Medicare Inpatient Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2015

Overview, Resources, and Comment Submission

On May 15, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2015 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes proposed by CMS and legislative changes previously adopted by Congress. Among other regular updates and policy changes, the rule includes policies that would:

- Change the Core-Based Statistical Area (CBSA) delineations for FFY 2015 and beyond—directly impacting the Medicare wage index and other factors used for payment purposes under the IPPS;
- Implement new payment penalties for non-compliance with the Electronic Health Record (EHR) Incentive Program; and
- Implement the first year of the Affordable Care Act (ACA)-mandated Hospital-Acquired Condition (HAC) Reduction Program and update the program rules for the Value-Based Purchasing (VBP) and the Readmissions Reduction Programs.

Also of note, the rule would require hospitals to make charge data is publicly available, solicits industry input on steps towards establishing a new short-stay payment policy, and updates the ACA-mandated Medicare Disproportionate Share Hospital (DSH) payment policies.

Outside of the IPPS directly, the rule would: modify policies related to provider reimbursement appeals; update aspects of the EHR Incentive Program's quality reporting requirements; change the enforcement procedures for organ transplant centers; update/revise the reasonable compensation equivalent limits for services furnished by physicians to teaching hospitals excluded from the IPPS; update payment rates for hospitals excluded from the IPPS; update the quality reporting program for cancer hospitals; update the payment rates/policies for long-term care hospitals; and expand the allowable uses of Medicare Advantage risk adjustment data.

A brief summary of the major hospital IPPS sections of the proposed rule is provided below. Program changes adopted by CMS would be effective for discharges on or after October 1, 2014 unless otherwise noted. Comments on all aspects of the proposed rule are due to CMS by Monday, June 30 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1607-P."

A copy of the proposed rule *Federal Register* (FR) and other resources related to the IPPS are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html.

An online version of the rule is available at https://federalregister.gov/a/2014-10067.

PPS Payment Rates

FR pages 28,086-28,088 and 28,313-28,325

Incorporating the proposed updates and the effects of budget neutrality adjustments, the table below lists the full federal operating and capital rates for FFY 2015 compared to the rates currently in effect:

	Final FFY 2014	Proposed FFY 2015	Percent Change
Federal Operating Rate *	**$5,370.28**	**$5,401.52**	**+0.58%**
Federal Capital Rate	**$429.31**	**$433.01**	**+0.86%**

* The federal operating rate proposed for FFY 2015 includes a significant budget neutrality reduction for MS-DRG recalibration. CMS has issued a correction to the proposed DRG weights for FFY 2015 and it is anticipated that the budget neutrality impact to the rate would be reduced for the final rule. Also, the operating rates shown reflect the full rates prior to any reductions for non-compliance under the IQR Program and EHR Incentive Program (see additional detail below).

The table below provides details and compares the proposed updates for the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2015. Additional detail on other factors affecting the payment rates/rate updates is provided below:

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	**+2.7%**	**+2.7%**	**+1.5%**
ACA-Mandated Reductions (0.4% productivity reduction and 0.2% pre-determined reduction)	**-0.6%**	**-0.6%**	**—**
American Taxpayer Relief Act (ATRA)-Mandated Retrospective Coding Adjustment Reduction	**-0.8%**	**—**	**—**
Rate Update (EXCLUDING BUDGET NEUTRALITY)	***+1.3%***	***+2.1%***	***+1.5%***

