures for the FY 2015 Payment Determination and Subsequent Years | 49   |
| New Survey-Based Measure Items for Inclusion in the HCAHPS Survey Measure | 49   |
| New Claims-Based Measures for the FY 2015 Payment Determination | 50   |
| Hospital-Wide Readmission Measure                          | 51   |
| Hospital IQR Program Quality Measures for the FY 2016 Payment Determination | 52   |
| Form, Manner, and Timing of Quality Data Submission        | 53   |
# TABLE OF CONTENTS

(Continued)

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplements to the Chart Validation Process for the Hospital IQR Program for the FY 2015 Payment Determination and Subsequent Years (77 Fed. Reg. 53539-53555)</td>
</tr>
<tr>
<td>Selection and Sampling of Clinical Process of Care Measures for Validation</td>
</tr>
<tr>
<td>Electronic Health Records (EHR)</td>
</tr>
<tr>
<td>PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program</td>
</tr>
<tr>
<td>Hospital VBP Program</td>
</tr>
<tr>
<td>Long Term Care Hospital Quality Reporting (LTCHQR) Program</td>
</tr>
<tr>
<td>Background</td>
</tr>
<tr>
<td>Retention of LTCHQR Program Measures Adopted in Previous Payment Determinations</td>
</tr>
<tr>
<td>CLABSI, CAUTI, and Pressure Ulcer Measures</td>
</tr>
<tr>
<td>Five (5) Additional LTCHQR Program Quality Measures Beginning with the FY 2015 Payment Determination</td>
</tr>
<tr>
<td>Public Display of Data Quality Measures</td>
</tr>
<tr>
<td>Quality Reporting Requirements Under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program</td>
</tr>
<tr>
<td>Background Information</td>
</tr>
<tr>
<td>Reporting Requirements under the ASCQR Program</td>
</tr>
<tr>
<td>Requirements Regarding Form, Manner and Timing for Claims-Based Measures for CYs 2014 and 2015 Payment Determination</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program</td>
</tr>
<tr>
<td>IX.</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>X.</td>
</tr>
<tr>
<td>ACRONYMS</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>ACA</td>
</tr>
<tr>
<td>Act</td>
</tr>
<tr>
<td>AHA</td>
</tr>
<tr>
<td>ASC</td>
</tr>
<tr>
<td>ASCQR</td>
</tr>
<tr>
<td>BBRA</td>
</tr>
<tr>
<td>BIPA</td>
</tr>
<tr>
<td>CAH</td>
</tr>
<tr>
<td>CCR</td>
</tr>
<tr>
<td>CMI</td>
</tr>
<tr>
<td>CMS</td>
</tr>
<tr>
<td>CY</td>
</tr>
<tr>
<td>DRG</td>
</tr>
<tr>
<td>DSH</td>
</tr>
<tr>
<td>ED</td>
</tr>
<tr>
<td>EHR</td>
</tr>
<tr>
<td>FFY</td>
</tr>
<tr>
<td>ACRONYMS</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>FY</td>
</tr>
<tr>
<td>GME</td>
</tr>
<tr>
<td>HAC</td>
</tr>
<tr>
<td>HAI</td>
</tr>
<tr>
<td>HBIPS</td>
</tr>
<tr>
<td>HCAHPS</td>
</tr>
<tr>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>IME</td>
</tr>
<tr>
<td>IPF</td>
</tr>
<tr>
<td>IPPS</td>
</tr>
<tr>
<td>IQR</td>
</tr>
<tr>
<td>IRF</td>
</tr>
<tr>
<td>LTCH</td>
</tr>
<tr>
<td>LTCHQR</td>
</tr>
<tr>
<td>MAC</td>
</tr>
<tr>
<td>MCE</td>
</tr>
<tr>
<td>MDC</td>
</tr>
<tr>
<td>MDH</td>
</tr>
<tr>
<td>MS-DRG</td>
</tr>
<tr>
<td>MS-LTC-DRG</td>
</tr>
<tr>
<td>Acronym</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>NQF</td>
</tr>
<tr>
<td>OPPS</td>
</tr>
<tr>
<td>PCHQR</td>
</tr>
<tr>
<td>PPS</td>
</tr>
<tr>
<td>Pre-MDC</td>
</tr>
<tr>
<td>QIO</td>
</tr>
<tr>
<td>RNHCI</td>
</tr>
<tr>
<td>RRC</td>
</tr>
<tr>
<td>RY</td>
</tr>
<tr>
<td>SCH</td>
</tr>
<tr>
<td>SSI</td>
</tr>
<tr>
<td>TPS</td>
</tr>
<tr>
<td>VBP</td>
</tr>
</tbody>
</table>
Introduction

Each FY, CMS provides updates and changes to the Inpatient Prospective Payment System (IPPS). The IPPS regulations govern how inpatient services are reimbursed at acute care hospitals, long term acute care hospitals (LTCHs), PPS-exempt cancer hospitals, certain hospitals excluded from IPPS, and inpatient psychiatric facilities. Effective for discharges on or after October 1, 2012, in this 2013 IPPS Final Rule, CMS implemented updates and changes for operating and capital-related costs of acute care hospitals. These changes implement certain statutory provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) as well as other legislative requirements.

For certain excluded hospitals, CMS updated the rate-of-increase limit and for LTCHs, CMS updated the payment policies and annual payment rate for inpatient hospital services provided in that setting. Academic institutions will want to review the changes related to graduate medical education (GME) and indirect medical education (IME) regulations, especially those addressing resident caps. All facilities affected by IPPS will want to review the quality reporting changes. CMS also implemented new administrative, data completeness, and extraordinary circumstance waivers or extension requests requirements. Other new initiatives include establishing requirements for both the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program. All of the changes implemented by the FY 2013 IPPS Final Rule are discussed in more detail below.

Changes to Medicare Severity Diagnosis Related Group (MS-DRG) Classifications and Relative Weights (77 Fed. Reg. 53273-53283 and 53303-53365)

In the 2013 IPPS Final Rule, CMS finalized adjustments related to a potential issue where aggregate payments to hospitals could have increased for FYs 2008 and 2009
without a corresponding increase in the actual patient severity of illness. CMS instituted adjustments to address this issue and maintain budget neutrality, phasing in those adjustments to minimize the impact on hospitals. The 2012 IPPS final rule implemented a portion of the adjustment to partially eliminate the full effect of documentation and coding changes not reflective of real changes in case-mix for future payments. CMS then delayed implementation of the final adjustments pending the outcome of a full case-mix analysis. For FY 2013, CMS proposed an additional -1.9% downward adjustment based on the methodology they felt most accurately estimated the adjustment amount. CMS received comments speaking to alternative methodologies for arriving at the downward adjustment amount, but finalized the -1.9%, stating that none of the alternative methods offered a more accurate estimate. The -1.9% document and coding adjustment will be applied to the standardized amount in FY 2013.

**Recoupment or Repayment Adjustment**

CMS finalized additional adjustments to offset previous adjustments as required by statute. A +2.9% adjustment to the standardized amount completes recoupment from earlier years and removes the effect of a one-time -2.9% adjustment implemented in FY 2012 to satisfy requirements of Section 7(b)(1)(B) of Pub. L. No. 110-90 (Transitional Medical Assistance, Abstinence Education and Quality Improvement Programs Extension Act of 2007). CMS also finalized an additional -0.5% adjustment to hospital specific rates, including SCHs, in this adjustment. The Medicare Dependent Small Rural Hospital program ends in 2012 so these facilities will not be impacted by this adjustment. CMS stated the authority to make this prospective adjustment came from its special exceptions and adjustment authority under Section 1886(d)(5)(1)(i) of the Social Security Act (Act). The Puerto Rico-specific hospital rate had no adjustments made to it for FY 2013 IPPS.

---

Refinement of the MS-DRG Relative Weight Calculation

In previous IPPS discussions, CMS proposed and finalized separate cost-to-charge ratios (CCRs), one factor in determining the MS-DRG reimbursement for services rendered, for the costs of implantable devices and the supply costs for implantable device procedures. The form used to report this information was revised and, therefore, CMS could not access enough information to fully analyze the new methodology and to calculate separate CCRs. For FY 2013 IPPS, CMS will continue to use the CCR for devices and supplies combined. CMS is continuing its data analysis and hopes to have that completed along with separate CCRs for MRIs and CTs for FY 2014 IPPS. CMS also used the FY 2013 IPPS rules to remind hospitals that CTs and MRIs should be reported on the hospital’s cost report as major moveable equipment.

Transition to ICD-10

CMS has instituted a partial freeze on changes to ICD-9 and ICD-10 in anticipation of the move to ICD-10 for diagnosis and procedure coding, originally planned for FY 2013. Recently, however, ICD-10 implementation was delayed until FY 2014 with the first updates to ICD-10 occurring in FY 2015.

Changes to Specific MS-DRG Classifications

Pre-Major Diagnostic Categories (Pre-MDCs)

Under the Pre-MDCs, CMS received requests to create a new MS-DRG for vascular access devices, but declined to do so stating that the five criteria established in FY 2008 IPPS rules for such creation were not met. CMS also declined to make changes to MS-DRG 014 (Allogeneic Bone Marrow Transplant) after analysis showed that there were issues with reporting some of the required information.

---

**Major Diagnostic Categories (MDCs)**

In the MDCs, CMS made several changes. After careful analysis, CMS agreed to reassign cases with a principal diagnosis code of 487.0 (Influenza with Pneumonia) and certain pneumonia codes listed as secondary from the Simple Pleurisy MS-DRG to the higher severity level MS-DRGs related to Respiratory Infections and Inflammations. CMS also reassigned fenestrated grafts, used for treating patients with abdominal aortic aneurysms, to a higher severity level MS-DRG, even though it could not perform an analysis on the data due to the newness of the procedure codes assigned. CMS received information from other sources it felt was sufficient to raise the severity level. CMS declined to move the procedure Percutaneous Mitral Valve Repair with Implant to a higher severity level MS-DRG for FY 2013. CMS also declined to create a new MS-DRG for Disorders of Porphyrin Metabolism, but agreed to continue to monitor this issue for future IPPS rules.

**Medicare Code Editor (MCE) Changes**

CMS made two changes to the MCE. CMS added a new edit for length of stay for Continuous Mechanical Ventilation for 96 Consecutive Hours or More due to errors it discovered in usage of this code. CMS removed an edit for non-coverage for procedure code 43.82 (Laparoscopic Vertical (Sleeve) Gastrectomy). Due to coverage changes, the edit is no longer valid.

**Complications or Comorbidity (CC) Exclusion List**

After review, CMS finalized the addition of codes 263.0 (Malnutrition of a Moderate Degree) and 263.1 (Malnutrition of a Mild Degree) as well as 440.4 (Chronic Total Occlusion of Artery of the Extremities) to the complications and comorbidities list. Code 548.8 (Acute Kidney Failure with Other Specific Pathological Lesion in Kidney) while still on the list, has been downgraded from a Major Complication or Comorbidity to a CC. CMS declined to add codes 263.9 (Unspecified Protein-Calorie Malnutrition), 285.3
(Antineoplastic Chemotherapy Induced Anemia), Cardiomyopathy, code 428.0
(Congestive Heart Failure, Unspecified), or 707.25 (Pressure Ulcer, Unstageable).

Changes to ICD-9

CMS considered several new technology or new diagnosis codes for inclusion in FY 2013 IPPS, but only accepted one new procedure code, 00.95 (Injection or Infusion of Glucarpidase), which was effective October 1, 2012.

