

hospital or CAH. These requirements are codified at § 489.20(w). The requirements of §§ 489.20(u) and (w) were made applicable to both inpatient hospital stays and outpatient services because, as we stated in the FY 2008 IPPS final rule with comment period, these provisions are in the interest of the health and safety of all individuals who receive services in these institutions. The notice requirements are intended to permit individuals to make more informed decisions regarding their treatment.

In the CY 2011 OPPI/ASC final rule with comment period (75 FR 72251), we stated that we saw no reason to treat the safety of hospital inpatients differently than hospital outpatients, and, thus, applied these patient safety requirements to hospital inpatients and outpatients. We continue to believe that both hospital inpatients and outpatients should receive these disclosures prior to admission. However, after hospitals in general informed us that it would be unduly burdensome to provide disclosures to *all* outpatients, and hospitals with emergency departments reported the individual notice requirement makes the registration process more cumbersome and time-consuming than is desirable in the emergency department setting, we revisited this issue. We have reconsidered the patient safety requirements related to patient notification of physician presence, and in this proposed rule, we are proposing that hospital outpatients would need to receive such disclosures only where the risk of an emergency or the length of the outpatient visit make their situations more like that of hospital inpatients. Under this proposal, disclosures would be required only for those outpatients receiving observation services, surgery, or any other procedure requiring anesthesia. Signage would be required for hospital outpatients in the emergency department, as we recognize the merit of finding a less cumbersome manner to provide the required notice in this setting. Other hospital outpatient encounters are relatively short and, in many cases, scheduled in advance. The risk of emergency is relatively low in most of these scheduled encounters. As a result, we believe the safety of these particular hospital outpatients would not be compromised in any way if hospitals were not required to provide disclosures in these circumstances.

In this proposed rule, we are proposing to revise paragraph (w)(1) of § 489.20 to reduce the categories of outpatients who must be notified if a hospital does not have a physician on site 24 hours per day/7 days per week.

We are proposing that only those outpatients who receive observation services, surgery, or services involving anesthesia, must receive such written notice. We believe this change would reduce burden, but ensure that notice goes to those categories of patients who are more likely to find themselves in a situation where a physician is not present when an emergency develops. (We note that we are not making any changes to similar patient safety requirements for physician-owned hospitals at § 411.362(b)(5)(i).) We are proposing to add a provision that notice would be required at the beginning of a planned or unplanned inpatient stay or outpatient visit, and we provide explanation of when a planned or unplanned stay or visit begins. We are proposing to add a provision to state that an unplanned stay or visit begins at the earliest point at which the patient presents to the hospital. The current regulation describes when a stay or visit begins by referring to the time when a package of information is provided regarding scheduled preadmission testing and registration for a planned hospital admission or outpatient service. However, many admissions to the hospital are unplanned admissions of patients who present on an unscheduled visit to the emergency department. Therefore, it was necessary to clarify when we considered such unplanned stays or visits begin.

We are proposing to add a new paragraph (w)(2) to § 489.20 (existing paragraph (w)(2) would be redesignated as discussed below) that would require a hospital that is a main provider that has one or more remote locations of a hospital or satellites to make the determination of whether notice is required separately at each location providing inpatient services. We are proposing to use the terms “main provider,” “remote location of a hospital,” and “satellite” as these terms are defined at § 413.65(a)(2), § 412.22(h), or § 412.25(e), as applicable. We are proposing that notice would be required for all applicable patients, that is, all inpatients and applicable outpatients, at each location at which inpatient services are furnished and at which a doctor of medicine or doctor of osteopathy is not present 24 hours per day/7 days per week. We are proposing to move language that is currently in paragraph (w)(1) to a new paragraph (w)(3), governing the content of the written notice. We are proposing to redesignate existing paragraph (w)(2), which requires the hospital to receive a signed acknowledgment from the patient who has received a notice that

the patient understands that a physician may not be present during all hours in which services are furnished to the patient, as paragraph (w)(4) and to revise the redesignated paragraph. We are proposing to add a provision to state that, before providing an outpatient service to an outpatient for whom a notice is required, the hospital must receive the signed acknowledgment. This revision would make this requirement consistent with our proposed revisions to paragraph (w)(1) limiting the notice requirement to certain categories of outpatients.

We are proposing to add a new paragraph (w)(5) which would require every hospital that has a dedicated emergency department in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day/7 days per week to post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. “Dedicated emergency department” would have the meaning found in existing § 489.24(b) of the regulations. We would require the notice to state that the hospital does not have a doctor of medicine or doctor of osteopathy present in the hospital 24 hours per day/7 days per week, and to indicate how the hospital will meet the needs of any patient with an emergency medical condition, as that term is defined in § 489.24(b), at a time when no doctor of medicine or doctor of osteopathy is present within the hospital. In the event that there is a decision to admit a patient from the emergency department as an inpatient, the individualized written disclosure and acknowledgment would have to be made at the time the patient is admitted.

XVI. Additional Proposals for the Hospital Value-Based Purchasing (Hospital VBP) Program

A. Hospital VBP Program

1. Legislative Background

Section 3001(a) of the Affordable Care Act added section 1886(o) to the Act. This section requires the Secretary to establish a hospital inpatient value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year. Both the performance standards and the performance period for a fiscal year are to be established by the Secretary.

Section 1886(o)(1)(B) of the Act directs the Secretary to begin making value-based incentive payments under the Hospital Inpatient Value-Based

Purchasing Program (Hospital VBP Program) to hospitals for discharges occurring on or after October 1, 2012. These incentive payments will be funded for FY 2013 through a reduction of 1.0 percent to the FY 2013 base operating DRG payment amount for each discharge, as required by section 1886(o)(7)(B)(i) of the Act.

