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FY 2015 Inpatient PPS Final Rule Teleconference

September 16, 2014

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Important Info on Final Rule

- In *Federal Register* on Aug 22 – available at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

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Topics for Today's Teleconference

Topic	FR Pages (August 22, 2014)
Payment Updates	49993-49996
Documentation & Coding	49871-49874
Wage Index & Occupational Mix Adjustment	49950-49991
GME Provisions	50104-50141
Medicare DSH	50004-50024
2 Midnight Rule and Short Stays	50146-50148
Outliers	50374-50381
New Technology	49915-49950
Hospital Acquired Conditions Program	50087-50104
Value Based Purchasing Program	50048-50087
Hospital Readmissions Reduction Program	50024-50048
Inpatient Quality Reporting Program	50202-50277

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FY 2015 IPPS Final Rule – Key Takeaways

- 1.4% hospital payment update (overall impact on all hospitals is -0.9%, but impact on major teaching hospitals is -1.3%)
- Documentation and Coding: -0.8% reduction for ATRA Recoupment (defers -0.55% prospective adjustment)
- Update labor market areas (based on most recent Census)
- 2 Midnight Rule: no consensus regarding alternative payment policies for short inpatient hospital stays
- Mostly technical GME changes
- Hospital Price Transparency: ACA requirement to make charges public
- Regarding the quality programs, almost all proposed changes were finalized

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Payment Updates

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FY 2015 Market Basket Update

- Market basket projected increase = 2.9 percent
  - Less 25 percent if hospital doesn't submit quality data
  - Less multi-factor productivity adjustment = -0.5 percent
  - Less ACA adjustment = -0.2 percent
  - Less documentation and coding recoupment required by ATRA = -0.8 percent

FY 2015 Payment Update: 1.4%

However, other factors may affect your payments…

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Additional Factors Affecting Aggregate Payments – FY 2015

Policy	Proposed Rule Impact	Final Rule Impact
FY 2015 increase in payment rates (from Slide 7)	+1.3%	+1.4%
DSH UC Payment Pool Reduction	-1.0%	**-1.3%**
Readmissions	-0.2%	-0.2%
Higher SCH rate update	+0.1%	+0.1%
Expiration of MDH Special Status	-0.1%	-0.1%
Frontier Wage Index Floor	+0.1%	+0.1%
HAC Reduction Program	-0.3%	-0.3%
FY 2015 Outlier Payments at 5.1% (compared to FY 2014 outlier payments at 5.79%)	-0.7%	-0.6%
Impact Including Additional Factors	-0.8%	-0.9%

Impact on Major Teaching = -1.3% (why? DSH + HAC policies)

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Wage Index Changes

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Wage Index Changes

New Labor Market Areas

- FY 2015 CBSAs based on updated (2010) Census data
- 12 urban hospitals become rural (p. 28056)
  - Transition? 3 years
- 81 rural hospitals become urban (p. 28056-57)
- Some urban hospitals remain urban but move to different CBSA (p. 28050-60)
- Transition for hospitals w/decrease in wage index? 1 year, 50-50 blended rate

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Wage Index Changes, cont.

Reminder re: Contract Housekeeping & Dietary

- Some hospitals aren't consistently providing documentable salaries, wages, and hours
- Contractors instructed to use reasonable estimates of wages and hours

Occupational Mix Adjustment

- New data required for FY 2016
- 2013 surveys were due to MAC by July 1, 2014

Temporary Imputed Floor

- "Floor" for states with no rural counties
- Extended 1 more year (through 9/30/15)
- Affects DE (new this year), NJ, RI

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Medicare DSH

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Medicare DSH Impact of Final New Labor Market Areas

- **Maximum DSH Payment Adjustment:** DSH operating payment adjustment can't exceed **12% for rural hospitals with < 500 beds and urban hospitals with < 100 beds** unless they are rural referral centers (RRCs)
- If a **hospital is currently in an urban county that will become rural** under the new labor market areas and does not become an RRC, it will become **subject to this maximum DSH payment adjustment, but this does not limit the hospital's DSH uncompensated care payment.**

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Transitional Period After Hospital Loses Urban Status

If a hospital will receive lower DSH payments because it loses its urban status, current regulations allow for additional payments for 2 years to transition to the lower payment.

- Year 1: hospital receives 2/3 of the difference b/w its DSH payments before redesignation and DSH payments after redesignation
- Year 2: hospital receives 1/3 difference b/w its DSH payments before redesignation and DSH payments after redesignation

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DSH - ACA Sec. 3133

- **Sec. 3133 of the ACA requires changes** to the Disproportionate Share Hospital (DSH) payment formula and applies to all hospitals that are currently eligible for DSH payments