Recalibration of MS-DRG Weights

CMS then discussed its recalibration of MS-DRG weights for FY 2013 IPPS. Due to changes made to the cost reporting form, CMS did not have access to all the information it usually has available to recalibrate the MS-DRG weights for FY 2013 IPPS. CMS developed a methodology that involved:

1. Regrouping all claims, where possible, to the proposed FY 2013 IPPS MS-DRG classifications;
2. Using cases from Medicare-approved transplant centers from FY 2010 MedPAR data for transplants;
3. Continuing to pay organ acquisition costs on a reasonable cost basis (these costs are paid outside of any prospective payment system (PPS));
4. Deleting claims where length of stay was less than or equal to zero and claims where providers did not have charges greater than zero in at least ten to fifteen cost centers;
5. Removing statistical outliers; and
6. Resetting the Present on Admission indicator field to Y (Yes) for all claims for relative weight setting purposes only.
Costs were standardized and then adjusted using the national CCR from FY 2009 and FY 2010 cost reports. This yielded a total standardized cost per MS-DRG that became the FY 2013 cost-based relative weights that were than normalized to ensure that the average case rate after recalibration was equal to the average case rate before recalibration. The FY 2013 IPPS Final Rule adopts these national CCRs and the MS-DRG weights as recalibrated based on those CCRs.

**Bundled Payments for Care Improvement Initiative**

Section 3021 of the ACA, codified at Section 1115A of the Act, authorizes CMS to test innovative payment and service delivery models. One such initiative is the Bundled Payment for Care Improvement (BPCI) Initiative. CMS is working with participating providers to test four models of bundling payments through BPCI. Data from participating hospitals is included in the final FY 2013 IPPS Final Rule, which describes each of the four BPCI models and identifies how that data is included when determining the final rules.

**Add on payments for New Services and Technologies**

Under the authority of Section 1886(d)(5)(K)(ii)(I) of the Act, CMS established criteria that must be met for a new service or technology to qualify for an add on payment. In FY 2009, CMS modified 42 C.F.R. § 412.87(c) to specify that all applicants must have U.S. Food and Drug Administration (FDA) approval or clearance for new medical services or technologies by July 1 of the year prior to the beginning of the FY for which the application is being considered. CMS provided a FY 2013 status update for the Auto Laser Interstitial Thermal Therapy (AutoLITT) System stating that it will be considered new for FY 2013 and is eligible for a new technology add on payment for FY 2013 IPPS, even though the technology initially appeared to fall short of CMS requirements.

---

7 42 C.F.R. § 412.87.
CMS received several other applications and approved all but one. Glucarpidase, Voraxaze and DIFICID™ (Fidaxomicin) Tablets, and Zenith® F. Graft all received approval for add on payments. DIFICID™ is the first oral drug to receive approval for an add on payment. Providers must use the National Drug Code number to receive the add on payment along with ICD-9 diagnosis code 008.45 (Intestinal Infection due to Clostridium difficile). Zilver® PTX® Drug Eluting Stent did not receive consideration for an add on payment as it did not meet the criteria of FDA approval by July 1.


In the FY 2013 Final Rule, CMS finalized the modifications to the HAC payment provision list including a new HAC condition (Iatrogenic Pneumothorax with Venous Catheterization) and sub-HAC condition (SSI Following Cardiac Implantable Electronic Device procedures) and revised an existing HAC category (Vascular Catheter-Associated Infection HAC category) with the addition of two new diagnosis codes. All of these modifications are for discharges occurring on or after October 1, 2012. As set forth in more detail in the preamble of section II.F.1, each HAC must meet the statutory conditions of Section 1886(d)(4)(D) of the Act and HACs must be: “(1) high cost, high volume, or both; (2) assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are [Complication or Comorbidity] or [Major Complication or Comorbidity]); and (3) could reasonably have been prevented through the application of evidence-based guidelines.” Also in the preamble of this rule, CMS set forth the Research Triangle Institute program evaluation summary on, among other things, the impact of the HAC program.

8 77 Fed. Reg. 53733.
Addition of Diagnosis Codes to the Vascular Catheter-Associated Infection HAC Category

In the FY 2013 IPPS Final Rule, CMS added diagnosis codes 999.32 (Bloodstream infection due to central venous catheter) and 999.33 (Local infection due to central venous catheter) to the Vascular Catheter-Associated Infection HAC category. These codes were created in order to better identify specific types of infections (systemic versus local) that occur because of central venous catheter placement. Prior to these additional codes, there was only one Vascular Catheter-Associated Infection HAC code (999.31 (Infection due to central venous catheter)).

Addition of a Sub-HAC Condition within the Surgical Site Infection (SSI) HAC Category

CMS finalized a new subcategory under the SSI HAC category called SSI following Cardiac Implantable Electronic Device (CIED) Procedures (e.g., HAC 9D SSI Following Cardiac Implementation). SSIs are an established HAC category, and CMS emphasized that the rate of CIED infection is increasing faster than the rate of CIED implantation, thereby justifying the creation of this new subcategory.

Addition of Iatrogenic Pneumothorax with Venous Catheterization as a HAC Category

CMS finalized the new HAC category Iatrogenic Pneumothorax with Venous Catheterization. Although there is no unique code that identifies Iatrogenic Pneumothorax with Venous Catheterization, CMS reasoned that the condition can be identified by reporting in combination with diagnosis code 512.1 (Iatrogenic pneumothorax) and associated procedure code 38.93 (Venous catheterization NEC). The new HAC is intended to apply to populations of patients who have “iatrogenic

---

9 “Pneumothorax of the lung and parietal pleura, or the part of the pleura that lines the chest wall. The presence of air in this space partially or completely collapses the lung and is life threatening. Air can enter the intrapleural space through a passage through the chest wall. Iatrogenic Pneumothorax is a type of traumatic pneumothorax that results from incursion into the pleural space secondary to diagnostic or therapeutic medical intervention, such as needle placement for central line catheter guidance.” 77 Fed. Reg. 53290.
pneumothorax as a complication of central venous placement of a catheter in the internal jugular vein.”\textsuperscript{10}

**Changes to Hospital Wage Index for Acute Care Hospitals (77 Fed. Reg. 53365-53374)**

Section 1886(d)(3)(E) of the Act requires that hospital wage indices be adjusted to the labor market where the hospital is located. The hospital labor market is defined by the Core-Based Statistical Areas calculated by the Office of Management and Budget. The FY 2013 regulation adopts the same labor market areas used for the FY 2012 wage index. The wage data evaluation included: salaries and hourly wages from short-term acute care hospitals, costs and hours for home offices, costs related to wages including pensions, and the hours and costs of contract employees as defined by 72 Fed. Reg. 47315 (June 4, 2007). Excluded from this were “direct and overhead salaries and hours for services not subject to IPPS payment.”\textsuperscript{11}

**Method for Computing the FY 2013 Unadjusted Wage Index**

CMS used the same method for FY 2013 to compute the unadjusted wage index without an occupational mix adjustment as it used for FY 2012. The final wage index is calculated based upon cost report data from 3,447 hospitals. CMS excluded data from 38 providers because their data were “too aberrant to include.”

To establish the wage index, CMS first evaluates the unadjusted wage index, and from this it computes the final wage index with an occupational mix adjustment. The unadjusted national hourly wage is $37.4855 for the United States and $15.8643 for Puerto Rico. The unadjusted national hourly wage is then modified with an occupational mix adjustment which takes into consideration the number and types of healthcare

\textsuperscript{10} 77 Fed. Reg. 53292.
\textsuperscript{11} 77 Fed. Reg. 53366.
workers the hospitals choose to employ. CMS computed its results based on survey 
data from 91.7% of responses received from hospitals subject to IPPS or who would be 
subject to IPPS without a waiver. CMS will review the explanations from hospitals in the 
future to determine why 7.3% of hospitals did not participate. After factoring out aberrant 
data, CMS used evaluated data from 3,192 hospitals applying the same methodology 
as FY 2012 to compute the occupational mix adjustment. The occupational mix adjusted 
national average hourly wage is $37.4608 for the United States and $15.9019 for Puerto 
Rico.

The next step involves calculation for each occupational mix nursing subcategory. For 
the entire nurse category, the national hourly wage is $31.8526. If a hospital has an 
average hourly wage greater than the national average for the entire nurse category, 
the hospital will receive an occupational mix adjustment factor of less than 1.0. 
Conversely, if a hospital’s average hourly wage is less than the national average, it will 
receive an occupational mix adjustment factor of greater than 1.0. The 2010 
occupational mix survey data shows that 43.47% of hospital employees nationwide are 
in the nurse category and 56.53% are in the all other occupations category. By 
comparing the 2010 survey data to previous years, CMS concluded that 48.3% of urban 
areas and 29.2% of rural areas will increase; 50.9% of urban areas and 70.8% of rural 
areas will decrease. According to CMS, “a larger percentage of urban areas . . . will 
benefit from the 2010 occupational mix survey as compared to the 2007-2008 survey 
than will rural areas.”

The occupational mix adjustment is applied to the entire FY 2013 wage index.
Other Decisions and Changes to the IPPS for Operating Costs and Graduate Medical Education (GME Costs) (77 Fed. Reg. 53374-53455)


In the 2013 IPPS Final Rule, CMS has completed its two-year implementation of the Hospital Readmissions Reduction Program,\(^\text{12}\) (Program) which applies to all discharges occurring on or after October 1, 2012. Under the Program, “base operating DRG payments” to “applicable hospitals” whose readmission rates for “applicable conditions” exceed risk-adjusted expected rates will be reduced (for all discharges) by up to 1% in federal FY (FFY) 2013, increasing to a maximum penalty of 2% in FFY 2014, and 3% in FFY 2015 and thereafter.

In the 2013 IPPS Final Rule, CMS has finalized definitions and procedures regarding “applicable hospital”; “base operating DRG payment amount”; “adjustment factor”; “aggregate payments for excess readmissions”; “aggregate payments for all discharges”; limitations on review; and reporting of hospital-specific information, including the process for hospitals to review and submit corrections. CMS has also codified without modification several definitions that were finalized in the FY 2012 Hospital IPPS Final Rule: e.g., “applicable conditions,” “readmission,” “applicable period,” and “excess readmission ratio.”

**Applicable Hospitals**

“Applicable hospitals” subject to the Program are subsection (d) hospitals, including SCHs and current Medicare-dependent, small rural hospitals (MDHs) (whose status will expire beginning in FFY 2013), Medicare-enrolled Indian Health Service hospitals, and Maryland hospitals paid under Section 1814(b)(3) of the Act. IPPS-excluded hospitals and hospital units (e.g., LTCHs, cancer hospitals, children’s hospitals, inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs)), CAHs, and hospitals

located in Puerto Rico or the Territories are not applicable hospitals. Although Maryland hospitals are applicable hospitals for purposes of assessing readmissions for applicable conditions to applicable hospitals, Maryland hospitals are exempt from participation in the Program in FFY 2013, and contingent upon the effectiveness of Maryland’s Admission-Readmission Revenue Program, may be exempt in future years as well.

**Base Operating DRG Payment Amount**

Hospitals subject to a readmissions penalty stand to lose up to 1% of their “base operating DRG payment amount” in FFY 2013. CMS has defined the “base operating DRG payment amount” as the wage-adjusted MS-DRG payment, determined without regard to the VBP Program, excluding outlier payments, IME payments, disproportionate share hospital (DSH) payments, and low-volume hospital payments, but including new-technology add-on payments\(^\text{13}\) and payment adjustments for transfer cases.\(^\text{14}\) CMS has clarified that for SCHs (and current MDHs), the “base operating DRG payment amount” also excludes the difference between the hospital-specific payment rate and the federal payment rate.

**Adjustment Factor**

The readmissions penalty (if any) is assessed by multiplying a hospital’s base operating DRG payment amount by its “adjustment factor.” The “adjustment factor” is subject to a statutory floor of 0.99 in FY 2013, 0.98 in FY 2014, and 0.97 in FY 2015 and thereafter. It will be rounded to four decimal places. On its website, CMS has published the FY 2013 adjustment factors for all “applicable hospitals” by provider number.\(^\text{15}\) CMS has clarified that the readmissions penalty will be applied on a per-claim basis. Because CMS has not published clear guidance on the payment mechanism through which the Readmissions Adjustment will be applied, the author exchanged emails with PRICER

\(^{13}\) 42 C.F.R. §§ 412.87 and 412.88.

\(^{14}\) 42 C.F.R. § 412.4(f).