Section 1886(o)(1)(C) of the Act provides that the Hospital VBP Program applies to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Act), but excludes from the definition of the term “hospital,” with respect to a fiscal year: (1) a hospital that is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) of the Act (the Hospital IQR Program) for such fiscal year; (2) a hospital for which, during the performance period for the fiscal year, the Secretary cited deficiencies that pose “immediate jeopardy” to the health or safety of patients; and (3) a hospital for which there are not a minimum number (as determined by the Secretary) of measures for the performance period for the fiscal year involved, or for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

2. Overview of the Hospital Inpatient VBP Program Final Rule

We recently issued the Hospital Inpatient VBP Program Final Rule, which implemented the Hospital VBP

Program under section 1886(o) of the Act (76 FR 26490 through 26547). The Hospital Inpatient VBP Program Final Rule was developed based on extensive research we conducted on hospital value-based purchasing, including research that formed the basis of a 2007 report we submitted to Congress, entitled “Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program.” This report is available on our Web site (<https://www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf>) and takes into account input from stakeholders and other interested parties.

As described more fully in the Hospital Inpatient VBP Program Final Rule, we adopted for the FY 2013 Hospital VBP Program 13 measures that we have already adopted for the Hospital IQR Program, categorized into two domains (76 FR 26495 through 26511). We grouped 12 clinical process of care measures into a clinical process of care domain, and placed the HCAHPS survey measure into a patient experience of care domain. We adopted a 3-quarter performance period from July 1, 2011 through March 31, 2012 for these measures (76 FR 26494 through 26495). To determine whether a hospital meets the proposed performance standards for these measures, we will compare each hospital’s performance during this performance period to its

performance during a 3-quarter baseline period from July 1, 2009 through March 31, 2010 (76 FR 26493 through 26495).

We also finalized a methodology for assessing the total performance of each hospital based on performance standards under which we will score each hospital based on achievement and improvement ranges for each applicable measure. We will calculate a Total Performance Score for each hospital by combining the greater of the hospital’s achievement or improvement points for each measure to determine a score for each domain, weighting each domain score (for the FY 2013 Hospital VBP Program, the weights will be clinical process of care = 70 percent, patient experience of care = 30 percent), and adding together the weighted domain scores. We will convert each hospital’s Total Performance Score into a value-based incentive payment using a linear exchange function. We refer readers to the Hospital Inpatient VBP Program Final Rule for further explanation of the details of the FY 2013 Hospital VBP Program (76 FR 26490 through 26547).

For FY 2014, we adopted 13 outcome measures comprised of 3 mortality measures, 2 AHRQ composite measures, and 8 hospital-acquired condition (HAC) measures (76 FR 26511). These measures are discussed fully in the Hospital Inpatient VBP Program Final Rule (76 FR 26510 through 26511). These finalized outcome measures for FY 2014 are set forth below.

FINALIZED OUTCOME MEASURES FOR THE FY 2014 HOSPITAL VBP PROGRAM

Mortality Measures (Medicare Patients):

- Acute Myocardial Infarction (AMI) 30-day mortality rate.
- Heart Failure (HF) 30-day mortality rate.
- Pneumonia (PN) 30-day mortality rate.

AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) Composite Measures:

- Complication/patient safety for selected indicators (composite).
- Mortality for selected medical conditions (composite).

Hospital Acquired Condition Measures:

- Foreign Object Retained After Surgery.
- Air Embolism.
- Blood Incompatibility.
- Pressure Ulcer Stages III & 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.

3. Proposed Additional FY 2014 Hospital VBP Program Measures

For the FY 2014 Hospital VBP Program, we are proposing to retain all 13 of the clinical process of care and patient experience of care measures that we adopted for the FY 2013 Hospital VBP Program. We also are proposing to add one measure to the clinical process of care domain: SCIP–Inf–9: Postoperative Urinary Catheter Removal

on Postoperative Day 1 or 2. This measure was specified for the Hospital IQR Program beginning with FY 2011 and subsequent payment determination years (74 FR 43869 through 43870), and information about the measure first appeared on *Hospital Compare* in December 2010. Thus, we believe that this measure meets the requirement in section 1886(o)(2)(C)(i) of the Act to be included in the Hospital VBP Program because it has been specified for the

Hospital IQR Program and will have been displayed on *Hospital Compare* for at least one year before the applicable performance period begins. In addition, SCIP–Inf–9 is NQF-endorsed (#453).

The measure is relevant for the Hospital VBP Program because it assesses a practice that reduces Catheter Associated Urinary Tract Infection (CAUTI), and improves patient safety, which is highlighted as one of the Institute of Medicine’s six quality aims

along with effectiveness, patient-centeredness, timeliness, efficiency, and equity. SCIP–Inf–9 is one of the NQF-endorsed SCIP infection prevention measures; these measures are referenced as a whole among the metrics listed in the HHS Action Plan to Prevent HAIs. This Action Plan can be found at the following Web site: <http://www.hhs.gov/ash/initiatives/hai/actionplan/>. Furthermore, this measure meets other criteria considered for measure selection

for the Hospital VBP Program, such as not being “topped-out” and displaying meaningful variability among hospitals. Therefore, we believe it would be a meaningful measure to include in the Hospital VBP Program. The table below lists the clinical process of care and patient experience of care measures we are proposing to adopt for the FY 2014 Hospital VBP Program. We note that these measures are currently NQF-endorsed and we will

continue to monitor these measures to ensure that they reliably measure hospital quality, for example, ensuring that, among other things, these measures are not “topped-out,” and their measurement criteria remain endorsed by NQF and/or are otherwise appropriate. To the extent we determine that these measures are topped-out, we may choose not to finalize them.

PROPOSED CLINICAL PROCESS OF CARE AND PATIENT EXPERIENCE OF CARE MEASURES FOR THE FY 2014 HOSPITAL VBP PROGRAM

Clinical Process of Care Measures	
Measure ID	Measure description
Acute myocardial infarction:	
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.
AMI–8a	Primary PCI Received Within 90 Minutes of Hospital Arrival.
Heart Failure:	
HF–1	Discharge Instructions.
Pneumonia:	
PN–3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.
PN–6	Initial Antibiotic Selection for CAP in Immunocompetent Patient.
Healthcare-associated infections:	
SCIP–Inf–1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
SCIP–Inf–2	Prophylactic Antibiotic Selection for Surgical Patients.
SCIP–Inf–3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.
SCIP–Inf–4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.
SCIP–Inf–9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2.
Surgeries:	
SCIP–Card–2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period.
SCIP–VTE–1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered.
SCIP–VTE–2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery.
Patient Experience of Care Measures	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey.*

* Proposed dimensions of the HCAHPS survey for use in the FY 2014 Hospital VBP Program are: Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, Communication about Medicines, Cleanliness and Quietness of Hospital Environment, Discharge Information and Overall Rating of Hospital.

