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Analysis of the FY2015 Final Rule for Inpatient Prospective Payment Systems (IPPS) for Acute Care and Long-Term Care Hospitals

The table below includes a summary of Consumer-Purchaser Alliance's comments on the FY 2015 IPPS proposed rule, as well as CMS' response in the final rule. Noteworthy changes to the programs include the addition of outcome measures, inclusion of more maternity measures, removal of many "topped out" process measures and a greater weight placed on outcome and safety measures in the incentive payment for the Hospital Value-Based Purchasing program. We are disappointed that the pace of progress in the Readmissions and Hospital Acquired Condition Reduction programs has slowed.

Program	FY 2015 Proposed Rule	C-P Alliance Comments	Final Rule/Response from CMS
Non-Payment Preventable Hospital-Acquired Conditions (HACs), Including Infections	-No additions made to existing 14 HACs (e.g., air embolism, falls). -Seeking input on expansion to new conditions.	-Encouraged public reporting of all data for this program, noting removal of data from data.medicare.gov this year that leaves lapse in publically available safety information. -Addition of SSIs for cesarean section surgery, hip replacement and knee replacement surgery.	**-Comments not addressed directly.** However, CMS did decide outside of rulemaking to continue to publicly report HAC information on data.medicare.gov based on input from consumers and purchasers.
Hospital Readmissions Reduction (HRRP)	- CABG readmission measure proposed for inclusion in FY 2017.	-Supported addition of CABG measure for FY 2016 – high volume, high cost and consistent with MedPac recommendations; support to report this measure in IQR. -Recommended PCI readmission measure for FY2016 (as recommended by MedPac). -Advocated for all-cause readmission measure to be implemented alongside condition-specific measure to promote system-wide progress and encourage continued alignment between this program and the IQR program.	-**Implementation of CABG measure in FY 2017** as opposed to FY2016 as C-P Alliance requested, to give providers time to adjust to reporting of previously finalized measures. -**No implementation of PCI measure** because inpatient admissions for PCIs are decreasing and are increasingly being performed in outpatient settings. -**No implementation of hospital-wide readmission measure** because it does not meet the current statutory definition of a measure with an "applicable condition." This is due to the fact that the measure reports a composite of five different categories of related discharges (surgery/gynecology; general medicine; cardiorespiratory; cardiovascular; and neurology), which cannot be defined as a single

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HRRP (continued)		-Acknowledged stakeholder concerns about the potential unintended consequences (due to the lack of SDS risk adjustment in the measures), particularly for hospitals serving patient populations with complex social situations. Encouraged CMS to monitor potential unintended consequences, including access, for vulnerable populations.	condition. -**CMS agrees that risk adjustment for SDS factors is not beneficial.** Risk adjustment may hold safety net hospitals to a different standard of quality and doing so may potentially mask disparities and prevent needed improvement. There is insufficient evidence to support claims that lack of risk adjustment unfairly penalizes safety net hospitals or that risk adjustment helps safety net hospitals.
Hospital Value-Based Purchasing (VBP)	-Removal of six "topped-out" process measures for FY2017.	-Supported removal of weak process measures performing very high (most hospitals in 95%-99% range).	**-Finalized removal of six "topped-out" process measures for FY 2017.**
	-Addition of 3 measures for FY2017 (including Elective Delivery prior to 39 weeks).	-Supported proposed measures for FY 2017 and FY 2019, but advocated for swifter implementation.	**-Finalized proposal to adopt three new measures for FY 2017, and one new measure for FY 2019.**
	-Proposed measures and measure concepts for future years.	-Advocated for additional inclusion of measures that address important gaps included in MAP's input, including: • PSI–4 Death among surgical inpatients with serious treatable complications (NQF #0351); • COPD 30-day mortality (NQF #1893); • AMI Payment Per Episode	- **CMS will consider new measures for Hospital VBP Program as they become eligible for inclusion in the measure set. CMS did not indicate that they would include the three C-P Alliance measures for FY2017.**
HVBP	- Sought input on domain weighting changes that impact scoring beginning in FY 2017: • 20% safety • 30 % clinical care (25 outcomes; 5 process)	-Supported proposal to update program methodology scoring in FY 2017.	-**Finalized the revised domain weighting for the FY 2017 as proposed**, which increased weighting of the patient safety domains and the outcomes portion of the clinical care domain.