\(^{15}\) Available at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html).
personnel for clarification. PRICER personnel confirmed that the Readmissions Adjustment Factors will be entered as hospital-specific information into the PC-PRICER, a software tool used to estimate Medicare payments found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/. CMS intends to modify the hospital cost report for FY 2013 to include lines for base operating DRG payments, readmissions payment adjustment factor, and readmissions penalty amount.

**Aggregate Payments for Excess Readmissions and Aggregate Payments for All Discharges**

A hospital’s “adjustment factor” is equal to one minus the ratio of its “aggregate payments for excess readmissions” to its “aggregate payments for all discharges.” In the 2013 IPPS Final Rule, CMS has explained that only Medicare fee for service (FFS) payments are included in this ratio. Thus, Part C (Medicare Advantage) payments are not taken into consideration in calculating the adjustment factor. CMS explained that “aggregate payments for excess readmissions” includes the base operating DRG payment amounts received by the hospital for applicable conditions, subject to the hospital’s “excess readmission ratio” for each applicable condition. “Aggregate payments for excess readmissions” exclude, to the extent possible, payments for admissions that were not counted as “index admissions” in the National Quality Forum (NQF)-endorsed readmissions measures and payments for RAC (Recovery Auditors) denials of inpatient stays that are processed within six months following the end of each FFY within the applicable period (July 1, 2008 – June 30, 2011, for FY 2013). “Aggregate payments for all discharges” for a hospital for an applicable period is defined as “the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.”

**Limitations on Review**

As provided by statute, CMS has finalized its regulation providing that there shall be no administrative or judicial review of determinations of “base operating DRG payment
amounts” or the methodology for determining the “adjustment factor,” including the
determinations of “excess readmission ratio,” “aggregate payments for excess
readmissions,” “aggregate payments for all discharges,” “applicable periods,” and
“applicable conditions.”

Reporting of Hospital-Specific Information

CMS is required by statute to publish information regarding hospital-specific
readmissions rates on the Hospital Compare website (http://hospitalcompare.hhs.gov).
Hospitals must have the opportunity to review and correct errors in published
information. In this rule, CMS finalized the process by which hospitals may review and
correct their readmissions information. Confidential reports will be delivered annually to
applicable hospitals’ QualityNet accounts. QualityNet accounts are established for all
IPPS providers and are set up through the QualityNet website
(https://www.qualitynet.org) as required by CMS. (For FY 2013, the reports were
delivered on June 20, 2012.) These reports will be accompanied by discharge-level
information including patient risk-factors relevant to the “excess readmission ratio”
calculation and associated readmission information. Hospitals have thirty days from the
date on which the report and data are posted to their QualityNet accounts during which
to review and submit corrections to their “excess readmission ratios” before they
become non-reviewable. No supplementation or corrections are permitted with respect
to the underlying claims data. The confidential report contains instructions as to whom
at CMS to notify regarding suspected errors. If errors are confirmed, CMS will issue
corrected confidential reports prior to publication of corrected ratios in the final rule. If
ratios take more time to correct and cannot be published in the final rule, new reports
will be issued after the final rule, followed by another thirty-day review and correction
period, and subsequent publication.
IV.B. Changes to Sole Community Hospital (SCH) and Medicare-Dependent Hospital (MDH) Status (77 Fed. Reg. 53401-53405).

The FY 2013 IPPS Final Rule adopts some significant changes in how CMS will treat providers classified as SCHs. Specifically, the final rule adds new language to the SCH regulation at 42 C.F.R. § 412.92(b)(3)(iv) requiring an SCH to report to CMS any “factor or information” that could have affected its initial SCH classification. Effective October 1, 2012, CMS will revoke a provider’s SCH status if the agency determines that the provider should never have been classified as an SCH in the first place. Such a revocation shall be effective thirty days from the date of CMS’ determination. The rule marks a significant change in CMS policy, which previously required SCHs to report only subsequent changes in circumstances that occurred after its initial SCH classification. The final rule also states that if a provider has knowledge of information that could have affected its initial SCH classification and does not report such information to CMS, CMS will revoke the provider’s SCH status retroactively to the date when the provider no longer qualified for SCH status (consistent with the Medicare regulations governing reopenings at 42 C.F.R. § 405.1885).

Initially, CMS proposed to make all such revocations retroactive to the date the initial SCH classification was made—without regard to when the SCH had knowledge of the information or whether the SCH reported it to CMS. Such a proposal essentially would have eviscerated the finality that the SCH regulation grants providers. If the entirety of a provider’s SCH status could be revoked upon a discovery of new information not known at the time of classification, SCHs would have no assurance that their classification truly was final.

The new regulation offers some measure of finality. If an SCH becomes aware of any “factor or information” that could have affected its initial classification, under only those criteria in effect at the time of its classification, and if the SCH furnishes that information to CMS or its Medicare Administrative Contractor (MAC), a potential revocation will only have prospective effect—thirty days from the date of CMS’ decision. Such information
may include a subsequent discovery that the SCH was not in fact far enough away from another like hospital to qualify for SCH status. However, a SCH that has knowledge of such information and does not furnish it to CMS could face a retroactive revocation. Thus, SCHs that become aware of such information must inform CMS to mitigate the risk of a retroactive revocation.

CMS also stated that it would assist MDHs transition to SCH status upon expiration of the MDH program on September 30, 2012, by permitting MDHs to apply for SCH status. To avoid a gap between the expiration of a provider’s MDH status and approval of a SCH application, CMS will make successful SCH applications effective retroactively to October 1, 2012, for all MDH applications submitted before September 1, 2012.

IV.C. Rural Referral Centers (RRCs): Annual Update to Case-Mix Index (CMI) and Discharge Criteria (77 Fed. Reg. 53401-53405).

A hospital that qualifies as a RRC does not have to meet the requirement for a hospital’s average hourly wage to exceed the average hourly wage of the labor market area where the hospital is located by a certain percentage. A RRC is also not subject to the proximity criteria when applying for geographic reclassification.

One criteria for a hospital to qualify as a RRC is to have 275 or more beds available for use. If a rural hospital does not satisfy the bed count criteria, it may still qualify as a RRC if it meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (related to specialty composition of medical staff, source of inpatients, or referral volume).

16 42 C.F.R. § 412.96(b)(1)(ii).
The FY 2013 IPPS Final Rule established the CMI value for hospitals with fewer than 275 beds. For these hospitals to qualify for initial RRC status for cost reporting periods on or after October 1, 2012, they must have a CMI value for FY 2011 that is at least:

- 1.5378; or
- The median CMI value (not transfer-adjusted) for urban hospitals calculated by CMS for the census region in which the hospital is located.

The final rule also established 5,000 discharges as the minimum criterion to be eligible for RRC status.17

**Payment Adjustment for Low-Volume Hospitals**

Low-volume hospitals receive a payment adjustment to account for higher costs per discharge. The final rule continues the low-volume adjustment of an additional 25% of total per discharge payment amount totals, established under Section 1886 of the Act, including capital, DSH, IME, and outlier payments for qualifying hospitals. Effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a subsection (d) hospital must be more than twenty-five road miles from another subsection (d) hospital18 and have less than 200 total discharges during the FY. For FY 2013, a hospital must make its request for low-volume hospital status in writing to its Fiscal Intermediary or MAC by September 1, 2012, in order for the 25% low-volume add-on payment adjustment to be applied to payments for it discharges beginning on or after October 1, 2012. The low-volume hospital policy in effect prior to the ACA’s two-year enhancement of the low-volume payment adjustment will return for FY 2013 and subsequent years.19

---

17 42 C.F.R. § 412.396(c)(1) through (c)(5).
18 See Section 1886(d)(1)(B) of the Act.
IME Payment Adjustment

A multiplier is applied to payments made to hospitals that have residents participating in an approved GME program. The final IPPS rule sets the IME formula multiplier for FY 2013 at 1.35.\(^2\)

The FY 2013 IPPS Final Rule included a clarification that in order for hospitals to receive additional IME, direct GME, and/or nursing or allied health education payments for services provided to beneficiaries of a Medicare Advantage Plan the hospital must comply with the timely filing requirements\(^2\) and submit no pay bills for the purpose of calculating the DSH patient percentage.

IV.F. Changes in Medicare DSH and IME (77 Fed. Reg. at 53411-13).

CMS acknowledged its prior acquiescence to include in a hospital’s Medicare DSH disproportionate patient percentage all Medicaid patient days associated with labor and delivery room patients who have been admitted to the hospital. This policy was effective beginning in FY 2010. In the FY 2013 Final Rule, CMS goes one step further and states that the agency will also count such days as available beds for IME payment purposes. Previously, CMS did not include labor and delivery beds because those beds were not used for “routine” Medicare services. However, because CMS has agreed that labor and delivery patients are treated in hospital units for services “generally payable under the IPPS,” CMS reasons that the beds associated with such days should be considered “available” for IME purposes. This policy appears to conflict with other Medicare definitions of an available bed, and the nearly nonexistent Medicare utilization of such beds augurs in favor of excluding them from the bed count. Nevertheless, this policy will begin for cost-reporting periods beginning on or after October 1, 2012.

\(^2\) 42 C.F.R. § 412.105.
\(^2\) 42 C.F.R. § 424.44.
IV.G.  MDH Discussion Included with IV.B.


CMS had initially “proposed an applicable percentage increase to the FY 2013 operating standardized amount of 2.1 percent,” which was composed of the “FY 2013 estimate of the market basket rate-of-increase of 3.0 percent less an adjustment of 0.8 percentage points for economy-wide productivity (the MFP adjustment) and less 0.1 percentage point.” In the final rule, CMS adopted an applicable percentage increase to the FY 2013 operating standardized amount of 1.8%, which is composed of “the FY 2013 estimate of the market basket rate-of-increase of 2.6% less an adjustment of 0.7 percentage point for economy-wide productivity (that is, the MFP adjustment) and less 0.1 percentage point.” If a hospital does not submit quality data as required by CMS’ quality reporting programs, the applicable percentage increase would be decreased an additional 2% to -0.2%. CMS adopted the same 1.8% increase for SCHs and for hospitals in Puerto Rico.


Since Congress passed the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99 272, in 1985, hospitals have received upward adjustments—known as GME and IME payments—for the costs of sponsoring graduate medical education and indirect costs associated with this education. GME payments are calculated by “multiplying the hospital’s updated PRA [per resident amount] by the weighted number of FTE [full time equivalent] residents working in all areas of the hospital complex (and at the nonprovider sites, when applicable), and the hospital’s Medicare share of total inpatient days.” IME payments are calculated based on “the ratio of the hospital’s number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital to the number of inpatient hospital beds.” Logically, the more FTE residents a hospital has, the greater its GME and IME costs. Congress placed a cap on the number of

22 42 C.F.R. §§ 413.75-413.83.
osteopathic and allopathic FTE residents that a hospital can count to disincentivize hospitals from unduly increasing their FTE residents. The ACA added a provision that reduced the cap for GME and IME for “hospitals training fewer residents than their caps, and . . . authorize[d] the ‘redistribution’ of the estimated number of excess FTE resident slots to other qualified hospitals.”

**IV.J. Changes to the Reporting Requirements for Pension Costs for Medicare Cost-Finding Purposes (77 Fed. Reg. 53411-53413).**

The FY 2013 IPPS Final Rule amended the general cost-reporting rules under 42 C.F.R. §§ 413.24 and 413.100 to note the exception for recognizing actual pension contributions funded during the cost-reporting period on a cash basis. The existing regulations specified that pension costs of qualified defined benefit plans are reported on an accrual basis of accounting.

**IV.K. Rural Community Hospital Demonstration Program (77 Fed. Reg. 53449-53453).**

Beginning in 2004, hospitals began participating in a Rural Community Hospital Demonstration Program pursuant to which rural community hospitals were paid under a reasonable cost-based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. The demonstration project was required to be implemented on a budget-neutral basis.