We invite public comment on these proposals.

4. Proposed Minimum Numbers of Cases and Measures for the Outcome Domain for the FY 2014 Hospital VBP Program

a. Background

Section 1886(o)(1)(C)(ii)(III) of the Act requires the Secretary to exclude for the fiscal year hospitals that do not report a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for the fiscal year. Section 1886(o)(1)(C)(ii)(IV) of the Act requires the Secretary to exclude for the fiscal year hospitals that do not report a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for the fiscal year. In the Hospital Inpatient VBP Program Final Rule, we adopted 13 outcome measures for the FY 2014 Hospital VBP Program (76 FR 26511), but we did not

adopt a minimum number of cases for such measures to apply to hospitals, nor did we adopt a minimum number of measures necessary for the outcome domain to be included in the Total Performance Score.

Under section 1886(o)(1)(C)(iii) of the Act, in determining the minimum number of reported measures and cases under sections 1886(o)(1)(C)(ii)(III) and (IV), the Secretary must conduct an independent analysis of what minimum numbers would be appropriate. As described in the Hospital Inpatient VBP Final Rule (76 FR 26528 through 26529), to fulfill this requirement, we commissioned Brandeis University to perform an independent analysis that examined technical issues concerning the minimum number of cases per measure and the minimum number of measures per hospital for clinical process of care measures needed to derive reliable domain scores. Based on that analysis, we finalized our policy to exclude any clinical process of care

measures for which a hospital reported fewer than 10 cases, and to exclude from the Hospital VBP Program any hospital to which fewer than 4 of the clinical process of care measures applied. We also finalized our proposal to exclude any hospital reporting fewer than 100 HCAHPS surveys during the performance period (76 FR 26529 through 26531).

To determine the minimum numbers of measures and cases that should be required for the outcome domain, we again commissioned Brandeis University to perform an independent analysis. This analysis examined hospital performance on the 13 finalized outcome measures using data from the proposed baseline periods (discussed below) for the FY 2014 Hospital VBP Program. As we did to analyze the reliability of scores in the clinical process of care domain, different minimum numbers of cases and measures were tested to determine the combination of minimum numbers of

cases and measures that would lead to reliable scores in the outcome domain while allowing the maximum number of hospitals to be scored for the Hospital VBP Program. Concurrent with the Brandeis analysis, we contracted with researchers at Mathematica Policy Research (Mathematica) to explore the minimum number of cases a hospital would need to report for each individual outcome measure.

b. Proposed Minimum Number of Cases for Mortality Measures, AHRQ Composite Measures, and HAC Measures

The analyses by Brandeis and Mathematica determined that in order to receive a score on a mortality measure, the hospital would need to report a minimum of 10 cases, and in order to receive a score on an AHRQ composite measure, a hospital would need to report a minimum of 3 cases. Consistent with these analyses, we are proposing that these case minimums would apply for the FY 2014 Hospital VBP Program.

Mathematica also examined the minimum number of cases a hospital would need to report in order to receive a reliable score on each HAC measure. Along with reliability concerns, when conducting this analysis, Mathematica also took into consideration our view, more fully explained in section XVI.A.6.d. of this proposed rule, that the incidence of HACs raises significant safety and quality concerns for patients and for the Medicare program. Therefore, we believe that a hospital should be held accountable when HACs occur in all instances in order to protect and promote patient safety. Mathematica concluded that a minimum of one Medicare claim would be sufficient to compute an accurate score on each HAC measure, and in accordance with this conclusion, we are proposing that hospitals be evaluated based on the presence or absence of HAC occurrences, regardless of the number of Medicare cases a hospital treats, as long as the hospital submits at least one Medicare claim during the performance period. As we discuss further below, we anticipate that all participating hospitals will submit at least one Medicare claim during the performance period, which would be sufficient for the hospitals to receive a score on seven of the eight HAC measures.

c. Proposed Minimum Numbers of Measures for Outcome Domain

Brandeis researchers also analyzed the reliability of the outcome domain scores for hospitals depending upon the total number of outcome measures on

which they reported. The analysis showed that the data provide a meaningful and sufficiently reliable indication of outcomes for hospitals in the outcome domain as long as the hospitals submit the minimum number of cases (discussed above) on each of 11 outcome measures for FY 2014. Specifically, the analysis found that using at least 11 outcome measures per hospital provided sufficiently comparable reliability of hospitals' scores in the outcome domain (particularly in terms of rank ordering relative to other hospitals) as compared with what hospitals' scores would have been if they had reported on more outcome measures. Brandeis concluded that this 11 measure minimum could be comprised of the 8 HAC measures, together with 3 measures comprised of any combination of the 3 mortality measures and the 2 AHRQ composite measures.

We note that, in conducting its analysis, Brandeis evaluated how the outcome domain score would be affected if a hospital reported all eight finalized HAC measures. However, one of these HAC measures, Foreign Object Retained After Surgery, will not apply to a very small subset of hospitals that do not perform surgeries. Taking this into account, as well as our own further analysis which shows that the reliability of the outcome domain score would not be significantly different as a statistical matter, we are proposing that the minimum number of measures a hospital would need to report in order to receive a score on the outcome domain is 10, comprised of 7 of the 8 HAC measures (all but the Foreign Object Retained After Surgery measure), along with 3 other measures comprised of any 3 of the other outcome measures (for example, 2 AHRQ composite measures and 1 mortality measure, or 3 mortality measures). We believe that this proposal is consistent with the conclusions reached by Brandeis. In addition, from an inclusiveness standpoint, we believe that a 10 measure minimum will maximize hospital participation in the FY 2014 Hospital VBP Program.