- **Effect of Budget Neutrality *(FR pages 28,324-28,325)*:** CMS must ensure that changes to the IPPS are budget neutral; meaning program expenditures do not increase or decrease based on changes proposed/adopted by CMS. Typically, budget neutrality adjustments have very little effect on the payment rates from year-to-year. However, this year's application of budget neutrality adjustments, as proposed, reduces the +1.3% update to the federal operating rate to an effective update of +0.58%. The main driver of the negative budget neutrality adjustment is the impact of the proposed updates to the Medicare-Severity Diagnosis Related Group (MS-DRG) payment weights. CMS recently published a correction to the proposed DRG payment weights and it is expected that the DRG budget neutrality factor would be reduced in the final rule. The hospital-specific and capital rates are also influenced by budget neutrality.
- **Effect of the IQR and EHR Incentive Programs *(FR pages 28,086-28,088 and 28,344)***: For the first time, the value of the MB update for hospitals will be tied to participation in both the IQR and the EHR Incentive Programs. Currently, the value of the MB update is only impacted by participation in the IQR Program. Beginning FFY 2015, the IQR MB penalty will shift from the traditional -2.0 percentage points to 25% of the full MB and a new EHR MB penalty of 25% of the full MB will begin. The EHR MB penalty will increase to 50% of the MB in FFY 2016 and 75% of the MB in FFY 2017 while the IQR penalty will hold constant at 25%. As designed, by FFY 2017, the full MB update will be at risk under these two programs before any ACA, coding, or other reductions are applied to the MB update/rate. This new penalty construct mandated by law will create 4 update scenarios for FFY 2015 and beyond. A CMS table that shows the various update scenarios for FFY 2015 is available on FR page 28,087. CMS has not yet finalized the list of hospitals that will be penalized under the IQR and/or EHR Incentive Programs but plans to release a list of hospitals to be penalized in the fall of 2014. Generally, successful participation in both programs is based on data collection two years prior to the payment adjustment year.
- **Retrospective Coding Adjustment *(FR pages 27,995-27,998)*:** CMS is proposing to apply a retrospective coding adjustment of -0.8% to the federal operating rate in FFY 2015. This rate reduction was authorized as part of the ATRA and requires inpatient payments to be reduced by $11 billion (or -9.3%) over a 4-year period. To

meet the ATRA requirements, CMS applied a -0.8% coding adjustment for FFY 2014 and is expected to apply similar reductions in FFYs 2016 and 2017. Because retrospective coding adjustments are one-time adjustments that are not permanently built into the rates, CMS will eventually adjust the federal operating rate upward through a positive adjustment (equivalent to the negative adjustments applied; anticipated to be +3.2%) once the $11 billion is fully recouped. The positive adjustment to "reset" the rates is anticipated in FFY 2018. CMS considered, but did not propose any additional documentation and coding adjustments beyond the adjustment mandated by the ATRA.

- **2-Midnight Rule Reduction** ***(no FR page reference)*****:** For FFY 2014, CMS applied a -0.2% reduction to the federal operating, hospital-specific, and federal capital rates to maintain program budget neutrality related to the implementation of the new 2-midnight policy (see additional policy details below). CMS is not proposing any changes to this policy for FFY 2015 and the -0.2% reduction will remain in the rate unless/until CMS actively makes a change to this policy.
- **Effect of Sequestration** ***(no FR page reference)*****:** While the proposed rule does not specifically address the 2.0% sequester reductions to all Medicare payments authorized by Congress and currently in effect through FFY 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and EHR incentives are also affected by the sequester reductions. Payments from Medicare Advantage plans should not be automatically impacted by sequester.

Wage Index
FR pages 28,054-28,084

CMS is proposing several changes that would affect the wage index and wage index-related policies for FFY 2015 and beyond. Of most significance, CMS is proposing updates to the CBSA delineations, the labor-markets that define a hospital's Medicare wage index. CMS is not proposing any major changes to the standard calculation of Medicare hospital wage indexes, the rural floor budget neutrality policy, the imputed rural floor methodology, the current Medicare Geographic Classification Review Board (MGCRB) administrative reclassification rules, or the cost-of-living adjustments applicable to hospitals in Alaska and Hawaii. The CBSA changes and other notable wage index-related items are detailed below:

- **CBSA Delineation Changes** ***(FR pages 28,054-28,064)*****:** CMS' proposed changes to the CBSA delineations would have a direct impact on the Medicare wage index and other factors used for payment purposes under the IPPS. CMS last updated the CBSA delineations in FFY 2005 (based on the 2000 Census). The CBSA changes proposed for FFY 2015 (based on the 2010 Census) are not as substantial as those made in FFY 2005 in terms of changes in the geographic make-up of the labor-market areas. However, under the new delineations there would be:
    - newly created CBSAs;
    - urban counties that would become rural;
    - rural counties that would become urban; and
    - existing CBSAs that would be split apart or incorporate additional counties.

  The new delineations would also have an effect on:
    - hospital reclassifications under the MGCRB;
    - the treatment of hospitals with Lugar status;
    - hospitals that reclassify as rural; and
    - the applicability of the out-migration adjustment.

  The proposed CBSA changes would have both positive and negative impacts on IPPS payments to hospitals. To mitigate negative impacts, CMS is proposing a 1-year transitional wage index for **ANY** hospital that experiences a wage index decrease (post-reclassified value) due solely to the new CBSA delineations (estimated to be about 670 hospitals). The transition value would be for FFY 2015 only, using FFY 2015 wage data, with 50% based on the current CBSA delineations and 50% based on the new CBSA delineations (the out-migration adjustment would apply after the 50/50 blend is calculated). The transitional wage index would expire for FFY 2016. At that point, the wage index values would be fully based on the new CBSA delineations. In very limited circumstances (urban to rural change that effects geographic location or Lugar status), CMS is proposing a 3-year transition to the new wage index.