The small number of hospital participants in the program made it unlikely that the program would be implemented on a budget-neutral basis. Therefore, the last eight IPPS final regulations have included adjustments to the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. For the FY 2013 final rule, CMS will utilize the “as submitted” cost report for each hospital

---

23 ACA, § 5503, amending the Social Security Act at § 1885(h)(8).
24 42 C.F.R. §§ 413.24 and 413.100.
participating in the demonstration for the cost report period ending in CY 2010 in estimating the costs of the demonstration in FY 2010. CMS adopted a three-step methodology for calculating the estimated FY 2013 demonstration costs for the participating hospitals.

IV.L. Hospital Routine Services Furnished under Arrangements (77 Fed. Reg. 53453-53455).

The FY 2012 IPPS final rule required that “Routine Services” (bed, board, and nursing and other related services) must be furnished by the hospital and may not be furnished by another entity under arrangements. Under the revised policy, only therapeutic and diagnostic services may be furnished under arrangements outside of the hospital to Medicare beneficiaries. CMS became aware that a number of affected hospitals need additional time to restructure existing arrangements and therefore extended the compliance date to permit hospitals to comply for cost reporting periods beginning on or after October 2013.

Teaching Hospitals

Commenters nearly unanimously supported CMS’ proposal to extend the period for new teaching hospitals to establish and develop new residency programs from three years to five years. Accordingly, CMS finalized its proposed rule, giving a new teaching hospital two additional years to establish its adjusted cap for FTE residents. Some commenters, however, opposed CMS’ proposal to make this change effective beginning October 1, 2012, and requested instead that CMS extend the inclusive dates to allow more hospitals that have not yet completed their three-year evaluation period to be included in the new five-year window. CMS rejected this idea and affirmed its position to make the new rule effective beginning October 1, 2012.

CMS finalized the rule establishing the following formula for a new teaching hospital to receive a GME and IME cap based on the first five years of its teaching program. First, identify the “highest total number of FTE residents trained in any program year,” during the fifth year of the first new program’s existence at all of the hospitals to which the residents in that program rotate; second, identify the minimum accredited length for each teaching program and then calculate the number of years that residents will take to complete the program; third, calculate the ratio “of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period.”

At the request of a commenter, CMS clarified that “accredited length for the ‘type’ of program” refers to a specialty-specific program; for example the “minimum accredited length for family medicine is [three] years.”

*Redistribution of FTE Resident Caps Under the ACA*

Section 5503 of the ACA permits a redistribution of the FTE resident cap for hospitals that do not use their full capacity; these hospitals will experience a reduction of 65% of the difference between the hospital’s “otherwise applicable resident limit” and its “reference resident limit” if this limit is less than the otherwise applicable resident limit. A few classes of hospitals, such as “rural hospitals with fewer than 250 acute care inpatient beds” are exempt from this rule.

The Secretary will evaluate the following criteria to determine if a hospital will be eligible for an increase in its cap. First, whether the hospital has demonstrated a likelihood of “filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011.” Second, whether the hospital has an “accredited rural training track program.” Third, the Secretary will distribute 70% of the available cap adjustments

---

to “hospitals located in [s]tates with resident-to-population ratios in the lowest quartile” with the remainder going to those states, territories, or the District that are “among the top 10 . . . in terms of the ratio of the total population living in an area designated as a health professional shortage area (HPSA), as of March 23, 2010, to the total population, and/or to hospitals located in rural areas.” The Secretary thus is required to favor those areas that have low physician-patient ratios.

Hospitals that receive cap increases must allocate over the first three years at least 75% of the new positions as primary care and general surgery residency. Hospitals receiving reallocations must use at least half of those reallocations during a single year during the first three twelve-month cost-reporting periods under the reallocation. Failure to do so is deemed a failure to satisfy the 75% threshold. Finally, hospitals receiving increased cap allocations must use all of their allocations within the first five years or they will lose all of the allocations. The requirement went into effect on July 1, 2011, and begins applying to a hospital as soon as it accepts reallocations under this provision of the Act, but the twelve-month cost-reporting period is determined by the hospitals particular FY. During the first five-years of reallocation, as often as it deems necessary, the Secretary may review the hospital’s allocations to determine whether the hospital has satisfied the statutory requirements, and if it has not, the Secretary must reduce the resident limit by the amount it was increased. The Secretary retains the authority to make these adjustments as soon as possible and need not wait until final settlement. These requirements are rigid to ensure hospitals that most need the reallocations will receive them.

---

29 Section 1886(h)(8)(B)(ii) of the Social Security Act.
30 However, “if hospitals have other than a June 30 fiscal year end, for their cost reports that include July 1, 2011 and June 30, 2016 respectively, [CMS will] consider whether the hospital meets the primary care average and the 75-percent threshold requirements based on an annualized FTE count.”
Many commenters expressed concern about the rigidity of the three-year rule that requires a hospital to use at least half of its allocation in a single twelve-month period during one of the first three years of its increase. CMS responded that this requirement was based on the statutory directive, but CMS’ proposal is less restrictive because it only requires the hospital to fill half of its slots within one of these three years. CMS agreed, though, that a difference existed between hospitals expanding existing programs and creating new programs, wherein there are more administrative, statutory, and regulatory hurdles for a hospital to overcome to create a new program than to expand an existing one. With this in mind, CMS modified its proposed rule to grant more latitude to hospitals that create new programs when it evaluates whether a hospital has “used” a slot. Hospitals creating new programs are considered to have “used” slots that are reported in the final cost report, but those expanding existing programs are considered to have “used” a slot by the fourth twelve-month reporting period.

Although CMS does not encourage hospitals to use its reallocations for cap relief, it admits that there is no statutory restriction prohibiting hospitals from doing so with the 25% of its slots that are not designated for primary care or surgery residents. If a hospital attempts to use more than 25% of its slots for cap relief, it risks losing all of its Section 5503 slots from the earliest cost-reporting period that can be reopened.

To determine whether a hospital complies with the 75% rule and the three-year primary care/general surgery requirement, a Medicare contractor will evaluate the following six data points, which must be provided by the hospital. First, the baseline FTE count which is the “unweighted allopathic and osteopathic FTE count from the hospital’s [twelve]-month cost report that immediately precedes the cost report that includes July 1, 2011.” Second, the number of additional FTE’s that were added above the baseline during the current cost-reporting period because of the Section 5503 award. Third, the hospital will identify all new specialties and the number of FTE residents for each new program. Fourth, the hospital will identify each expanded program specialties and the number of FTE residents for these expansions. Fifth, the hospital will indicate the amount of the
award that is being used for cap relief. Sixth, the hospital will identify the total unweighted primary care FTE count for the current year.

The MAC will then evaluate the number of used slots and whether the hospital reported a full or partial increase of its ACA Section 5503 cap in the cost report. If the hospital uses slots for cap relief but fails to satisfy the 75% requirement, it fails to satisfy the regulatory requirement of 42 C.F.R. § 413.79(n)(2)(iv). CMS finalized in the FY 2013 Final Rule its policy that MACs can remove Section 5503-awarded slots from a provider who reports them as unused in the final cost report of the evaluation period. When slots are awarded as part of an expansion for an existing program, the only slots that would be removed are those associated with the additional expanded FTEs. CMS also defined base year or baseline number of FTEs to provide a clear reference point when determining whether the number of slots awarded had been used. CMS noted that the Section 5503 awarded slots were statutorily directed to only certain states so this policy does not apply to GME programs in all states. Providers in states where this Section 5503 does apply will see cost report modifications requiring that they show how their slots were used.

Section 1886(h)(8)(B)(ii) of the Act provides another avenue whereby providers lose slots awarded under Section 5503. If a hospital fails to meet one of the two requirements established in Section 1886(h)(8)(B)(ii) of the Act, those slots can be removed even if a program demonstrates the necessary use of those slots.

*Preservation of Resident Cap Positions from Closed Hospitals (Section 5506 of the ACA)*

Currently, a hospital that accepts resident FTEs from a closed hospital is awarded those resident slots on a temporary basis. Once the resident from the closed hospital

---

32 42 C.F.R. § 413.79(n)(2)(ii).
completed training, the slot expired.\textsuperscript{33} ACA Section 5506 amends Section 1886(h)(4)(H) of the Act requiring a change so that those temporary slots become permanent if a hospital meets certain criteria. The amendment provides the method by which slots for a closed hospital will be distributed. For purposes of this regulation, a closed hospital is one that terminates its Medicare Provider Agreement.

Section 1886(h)(4)(H)(iv) of the Act established seven Ranking Criteria for hospitals to use when applying for resident slots. ACA Section 5506(a) added a requirement that hospitals show that they will use those slots within the three academic years following that application. Section 5506 also requires that CMS be aware of and prepare for those slots awarded on a temporary basis becoming permanent slots available for distribution once the resident from a closed hospital completes training.

CMS implemented a program to meet Section 5506 requirements, initially providing hospitals four months to apply for permanent slots created by the closing of a hospital following public notice of the closure. Comments were received indicating that four months was too long. CMS agreed, proposed a sixty-day time period, which commenters thought too short, then compromised on a ninety-day time period for applications. CMS received requests to use the annual IPPS proposed regulations as the only public notice of hospital closure. CMS declined to honor that request as it prefers to have flexibility around publication of the closure notice.

CMS revised the Ranking Criteria by adding an eighth criterion, developed by splitting the current seventh criterion into two parts.\textsuperscript{34} Clarification is provided to distinguish new

\textsuperscript{33} 42 C.F.R. § 413.79(h) and § 413.105(f)(1)(ix).

\textsuperscript{34} “Ranking Criterion One: The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program exactly as it has been operated by the hospital that closed; Ranking Criterion Two: the applying hospital was listed as a participant of a Medicare GME-affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed and under the terms of that Medicare affiliation the applying hospital
Ranking Criterion 7 from Ranking Criterion 5 and Ranking Criterion 6. Ranking Criteria 1 through 6 remain unchanged. CMS went on to provide clarification around Ranking Criterion 2. Hospitals qualifying under this criterion are awarded slots effective with the closed hospitals closure date. However, hospitals awarded slots are not exempt from the three-year rolling average. Per the regulations at 42 C.F.R. § 412.105(a)(1)(i), when an affiliation agreement exists between two hospitals, one of which closes, the IME Intern and resident-to-bed (IRB) ratio is adjusted to only reflect the portion of the affiliated FTEs a hospital received prior to the other hospital's closure and affiliation agreement termination. Further, CMS clarified that there are no adjustments where an applying hospital qualifies under Ranking Criterion 1 or Ranking Criterion 3.

Award letters for hospitals qualifying under all other criteria will specify the program for which slots are awarded, the number of FTE slots awarded, and the Ranking Criterion under which they are awarded. The slots will be in pending status until a hospital contacts the MAC, submitting documentation proving the hospital needs the slots awarded because it filled that number of positions in the National Resident Match Program as of that date, over the number of positions it trained in the previous year.

Under new Ranking Criterion 8, if slots are awarded for cap relief, those slots become received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement; Ranking Criterion Three: The applying hospital took in residents displaced by the closure of the hospital, but it is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same program as the displaced residents, even after those displaced residents complete their training (that is the applying hospital is permanently expanding its own existing program); Ranking Criterion Four: The applying hospital does not fit into Ranking Criterion One, Two, or Three and will use the additional slots to establish a new or expand and existing geriatrics residency program; Ranking Criterion Five: Applying hospital does not meet Ranking Criterion One, Two, or Three, is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program; Ranking Criterion Six: Applying Hospital does not meet Ranking Criterion One, Two, or Three, is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program; Ranking Criterion Seven (previous definition): Applying hospital seeks the slots for purposes that do not fit any of the above ranking criteria; Ranking Criterion Seven (new definition): The applying hospital will use additional slots to establish or expand a primary care or general surgery program, but the program does not meet Ranking Criterion Five or Six because the hospital is also separately applying under Ranking Criterion Eight for slots to establish or expand a nonprimary care or nongeneral surgery program and/or for cap relief; Ranking Criterion Eight (new): The program does not meet Ranking Criteria One through Seven, and the applying hospital will use additional slots to establish or expand a nonprimary care or nongeneral surgery program of for cap relief.” 77 Fed. Reg. 53443.
effective the later of the award announcement date or July 1 after the displaced residents complete their training if the slots were awarded based on a temporary adjustment for displaced residents.