Furthermore, because we believe that every domain is an important component of an accurate Total Performance Score, we are proposing that, in order for a hospital to receive a Total Performance Score and be included in the FY 2014 Hospital VBP Program, the hospital must have enough cases and measures to report on all finalized domains. This proposed requirement should not impose any new barrier to hospitals or greatly reduce the number of hospitals in the FY 2014

Hospital VBP Program as compared to the FY 2013 Hospital VBP Program, when hospitals will only be scored on clinical process of care and patient experience of care measures. This is because, as stated above, an analysis of the existing data shows that virtually all hospitals participating in the FY 2014 Hospital VBP Program will report on a sufficient number of cases and measures to receive outcome domain scores in addition to the clinical process and patient experience domain scores for FY 2014.

We invite public comment on the proposed minimum numbers of cases and measures required for the FY 2014 Hospital VBP Program. We also invite public comment on the proposed requirement that hospitals must report on all four domains (if finalized) to receive a Total Performance Score for the FY 2014 Hospital VBP Program.

5. Proposed Performance Periods and Baseline Periods for FY 2014 Measures

Section 1886(o)(4) of the Act requires the Secretary to establish a performance period for the Hospital VBP Program for a fiscal year that begins and ends prior to the beginning of such fiscal year.

a. Proposed Clinical Process of Care Domain and Patient Experience of Care Domain Performance Period and Baseline Period

For the FY 2014 Hospital VBP Program, we are proposing a 9-month (3-quarter) performance period from April 1, 2012 to December 31, 2012 for the clinical process of care and patient experience of care domain measures. As described in the Hospital Inpatient VBP Final Rule (76 FR 26494 through 26495), due to various statutory deadlines and other challenges we faced in implementing the FY 2013 Hospital VBP Program in a timely fashion, we adopted a 3-quarter performance period for the clinical process of care and patient experience of care domains for the FY 2013 payment determination. We have stated our intent to move to a 12-month performance period when feasible. While a 12-month performance period is not yet feasible for FY 2014, we believe that this proposed 3-quarter performance period will allow us to notify hospitals of the amount of their value-based incentive payment at least 60 days before the start of FY 2014. It would also allow us to consider selecting CY 2013, a 12-month performance period, as the performance period for the FY 2015 Hospital VBP Program. In addition, this proposed performance period for FY 2014 would begin immediately after the end of the FY 2013 performance period, provide

reliable performance information, and ensure that incentive payments can be made beginning with October 1, 2013 discharges.

As we explained in the Hospital Inpatient VBP Program Final Rule (76 FR 26485), we believe that baseline data should be used from a comparable 9-month (3-quarter) period. Therefore, we are proposing April 1, 2010 to December 31, 2010 as the baseline period for these proposed measures for FY 2014. We invite public comment on these proposals.

b. Proposed Outcome Domain Performance Periods and Baseline Periods

In the Hospital Inpatient VBP Program proposed rule, we proposed an 18-month performance period of July 1, 2011 to December 31, 2012 and an 18-month baseline period of July 1, 2008 to December 31, 2009 for the three mortality outcome measures currently specified under the Hospital IQR Program (MORT-30-AMI, MORT-30-HF, MORT-30-PN). In response to public comment and for reasons discussed in the Hospital Inpatient VBP Program Final Rule (76 FR 26494), we adopted a 12-month performance period of July 1, 2011 to June 30, 2012 and a

12-month baseline period of July 1, 2009 to June 30, 2010 for these measures.

In the Hospital Inpatient VBP Program Final Rule, we stated that we would begin the performance period for the proposed HAC and AHRQ measures 1 year after such measures were included on *Hospital Compare*. Because all the finalized HAC and AHRQ measures were included on *Hospital Compare* on March 3, 2011, we finalized March 3, 2012 as the start of the performance period for these measures in the Hospital Inpatient VBP Program Final Rule (76 FR 26494 through 26495). We stated in the Hospital Inpatient VBP Program Final Rule (76 FR 26495) that we would propose the end performance period date for these measures in this proposed rule.

In order for the HAC and AHRQ measures to be scored for the FY 2014 Hospital VBP Program, the performance period for these measures would need to end by the fourth quarter of FY 2012 to allow us sufficient time to collect and process the necessary claims data. We note that this time period needs to be longer for HAC and AHRQ measures than for clinical process and patient experience measures, which are based on chart-abstracted data and surveys rather than claims. Claims data require

at least three months following a given calendar quarter to process and necessitate two additional months to complete measure calculation, including risk adjustment, statistical modeling, quality assurance, programming, and generating reports on patient-level data, which is provided to hospitals.

Therefore, we are proposing to adopt a nearly 7-month performance period for the HAC and AHRQ measures for FY 2014 by selecting September 30, 2012 as the end of the performance period. While we would prefer to use a 12-month performance period, analysis of existing data indicates that a 7-month performance period would provide sufficiently robust values on these critical measures.

As stated above, because we believe that a comparable period should be selected for the baseline data, we are proposing to set March 3, 2010 to September 30, 2010 as the baseline period for the proposed HAC and AHRQ measures for the FY 2014 Hospital VBP Program. We invite public comment on these proposals.

The following tables include all proposed and finalized baseline and performance periods for the FY 2013 and FY 2014 program years.

FY 2013 HOSPITAL VBP PROGRAM BASELINE AND PERFORMANCE PERIODS

Domain	Baseline period	Performance period
<i>Clinical Process</i>	July 1, 2009–March 31, 2010	July 1, 2011–March 31, 2012.
<i>Patient Experience</i>	July 1, 2009–March 31, 2010	July 1, 2011–March 31, 2012.

FY 2014 HOSPITAL VBP PROGRAM BASELINE AND PERFORMANCE PERIODS

Domain	Baseline period	Performance period
<i>Clinical Process</i> *	April 1, 2010–December 31, 2010	April 1, 2012–December 31, 2012.
<i>Patient Experience</i> *	April 1, 2010–December 31, 2010	April 1, 2012–December 31, 2012.
<i>Efficiency</i> *	May 15, 2010–90 days prior to February 14, 2011 ..	May 15, 2012–February 14, 2013.
<i>Outcomes</i>		
• Mortality	• July 1, 2009–June 30, 2010	• July 1, 2011–June 30, 2012.
• HAC *	• March 3, 2010–September 30, 2010	• March 3, 2012–September 30, 2012.
• AHRQ *	• March 3, 2010–September 30, 2010	• March 3, 2012–September 30, 2012.