Hospitals should be vigilant in reviewing their hospital-specific wage index value and wage index circumstance for FFY 2015 and beyond; especially hospitals receiving a transitional wage index, those with MGCRB reclassifications, hospitals that may lose rural/urban status, and those that have a change in Lugar status. Hospitals should ensure that they are receiving the most advantageous wage index for FFY 2015. In reviewing the wage index, hospitals should utilize FFY 2014 and FFY 2015 wage index information in the IPPS Impact Files and wage index tables 2, 4A/4B (home CBSA values), 4C (reclassified values), 4J (out-migration adjustments), 9A/9C (reclassified hospitals and CBSAs). These tables are available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html.

- **Labor-Related Share *(FR pages 28,083-28,084)*:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2015, CMS is proposing to continue applying a labor-related share of 69.6% for hospitals with a wage index greater than 1.0. By law, the labor-related share for hospitals with a wage index less than 1.0 will remain at 62%.

- **FFY 2016 Wage Index Reclassification Applications *(FR pages 28,074-28,075)*:** Applications for FFY 2016 wage index reclassifications are due to the MGCRB by September 2, 2014. Reclassification requests for FFY 2016 would be based on the new CBSA delineations proposed for FFY 2015. Applications and other information regarding MGCRB reclassifications are available on the CMS website at http://www.cms.gov/MGCRB/.

- **New Occupational Mix Survey for FFY 2016 *(FR page 28,067)*:** CMS is required to include an occupational mix adjustment in its calculation of the hospital wage index. This adjustment is intended to neutralize the effect of employee mix, resulting in a decreased wage index for hospitals with higher skill mixes and an increased wage index for hospitals with lower skill mixes. As required by law, CMS must perform a new measurement of occupational mix for the FFY 2016 wage indexes. Hospitals must submit their 2013 occupational mix surveys to their Medicare Administrative Contractors (MACs) by July 1, 2014. The new 2013 survey collects hospital-specific wage and hour data for calendar year (CY) 2013 (the current data is from CY 2010). The 2013 survey tool is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/WAGE-INDEX-OCCUPATIONAL-MIX-SURVEY2013.pdf.

- **New Wage Index Development Timetable for FFY 2016 and Beyond *(FR pages 28,082-28,083)*:** Each year, CMS takes on a three-part process to refine unaudited wage and occupational mix data to develop the upcoming year's Medicare wage index. This process is critical for hospitals to ensure accurate data is considered by CMS. CMS is proposing changes to the timeline for FFY 2016 and beyond to improve the data review process. Of most significance, CMS is moving the first data review period back by 4 months (from September back to May). This change will allow hospitals more time to review and make corrections to their data and additional time for MACs to validate the data. The FFY 2016 wage index development timeline is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2016-Tentative-Hospital-Wage-Index-Development-Time-Table.pdf.

Quality-Based Payment Adjustments

FR pages 28,105-28,144

For FFY 2015, based on previously established and newly proposed program rules, IPPS payments to hospitals will be adjusted for historic quality performance under the VBP Program, Readmissions Reduction Program, and, for the first time, the HAC Reduction Program. The following provides detail on the FFY 2015 programs and payment adjustment factors (future program year program changes are addressed at the end of this document):

- **VBP Adjustment *(FR pages 28,117-28,118)*:** The FFY 2015 program will evaluate hospital quality data in 4 areas: process of care; patient experience of care; patient outcomes; and efficiency (for 19 measures measures, up from 3 domains and 17 measures in the current year). By law, the VBP Program must be budget neutral and the FFY 2015 program will be funded through a 1.5% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.4 billion). The FFY 2014 program is currently being funded through a 1.25% reduction in IPPS payments. Because the program is budget neutral, hospitals have an opportunity to earn back some, all, or more than the 1.5% reduction in payments used to fund the program. While the data applicable to the FFY 2015 program is still being finalized, CMS has calculated and published proxy factors based on current year program performance. Hospitals should use caution in reviewing these factors as they do not consider hospital performance on the new outcomes and efficiency measures for FFY 2015 and do not calculate factors for hospitals that may be part of the VBP Program under changes that have expanded eligibility. The proxy factors published with the proposed rule are available in Table 16 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html. CMS anticipates making actual FFY 2015 VBP adjustment factors available in October 2014. Details and information on the program currently in place for FFY 2015 and FFY 2016 program are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