- **Aggregate DSH payments will again be reduced in FY 2015**

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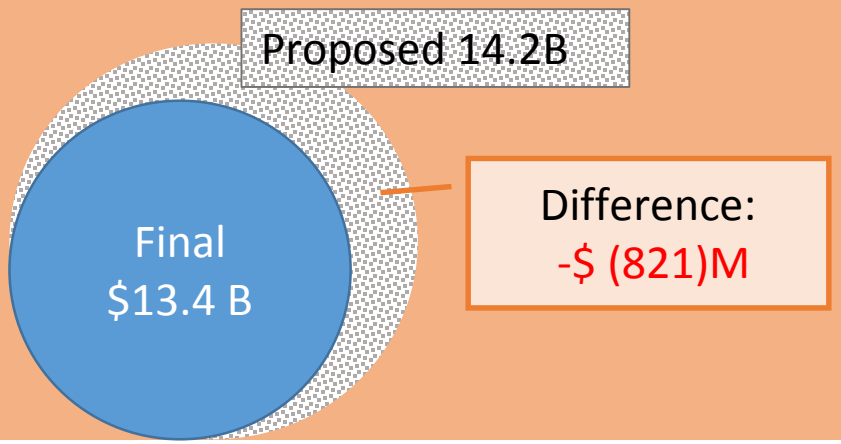
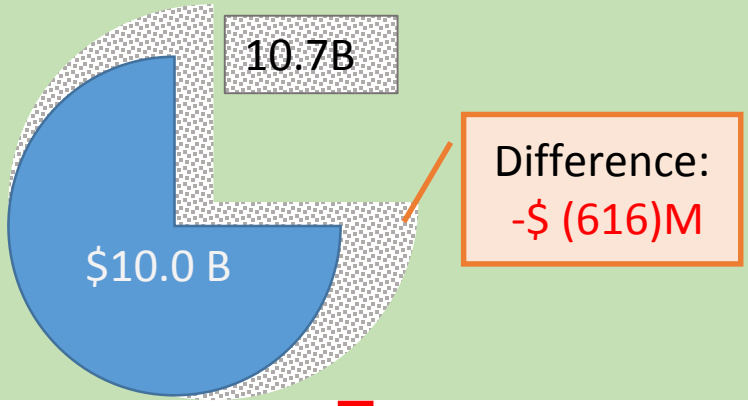
The Shrinking Uncompensated Care Payment Pool

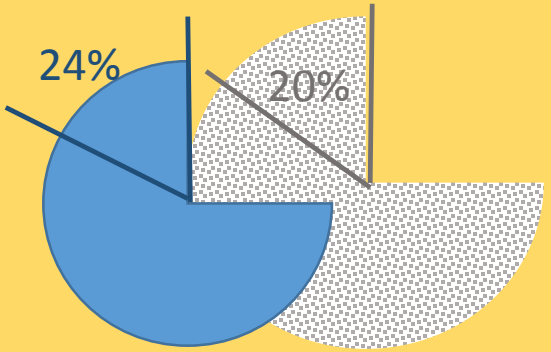
1. Projected Aggregate DSH Payment in FY2015



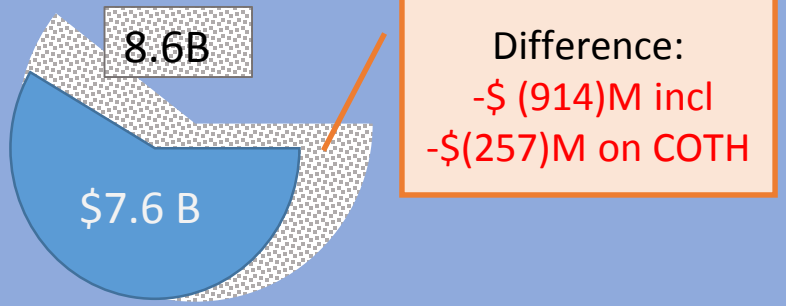
2. 75% Aggregate DSH Payment as the base to estimate UCP



3. Reduction ties to expansion of insurance coverage



4. Final Estimated UCP Pool



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Upcoming Deadline for Factor 3 Tables

- **CMS will not use the S-10 data** for purposes of redistributing UC DSH payments, but suggests it will be used in the future.
- Again, **CMS finalizes basing Factor 3** on the most recent available data on utilization of insured low-income patients => **Inpatient days of Medicaid patients + inpatient days of Medicare SSI patients.**
- The FY 2015 final rule is accompanied by tables listing Factor 3 levels. **Hospitals have 30 days following the publication of the final rule (until Sept. 22) to comment** on their eligibility for DSH/UC DSH payments. Submit comments to **Section3133DSH@cms.hhs.gov.** CMS will post a revised table by Oct. 1, 2014.

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How to Figure Out Your UC DSH Payment

The UC Payment Pool= 75% x $14.205 B = $10.654 B

The Pool is Reduced by the Percentage Insured = $10.037 B x 76.19% = $7.6476 B (about $1.4 B less than FY 2014)

UC Payment = $7.6476 B x [(Your Hospital Medicaid Days + SSI Days) ÷ (Medicaid Days + SSI Days for All DSH Eligible Hospitals)] = YOUR UC DSH PAYMENT

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UC DSH for Hospitals that Merge

- Final rule includes **new** policies for addressing hospital mergers. CMS finalizes:
  - To **incorporate data from both merged hospitals' separate CCNs until data for the merged hospital becomes available under the surviving CCN.**
  - **To identify hospitals that merged after the period from which data was used to calculate Factor 3** (for FY 2015, after 2012 and 2011 cost reports) but before publication of each year's rule.

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UC DSH for Hospitals that Merge

- **CMS finalizes proposal to treat hospitals that merge after the development of the final rule as new hospitals are treated:**
  - **Interim UC payments would be based only on the data of the surviving hospital's CCN** at the time of the preparation of the final rule.
  - But, **at cost report settlement, CMS will determine the newly merged hospital's final UC payments based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year** (revising the numerator of Factor 3 to reflect the low income days reported on the cost report).