* Proposed

6. Proposed Performance Standards for the FY 2014 Hospital VBP Program

a. Background

Section 1886(o)(3)(A) of the Act requires the Secretary to establish performance standards for the measures selected under the Hospital VBP Program for a performance period for the applicable fiscal year. The performance standards must include levels of achievement and improvement, as required by section 1886(o)(3)(B) of the Act, and must be established and

announced not later than 60 days before the beginning of the performance period for the fiscal year involved, as required by section 1886(o)(3)(C) of the Act. Achievement and improvement standards are discussed more fully in the Hospital Inpatient VBP Program Final Rule (76 FR 26511 through 26513). In addition, when establishing the performance standards, section 1886(o)(3)(D) of the Act requires the Secretary to consider appropriate factors, such as: (1) Practical experience with the measures, including whether a

significant proportion of hospitals failed to meet the performance standard during previous performance periods; (2) historical performance standards; (3) improvement rates; and (4) the opportunity for continued improvement.

(1) Mortality Measures

In the Hospital Inpatient VBP Program Final Rule, we finalized the achievement performance standard (achievement threshold) for each of the proposed FY 2014 Hospital VBP

Program mortality measures at the median of hospital performance (50th percentile) during the applicable baseline period. We also finalized the improvement performance standard

(improvement threshold) for each mortality measure at each specific hospital's performance on each measure during the baseline period of July 1, 2009 to June 30, 2010 (76 FR 26511

through 76 FR 26512). In addition, we finalized the precise achievement thresholds for these mortality measures (76 FR 26513), as shown below:

ACHIEVEMENT THRESHOLDS FOR THE FY 2014 HOSPITAL VBP PROGRAM MORTALITY OUTCOME MEASURES
[Displayed as survival rates]

Measure ID	Measure description	Performance standard (achievement threshold)	Benchmark
Mortality Outcome Measures			
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	0.8477	0.8673
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	0.8861	0.9042
MORT-30 PN	Pneumonia (PN) 30-Day Mortality Rate	0.8818	0.9021

(2) Proposed Medicare Spending per Beneficiary Measure

In section IV.B.3.b.(2)(A) of the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25927), we proposed to calculate a ratio of the Medicare spending per beneficiary amount for each hospital to the median Medicare spending per beneficiary amount across all hospitals during the performance period. We proposed to set the achievement threshold at the median Medicare spending per beneficiary ratio across all hospitals during the performance period. The proposed value of the achievement performance standard (achievement threshold) for the Medicare Spending per Beneficiary measure would be 1.0. This would be the middle ratio, or the Medicare spending per beneficiary for the median hospital divided by the median Medicare spending per beneficiary for all hospitals.

Likewise, in section IV.B.3.b.(2)(B) of the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25927 through 25928), we proposed to set the improvement performance standard (improvement threshold) for the proposed Medicare spending per beneficiary measure at the

hospital's own Medicare spending per beneficiary ratio, as calculated during the proposed baseline period. We also proposed to set the achievement performance benchmark at the mean of the lowest decile of Medicare spending per beneficiary ratios during the performance period, and that the improvement benchmark would be equal to the achievement performance benchmark for the performance period, which is the mean of the lowest decile of Medicare spending per beneficiary ratios. We refer readers to the FY 2012 IPPS/LTCH proposed rule for a complete discussion of these proposals.

b. Proposed Clinical Process of Care and Patient Experience of Care FY 2014 Performance Standards

As discussed in section XVI.B.5.a. of this proposed rule, we are proposing to adopt a 9-month (3-quarter) performance period of April 1, 2012 to December 31, 2012 for the clinical process of care and patient experience of care measures for the FY 2014 Hospital VBP Program. To set achievement and improvement performance standards for these proposed measures for the FY 2014 Hospital VBP Program, we are

proposing to use the same approach adopted in the Hospital Inpatient VBP Program Final Rule. That approach, as well as our rationale for adopting it, is explained in detail at 76 FR 26511 through 76 FR 26513. We are proposing to set the achievement performance standard (achievement threshold) for each proposed measure at the median of hospital performance (50th percentile) during the proposed baseline period of April 1, 2010 through December 31, 2010. We also are proposing to set the improvement performance standard (improvement threshold) for each of the proposed measures at each specific hospital's performance on the applicable measure during the proposed baseline period of April 1, 2010 through December 31, 2010. We are proposing to set each benchmark for each measure as the mean of the top decile performance of applicable hospitals during the proposed baseline period. We invite public comment on these proposals.

We set out proposed achievement performance standards for the proposed clinical process of care and patient experience of care measures using the applicable baseline period data in the table below.

PROPOSED ACHIEVEMENT PERFORMANCE STANDARDS FOR PROPOSED FY 2014 CLINICAL PROCESS OF CARE AND PATIENT EXPERIENCE OF CARE MEASURES

Measure ID	Measure description	Performance standard (achievement threshold)	Benchmark
Process of Care Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.8066	0.9630
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9344	1.0000
HF-1	Discharge Instructions	0.9266	1.0000
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.	0.9730	1.0000
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9446	1.0000
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9807	1.0000
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9813	1.0000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9663	0.9996

PROPOSED ACHIEVEMENT PERFORMANCE STANDARDS FOR PROPOSED FY 2014 CLINICAL PROCESS OF CARE AND PATIENT EXPERIENCE OF CARE MEASURES—Continued