- **Readmissions Adjustment** ***(FR pages 28,105-28,108 and 28,112-28,117)*****:** The FFY 2015 program will increase the number of readmissions condition areas evaluated from 3 to 5. In addition to the current acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN) measures, this year's program will evaluate readmissions for patients admitted for chronic obstructive pulmonary disease (COPD) and elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). CMS is proposing a slight refinement to the algorithm adopted last year to better account for planned/unplanned readmissions. This proposal would slightly increase the nationwide readmissions rates for HF, PN, and THA/TKA. Unlike the VBP Program, the Readmissions Reduction Program is not budget neutral. Hospitals can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 3.0% (up from 2.0% in the current year). This capped reduction amount will remain at 3.0% for future program years. As a result of the measure expansion along with the higher capped reduction amount, CMS estimates that the FFY 2015 program would cut about $422 million from IPPS payments (up from about $227 million in the current year). While the data applicable to the FFY 2015 program is still being finalized, CMS has calculated and published proxy adjustment factors. Unlike the VBP proxy factors, the Readmissions Reduction Program proxy factors take into consideration performance on all program measures and provide a good assessment of relative performance and potential exposure. The proxy factors published with the proposed rule are available in Table 15 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html. It is anticipated that CMS will make actual FFY 2015 adjustment factors available in August 2014 with the final rule. Details and information on the program currently in place is available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.
- **HAC Adjustment** ***(FR pages 28,134-28,142)*****:** The FFY 2015 program will evaluate hospital performance on 3 measures: Patient Safety Indicator (PSI)-90—a composite of 8 individual HAC measures, Central Line-Associated Bloodstream Infection (CLABSI), and Catheter-Associated Urinary Tract Infection (CAUTI). Similar to the Readmissions Reduction Program, the HAC Reduction Program is not budget neutral. By law, hospitals with a Total HAC Score— as calculated under the adopted polices—that fall within the top quartile (the worst performing quartile) for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. CMS estimates that the FFY 2015 program would cut about $330 million from IPPS payments. Because the 1.0% reduction factor is not scheduled to increase in future years, the IPPS cut should remain around $300-$400 million each year going forward. While the data applicable to the FFY 2015 program is still being finalized, CMS has calculated and published list of hospitals that could potentially be subject to the program penalty. Similar to the validity of the Readmissions Reduction Program proxy factors, the list of potentially penalized hospitals under the HAC Reduction Program takes into consideration performance on all program measures and provides a good assessment potential exposure. The proxy factors published with the proposed rule are available in Table 17 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html. It is anticipated that CMS will make actual FFY 2015 adjustment factors available in August 2014 with the final rule.

DSH Payments

FR pages 28,094-28,104

The ACA requires the implementation of new Medicare DSH payment policies that reduce and redistribute DSH funding when compared to the traditional DSH payment methodology. Under the law, 25% of estimated DSH funding under the traditional formula will continue to be paid to each DSH-eligible hospital under that formula. The remaining 75% is reduced to reflect the impact of insurance expansion under the ACA and is then redistributed to hospitals as a new and separate uncompensated care (UCC) payment based on each hospital's ratio of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2015** ***(FR pages 28,094-28,104)*****:** CMS is not proposing to make any major changes to the DSH payment policies for FFY 2015 when compared to the current year program. The following schematic describes the new DSH payment methodology mandated by the ACA along with how the program is proposed to change from FFY 2014 to FFY 2015 with a specific focus on 3 key payment methodology factors: Factor 1 (program funding); Factor 2 (program reductions); and Factor 3 (hospital-specific UCC factor/payments):

1. Project DSH-eligible hospitals using traditional DSH formula (15% DPP or more) and project total DSH payments for the nation using traditional per-discharge formula.