CMS notes that during the first two rounds of Section 5506 slot awards, a hospital may receive slots with various effective dates. Hospitals need to be aware of that and report their data on the cost report covering the effective date.

On the revised CMS Application Form for resident slots when applying under Ranking Criterion 1 and Ranking Criterion 3 hospitals must list the names and graduation dates of residents from closed hospitals (also known as displaced residents) whom the hospital believes it has seamlessly replaced or will replace with new PGY1 residents upon the displaced residents graduation. Other changes to the Application Form include asking the applicant the purpose of the application and asking for the particular program: general cap relief or slots related to a closed hospital. One final change involves changing the titles of sections for better clarity regarding those sections. Under Demonstrated Likelihood Criterion 2 (now to be known as Taking Over All or Part of an Existing Resident Program from a Closed Hospital or Expanding an Existing Residency Program), CMS added a new category requiring a hospital with Accreditation Council for Graduate Medical Education, American Osteopathic Association, or American Board of Medical Specialties previously approved but unfilled positions that wants to fill those positions to provide documentation clearly showing the number of approved positions and the hospital's current number of unfilled positions.

**Changes to IPPS Capital-Related Costs (77 Fed. Reg. 53455-53457)**

The basic formula for calculating the capital payments for each discharge is:
Hospitals may also receive “outlier payments” for “extraordinarily high-cost cases that qualify under the thresholds established for each fiscal year.” The hospital would be eligible for additional payment if it “incurs unanticipated capital expenditures” exceeding “$5 million due to extraordinary circumstances beyond the hospital’s control.” Exception payments are otherwise no longer available to hospitals after FY 2012.

For capital payments purposes, new hospitals are defined as hospitals that “operated (under previous or current ownership) for less than 2 years.” New hospitals are ordinarily paid 85% of their allowable Medicare capital-related costs during and through their first two years of operation. New hospitals may elect, however, to receive “full prospective payment based on 100 percent of the Federal rate.” In Puerto Rico, the regulations permits hospitals to blend 25% of the capital IPPS Puerto Rico rate with 75% of the capital IPPS federal rates to determine the prospective payments for capital-related costs.

Adjustments for Documentation and Coding Effect

After implementing the MS-DRGs, CMS believed it was inappropriate for expenses under the capital IPPS to increase because of documenting and coding changes unrelated to “real changes in case mix” or “an increase in patient severity of illness (and costs).” CMS thus adjusted the national capital federal rate and national operating standardized amount to ensure the MS-DRGs are implemented in a neutral manner and to eliminate the financial effect of changes in coding and documentation that were not a

35 42 C.F.R. § 412.312.
36 42 C.F.R. § 412.300.
result of case-mix severity. Because these adjustments were first made in FY 2009, the percent adjustments have been applied in a cumulative manner to ensure “future annual aggregate IPPS payments are the same as payments that would otherwise have been made” in those years absent the change to the MS-DRGs. For FY 2013, the cumulative effect of documentation and coding changes unrelated to case-mix severity is -6.2%, a 0.8% increase from FY 2012.

Some of the commenters expressed concern that the entity evaluating the effect of documenting and coding costs, the Medicare Payment Advisory Commission (MedPAC), may have overestimated the effect. CMS admits that it is theoretically possible for MedPAC to have overestimated, but states its view that the estimates were “theoretical maximums,” and at this point the data presented by the commenters does not adequately challenge those theoretical maximums. CMS elected, however, not to finalize the 0.8% increase from FY 2012 until it can more thoroughly analyze the data.

Similar to other calculations, Puerto Rico uses the same methodology, blending the federal and the local rates: Puerto Rican hospitals pay 75% of the national capital federal rate and 25% of the Puerto Rico-specific capital rate. CMS established a -2.6% adjustment for FY 2011 and found no additional effect on documenting and coding costs relating to the MS-DRGs that would justify further adjusting the Puerto Rican capital rate; for FY 2013, the capital rate for Puerto Rico remains -2.6%.

Changes for Hospitals Excluded from the IPPS (77 Fed. Reg. 53457-53458)

Excluded Hospitals

Hospitals and hospital units excluded from IPPS, such as children’s hospitals, are paid on reasonable costs subject to a rate of increase ceiling. A per-discharge limit was set for each excluded hospital or hospital unit based on its own cost-report experience and
updated annually by a rate-of-percentage.\textsuperscript{39} The updated target amount is then multiplied by total Medicare discharges and applied as an aggregate upper limit on total inpatient operating costs for a hospital’s cost reporting period. Due to IPPS regulations existing for IRFs and IPFs, “excluded hospitals” only refers to children’s hospitals, certain cancer hospitals, and Religious Nonmedical Health Care Institutions (RNHCIs).

For FY 2013, CMS proposed to apply the FY 2013 IPPS operating market basket percentage increase, estimated at 3.0%, to children’s hospitals, excluded cancer hospitals, and RNHCIs. CMS received updated data prior to the final rule and, therefore, based the percentage on that updated information. The rate-of-increase percentage for FY 2013 will be 2.6%.

\textit{Report on Adjustment (Exception) Payments}

Section 4419 of Public Law 105-33 Balanced Budget Act of 1997 requires annual publication in the \textit{Federal Register} of a report describing the total amount of adjustment payments made to excluded hospitals and hospital units by reason of Section 1866 (b)(4) of the Social Security Act during the previous FY. It can take two or more years to arrive at the total adjustments for any given year. The information for the most recent report is FY 2011 and includes cost-reporting periods ending in years prior to 2010. For FY 2011, total adjustment payments to excluded hospitals were $3,118,588.00.

\textit{Changes to the Long Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2013 (77 Fed. Reg. 53458-53502)}

\textit{Background of the LTCH PPS}

Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) as amended by Section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provides for payment for both

\textsuperscript{39} 42 C.F.R. § 413.40(a).
the operating and capital-related costs of hospital inpatient stays in LTCHs under Medicare Part A based on prospectively set rates. The Medicare LTCH PPS applies to hospitals that are described in Section 1886(d)(1)(B)(iv) of the Act, effective for cost-reporting periods beginning on or after October 1, 2002.

A LTCH is defined as “a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 24 days.” Alternatively, the Act also defines an LTCH as a hospital that first received payment under Section 1866(d) in 1986 and has an average inpatient length of stay (as determined by the Secretary) of greater than twenty days and has 80% or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the twelve-month cost-reporting period ending in FY 1997.

On August 30, 2001, CMS issued a final rule implementing the LTCH PPS authorized under the BBRA and BIPA. Starting with FY 2008, CMS began using the Medicare severity long term care diagnosis-related groups (MS-LTC-DRGs) as the patient classification system under the LTCH PPS. CMS calculates payments and makes adjustments as needed for each MS-LTC-DRG, and payment rates under the LTCH PPS are updated on an annual basis and are published in the Federal Register. It is important to note that reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97 248 (TEFRA), was replaced by the LTCH PPS for inpatient services provided by LTCHs with a cost reporting period beginning on or after October 1, 2002. The August 30, 2002 final rule provided for a five-year transition period from payments under the TEFRA System to payments under the LTCH PPS.

---

41 Section 1866(d)(1)(B)(iv)(II) of the Act.
**MS-LTC-DRG Classifications and Relative Weights for FY 2013**

*Changes to the MS-LTC-DRG Relative Weights*

In the FY 2013 Final Rule, CMS notes that it is updating the MS-LTC-DRG classifications effective October 1, 2012, through September 30, 2013, consistent with the changes to specific MS-DRG classifications. Thus, the MS-LTC-DRGs for FY 2013 are the same as the MS-DRG changes under FY 2013 IPPS.

A primary goal for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. To further this goal, CMS annually adjusts the LTCH PPS standard federal PPS rate by the applicable relative weight in determining payment to LTCHs for each case. CMS used the same basic methodology for FY 2013 updates as it used for FY 2012. Because CMS did not receive any public comments on its proposal regarding relative weights for FY 2013, it adopts the proposals without any modifications.

Consistent with prior policy, for the FY 2013 Final Rule, CMS continues to apply its established two-step budget neutrality methodology, such that the annual update to the MS-LTC-DRG classifications and relative weights are based on previously established FY 2012 MS-LTC-DRG classifications and relatives weights. The adjustment first includes a normalization adjustment of 1.12412, which CMS applies to the recalculated relative weights to ensure that the recalibration does not change the average case-mix index. CMS then applies a budget neutrality adjustment of 0.9880413.

*Use of LTCH-Specific Market Basket Under the LTCH PPS*

In the FY 2013 proposed rule, CMS sought comments on the proposed methodology for determining an LTCH-specific market basket. Historically, the Medicare program has used a market basket to account for price increases in the services furnished by

---

providers. Beginning in RY 2007, LTCH PPS payments were updated using a FY 2002-based market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (the rehabilitation psychiatric long term care (hospital) market basket). In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, CMS expressed its interest in exploring the possibility of creating a stand-alone LTCH market basket, which would only reflect the cost structures for LTCHs. After its review of comments on this matter in the FY 2013 proposed rule, CMS created a FY 2009-based LTCH-specific market basket. In the FY 2013 Final Rule, CMS establishes a market basket update of 2.6%.

**Changes to the LTCH Payment Rates for FY 2013 and Other Changes to the LTCH PPS for FY 2013**

**Expiration of Certain Payment Rules for LTCH Services and the Moratorium on the Establishment of Certain Hospitals and Facilities and the Increase in Number of Beds in LTCHs and LTCH Satellite Facilities**

The five-year moratoria on the implementation of certain LTCH payment policies and on the development of new LTCHs and LTCH satellite facilities and on bed increases in existing LTCHs and LTCH satellite facilities under the Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110 173, and the ARRA, as further amended by the ACA, are set to expire during CY 2012, under current law.

**The 25 Percent Payment Adjustment Threshold**

In the FY 2013 proposed rule, CMS proposed a one-year continuation of the existing delay of the full implementation of the 25% Payment Adjustment Threshold, so that for cost-reporting periods beginning on or after October 1, 2012, and before October 1, 2013, the full implementation of the 25% Payment Adjustment Threshold would not apply. This threshold was implemented after research suggested a strong correlation between growing numbers of discharges from IPPS hospitals after short-stays to onsite

---

or nearby LTCHs, yielding higher costs to Medicare. Thus, in the FY 2013 Final Rule, CMS states that for those LTCHs for which the statutory moratorium will expire effective with the hospitals’ cost-reporting periods beginning on or after October 1, 2012, the regulatory moratorium will seamlessly provide for an additional moratorium for the hospitals’ first cost-reporting period beginning on or after October 1, 2012. For LTCHs for which the statutory moratorium expires effective with the hospitals’ cost-reporting periods beginning on or after July 1, 2012, the proposed moratorium will be finalized effective for the hospitals’ first cost-reporting period beginning on or after October 1, 2012. In addition, for hospitals with cost-reporting periods beginning on or after July 1, 2012 and before October 1, 2012, CMS finalizes a regulatory moratorium effective with discharges occurring beginning October 1, 2012, through the end of the hospital cost-reporting period.

Ultimately, CMS finalized the proposed regulatory moratorium on the full application of the 25% Payment Adjustment Threshold Policy for LTCHs with reporting periods beginning on or after October 1, 2012. It also established a discharge-based moratorium on the application of the policy solely for those LTCHs that would have been affected by the “gap” for discharges on or after October 1, 2012, and through the end of their first cost-reporting period beginning on or after July 1, 2012, and before October 1, 2012.