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Documentation & Coding

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Documentation & Coding

Two types of adjustments:

- **Retrospective**
  - Recoup overpayments that were already made as a result of documentation and coding improvements
  - ATRA requires $11B retrospective for FY 2010 - FY 2012 overpayments
- **Prospective**
  - Eliminate the effects of documentation and coding changes on future payments

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Documentation & Coding Proposal

- CMS finalized a second year of a -0.8 percent recoupment adjustment to the $11 billion required by the ATRA
  - Full adjustment ($11B) must be completed by FY 2017. CMS is phasing in these cuts.
  - CMS estimates the -0.8 percent for FY 2015 will recover almost $2B. (With $1B for FY 2014, leaves $8B to recoup)
  - In DSH section of rule, CMS notes future years could be >0.8 percent cut, because of decreasing discharges
- Again postpones -0.55% prospective adjustment

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Price Transparency

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Price Transparency

- CMS received support for the "reminder" of ACA requirement to make charge master public
- "Guidelines" require hospitals to make public either:
  - (1) a list of their standard charges ("whether that be the chargemaster itself or in another form of their choice"), OR
  - (2) their policies for allowing the public to view a list of their charges in response to an inquiry
- Encourages "consumer friendly communication"
- Update at least annually

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Graduate Medical Education (GME)

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GME Provisions – Affect You If:

- You are working with a new teaching hospital to build a cap under the 5-year window
  - Rule says: cap, 3 year rolling average, and IRB ratio cap go into effect at beginning of the cost reporting period that coincides with or follows the start of the sixth program year
  - Change from proposal that these go into effect at beginning of cost reporting period preceding 6th year

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GME Provisions – Affect You If:

- You train residents in a rural hospital that is now considered urban, and the rural hospital is in the middle of building a new program
  - Rule says: rural hospital can finish building its cap for the new program
    - All new programs had to have received a letter of accreditation (new in final rule) OR started while hospital was rural

GME Provisions – Affect You If:

- You train residents in a rural training track (RTT) program, and one of your rural hospitals is now considered urban
  - Rule says: transition period from Oct. 1, 2014 – June 30, 2017 (longer than the 2 years in the proposed rule), formerly rural must classify back to rural & only get IME, or urban must find a new rural partner
    - If in middle of RTT cap-building period, can keep building that cap
- CMS notes that if "original" urban hospital develops a rural track in another specialty, it can receive a separate rural track FTE cap in that different specialty

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GME Provisions – Affect You If:

- You had a jurisdictionally proper appeal pending on DGME or IME payments as of March 23, 2010, and you are appealing nonprovider site FTE count
  - Rule says: CMS "clarifying" ACA Sec. 5504 prohibits reopening
    - Talk to your appeals lawyers…

GME Provisions – Affect You If:

- You are considering applying for Sec. 5506 slots from closed hospitals in rounds announced on or after 10/1/14
  - Final Rule says:
    - No more cap relief option
    - No more "seamless" requirement for RC #1 and #3
      - But still have to show commitment to permanent expansion
    - Emergency GME affiliation agreement now counts for RC #2

GME Provisions – Affect You If:

- You are considering applying for Sec. 5506 slots from closed hospitals, cont.:
  - Rule says: Slot effective dates for rounds announced on or after 10/1/14:
    - RC #1 & 3:
      - No temporary slots: date of closure
      - Yes, temporary slots: after residents graduate
    - RC #2:
      - Date of closure
    - RC #4-8:
      - No temporary slots: when you prove to MAC you filled them
      - Yes, temporary slots: later of either graduation or prove to MAC you filled them

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GME Provisions – Affect You If:

- You train residents in an FQHC or RHC that receives DGME money
  - Rule says: As with a teaching hospital, if FQHC or RHC incurs cost of resident stipends/benefits, it can claim nonhospital clinical training time

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2 Midnight Rule and Short Stays

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2 Midnight Rule and Short Stays

- CMS acknowledges no consensus among commenters **regarding alternative payment policies for short inpatient hospital stays**, but the Agency will take comments into account in the future.
- CMS will evaluate the results of the "probe & educate" process during the summer and fall of 2014.
- **CMS will issue additional subregulatory guidance and will consider suggestions from stakeholders while developing this guidance.**

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Outlier Payments

- **For FY 2015, the target for total outlier payments continues to be set at 5.1% of total operating DRG payments**
  - Current estimate is that actual outlier payments for FY 2013 were 4.86% of actual total MS-DRG payments
  - Current estimate is that actual FY 2014 outlier payments will be 5.71% of actual total MS-DRG payments (about 0.61 percentage points higher than the 5.1% projected)

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Outlier Threshold

- **For FY 2015**, CMS establishes an outlier fixed-loss cost threshold = to the prospective payment rate for the MS-DRG
  - + any IME, empirically justified DSH payments, estimated uncompensated care payment, and any add-on payments for new technology
  - **+ $24,758 (lower than the proposed fixed dollar add-on of $25,799 but significantly higher than the FY 2014 level of $21,748)**.
- CMS attributes the **higher FY 2015 threshold** to a charge inflation factor higher than FY 2014.