- **$14.205 B (proposed); $12.791 B (FFY 2014)**
- **Includes adjustments for inflation, utilization, and case mix changes**
- **Fixed amount once adopted — re-estimated each year**

2. Continue to pay traditional DSH at 25% of current DSH adjustment value

- **$3.551 B (proposed); $3.198 B (FFY 2014)**
- **Will fluctuate based on hospital-specific utilization changes**
- **Pay on per-discharge basis**

3a. (<u>FACTOR 1</u>) Take 75% of total DSH payments to fund UCC payments

- **$10.654 B (proposed); $9.593 B (FFY 2014)**
- **Fixed amount once finalized**

3b. (<u>FACTOR 2</u>) Adjust amount for UCC payments to reflect impact of ACA insurance expansion

- **$8.561 B (19.64% cut—proposed); $9.046 B (5.7% cut—FFY 2014)**
- **$485 M reduction compared to FFY 2014 UCC pool**
- **Fixed amount once finalized**
- **Based on latest CBO projections of insurance expansion**

3c. (<u>FACTOR 3</u>) Distribute amount for UCC payments to each DSH-eligible hospital based on hospital's ratio of UCC relative to the total for all DSH-eligible hospitals

- **UCC factor = Medicaid days + Medicare SSI days (same as FFY 2014)**
- **Based on 2011/2012 data (proposed); 2010/2011 data (FFY 2014)**
- **Combines days data for mergers for calc. of Factor 3 (new for FFY 2015)**
- **Pay on per-discharge basis (same as FFY 2014)**

4. Cost report settlement

- **Determine actual DSH eligibility at cost report settlement**
- **Reconcile 25% traditional DSH per-discharge payment based on actual program year cost report data**
- **Reconcile UCC per-discharge payment to ensure value paid out = hospital-specific value identified by CMS during rulemaking process**
- **Do not update nationwide value of UCC payment amount or hospital-specific UCC factors (unless merger occurs) – these data are fixed once finalized by CMS**
- **Recoup both 25% traditional DSH payment and UCC payment if projected by CMS to be DSH-eligible, but ultimately determined to be ineligible at cost report settlement**
- **Pay both 25% traditional DSH payment and UCC payment if not determined to be DSH-eligible until cost report settlement**

As identified in the schematic above, overall traditional DSH dollars that drive the payment methodology increase by $1.4 billion (box 1). However, due to the mandated payment reduction policies, DSH dollars available for distribution from the UCC pool would decrease by $485 million when compared to the current year pool (box 3b). This pool is expected to see additional reductions in the coming years as insurance coverage rates are expected to increase.

- **Eligibility for FFY 2015 DSH Payments** ***(FR pages 28,096-28,097)*****:** Based on analysis of the most recent cost report and claims data available, CMS is projecting that 2,368 hospitals would be eligible for DSH payments in FFY 2015. This projection is significant because under the DSH payment policies, hospitals identified as DSH-eligible would be paid as such during FFY 2015. CMS has made a file available on its website that includes DSH eligibility status. The file also includes the UCC factors/payment amounts and other data critical to the DSH payment methodology. The file is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html.
- **Impact of the New CBSA Delineations on DSH Payments** ***(FR pages 28,063-28,064)*****:** Under the new CBSA delineations, a hospital's DSH payments may be impacted by the loss of urban status. If DSH payment would be impacted by the loss of urban status, CMS would provide a 2-year transition from the urban DSH payment amount to the new DSH payment amount based on rural status.
- **Future Use of Data from Cost Report Worksheet S-10 for Determining Factor 3** ***(FR pages 28,100-28,101)*****:** As identified last year, CMS again indicates its desire to eventually determine the UCC payment factor (Factor 3) using UCC data from Worksheet S-10 of the Medicare cost report. CMS used the low-income patient days proxy for Factor 3 in FFY 2014 and is proposing to do so again for FFY 2015 due to concerns regarding data variability and lack of reporting experience with this relatively new cost report Worksheet. In the proposed rule, CMS again states its commitment to making the necessary revisions and clarifications to the S-10 instructions to ensure accurate and consistent reporting across hospitals. CMS is inviting comments on the reasonable timeline for adopting the S-10 as the data source for determining Factor 3.

GME Payments

FR pages 28,092-28,094 and 28,144-28,164

CMS is not proposing to make any major changes to the Indirect Medical Education (IME) and direct GME payment policies for FFY 2015. Instead, CMS is proposing program tweaks to:

- Account for the loss of rural status due to the proposed new CBSA delineations as it relates to full-time equivalent (FTE) resident counts/caps for formerly rural hospitals with a new teaching program and for urban hospitals that have established residency training programs with an integrated rural track in a formerly rural area;
- Align the effective dates of the FTE resident and Intern-and Resident-to-Bed Ratio (IRB) ratio caps for new teaching program; and
- Update the review and award process for the ACA-mandated policies that allow hospitals to add new residency slots due to hospital closures.