**One-Time Prospective Adjustment to the Standard Federal Rate Under § 412.523(d)(3)**

In the August 2002 final rule, CMS set the LTCH PPS rates to achieve budget neutrality for FY 2003 with the prior TEFRA-based system, and it also stated its intention to provide for a prospective one-time adjustment if future data suggested that the original budget-neutrality calculation for payments in FY 2003 resulted in rates that were either too high or too low. For the FY 2013 Final Rule, to determine whether a one-time prospective adjustment is warranted, CMS evaluated several issues regarding the data to use for this purpose. Based on a complicated methodology described in both the proposed and final rules, under the broad authority granted to the Secretary under
Section 123 of the BBRA, as amended by Section 307(b) of the BIPA, CMS proposed in the FY 2013 proposed rule to make a one-time prospective adjustment of 0.9625, which would permanently reduce the standard federal rate by approximately 3.75%. This reflects the estimated difference between the projected aggregated LTCH PPS payments in FY 2003 and the projected aggregate payments that would have been made in FY 2003 under the TEFRA payment system if the LTCH PPS had not been implemented. In the final rule, CMS finalizes this one-time prospective adjustment. However, given the magnitude of this adjustment, CMS states that it will phase-in this approximate 3.75% reduction to the standard federal rate over a three-year period. CMS reiterates in the final rule that the intended goal of the one-time prospective adjustment establishes the LTCH PPS standard federal rate in a manner that results in bringing the current estimated aggregate LTCH PPS payments to the level they would have been had the estimated total FY 2003 LTCH PPS payments been 2.5% lower. Thus, this one-time adjustment assures that the original “miscalculation” of the budget neutrality adjustment built into the FY 2002 payment rates, which made the adjustment inadequate, is not perpetuated into future payment rates. LTCH providers need to be aware that the final rule makes the standard federal rate adjustment of 3.75% permanent.

Quality Data Reporting Requirements for Specific Providers and Suppliers (77 Fed. Reg. 53502-53660)

VIII.A. Hospital Inpatient Quality Reporting (IQR) Program (77 Fed. Reg. 53503-53555).

Maintenance of Technical Specifications for Quality Measures

In the 2013 Final Rule, CMS made several changes to the Hospital IQR program. CMS finalized its proposal to “use a subregulatory process to make nonsubstantive updates to NQF-endorsed measures used for the Hospital IQR program” while continuing the use of the “rulemaking process for substantive changes that arise from NQF review.” Although CMS stated that it will determine whether a change is substantive or nonsubstantive on a case-by-case basis, CMS’ definition of substantive appears quite narrow: “Examples of changes that we might consider to be substantive would be those
in which the changes are so significant that the measure is no longer the same measure, or when a standard of performance assessed by a measure becomes more stringent.\textsuperscript{45} CMS stated that it would “provide at least six months lead time for hospitals to implement updates to measures that would require changes to abstraction or data collection systems” including “non-substantive changes.”

\textit{Removal and Suspension of Hospital IQR Program Measures}

CMS finalized its proposal to remove seventeen measures from the Hospital IQR including one chart-abstracted measure (SCIP–VTE–1: Surgery patients with recommended VTE prophylaxis ordered). The chart below appears on page 53509 of the 2013 IPPS Final Rule and lists the measures that will be removed from the IQR program. Most of the measure were removed from the IQR program because they were redundant with other measures or already encapsulated in composite measures.

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


\textsuperscript{45} 77 Fed. Reg. 53504.
Hospital IQR Program Measures for the FY 2015 Payment Determination and Subsequent Years

In response to a commenter who “recommended the exclusions of various patients from the Influenza Immunization and Pneumococcal Immunization measures that were finalized for the FY 2014 payment determination,” beginning with January 1, 2013, CMS adopted exclusions for patients transferring to another acute care facility and patients who leave against medical advice. CMS rejected the commenter’s suggestion to exclude hospice patients from this measure, however, because “a secondary infection, potentially resulting from withholding of a vaccination, in this vulnerable population could reduce quality of life.”

Another commenter “recommended delaying the reporting of the [Influenza Immunization and Pneumococcal Immunization] measure on Hospital Compare” because the measure’s developer had significantly revised the measure with new data collection protocols, forms, and reports.” CMS agreed that hospitals needed time to gain experience with the revised measure and stated it would “allow the first submission of cases spanning October 1, 2012 to December 31, 2012 to be on a voluntary basis.” CMS will not publicly report this first submission on Hospital Compare. Public reporting will begin, however, with the “second submission of the Healthcare Personnel Influenza Vaccination measure, which would span the complete flu season from October 1, 2013 through March 30, 2014, in December of 2014.”

New Survey-Based Measure Items for Inclusion in the HCAHPS Survey Measure

CMS finalized its proposal to “add the NQF-endorsed 3-Item Care Transition Measure (CTM–3) . . . to the existing HCAHPS survey.” These three questions ask respondents to rate whether they “strongly disagree,” “disagree,” “agree,” or “strongly agree” with the following statements:

During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

When I left the hospital, I clearly understood the purpose for taking each of my medications.

CMS also added the following two questions to the “About You” section of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey beginning with January 2013 discharges: (1) During this hospital stay, were you admitted to this hospital through the Emergency Room? and (2) In general, how would you rate your overall mental or emotional health? CMS stated that these two items would not be included in public reporting of the HCAHPS survey but could be employed in the patient-mix adjustment of survey responses.

NEW CLAIMS-BASED MEASURES FOR THE FY 2015 PAYMENT DETERMINATION

CMS added a new outcome measure that “assesses complications occurring after THA [Total Hip Arthroplasty] and TKA [Total Knee Arthroplasty] surgery from the date of the index admission to 90 days post date of the index admission.” CMS added this measure in part because it found that the “variation in complication rates suggest that there are important differences in the quality of care delivered across hospitals, and that there is room for quality improvement.” The measure will be risk-adjusted.

CMS also added another outcome measure, the Hip/Knee Readmission: Hospital 30-Day All-Cause Readmission Following Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) measure. This measure would assess the readmission rate from any cause within thirty days of the initial THA and TKA admissions for patients discharged from the hospital following elective primary THA and TKA. To be included, patients must have had continuous enrollment in Medicare for one year prior to the date of index admission to ensure full data availability for risk adjustment. Patients with hip fractures and planned readmissions are excluded from the measure. CMS stated that it “plans to use three years of data to calculate the hospital rates” to “ensure sufficient
data for meaningful statistical analysis.” CMS argued that it was necessary to count “all cause” readmissions, and not just readmissions obviously related to the surgery, for several reasons. CMS argued, e.g., that “from the patient perspective, readmission for any reason is likely to be an undesirable outcome of care after an acute hospitalization” and that “readmissions not directly related to hip/knee replacement may still be a result of the care received during hospitalization for the procedure.”

**Hospital-Wide Readmission Measure**

Citing the fact that “during 2003 and 2004, over 2.3 million Medicare patients (almost one fifth of all Medicare beneficiaries) were rehospitalized within 30 days of discharge from an acute care hospital,” CMS finalized its proposal to adopt a Hospital-Wide Readmission (HWR) measure using 2008 Medicare FFS data. This measure will “assess the hospital-level, risk standardized rate of unplanned, all cause readmissions after admissions for any eligible condition within 30 days of hospital discharge.” (Emphasis added.) Although planned readmissions are excluded, the measure will employ an “algorithm” to determine whether the admission was likely planned or unplanned. According to CMS, (1) “the algorithm was based on two main principles: The ‘planned’ readmissions are those in which one of a pre-specified list of procedures took place . . . or those for maintenance chemotherapy or rehabilitation. . . . [and (2)] Admissions for acute illness or for complications of care are likely not ‘planned.’” CMS then provides a relatively short list of “procedure categories considered planned depending on the discharge condition.” The HWR measure will be “calculated based on the claims that hospitals submitted to and were paid by CMS” but it does not “differentiate between related and unrelated readmission.” While the measure is not NQF endorsed, it is “in the final stages of the NQF measure endorsement process.” For 2013 public reporting, CMS plans to use one year of data to calculate the measure. Some commenters warned of possible “harmful unintended consequences by resulting

---

46 77 Fed. Reg. at 52524.
in more emergency visits or more repeated observation stays during the 30-day period.” CMS responded it would monitor for any such developments.

Finally, CMS finalized a new chart-abstracted measure, Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation. The purpose of the measure is to reduce early elective deliveries given the “variety of health problems for mothers and infants” linked to such deliveries. The measure will encompass all patients, not just Medicare patients, even though Medicare patients accounted for just 14,000 births out of approximately four million in 2011.

CMS summarized its changes to the IQR program as follows:

In summary, we are adopting all the Hospital IQR Program measures adopted in previous payment determinations, with the exception of the 17 measures (1 chart-abstracted measure and 16 claims-based measures) that we are removing. We are finalizing new survey based measure items for inclusion in the HCAHPS survey measure, 3 claims based measures, and 1 chart-abstracted measure, for a total of 59 measures for the FY 2015 payment determination and subsequent years.

*Hospital IQR Program Quality Measures for the FY 2016 Payment Determination*

For the 2016 IQR program, CMS adopted the Safe Surgery Checklist structural measure that will assess whether a respondent “uses a safe surgery checklist for its surgical procedures that includes safe surgery practices during each of the three critical perioperative periods.” No particular checklist would be required. Although this measure has not been adopted by NQF, CMS stated that “because the use of a safe surgery checklist is a widely accepted best practice for surgical care, we believe that the proposed structural measure of Safe Surgery Checklist use reflects consensus among affected parties.”
Form, Manner, and Timing of Quality Data Submission

CMS finalized its proposal “that a subsection (d) hospital may withdraw from the Hospital IQR Program by submitting to CMS a withdrawal form. . . by May 15 prior to the start of the payment year affected.”

Supplements to the Chart Validation Process for the Hospital IQR Program for the FY 2015 Payment Determination and Subsequent Years (77 Fed. Reg. 53539-53555)

CMS proposed to continue using validation requirements and methods adopted in previous year’s IPPS regulations with a few modifications. Those modifications include using separate validation approaches for chart-abstracted clinical process of care and Healthcare Associated Infection (HAI) measures, changing the number of hospitals included in the base annual validation random sample, and using targeted selection of supplemental hospitals to be added to the base sample. These changes are aimed at strengthening the Hospital IQR Program through the validation of a larger set of measures, increasing opportunities to identify poor reporting, and increasing the rigor associated with the validation process while at the same time minimizing the burden of validation activities on hospitals. One exception to the separate validation approaches for chart-abstracted clinical process of care and HAI measures is that CMS will not require hospitals to receive separate passing scores on both clinical process of care and HAI measures.

Selection and Sampling of Clinical Process of Care Measures for Validation

In previous year’s IPPS regulations, CMS finalized the sampling approach used for validation purposes and included abstracting from emergency department throughput (ED) and Immunization (IMM) data from all cases selected from other measures sets. For FY 2013, CMS will discontinue abstracting ED and IMM data from cases selected for the Central Line-Associated Blood Stream Infection (CLABSI) measure to be

---

consistent with its policy to calculate separate scores for HAI and clinical process of care measure sets.

CMS will use three HAI measures for validation beginning with FY 2015 payment determination and for future years. Those measures are CLABSI, Catheter-Associated Urinary Tract Infection (CAUTI), and SSI. Validation of these measures will be through identifying records that are “candidate HAI events,” constructing a separate list for each HAI measure that includes actual HAI events and non-events, then combining the lists and generating a random sample of medical records to be reviewed and evaluated. CMS also finalized a modification to the method adopted in FY 2012 IPPS for identifying and constructing lists of candidate CLABSI events. Previously the list included all positive blood cultures drawn from Intensive Care Unit (ICU) patients. To reduce the burden on hospitals, CMS is redefining “positive blood cultures among ICU patients” to include only those blood cultures drawn from ICU patients during their actual ICU stay during the discharge quarter for the FY 2014 payment determination and future years. For FY 2014 payment determination only, CMS will not penalize hospitals that submit data using the prior definition.

CMS also plans on working with the Centers for Disease Control and Prevention (CDC) to add another required field to the Hospital IQR Program to capture HIC numbers for patients to further reduce some of the burden on hospitals associated with demographic data elements. The HIC number identifies a Medicare beneficiary and CMS can obtain demographic information from its own files as opposed to the hospital having to provide that information.