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New Technology

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New Technology Add-On

Update on FY 2014 New Technologies

New Tech	Approved for FY 2015?	Max Add-On per Case
Voraxaze®	Yes	$45,000
DIFICID™	No	$868
Zenith® F. Graft	Yes	$8,171.50
Kcentra™	Yes	$1,587.50
Argus® II System	Yes	$72,028.75
Zilver® PTX®	Yes	$1,705.25

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New Technology Add-On

FY 2015 Applications for New Technology Add-On Payments:

- **Dalbavacin: Not eligible for new technology add-on payments for FY 2015 because it does not meet the substantial clinical improvement criterion.**
- **Heli-FX™ EndoAnchor System for Treatment of AAA: Not eligible for new technology add-on payments for FY 2015 because it does not meet the newness criterion.**
- **Heli-FX™ EndoAnchor System for Treatment of TAA: Not eligible for new technology add-on payments for FY 2015 because it does not meet the substantial clinical improvement criterion.**
- **CardioMESH™ HF (Heart Failure) System: Approved for new technology add-on payments in FY 2015.**
- **MitraClip® System: Approved for new technology add-on payments in FY 2015.**
- **Responsive Neurostimulator (RNS®) System: Approved for new technology add-on payments in FY 2015.**

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Quality Programs in IPPS

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Quality Summary- FY 2015

5.5% at risk in FY 2015 for performance

Hospital Compare

IQR
25% reduction of market basket update for not reporting

Measures must be publicly reported at least 1 year before being including in VBP

Readmission and HAC measures do not need to be publicly reported or included in IQR in advance, but they typically are

VBP
1.5% of base DRG
(goes up to 2% by FY2017)

- Rewards for good performance/penalties for poor performance
- Credit for improvement
- Readmission measures cannot be in VBP; HAC measures eligible for VBP

Readmissions
3.0% of base DRG

- Penalties for excess readmissions
- No credit for improvement
- Up to 3% of base DRG at risk

HAC
1.0% of total payment

- Automatic penalty for one quarter of hospitals deemed as having "worst" performance.
- No credit for improvement
- HAC measures are in VBP too

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FY 2015 IPPS Final Rule Key Takeaways – Almost All Proposed Changes Finalized

Hospital Acquired Condition Reduction Program

- Starts FY 2015, disproportionately penalizes teaching hospitals
- 1% reduction affects Base DRGs, and add-on payments IME, DSH
- Increase in weighting for Domain 2 (CDC NHSN) to 75 percent starting FY 2016
- Single Surgical Site Infection (SSI) Standard Infection Ratio (SIR) calculation

Value Based Purchasing Program

- Removal of six process of care measures in FY 2017
- Addition of three new measures for FY 2017 and one new measure in FY 2019

Readmissions Reduction Program

- CABG finalized starting FY 2017 (also proposed for IQR in FY 2017)
- Update of planned readmission algorithm (Version 3.0)

Inpatient Quality Reporting Program

- New episode of care, complication, and readmission measures finalized starting FY 2017
- Voluntary electronic measure reporting

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Hospital Acquired Condition (HAC) Reduction Program

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Background on HAC Reduction Program

- HAC Reduction Program starting FY 2015
- Hospitals in the worst performance quartile of HACs will face a 1 percent reduction in all payments (including IME and DSH)
- HAC reductions will be applied after adjustments for the VBP and the Readmission Reduction Programs
- CMS will publicly release updated FY 2015 hospital level data set by October, 2014
- In FY 2015, the preliminary estimate is that 726 hospitals will be affected
  - This translates into 21.7 percent of all hospitals
  - Aggregate reduction will be approximately $369 million
- Teaching hospitals disproportionately affected by HAC Program
  - 56.4 percent of major teaching hospitals hit with penalty

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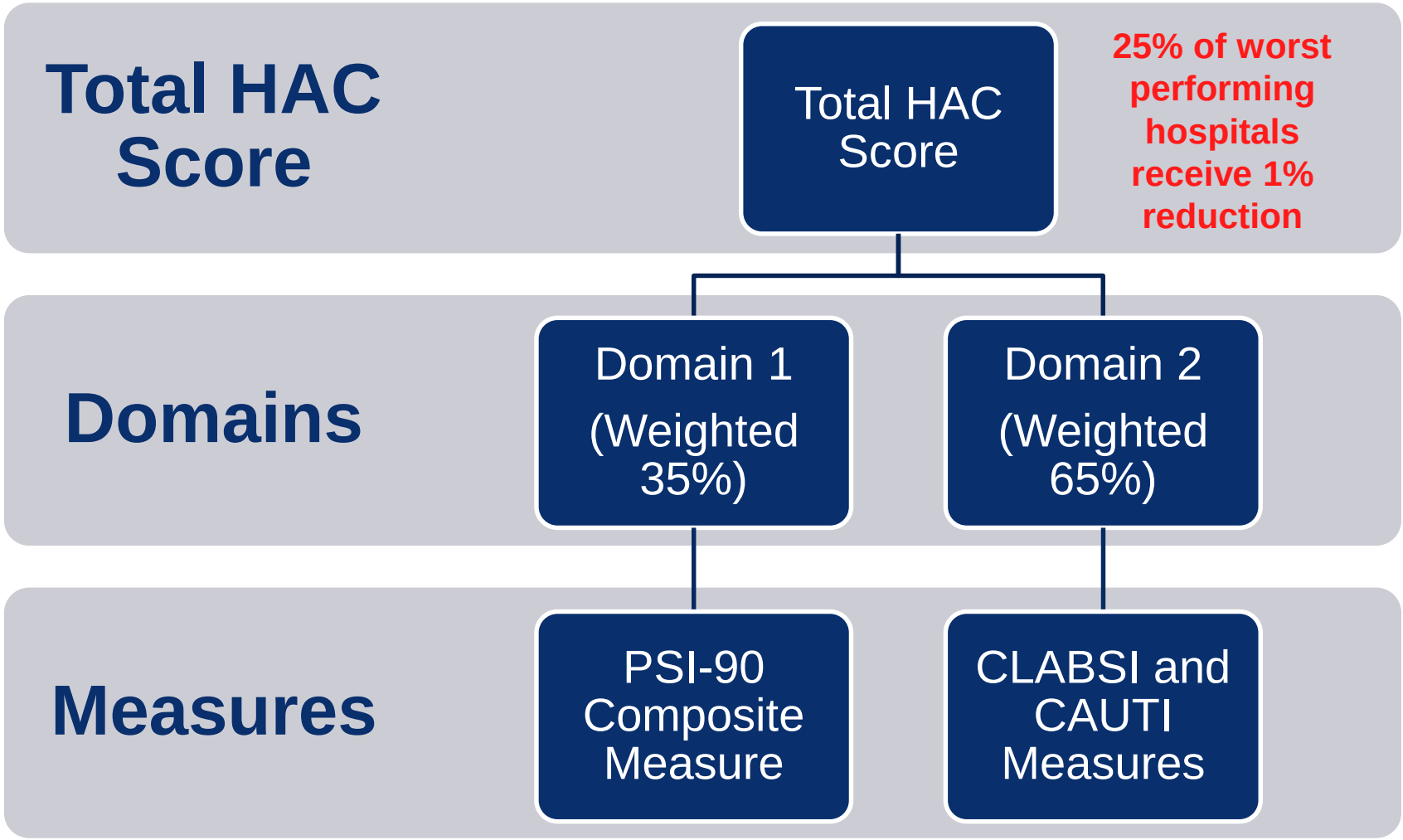
HAC Reduction Program Framework Finalized for FY 2015