In addition, CMS is proposing to begin paying the Medicare Part C (Medicare Advantage) IME add-on amount to Sole Community Hospitals (SCHs) paid at the hospital-specific rate. Currently, CMS only pays this add-on amount to non-special status teaching hospitals and SCHs paid at the federal rate. For FFY 2015, the IME adjustment factor will remain at 1.35.

Updates to the MS-DRGs

FR pages 27,995-28,054 and 28,084-28,086

Each year, CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes proposed to the DRGs for FFY 2015 would increase the number payable DRGs from 749 to 751. As described above, CMS is proposing to apply a significant budget neutrality adjustment to the IPPS rates to compensate for increases to DRG payment weights. Since publication of the original proposed rule on May 15, CMS has issued a correction to the DRG payment weights and it is expected that the DRG budget neutrality effect would be reduced in the final rule. The corrected weights are available in a file called "Revised . . . MS-DRG Relative Weights File" on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html. Overall, while some DRG weights are proposed to shift significantly from FFY 2014 to FFY 2015, when compared to the current weights, nearly 85% of the DRG weights would change by less than +/- 5% for FFY 2015. Related to the general updates to the DRGs, CMS is also proposing to update the list of DRGs subject to the post-acute care transfer policy, adding 5 DRGs and eliminating 1. The post-acute transfer DRG changes are listed on FR pages 28,085-28,086. The full list of DRGs subject to the post-acute care transfer policy are available in Table 5 on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html (please remember that the DRG payment weights shown in Table 5 have been corrected by CMS).

Outlier Payments

FR pages 28,321-28,324

To maintain total outlier payments at 5.1% of total IPPS payments, CMS is proposing an outlier threshold of $25,799 for FFY 2015. The proposed threshold amount represents a +18.6% increase compared to the current threshold of $21,748. CMS cites an increase in hospital charges as the reason for the proposed threshold increase.

HAC MS-DRG Payment Policy

FR pages 28,000-28,003

CMS did not propose any expansion to the categories/conditions under the current HAC MS-DRG payment policy and will continue to recognize 11 HAC categories. As has been the case in prior years, when any of these conditions are not present on admission (POA), the diagnosis will not be recognized in the assignment of a case to a MS-DRG. Additional detail on the HAC MS-DRG payment policy is available on CMS' website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

Updates to the IQR Program and Electronic Reporting Under the Program

FR pages 28,218-28,253

As previously adopted for FFY 2015 payment determinations under the IQR Program, hospitals were required to report on a total of 59 quality measures. IPPS payment is linked to successful participation in IQR Program. Importantly, the traditional payment penalty structure for non-compliance with the IQR program will change for FFY 2015 due to the addition of a payment penalty for non-compliance with the EHR Incentive Program (see "Effect of the IQR and EHR Incentive Programs" section above). A table that lists the 59 measures CMS collected for FFY 2015 payment determinations is available on FR pages 50,784-50,785 of the FFY 2014 IPPS final rule (https://federalregister.gov/a/2013-18956). A table that lists the 57 measures CMS is currently collecting for FFY 2016 payment determinations is available on FR pages 50,805-50,807 of the same final rule. CMS is using this proposed rule to put forward IQR Program changes for FFY 2017 payment determinations and beyond. CMS is focusing its proposed program updates in two main areas: increased measurement of outcomes and efficiency and expansion of the voluntary electronic reporting for the clinical quality measures with the movement toward electronic reporting for all. The following describes the major IQR Program updates:

- **New Outcomes and Efficiency Measures** ***(FR pages 28,227-28,238)*****:** Last year, for FFY 2016 payment determinations, CMS added an episode of care payment measure for AMI patients and a readmissions/mortality measure for COPD patients. CMS is continuing its effort to move the focus of the IQR Program towards the collection of outcomes and efficiency measures. Among the measure additions (and deletions), CMS is proposing to add the following claims-based outcomes/efficiency measures for FFY 2017 payment determinations:
    - Readmissions rate for coronary artery bypass graft (CABG) patients;
    - Mortality rate for CABG patients;
    - Episode of care payment for PN patients; and
    - Episode of care payment for HF patients.
- **Electronic Reporting of Clinical Quality Measures** ***(FR pages 28,238-28,244)*****:** Last year, for FFY 2016 payment determinations, CMS established policies allowing hospitals to voluntarily report clinical quality measures

electronically to satisfy a portion of the IQR Program requirements. Establishment of this policy essentially created two IQR Program participation tacks: the traditional chart-abstraction track and the electronic clinical quality measure (eCQM) track. For FFY 2017 payment determinations (data collection during CY 2015), CMS is proposing to increase, from 16 to 28, the number of eCQMs available for voluntary reporting. Hospitals participating in this track would be required to report performance on 16 of the 28 available measures for FFY 2017 payment determinations. Successful participation in the voluntary option would satisfy the quality reporting requirements for both the IQR and EHR Incentive Programs. CMS believes that EHR-based collection of quality data would streamline the various federal quality data reporting programs. In this proposed rule, CMS states that it intends to propose mandatory eCQM reporting under the IQR Program beginning with FFY 2018 payment determinations (data collection during CY 2016).