Measure ID	Measure description	Performance standard (achievement threshold)	Benchmark
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	0.9634	1.0000
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	0.9286	0.9989
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period.	0.9565	1.0000
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered.	0.9462	1.0000
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery.	0.9492	0.9983
Patient Experience of Care Measure			
HCAHPS	Communication with Nurses	75.79%	84.99%
	Communication with Doctors	79.57%	88.45%
	Responsiveness of Hospital Staff	62.21%	78.08%
	Pain Management	68.99%	77.92%
	Communication about Medicines	59.85%	71.54%
	Hospital Cleanliness & Quietness	63.54%	78.10%
	Discharge Information	82.72%	89.24%
	Overall Rating of Hospital	67.33%	82.55%

c. AHRQ Measures

For the reasons we have discussed in the Hospital Inpatient VBP Program Final rule (76 FR 26514), we are proposing to set the achievement performance standard (achievement threshold) for each AHRQ composite measure at the median of hospital performance (50th percentile) during the proposed baseline period of March 3, 2010 to September 30, 2010. We are proposing to set the benchmark for each AHRQ composite measure at the mean of the top decile of hospital performance during the proposed baseline period of March 3, 2010 to September 30, 2010. We also are proposing to set the improvement performance standard (improvement threshold) for each of the proposed measures at each specific hospital's performance on the applicable measure during the proposed baseline period of March 3, 2010 to September 30, 2010.

d. HAC Measures

We adopted eight HAC measures in the Hospital Inpatient VBP Final Rule. For each of these eight HAC measures, at least one quarter of hospitals achieved a 100 percent rating based on administrative data for all IPPS hospitals participating in the Hospital IQR Program for Medicare discharges from October 1, 2008 through June 30, 2010 (that is, they do not have any reportable HAC occurrences). In addition, based on the administrative data from October 1, 2008 through June 30, 2010, at least one half of all hospitals achieved a measure rate of 100

percent on six of the eight HAC measures (Foreign Object Retained After Surgery; Air Embolism; Blood Incompatibility; Pressure Ulcer Stages III and IV; Catheter-Associated UTI; Manifestations of Poor Glycemic Control). Accordingly, the achievement threshold for these measures would be zero if we proposed to set performance standards for each individual measure using the same methodology that we finalized with respect to the mortality measures.

We believe that the HAC measures are extremely important in promoting patient safety, improving quality of care, and reducing costs. According to a 2010 HHS Office of the Inspector General report, entitled "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries" (<http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>), an estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays. We believe that all the finalized HAC measures assess the presence of conditions and outcomes that are reasonably preventable if high quality care is furnished to the Medicare beneficiary. We also believe that the incidence of HACs in general raises major patient safety issues for Medicare beneficiaries. Outcome measures, including HAC outcome measures, are widely regarded by the provider community as strongly indicative of the quality of medical care and as integral to reporting and improving quality and patient safety. Therefore, we believe it is

important to include HAC outcome measures in the Hospital VBP Program.

For these reasons, we are proposing that our topped-out policy would not apply to the HAC measures. We also are proposing to treat the eight individual HAC measures as a single aggregate HAC score for purposes of scoring, and believe that this approach will enable us to calculate meaningful distinction among hospitals and variation in hospital performance. In addition, this aggregation of the scores for the HAC measures ensures that the HAC measures do not unduly outweigh the remainder of the measures in the outcome domain. Accordingly, in taking into account our HAC policy and reliability concerns, we are proposing to set achievement performance standards, benchmarks, and improvement performance standards based on hospital combined performance on seven or eight HAC measures, as applicable, during the proposed performance or baseline period. Because certain hospitals will report on only seven of the eight HAC measures, we are proposing separate standards for hospital performance depending on whether the hospitals report on seven or eight HAC measures. As discussed more fully below, we are also proposing to score hospital performance on the HAC measures by combining hospital performance scores on each of the HAC measures to calculate a single, aggregate HAC score for this purpose.

As finalized in the Hospital Inpatient VBP Program Final Rule (76 FR 26514), we are proposing to set the achievement performance standard (achievement

threshold) for the HAC aggregate score for those hospitals that report on all eight of the HAC measures at the median of hospital performance (50th percentile) of those hospitals reporting on all eight of the HAC measures during the proposed baseline period of March 3, 2010 to September 30, 2010. We are proposing to set the achievement performance standard (achievement threshold) for the HAC aggregate score for those hospitals that report on seven of the HAC measures at the median of hospital performance (50th percentile) on only those seven measures for those hospitals reporting on either seven or eight of the HAC measures during the proposed baseline period of March 3, 2010 to September 30, 2010.

We are proposing to set the benchmark for the HAC aggregate score for those hospitals that report on all eight of the HAC measures at the mean of the top decile of hospital performance for those hospitals reporting on all eight HAC measures during the proposed baseline period of March 3, 2010 to September 30, 2010. We are proposing to set the benchmark for the HAC aggregate score for those hospitals that

report on seven of the HAC measures at the mean of the top decile of hospital performance on only those seven measures for hospitals reporting on either seven or eight of the HAC measures during the proposed baseline period of March 3, 2010 to September 30, 2010.

We also are proposing to set the improvement performance standard (improvement threshold) for the HAC aggregate score at each specific hospital's performance during the proposed baseline period of March 3, 2010 to September 30, 2010, whether the hospitals report on seven or eight HAC measures. Please see below for further discussion of the aggregate HAC scoring methodology.

We note that the performance standards for the HAC aggregate score are displayed in the table below as a score composed of all eight individual HAC measures. We recognize that all hospitals report on seven of these individual measures, and nearly all (about 95 percent) of hospitals report all eight. However, a small number of hospitals do not report on the Foreign Object Removal after Surgery HAC

measure. We believe that any numerical differences between the HAC performance standards for hospitals reporting on seven of eight HAC measures compared to the standards for hospitals reporting on all eight HAC measures will be statistically insignificant. However, we intend to provide updated performance standards in the CY 2012 OPPTS/ASC final rule with comment period for those hospitals only reporting on seven of the eight HAC measures.

We invite public comment on the proposed methodology for setting performance standards for the aggregate HAC score for HAC measures finalized for the FY 2014 Hospital VBP Program. We specify the proposed performance standards for the aggregate HAC score (all eight measures) and AHRQ measures using the proposed baseline period data in the table below. We note that, for both AHRQ and HAC measures, a lower value represents better performance on the measures. Thus, a "perfect" score on each measure would be a 0.00.