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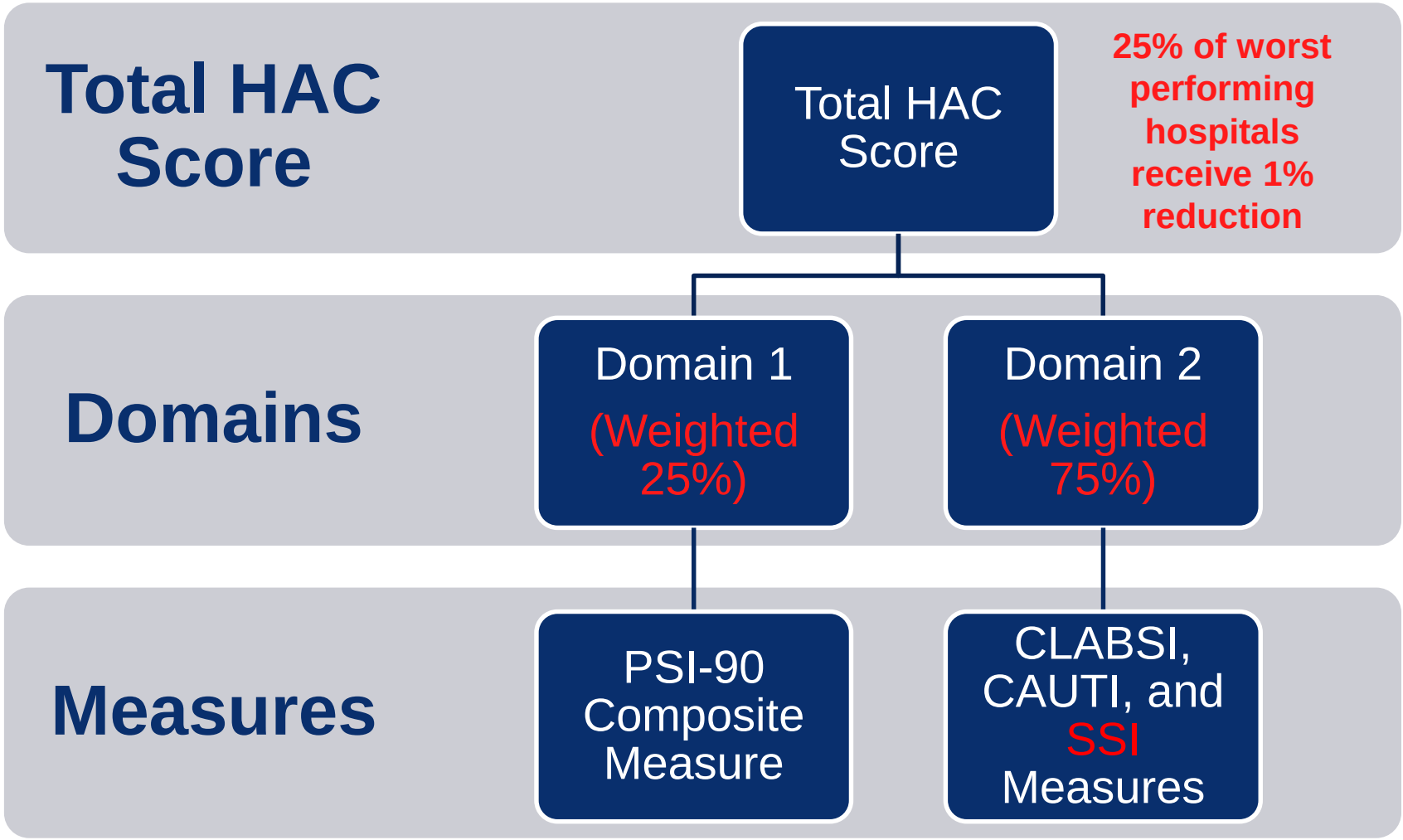
HAC Reduction Program Framework Finalized for FY 2016