CMS' proposals not only update the IQR Program and work towards alignment between the IQR and EHR Incentive Programs, but also remove and/or potentially put in place measures for future use under the VBP Program, Readmissions Reduction Program, and HAC Reduction Program.

A table that lists the measures CMS is proposing to collect for FFY 2017 payment determinations is available on FR pages 28,240-28,242. The table identifies the new/expanded measures for FFY 2017 payment determinations, which measures are eCQMs, and which measures are voluntary for electronic reporting. Details on the IQR Program data submission deadlines and procedures, chart validation requirements and methods, and other IQR-related procedures and processes are available on FR pages 28,244-28,253.

Two-Midnight Policy

FR pages 28,169-28,170

For FFY 2014, CMS established a time-based, 2-midnight benchmark for determining the appropriateness of treatment and payment on an inpatient basis versus treatment and payment on an outpatient basis. This policy was established in response to concerns about appropriate inpatient hospital admission decisions and recent increases in denials of short-stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs). As of this writing, legislative action by Congress has delayed full enforcement of this policy. For FFY 2015, CMS is not proposing any major changes to the 2-midnight policy. The following items included in the proposed rule are related to the 2-midnight policy:

- **Short-Stay Payment Policy Development *(FR pages 28,169-28,170)*:** Citing industry support for the development of a short-stay payment policy, CMS is seeking comment how to design a new payment methodology for short-stay inpatient cases (i.e. medically necessary inpatient stays that span less than 2-midnights). Specifically, CMS is asking the industry how to define the length of a short-stay, how to design the payment methodology, and how to rationalize payment between the inpatient and outpatient settings.
- **Exceptions to the 2-Midnight Policy *(FR page 28,170)*:** Under the current 2-midnight policy, there are some exceptions applied to the 2-midnight benchmark. For example, procedures listed on the Outpatient PPS's "Inpatient Only" list are exempt from the 2-midnight policy. Since implementation of the policy, CMS has put in place additional exceptions. CMS believes that there could be other limited exception circumstances that could apply and is asking the industry to suggest exceptions by emailing SuggestedExceptions@cms.hhs.gov.

Public Reporting of Hospital Charges

FR page 28,169

The ACA includes a provision requiring hospitals to make public a list of the standard charges for items and services provided by the hospital, including a list of charges for services by MS-DRGs. Until now, CMS has not issued guidance on the implementation of this ACA requirement. In this proposed rule, CMS is reminding hospitals of their obligation to comply with this provision and is providing flexibility as to how hospitals should make their charges public. CMS states that hospitals should either make public a list of their standard charges (whether that be the charge master itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry. CMS does not provide a deadline for compliance, but sets the expectation that hospitals should update the information at least annually, or more often as appropriate.

Expiration of the More Inclusive Low-Volume Adjustment Criteria

FR pages 28,090-28,092

Legislative action by Congress over the past several years has mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. Absent additional legislation, beginning mid-FFY 2015 (April 1, 2015), the low-volume adjustment criteria will revert to the more restrictive requirements previously in effect (25-mile/800 discharge criteria and 25% payment adjustment). This change would reduce the number of hospital eligible for the adjustment from about 600 to 6. Hospitals that qualified for the low-volume adjustment in FFY 2014 do not need to reapply to receive the adjustment for the partial FFY. Instead, hospitals only need to notify their MAC in writing that the 15-mile distance criterion continues to be met. Hospitals newly seeking the adjustment must make a request in writing to their MAC by September 1, 2014 in order to achieve the adjustment beginning October 1. Hospitals that request the status after September 1 and qualify would be eligible for the adjustment effective prospectively within 30 days of the date of the MAC determination.