PROPOSED ACHIEVEMENT PERFORMANCE STANDARDS FOR FY 2014 HAC * AND AHRQ MEASURES

Measure ID	Measure description	Performance standard (achievement threshold)	Benchmark
Outcome Measures			
HACs**	Hospital Acquired Conditions per 1,000 (aggregated)	0.00109	0.0000
AHRQ Composite	Complication/patient safety for selected indicators (composite)	0.4006	0.2754
AHRQ Composite	Mortality for selected medical conditions (composite)	0.7542	0.6130

* Finalized HACs for use in the FY 2014 Hospital VBP Program include: Foreign Object Retained After Surgery, Air Embolism, Blood Incompatibility, Pressure Ulcer Stages III & IV, Falls and Trauma, Vascular Catheter Associated Infections, Catheter Associated Urinary Tract Infection, and Manifestations of Poor Glycemic Control.

** HAC performance standards were calculated using data from hospitals reporting on 8 HAC measures. The final rule will include the performance standards for hospitals reporting on seven HAC measures.

7. Proposed FY 2014 Hospital VBP Program Scoring Methodology

a. Proposed FY 2014 Domain Scoring Methodology

In the Hospital Inpatient VBP Program Final Rule, we adopted a methodology for scoring all clinical process of care, patient experience of care, and outcome measures. As noted in the Hospital Inpatient VBP Program Final Rule, this methodology outlines an approach that we believe is well-understood by patient advocates, hospitals and other stakeholders because it was developed during a year-long process that involved extensive stakeholder input, and was presented by us in a report to Congress. Further, we have conducted extensive research on a number of other scoring models for the Hospital VBP Program to ensure a high level of confidence in the

scoring methodology (76 FR 26514). In addition, we believe that, for simplicity and consistency of the Hospital VBP Program, it is important to score hospitals under the same methodology for subsequent fiscal years, with appropriate modifications to accommodate new domains and measures. Therefore, we are proposing to use the same scoring methodology for these measures in the FY 2014 Hospital VBP Program, with the changes discussed below for HAC measures. We also refer readers to discussion of the proposed Medicare Spending per Beneficiary measure in the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25927 through 25928). We invite public comment on this proposal.

b. Proposed HAC Measures Scoring Methodology

We are proposing to score the HAC measures using an aggregated HAC rate based on the unweighted average of the rates of the individual HAC measures. However, as explained above, we are aware that hospitals may only report on seven of the eight finalized HAC measures. This is because some hospitals do not perform surgeries, and therefore would not submit eligible claims that would be the basis for the Foreign Object Retained After Surgery HAC measure. The remaining seven HAC measures would apply to all hospitals, however, because all hospitals that participate in the Hospital VBP Program will submit eligible claims for these measures. We also anticipate that most hospitals will report on all

eight of the individual HAC measures because most hospitals that participate in the Hospital VBP Program perform surgeries and would submit eligible surgical claims that would be the basis for the Foreign Object Retained After Surgery HAC measure. Accordingly, we are proposing that the aggregate HAC score for each hospital be calculated as the equally weighted average of the rates on all HAC measures for which the hospital reports Medicare claims, which will most often be an equally weighted average of the rates on all eight measures, but may be scores on seven of the HAC measures. As stated above, the HAC aggregate score will be calculated if a hospital submits at least one Medicare claim during the performance period. For example, if a hospital submits one or more Medicare claims during the performance period, and those claims do not indicate any HAC occurrences, the hospital will receive a perfect score on all applicable HAC measures. The aggregate HAC rate would then be used to assign points in accordance with the proposed performance standards discussed above to calculate an individual hospital's aggregate HAC achievement and improvement scores. The single aggregate HAC score would be the greater of the hospital's achievement or improvement score. The hospital's aggregate HAC score would be combined with the hospital's score on other outcome measures to derive an outcome domain score, with the aggregate HAC score weighted equally with the other outcome measures in the domain. We note that in assigning points for this aggregate HAC score, lower aggregate HAC scores represent better performance. We believe our proposed aggregate scoring methodology for HAC measures allows us to meaningfully score hospitals on these critical patient safety measures.

We welcome public comment on this proposal.

8. Ensuring HAC Reporting Accuracy

For the FY 2013 Hospital VBP Program, the validation process we adopted for the Hospital IQR Program will ensure that the Hospital VBP data are accurate (76 FR 26537 through 26538). In addition, Medicare Administrative Contractors (MACs) review claims to ensure that accurate Medicare payments are made. This claims review ensures that HAC data included on the claims are accurately reported both for the Hospital IQR Program and the Hospital VBP Program. In addition, we are considering proposing to adopt additional targeting to assess the accuracy of HAC data

reported on claims. Specifically, we are considering targeting a subset of hospitals that report zero or an aberrantly low percentage of HACs on Medicare fee-for-service IPPS claims relative to the overall national average of HACs.

This consideration is supported by our analysis of HAC rates calculated using data from Medicare fee-for-service claims from October 1, 2008 through June 30, 2010. We publicly released these rates in March 2011, and they can be found on our Web site at: http://www.cms.gov/HospitalQualityInits/06_HACPost.asp#TopOfPage. This analysis revealed a range in hospital-reporting of the eight HACs from a low of 0.0001 percent (that is, 1 discharge out of every 100,000 applicable discharges) of hospital inpatient discharges (23 discharges) reporting a blood incompatibility, to a high of 0.0564 percent (that is, 56.4 discharges out of every 100,000 applicable discharges) reporting Falls and Trauma. According to this analysis, however, these HAC rates appear to be underreported occurrences when compared to similar HAI measures. For example, the Catheter Associated Urinary Tract Infection (CAUTI) measure rate was 5.4 percent, or 54 out of every 1,000 eligible discharges, as reported in the AHRQ 2008 National Healthcare Quality Report. This rate is more than 125 times greater than the national HAC reported CAUTI rate of 0.317 out of every 1,000 eligible discharges. While we recognize that definitional differences in the measures might contribute to this rate difference, we also believe that underreporting of HAC claims data contributed to this difference. It is important to note that the 5.4 percent CAUTI rate was calculated using medical record documentation as a data source and a random sample of Medicare beneficiaries for acute care hospital stays, as discussed in a separate Federal report about healthcare quality (AHRQ 2008 National Healthcare Quality Report). We note that this analysis is exploratory in nature, and we cannot definitively conclude any systematic underreporting by any particular hospitals. Nonetheless, we believe that this analysis provides sufficient information for CMS to consider development of a HAC validation process to assess potential underreporting by hospitals and ensure accurate reporting among all hospitals reporting HACs on Medicare claims. Our goal is to improve quality and patient safety through accurate reporting of hospital quality data and accurately linking quality to payment in the

Hospital VBP Program. We strive to ensure accurate reporting, and we believe that validating a random subset of hospitals that report an aberrantly low number of HACs would strengthen our overall effort to link value to quality. We welcome public comments regarding our consideration of a HAC validation process. We also note that we intend to take appropriate action if we discover systematic underreporting of HAC and other adverse event information, including, where appropriate, reporting such instances to the HHS Office of the Inspector General for its review.