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(continued)	• 25% efficiency • 25% Patient- and Caregiver-Centered (PCC) Experience of Care/Care Coordination		
Hospital Acquired Condition (HAC) Reduction	-No new measures being proposed for FY 2016.	-Disappointed that CMS ignored MAP recommendation for PSI-16 (NQF #0349) to fill gap for blood incompatibility – problem was that it wasn't on the MUC list; should be priority for next year's MUC list -Gaps persist that are key to improving patient safety: adverse drug events, ventilator-associated events (VAEs) but no good measures readily available to be added.	-**No additional measures** (including PSI 16) in order to give providers time to gain experience with finalized measures
	-Seeking comment on future electronic composite measure of all-cause harm.	- Supported all-harm measure to supplement existing domains. Weighting/scoring strategy should be dependent on comprehensiveness of the measure, but in theory it could serve as a third domain that is weighted equally or more than the other two.	- **CMS will consider development of an all-harm measure for future rulemaking.**
HAC	-The CDC NHSN measures, CAUTI and CLABSI, are currently collected and calculated on a quarterly basis, but proposal to use 2 years of data to calculate their scores.	-Expressed concern that hospitals receiving less actionable data on CDC measures given 2 year lag time.	-**Decision to finalize with 2-year data collection**. CMS refers providers to Hospital Compare for quarterly data that might be more useful and actionable.

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(continued)	-Changes to scoring and weighting beginning in FY 2016: • proposed to decrease Domain 1 weighting to 25 percent, and increase Domain 2 to 75 percent.	-Expressed concern about low weighting of Domain 1; defines safety narrowly based on infections.	- **Shift to weighting of Domain 1 to 25 percent.** CMS did so for two reasons: to reflect the addition of the SSI measure to Domain 2 and to respond to comments from MedPac and others in the FY2014 IPPS final rule.
		-Suggested changing ''hospital-acquired conditions'' to ''hospital-acquired complications'' to signal more clearly the program's focus on complications that arise from inappropriate delivery of care.	**-No name change to program because it reflects Congresses initial intent and is reflected in the Affordable Care Act.**
Inpatient Quality Reporting (IQR)	-FY2017 proposed removal of 10 "topped out" measures.	-Supported removal of topped out process measures and measures recommended by MAP for removal.	-**Finalized the removal of topped out process measures for FY2017.**
	-Proposal to retain 12 topped out measures from the program as voluntary e-measures in FY 2017– these are measures already finalized for use in the EHR Incentive Program for FY 2014.	-Disagreed with readoption of topped out measures and advocated that hospitals place their effort on reporting more meaningful measures.	-**Finalized proposal to retain reporting for 11 topped-out measures as voluntary electronic clinical quality measures**. They believe hospitals can choose not to report these measures, and in the meantime, they can familiarize themselves with the e-measure submission process and allow CMS to monitor potential declines in performance.
	-Proposal to add four new voluntary electronic measures in FY 2017 (including Exclusive Breast Milk Feeding and Healthy Term Newborn measures).	- Encouraged mandatory reporting for the Exclusive Breast Milk Feeding and Healthy Term Newborn measures.	-**Finalized voluntary reporting of electronic measures only.** Adopted these measures to align with the Medicare EHR Incentive Program and to provide hospitals with flexibility in their quality reporting. Reiterated that the proposed measures are voluntary and a hospital may choose not to report them.
IQR	-Addition of 5 new required measures in FY2017, including several outcome measures.	-Supported inclusion of new measures that seek to address high-value care and improved patient outcomes relevant to Coronary Artery Bypass Graft (CABG) surgery, episode-of-care	-**Finalized inclusion of all newly required measures.** However, since the final rule was released CMS announced a decision to suspend data collection for one of these measures – Severe Sepsis and Septic Shock:

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(continued)	-Proposed future measures for electronic reporting, with data collection beginning in January 2017.	payments, patient safety, and maternity care. -Supported future priority measures, and specifically asked for the inclusion of PC-02 Cesarean Section to be included in the program as swiftly as possible. Also identified additional gaps that remain in this program – e.g., pediatric care, safety, cancer and behavioral health.	Management Bundle (NQF #0500) due to potential changes to the measure during the NQF endorsement maintenance process. -**CMS to consider additional measures for inclusion in future rulemaking.**
Prospective Payment System Exempt Cancer Hospital Quality Reporting (PCHQR)	- Addition of External Beam Radiotherapy for Bone Metastases (NQF #1822) for FY2017.	-Supported proposed measure for inclusion in FY 2017, which encourages the appropriate use of EBRT for palliation to relieve pain of bone metastases and addresses gap in program. -Expressed concern about lack of incentive or penalty included in the program. -Emphasized the need to address several gaps, such as patient family/caregiver experience, patient-reported outcomes, survival rates, link cancer care to palliative and hospice care, and psychosocial/supportive services.	**-Finalized newly proposed measure.** **-No comment on lack of incentive or penalty in this program.** - **CMS will consider these gap areas in future rulemaking**. CMS noted that FY 2014 Final Rule will implement HCAHPS in FY 2016.
Long-Term Care Hospital Quality Reporting Program	-Proposing 3 new quality measures for FY 2018.	-Supported all newly proposed measures but encouraged swifter implementation -Encouraged public reporting of measures in this program.	-**Finalized inclusion of 3 new measures for FY 2018.** -**CMS has no established procedures or timeline for reporting, but it will consider in future rulemaking.**