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HAC Domains and Measures

Domain 1
(AHRQ PSI-90 Composite)

- The PSI-90 Composite consists of:
- PSI-3: pressure Ulcer
- PSI-6: latrogenic pneumothorax
- PSI-7: central venous catheter-related blood stream infection rate.
- PSI-8: hip fracture rate
- PSI-12: postoperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

PSI-90 Composite could expand (currently under NQF review). Any changes to the measure would go through rulemaking before it is used in a reporting or performance program

Domain 2
(CDC Measures)

- **2015 (2 measures)**
  - CAUTI
  - CLABSI
- **2016 (1 additional measure)**
  - Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)
- **2017 (2 additional measures)**
  - MRSA
  - C Diff

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HAC Measure Scoring Methodology

Points will be assigned according to a hospital's performance on these measures:	
Starting FY 2015	**Starting FY 2016**
PSI-90 Composite	Surgical Site Infections (SSI)
CLABSI	CMS will pool SSI for abdominal hysterectomies and colon procedures into a single standardized infection ratio (SIR) for each hospital.
CAUTI	

- The performance range for each of the measures will be divided into 10 deciles. All hospitals will receive between 1 and 10 points for each measure
- CMS will handle "ties" by assigning all hospitals with the same result the same number of points based on the lowest appropriate percentile (i.e. if 14% of hospitals score a zero on a measure, all 14% would receive 1 point)

To Calculate FY 2016 HAC Score:

(Domain 1 Score x 25%) + (Domain 2 Score x 75%) =Total HAC Score*

*Hospitals reporting measures in 2 domains

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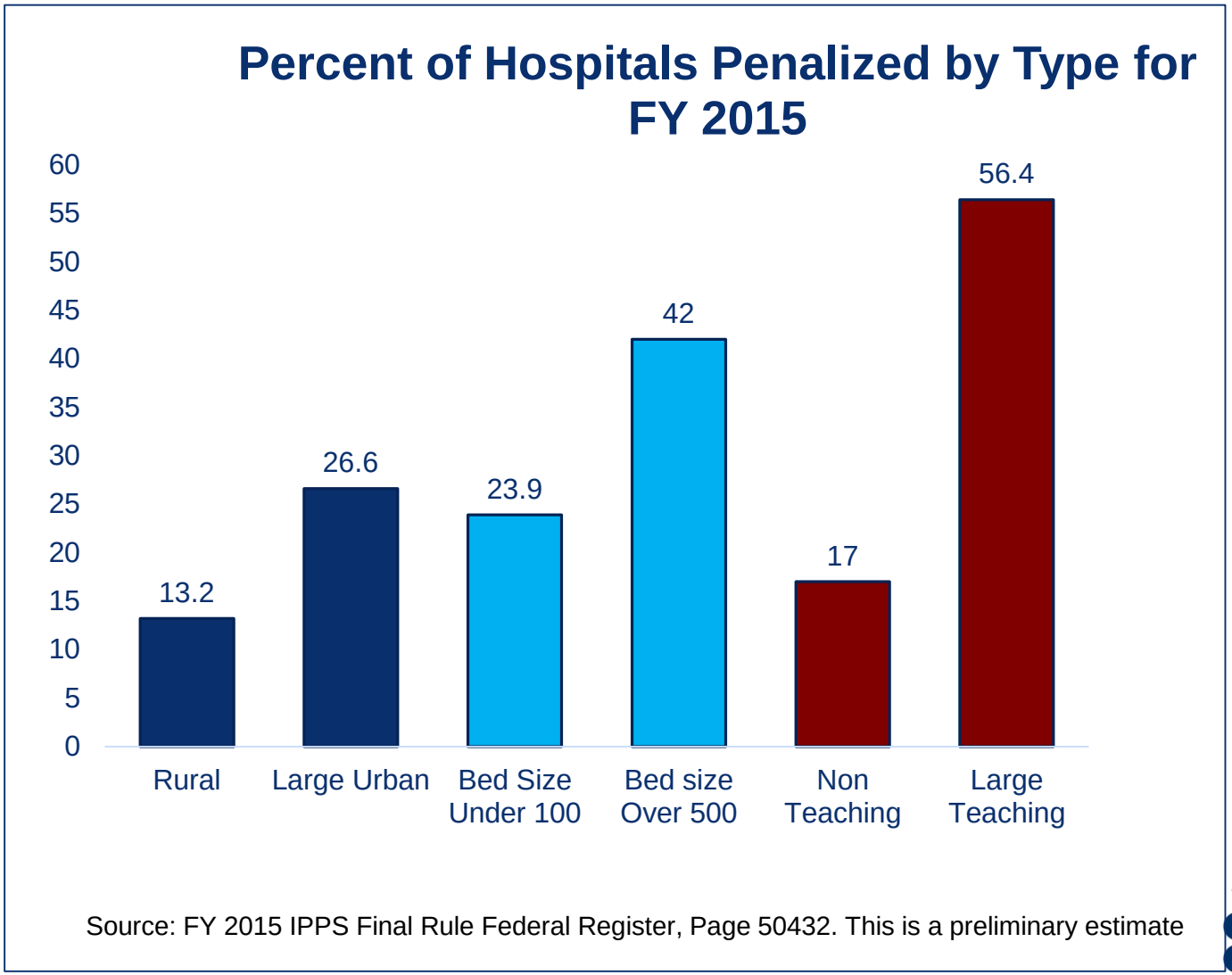
Breakdown of Hospitals Affected By HAC Reduction Program