In the FY 2013 IPPS regulations, CMS finalized the process for validation of SSIs among patients with colon surgeries and abdominal hysterectomy procedures under the Hospital IQR Program. CMS will select patients from Medicare FFS claims for colon surgeries or abdominal hysterectomies based on a certain set of ICD-9 codes for each
procedure as identified in the regulations. CMS will look at discharges on the index claim (the one targeted for the validation process) and all inpatient claims within the thirty-day post discharge period that might indicate infection. CMS excludes from validation claims for readmissions to hospitals other than the index hospital.

CMS historically has used two criteria for whether or not a score passes validation in the Hospital IQR Program. One is to require all participating hospitals selected for validation to attain at least a 75% validation score per quarter. The other is to use the upper bound of a one-tailed 95% confidence interval to estimate the validation score. In the FY 2013 proposed IPPS regulations, CMS proposed to compute validation scores for each of the chart-abstracted and HAI measure sets by combining the data across four quarters instead of the current method of looking at each quarter separately. CMS stated that this is consistent with its current policy so it will make this final. CMS stated that it will continue to provide quarterly feedback to hospitals. The hospital’s validation score will be computed annually as described above for the basis of payment determination only. If a hospital has no candidate CLABSI, CAUTI, or SSI in a given year or the hospital has been excepted from National Health Safety Net (NHSN) reporting for all three HAIs, then that hospital will only be required to achieve the 75% score for the chart-abstracted clinical process of care to pass validation.

In previous years’ IPPS regulations, CMS established policies for supplementation to the base annual random sample of hospitals, which included those hospitals that failed validation in the previous year. That will not change, but CMS did identify a different approach that yields comparable benefits while at the same time reducing the burden on hospitals and reducing costs for CMS. For FY 2015 payment determination, CMS changed the criteria for selecting supplemental hospitals to include any hospital with an abnormal or conflicting data pattern (i.e., one that falls more than three standard deviations from the mean); any hospital with rapidly changing data patterns; any hospital that submits data to NHSN after the deadline has passed; any hospital that joined the Hospital IQR Program within the previous three years that has not been
previously validated; and any hospital not randomly selected in any of the previous three years. For FY 2016 payment determination and future years, CMS will add to those criteria any hospital that passed validation in the previous year, but had a two-tailed confidence interval that included 75%. This last criterion is delayed to allow CMS time to implement the changes to the confidence interval. CMS will select hospitals under the supplemental sample for FY 2015 payment determination after the FY 2014 payment determination to separate the timing of the selection of the base and supplemental samples.

*Electronic Health Records (EHR)*

CMS indicated its intention to move toward EHR-based reporting for all quality measures, but acknowledged that significant testing is still required before that can happen. CMS believes that all hospitals participating in the Hospital IQR Program need to transition to EHR-based reporting as soon as feasible.

**VIII.B. PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (77 Fed. Reg. 53555-53567).**

The ACA added new subsections to Section 1866 of the Act establishing a quality reporting program for PPS-exempt cancer hospitals, similar to the hospital quality reporting program. Effective with FY 2014 and for all future years, PPS-exempt cancer hospitals will report certain quality measures. These measures must be endorsed by the NQF(currently under contract with CMS) or such other entity operating under contract as described in Section 1890(a) of the Act, provided an exception does not apply. Section 1866(k)(3)(B) of the Act provides one such exception for specific areas or medical topics where a feasible and practical measure has not been endorsed by the contracted entity. In that case, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.
Section 1866(k)(4) of the Act requires data submitted by PPS-exempt cancer hospitals to be made public via CMS’ Internet website following the PPS-exempt cancer hospital having the opportunity to review said data. Published information will include quality measures of process, structure, outcome, patients’ perspective on care, efficiency, and costs of care that relate to services provided by the PPS-exempt cancer hospital. CMS clarified that this final rule impacting PPS-exempt cancer hospitals only applies to those entities meeting the criteria of 42 C.F.R. § 412.23(f).

Five measures were proposed and finalized by CMS for the PCHQR Program. Two measures are HAI measures and the other three are cancer process of care measures. The two HAI measures will be NHSN CLABSI Outcome Measure and NHSN CAUTI Outcome Measure. CMS proposed these measures because it believes the measures support patient safety and safer care. The measures were identified as high-priority issues for PPS-exempt cancer hospitals as they have potential to promote improved outcomes and they align with other quality reporting programs already in existence. Collection of data on these measures will be through the NHSN, a secure, Internet-based surveillance system maintained and managed by the CDC.

The three cancer-specific measures are:

- Adjuvant chemotherapy is considered or administered within four months (120 days) of surgery to patients under age eighty with AJCC III (lymph node positive) colon cancer;
- Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under age seventy with AJCC T1c or Stage II or III hormone receptor negative breast cancer; and
- Adjuvant hormonal therapy.

While data from these measures is not currently collected by any HHS program, it is reported by a significant number of PPS-exempt cancer hospitals who are accredited by the American College of Surgeons Commission on Cancer. The measures only assess
if the specific process referenced in the measure was performed. This information will be reported directly to a CMS contractor who will compile the data and send reports to CMS.

CMS through future rulemaking intends to propose other measures that help further its goal of “achieving better healthcare and improved health for Medicare beneficiaries who obtain cancer services.” This approach promotes better cancer care and brings PPS-exempt cancer hospitals quality reporting in line with CMS’ other quality reporting initiatives.

Section 1866(k)(4) of the Act also requires the Secretary to establish procedures for making submitted data publicly available. CMS proposed and finalized using the Hospital Compare Website for this purpose. PPS-exempt cancer hospitals will have thirty days to review their own data prior to that data being made public.

To participate in the PCHQR Program for FY 2014 and future years, PPS-exempt cancer hospitals must:

1. Register with QualityNet prior to reporting, regardless of the method used for data submission.

2. Identify a QualityNet Administrator(s) who will follow the registration process located on the QualityNet website.

3. Complete the online Data Accuracy and Completeness Acknowledgement (DACA) via QualityNet.

4. Enroll in CDC/NHSN and register with the CMS contractor collecting the cancer-specific measures prior to reporting.
CMS also strongly encourages PPS-exempt cancer hospitals to complete an online Notice of Participation through QualityNet to inform and educate themselves about the program and other related requirements.

Reporting mechanisms for the five measures will be slightly different. Data for the HAI will be reported initially for only one quarter, the first quarter of 2013. This information must be submitted to NHSN by August 31, 2013, and will be considered the FY 2014 submission. Once the submission deadline passes, NHSN will calculate the necessary statistical information and report that to CMS. The three cancer-specific measures will be submitted to the CMS contractor beginning with the FY 2014 program. The reporting period for these measures will begin January 1, 2013, with data due November 15, 2013, for two of the measures (Adjuvant chemotherapy is considered or administered within four months (120 days) of surgery to patients under age eighty with AJCC III (lymph node positive) colon cancer; Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under age seventy with AJCC T1c or Stage II or III hormone receptor negative breast cancer). For the measure Adjuvant hormonal therapy the deadline for data submission will be May 15, 2014, because this measure includes an assessment of the twelve-month therapeutic effect from the time of diagnosis to hormonal therapy. The CMS contractor will calculate the measure rates and submit that information to CMS. For all future years, data submission will be required on a quarterly basis for all five measures.

CMS will require all PPS-exempt cancer hospitals acknowledge the data accuracy and completeness of their data annually by submitting an electronic acknowledgement. This annual acknowledgement begins with FY 2015, but requires the acknowledgement to be submitted no later than August 31, 2014. CMS' reasoning behind requiring the acknowledgement by August 31 preceding the respective PCHQR Program year is it gives CMS time to ensure compliance with the Program by the start of the next FY (October 1) and this deadline aligns with other quality reporting deadlines.
VIII.C. Hospital VBP Program (Fed. Reg. 53567-53614).

The ACA required the establishment of a Hospital VBP program under which value-based incentive payments are made in a FY to hospitals that meet performance standards established for a performance period during such FY.\textsuperscript{48} The hospital VBP Program applies to payments for hospital discharges on or after October 1, 2012.

The 2013 final rule set forth the methodology for calculating payments made to hospitals pursuant to the VBP program. The measurement criteria for the VBP program will be posted to the Hospital Compare website at least one year prior to the beginning of the performance period.\textsuperscript{49} For FY 2014, CMS adopted 17 measures for the Hospital VBP program.

CMS codified many of the VBP requirements, including the finalization of the definition of “base operating DRG payment amount” as the wage-adjusted DRG payment plus any applicable new technology add-on payments, but excluding outlier, IME, DSH, and low-volume payment adjustments. CMS also finalized the definition of “wage-adjusted DRG operating payment” as the applicable average standardized adjustment for: (1) resource utilization by the applicable MS-DRG relative weight; (2) differences in geographic costs by the applicable area wage index; and (3) an applicable transfer under 42 C.F.R. § 412.4(f).\textsuperscript{50} CMS adopted a specific definition of base operating DRG payment amounts applicable to SCHs and MDHs in the final rule as well.

CMS also codified the criteria for exclusion from the VBP program based on “immediate jeopardy” citations. Under the ACA, if a hospital has been cited for deficiencies that pose immediate jeopardy to the health or safety of patients, it will be excluded from

\textsuperscript{48} Social Security Act § 1886(o).
\textsuperscript{49} 42 C.F.R. § 412.164.
\textsuperscript{50} 42 C.F.R. § 412.160.
participation in the VBP program. CMS finalized its policy to consider only those immediate jeopardy citations noted on Form CMS-2567 issued to a hospital based on a federal survey. Because the statute uses the plural word “deficiencies,” only if a hospital receives two such Form CMS 2567s noting immediate jeopardy during a performance period will it be excluded from the VBP program.

In the 2013 Final Rule, CMS established the use of the December and March prior year MedPAR data sets to estimate the total amount of the reductions for all eligible hospitals and the available funding pool for the value-based incentive payments under the VBP program. The estimated payment available for FY 2013 value-based incentive payment is $917 million.

The 2013 Final Rule codified a review and corrections process that will enable hospitals to review and submit corrections with respect to their performance on each condition, their performance on each domain, and their Total Performance Score (TPS). Hospitals will have thirty days to review their confidential claims based reports and their TPS Reports and submit their corrections through Quality Net. The review and corrections process may not be used to reconsider a hospital’s participation in the VBP program.

In order for a hospital to appeal its calculated performance assessment, standards, and score, a hospital must first submit corrections through the review and corrections process. A hospital may not appeal the methodology used to calculate the incentive payment, amount of funding available, performance measures, or the methodology to calculate performance scores. Appeals are effectively limited to technical errors. The 2013 Final Rule sets forth the time line for the appeal process, and the information that must be included in a hospital’s appeal.

---

51 42 C.F.R. § 412.160.
52 42 C.F.R. § 412.163.
53 42 C.F.R. § 412.167.
In the 2013 Final Rule, CMS added new VBP measures for FY 2015. The new measures include the following two “outcome measures”:

(1) **CLABS1**, an HAI measure that assesses the rate of bloodstream infection or clinical sepsis among ICU patients. CMS adopted the CDC’s minimum case criteria for this measure.

(2) Complication/patient safety for selected indicators (PSI-90), a composite measure developed by AHRQ. CMS adopted AHRQ’s three case minimum criteria.

For FY 2015, CMS also adopted an “efficiency domain” that includes the Medicare Spending per Beneficiary (MSB) measure. The MSB measure will include Part A and Part B payments from three days prior to an admission through thirty-day post discharge with certain exclusions. The measure will be risk-adjusted for age, severity of illness, comorbidities and will be standardized to remove difference in geographic payment adjustments and other payment factors.