Expiration of MDH Status

FR pages 28,104-28,105

Legislative action by Congress over the past several years has extended the Medicare-Dependent Hospital (MDH) program through mid-FFY 2015 (March 31, 2015). Absent legislation to extend the program, MDH status and the associated IPPS payment benefits will expire April 1. MDHs losing their status that can achieve SCH status must apply in writing to their MAC. If the request is made 30 days prior to the expiration of MDH status (March 1, 2015), SCH status would be effective immediately after the MDH expiration. Approved requests made after March 1 would be effective 30 days after the date of CMS approval.

RRC Status

FR pages 28,089-28,090

Hospitals that meet certain criteria can be classified as Rural Referral Centers (RRCs). This special status allows exemption from the 12% cap on traditional DSH payments and special treatment under the geographic reclassification rules. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The proposed FFY 2015 minimum case-mix and discharge values by region are available on FR pages 28,089-28,090.

CAH Payment Policies

FR pages 28,175-28,177

- **CBSA Delineation Changes *(FR page 28,176)*:** Critical Access Hospital (CAH) status may be at risk for CAHs that lose rural status under the new CBSA delineations. CMS would allow a 2-year grace period for CAHs to retain their current status, giving CAHs an opportunity to achieve rural status under a reclassification or other mechanism.
- **96-Hour Rule *(FR pages 28,176-28,177)*:** Inpatient payment for CAHs requires that a physician certify the patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Prior to FFY 2014, this physician certification was required no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted. For FFY 2014, in implementing the 2-midnight policy, CMS changed the certification policy to require the certification be completed, signed, and documented in the medical record prior to discharge. To provide CAHs with more flexibility, CMS is proposing to revert back to the pre-FFY 2014 standard: physician certification would be required no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted.

Quality-Based Payment Policies—FFYs 2016 and Beyond

For FFYs 2016 and beyond, CMS is proposing to put in place new quality-based payment policies and measures for the VBP Program, Readmissions Reduction Program, and HAC Reduction Program. The following provides a brief description of the proposed policies by program:

- **VBP Program–FFYs 2017-2020** ***(FR pages 28,118-28,134)*****:** CMS has already adopted VBP program rules through FFY 2016 and some program policies and rules beyond FFY 2016. CMS is proposing program updates/changes for FFYs 2017-2020. These proposals include:
  - Measure additions/deletions for FFYs 2017 and 2019 (the proposed measure changes would continue the shift of the program's focus from process to patient outcomes/safety measures—CMS suggests that future program expansion would include efficiency measures targeted at select conditions);
  - New data collection time periods (baseline/performance periods) for the FFY 2017-2020 program years (some periods were previously adopted and some are newly proposed);
  - National performance standards for a subset of the FFY 2017, 2019, and 2020 program measures (performance standards for other program measures, including the FFY 2018 program measures, would be put forward in future rulemaking);
  - New measure weighting formulas for FFY 2017 used for calculating each hospital's VBP Total Performance Score (TPS) and resulting payment adjustment (the proposed weighting formula would continue the shift toward putting a greater emphasis on patient outcomes, safety, and efficiency); and
  - Updates to the minimum measure/case counts and domain scores hospitals must need in order to be included in the program.

  CMS is also proposing to allow for retroactive updates to the national performance standards if there are major changes in a measure's specifications. Currently CMS holds the standards constant.

  Details and CMS tables on the newly proposed measures, collection time periods, performance standards, and measure weighting are available on the FR pages listed above. Other details and information on the program currently in place for FFY 2015 and FFY 2016 program are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

- **Readmissions Reduction Program–FFYs 2016 and 2017** ***(FR pages 28,108-28,112)*****:** CMS is not proposing to add any additional readmissions measures to the FFY 2016 program. For the FFY 2017 program, CMS is proposing to add a new measure: readmissions for patients admitted with CABG. CMS is not proposing any changes to the payment adjustment factor calculation. The maximum adjustment applicable for FFY 2015 and beyond is -3.0% (0.9700 adjustment factor). Details and information on the program currently in place is available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458.

- **HAC Reduction Program–FFYs 2016 and 2017** ***(FR pages 28,142-28,144)*****:** Last year, CMS adopted policies to add one surgical site infection (SSI) measure to the FFY 2016 program and two additional measures for the FFY 2017 program to evaluate Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia and Clostridium difficile (C. difficile) infection. CMS is not proposing any additional measure expansion. For FFY 2016, CMS is proposing to shift the domain weighting scheme used to calculate a hospital's Total HAC Score for determining penalty applicability. CMS would decrease the Domain 1 weight (PSI-90 composite measure) to 25% (from 35%) and increase the Domain 2 weight (all other program measures) to 75% (from 65%).

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