Source: FY 2015 IPPS Final Rule Federal Register, Page 50432. This is a preliminary estimate

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Value Based Purchasing (VBP) Program

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Updates to VBP Program for FY 2015

- Reduction in base DRGs increased from 1.25% to 1.5% to fund incentive pool
- Amount at risk is $1.4 billion
- First year of the efficiency domain (20% of the total VBP score). Domain contains one measure: Medicare Spending Per Beneficiary (MSPB)
- FY 2015 VBP payment adjustment factors have not yet been published. This information will be publicly available in October (Table 16B)

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Expansion of CLABSI and CAUTI Beyond ICU

VBP Payment Year	FY 2015	FY 2016	FY 2017	FY 2018	**FY 2019**
	⬇	⬇	⬇	⬇	⬇
Performance Year	Feb-Dec 2013	CY 2014	CY 2015	CY 2016	**CY 2017**
Baseline Year	CY 2011	CY 2012	CY 2013	CY 2014	**CY 2015**
Baseline Year Data Collection	ICU Only	ICU Only	ICU Only	ICU Only	**ICU & Select Non-ICU Locations**

FY 2019 is the earliest payment year that CMS could apply data from non-ICU locations for CLABSI and CAUTI in VBP

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Six Measures Finalized for Removal Starting FY 2017

- PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patient
- SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients
- SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- SCIP-INF-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
- SCIP-Card-2: Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
- SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

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Six Measures Finalized For VBP in 2017 & 2019

2017

- Hospital-onset Methicillin-Resistant Staphylococcus Aureas (MRSA) Bacteremia
- *Clostridium Difficile* (C.Diff) Infection
- Early Elective Deliveries (PC-01)
- Re-adoption of CLABSI (Current Measure, not the Reliability-adjusted Measure)

2019

- Hospital-level Risk-standardized Complication Rate (RSCR) Following Elective Hip and Knee Arthroplasty
- Re-adoption of PSI-90

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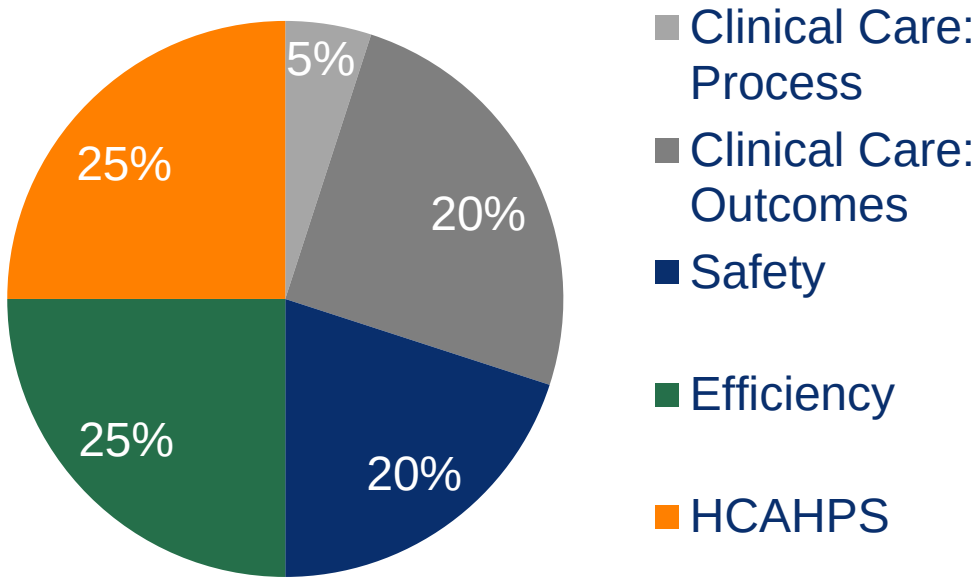
Finalized VBP Domain Weighting for FY 2017 – Increase in Safety Domain, Decrease in Process Domain



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Readmissions Reduction Program

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Updates to Hospital Readmissions Reduction Program

- Maximum penalty increases to 3% in FY 2015
- CMS finalized 1 new measure in FY 2017:
  - CABG
- Performance period July 1, 2010 through June 30, 2013
- Finalized changes to Planned Readmissions Algorithm (Version 3.0) and to Total Hip/Total Knee Arthroplasty methodology
- FY 2015 readmission payment adjustment factors will be posted on CMS website by October (Table 15B)

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Inpatient Quality Reporting (IQR) Program

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CMS Finalized Removal of IQR Measures Starting FY 2017

9 Measures Finalized for Removal from the IQR Program
AMI-1: Aspirin at Arrival (Previously Suspended)
AMI-3: ACEI or ARB for Left Ventricular Systolic Dysfunction- Acute Myocardial Infarction (AMI) Patients (NQF #0137) (Previously Suspended)
AMI-5: Beta-Blocker Prescribed at Discharge for AMI (NQF#0160) (Previously Suspended)
HF-2: Evaluation of Left Ventricular Systolic Function (NQF #0135)
SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (48 Hours for Cardiac Surgery) (NQF #0529)
SCIP-Inf-6: Surgery Patients with Appropriate Hair Removal (NQF #030) (Previously Suspended)
SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Arrival Who Received a Beta Blocker During the Perioperative Period (NQF #0284)
SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)
Participation in a Systematic Database for Cardiac Surgery (NQF #0113)

One measure not finalized for removal:

- SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300)

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CMS Finalized Proposal to Remove IQR Measures Starting FY 2017, Cont.