CMS finalized the FY 2015 performance period and baseline period for the domain measures. The performance data for the Medicare Spending per Beneficiary measure was posted on the Hospital Compare website on April 19, 2012. Because the ACA requires that all measures included in the Hospital VBP program (other than readmission measures) be selected from those specified under the IQR program for at least a year, the performance period for the MSB measure will not begin until May 1, 2013. The final performance and baseline periods for all of the FY 2015 measures are:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
</table>
The domain weights for the FY 2015 Hospital VBP Program are:

| Domain Weight for the FY 2015 Hospital VBP Program for Hospitals Receiving a Score on All Proposed Domains |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| Domain                                          | Weight                                          |
| Clinical Process of Care                        | 20%                                             |
| Patient Experience of Care                      | 30%                                             |

The domain weights for the FY 2015 Hospital VBP Program are:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>October 1, 2010-June 30, 2011</td>
<td>October 1, 2012-June 30, 2013</td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary-1</td>
<td>May 1, 2011-December 31, 2011</td>
<td>May 1, 2013-December 31, 2013</td>
</tr>
</tbody>
</table>
Domain Weights for the FY 2015 Hospital VBP Program for Hospitals Receiving a Score on All Proposed Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>30%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>20%</td>
</tr>
</tbody>
</table>

For FY 2016, CMS opted not to finalize its proposal to reclassify the VBP measures into the following six domains to mirror the NQFs: Clinical Care; Person and Caregiver – Centered Experience and Outcomes; Safety; Efficiency and Cost Reduction; Care Coordination; and Community and Population Health.

VIII.D. Long Term Care Hospital Quality Reporting (LTCHQR) Program (Fed. Reg. 53614-53660).

Background

In accordance with Section 1886(m)(5) of the Act, as added by Section 3004 of the ACA, the Secretary established the LTCHQR Program. Under this program, for rate year (RY) 2014 and each subsequent rate year, a LTCH that does not submit data to the Secretary in accordance with Section 1886(m)(5)(C) of the Act with respect to such rate year, will suffer a 2% reduction during the RY of any annual update to the standard federal rate for discharges for the hospital. The NQF currently holds the contract that endorses measures that will be selected by the Secretary as quality measures for the LTCHQR Program.

Retention of LTCHQR Program Measures Adopted in Previous Payment Determinations

Of importance, the FY 2013 final rule finalizes CMS’ policy that once a quality measure is adopted, it is retained for use in subsequent FY payment determinations, unless
otherwise stated. As with the Hospital IQR program, rulemaking will continue to be used to adopt substantial changes to quality measures. CMS believes this policy will help streamline the rulemaking process and that, in most cases, the comment process during the year CMS initially proposes to adopt a measure is sufficient to identify any potential problems with the measure. This subregulatory process allows for the incorporation of non-substantive updates made by the NQF into the measure specifications CMS has adopted for the LTCHQR Program, thus ensuring the measures remain up to date.

**CLABSI, CAUTI, and Pressure Ulcer Measures**

In the FY 2012 IPPS/LTCH PPS final rule, CMS adopted three quality measures for FY 2014 payment determinations as listed below:

| Previously Finalized LTCHQR Quality Measures for the FY 2014 Payment Determination |
|---------------------------------|-----------------------------------------------------------------------------------|
| NQF #0138 | Urinary CAUTI rate per 1,000 urinary catheter days for ICU Patients |
| NQF #0139 | CLABSI Rate for ICU and High-Risk Nursery (HRN) Patients |
| NQF #0678 | Percent of Residents with Pressure Ulcers that are New or Worsened (Short-Stay) |

In the FY 2013 final rule, CMS finalizes the use of the data collection and submission methods for the CAUTI, CLABSI and Pressure Ulcer measures for the LTCHQR Program. CMS also states that it will continue these three measures into FY 2015 and 2016.

**Five Additional LTCHQR Program Quality Measures Beginning With the FY 2015 Payment Determination**

In the FY 2013 proposed rule, for the FY 2015 payment determination and subsequent FY payment determinations, CMS proposed to adopt five additional quality measures
for the LTCHQR Program in addition to the CAUTI, CLABSI, and Pressure Ulcer measures. These proposed measures are as follows:

<table>
<thead>
<tr>
<th>Proposed New Quality Measures for FY 2016 LTCHQR Program Payment Determination and Subsequent Payment Determinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF #0680</td>
</tr>
<tr>
<td>NQF #0682</td>
</tr>
<tr>
<td>NQF #0431</td>
</tr>
<tr>
<td>NQF #0302</td>
</tr>
<tr>
<td>Not NQF Endorsed</td>
</tr>
</tbody>
</table>

After assessing and responding to public comments on the proposed adoption of these five additional quality measures, CMS ultimately decided to proceed as follows with respect to the quality measures:

1. After consideration of the public comments and in light of the recent NQF endorsement approval for the expansion of the measure to the LTCH setting, CMS finalized the Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (NQF #0680) for the FY 2016 payment determination and subsequent payment determinations;

2. Because the CDC has advised that the Advisory Committee on Immunization Practices (ACIP) guidelines for adult and pediatric pneumococcal vaccination are currently being re-evaluated, and the measure specifications might change as a result, CMS did not finalize the Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (NQF #0862) at this time;
3. After consideration of the public comments it received, CMS finalized the Influenza Vaccination Coverage among Healthcare Personnel quality measure (NQF #0431) for FY 2016 payment determinations and subsequent FYs;

4. After consideration of the public comments it received and in light of the withdrawal of this measure from the NQF re-endorsement process, CMS did not finalize the Ventilator Bundle measure (NQF #0302) for the LTCHQR Program at this time; and

5. After consideration of the public comments it received, CMS did not adopt the Restraint Rate per 1,000 Patient Days in the LTCHQR Program.

Public Display of Data Quality Measures

While Section 1886(m)(5)(E) of the Act requires the Secretary to establish procedures for making any quality data submitted by LTCHs available to the public, CMS did not propose procedures or timelines for public reporting of LTCHQR Program data in the FY 2013 proposed rule. CMS will presumably take this up in future rulemaking.

VIII.E. Quality Reporting Requirements Under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program (77 Fed. Reg. 53637-53644).

Background Information

The 2012 Outpatient Prospective Payment System (OPPS)/ASC final rule established the ASC Quality Reporting (ASCQR) Program, with implementation beginning with the CY 2014 payment determination. At that time, CMS indicated that the FY 2013 IPPS/LTCH rulemaking process would be used to further address elements of the program regarding administrative requirements, date validation, and reconsiderations and appeals, amongst other things. CMS stated that its reasoning was based on the fact that the FY 2013 proposed rule is scheduled to be finalized earlier and before data
collection for the CY 2014 payment determination, which is to begin with services furnished on October 1, 2012.

**Reporting Requirements Under the ASCQR Program**

In the 2013 Final Rule, CMS finalizes its proposals without modification that ASCs must identify and register a QualityNet administrator who follows the registration process on the QualityNet website and submits the information as specified on that website. Moreover, ASCs must have a QualityNet administrator at the time facilities submit structural measure data in 2012 for the CY 2015 payment determination, which is no later than August 15, 2013. The FY 2013 final rule also ensures that once an ASC submits any quality measure data, it is considered as participating in the ASCQR Program.

**Requirements Regarding Form, Manner, and Timing for Claims-Based Measures for CYs 2014 and 2015 Payment Determination**

In CY 2012 OPPS/ASC final rule, CMS confirmed that, to be eligible for the full CY 2014 ASC annual payment update, an ASC must submit complete data on the individual quality measures through a claims-based reporting mechanism by submitting the appropriate Quality Data Codes (QDCs) on the ASC’s Medicare claims. The FY 2013 final rule confirms that claims for services furnished between October 1, 2012, and December 31, 2012, would have to be paid by the administrative contractor by April 30, 2013, to be included in the data used for the CY 2014 payment determination.

In the CY 2012 OPPS/ASC final rule, CMS also finalized that data completeness for claims-based measures would be determined by comparing the number of claims meeting measure specifications that contain the appropriate QDCs with the number of claims that would meet measure specifications, but that did not have the appropriate QDCs on the submitted claim. The FY 2013 IPPS/LTCH PPS proposed rule proposed that for CY 2014 and CY 2015, the minimum threshold for successful reporting is at
least 50% of the claims meeting measure specifications containing QDCs. The 2013 Final Rule adopts this proposal.

Also in the FY 2013 Final Rule, CMS implemented procedures for extraordinary circumstances in which an extension or waiver request would be granted for the submission of information required under the ASCQR program. This is consistent with CMS’ stated policy of not penalizing entities for such circumstances that would unduly increase facilities’ burdens during this time.


Background

Section 1886(s)(r) of the Act, as amended by Sections 3401(f) and 10322(a) of the ACA, requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. For RY 2014 and each subsequent rate year, any inpatient psychiatric hospital or psychiatric unit that does not comply with quality data submission requirements will suffer a decrease of 2.0 percentage points each rate year. In the final rule, CMS finalizes the policy for application of the payment reduction to the annual update of the standard federal rate for failure to report quality data for FY 2014 and subsequent years as proposed.

Quality Measures Beginning with FY 2014 Payment Determination and Subsequent Years

In the FY 2013 IPPS/LTCH PPS proposed rule, CMS proposed to adopt six (6) quality measures for FY 2014 and subsequent FYs. These six Hospital-Based Inpatient Psychiatric Services (HBIPS) measures are currently in use by an estimated 450 inpatient psychiatric facilities that are accredited by The Joint Commission, thereby posing minimal collection burden for these facilities. The six HBIPS measures and their statuses under the final rule are as follows:
1. Hours of Physical Restraint Use (HBIPS-2) – finalized for the FY 2014 payment determination and subsequent years;

2. Hours of Seclusion Use (HBIPS-3) – finalized for the FY 2014 payment determination and subsequent years;

3. Patients Discharged on Multiple Antipsychotic Medications (HBIPS-4) – finalized for the FY 2014 payment determination and subsequent years;

4. Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) – finalized for the FY 2014 payment determination and subsequent years;

5. Post-Discharge Continuing Care Plan Created (HBIPS-6) – finalized for the FY 2014 payment determination and subsequent years; and

6. Post-Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider upon Discharge (HBIP-7) – finalized for the FY 2014 payment determination and subsequent years.

CMS finalized these six HBIPS quality measures to be reported in aggregate form for FY 2014 and subsequent years. Measures adopted for the IPFQR Program will remain in the quality program for all subsequent years unless specifically stated otherwise.

**MedPAC Recommendations and Other Related Studies and Reports for the IPPS and the LTCH PPS (Fed. Reg. 53660 - 53664)**

Section 1886(e)(4)(B) of the Act requires CMS to consider MedPAC’s recommendations regarding hospital inpatient payments. CMS’ comments in the 2013 Final Rule focus on MedPAC’s suggested reforms to the wage index system and contrasts those recommendations to the recommendations submitted by Secretary Sebelius to Congress on April 11, 2012. The report submitted by the Secretary was titled “Report to Congress—Plan to Reform the Medicare Hospital Wage Index” and described the concept of a Commuting Based Wage Index (CBWI) as a potential replacement to the
current Medicare wage index methodology. In the 2013 Final Rule, CMS responded to MedPAC’s criticisms of CMS’ reform proposal. In addition, CMS noted that the “AHA anticipates issuing a report on the subject by early 2013” and stated that it “look[s] forward to reviewing the findings of the upcoming AHA report.” CMS also provided a useful chart comparing the current wage index system against the various reform proposals from CMS, MedPAC, and IOM.

Quality Improvement Organization (QIO) Regulation Changes Related to Provider and Practitioner Medical Record Deadlines and Claims Denials (Fed. Reg. 53664 - 53665)

In the final rule, CMS noted that “QIOs have historically experienced difficulty in obtaining medical information in a timely manner from providers and even more difficulty obtaining this information in a timely manner from practitioners.” Several of the relevant QIO regulations specifically mention providers but do not also mention practitioners. For example, 42 C.F.R. § 476.90(b) “limits the QIO’s authority to deny claims to providers for failing to respond to a QIO’s request for information, [but] no similar provision exists for practitioners.” CMS, therefore, finalized its proposal to revise the relevant QIO regulations defining the term “providers” while adding references to “practitioners” as well.