10 Measures Finalized for Removal from IQR, but Retained as a Voluntary Electronic Clinical Quality Measure
AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival (NQF #0163)
PN-6: Initial Antibiotic Selection for Community-acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147)
SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (NQF #0527)
SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) With Day of Surgery Being Day Zero (NQF #0453)
STK-2: Discharged on Antithrombotic Therapy (NQF #0435)
STK-3: Anticoagulation Therapy for Atrial Fibrillation/flutter (NQF #0436)
STK-5: Antithrombotic Therapy by the End of Hospital Day Two (NQF #0438)
STK-10: Assessed for Rehabilitation (NQF #0441)
VTE-4: Patients Receiving un-fractionated Heparin with Doses/labs Monitored by Protocol

Updates to Existing Measures

- Expansion of CLABSI and CAUTI to select non-ICU locations will start January 1, 2015
- CMS finalized proposal to update the planned readmission algorithm methodology and the THA/TKA measure
- CMS clarified that for the healthcare personnel vaccination measure (adopted for IQR and OQR), hospitals should report this information through the NHSN OrgID, and not as a total count by CMS Certification Number (CCN).

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CMS Finalized New IQR Measures

5 Measures Finalized as IQR Required Measures

Measure	Data Collection	NQF-Endorsed?
Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery	Claims	No
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery	Claims	No
Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Claims	No
Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Claims	No
Severe Sepsis and Septic Shock: Management Bundle (NQF# 500)*	Chart-abstracted	Yes

6 Measures Finalized as Voluntary Electronic Health Reporting

Measure
Hearing Screening Prior to Hospital Discharge (NQF #1354)
PC-05 Exclusive Breast Milk Feeding and the subset 1042 measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (NQF #0480)
CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
Healthy Term Newborn (NQF #0716)
AMI-2 Aspirin Prescribed at Discharge for AMI (NQF #0142)
AMI-10 Statin Prescribed at Discharge (NQF #0639)

*Data Collection Delayed for this Measure Until Further Notice

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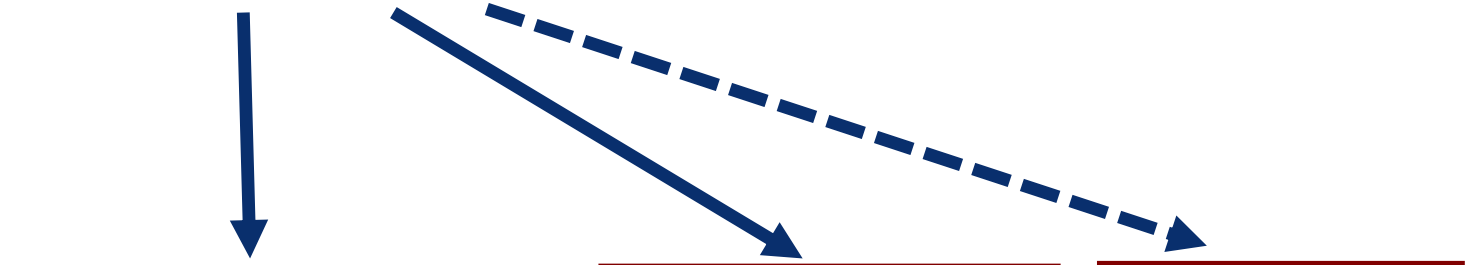
Breakdown of Finalized IQR Measures for FY 2017

Chart Abstracted/ EHR	Claims	CDC NHSN	HCAHPS	Structural
16 required measures	21 measures	6 measures	1 measure	3 measures



Required - Chart only (EHR specs not available)	Required - Chart or EHR	Voluntary - EHR only
4 measures	12 measures	16 measures

2014 CEHRT eCQM requires reporting of 16 measures of 29 (28 inpatient) across 3 domains

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Finalized Requirements for Electronically Submitted Measures Starting FY 2017

- Providers may voluntarily report 16 of 28 measures that align with EHR Incentive Program
  - Measures must span at least 3 NQS Domains
- Hospitals must electronically submit data for a minimum of one quarter
  - Either Q1, Q2, and/or Q3 of FY 2015. **NOT Q4**
  - Deadline is November 30, 2015 to submit data
  - CMS did not finalize the proposed deadlines requiring quarterly electronic reporting
- Hospitals that successfully submit electronic measures would not need to submit chart abstracted data for validation purposes
- **Public Reporting of Electronically Submitted Data**
  - Data submitted for **FY 2016** payment determination: CMS will report this data if it is deemed "accurate enough"
  - Data submitted for **FY 2017** payment determination: CMS will publish the names of those hospitals that successfully submit electronic data. No actual data or performance rates will be posted on Hospital Compare

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Questions?

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