9. Proposed Domain Weighting for FY 2014 Hospital VBP Program

For the FY 2013 Hospital VBP Program, we adopted a weighting scheme that weights the clinical process of care domain at 70 percent of the Total Performance Score, and weights the patient experience of care domain at 30 percent. However, the addition of the outcome domain and the proposed addition of an efficiency domain necessitate the adoption of a different domain weighting scheme than we adopted for the FY 2013 Hospital VBP Program. We discuss below the factors we considered in determining the appropriate weight to propose for each domain in the FY 2014 Hospital VBP Program.

As we have previously stated, we believe that the patient's experience associated with receiving inpatient services in a hospital is important in determining the hospital's overall quality of care for purposes of the Hospital VBP Program. However, we also believe that a majority of the Total Performance Score should be based on the objective data submitted by hospitals on the measures selected for the Hospital VBP Program. Thus, as we finalized for the FY 2013 Hospital VBP Program, we are proposing to weight the patient experience of care domain at 30 percent for the FY 2014 Hospital VBP Program. We believe that this weighting proposal appropriately incentivizes hospitals to provide patient-centered care across the full spectrum of their services. As we stated in the Hospital Inpatient VBP Program Final Rule (76 FR 26491), we believe that domains need not be given equal weight, and that over time, scoring methodologies should be weighted more towards outcomes, patient experience of care and functional status measures (measures assessing physical and mental capacity, capability, well-being and improvement). Consistent with this policy and our analysis showing that many of the clinical process of care

measures are nearly topped-out, we are proposing to reduce the weighting for the clinical process of care domain to 20 percent. We also are proposing to weight the outcome domain at 30 percent of the Total Performance Score for the FY 2014 Hospital VBP Program. Because we believe that scoring hospitals on outcome measures will improve treatment outcomes and patient safety, we intend to propose increasing the weighting for the outcome domain in subsequent fiscal years as more outcome measures become available.

As we indicated in the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25927 through 25928), we believe that efficiency is an important component of improving outcomes, the patient experience of care and the overall quality of care provided to Medicare beneficiaries in the inpatient hospital setting. However, we also recognize the importance of clinical quality based upon industry standards of care and the patients' experience of care. Accordingly, we are proposing to weight the efficiency domain at 20 percent of the Total Performance Score for the FY 2014 Hospital VBP Program.

Therefore, we are proposing the following domain weights for the FY 2014 Total Performance Score: outcome domain = 30 percent; clinical process of care domain = 20 percent; patient experience of care domain = 30 percent; and efficiency domain = 20 percent. Under this proposed weighting scheme, the clinical care-related domains (process of care and outcome domains) would, together, constitute 50 percent of the total performance score (20 percent for clinical process of care and 30 percent for outcome), the patient experience of care domain would constitute 30 percent, and the efficiency domain would constitute 20 percent. We believe that this proposed weighting scheme will hold hospitals accountable for all aspects of patient care, including clinical outcomes and efficiency.

We invite public comment on the proposed weighting of the four proposed domains to be used in the calculation of the Total Performance Score for the FY 2014 Hospital VBP Program.

B. Proposed Review and Correction Process Under the Hospital VBP Program

1. Background

Section 1886(o)(10)(A)(i) of the Act requires the Secretary to make information available to the public regarding individual hospital performance in the Hospital VBP Program, including: (1) Performance of

the hospital on each measure that applies to the hospital; (2) the performance of the hospital with respect to each condition or procedure; and (3) the hospital's Total Performance Score. To meet this requirement, we stated our intention in the Hospital Inpatient VBP Program Final Rule to publish hospital scores with respect to each measure, each hospital's condition-specific score (that is, the performance score with respect to each condition or procedure, for example, AMI, HF, PN, and SCIP), each hospital's domain-specific score, and each hospital's Total Performance Score on Hospital Compare (76 FR 26534 through 26536). We intend to make proposals related to making this information publicly available in future rulemaking.

Section 1886(o)(10)(A)(ii) of the Act requires the Secretary to ensure that each hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to each hospital under section 1886(o)(10)(A)(i) of the Act prior to such information being made public.

For the FY 2013 Hospital VBP Program, the finalized measures consist of chart-abstracted clinical process of care measures and a patient experience of care measure. We are proposing that hospitals will have an opportunity to review and correct chart-abstracted data and patient experience data through the processes discussed below. We intend to make additional proposals regarding the review and correction of outcome measures, efficiency measures, and domain, condition, and Total Performance Scores in future rulemaking.

2. Proposed Review and Corrections of Data Submitted to the QIO Clinical Warehouse on Chart-Abstracted Process of Care Measures and Measure Rates

We are proposing that the process utilized to give hospitals an opportunity to review and correct data submitted on the Hospital IQR Program chart-abstracted measures also be used to allow hospitals to correct data and measure rates on chart-abstracted measures for the Hospital VBP Program. Under this proposed process, hospitals would continue to have the opportunity to review and correct data they submit on all Hospital IQR Program chart-abstracted measures, whether or not the measure is adopted as a measure for the Hospital VBP Program. We are proposing to use the Hospital IQR Program's data submission, review, and correction processes, which will allow for review and correction of data on a continuous basis as it is being submitted for the Hospital IQR Program, which in

turn would allow hospitals to correct data and measure rates used to calculate the Hospital VBP Program Total Performance Score for those hospitals that participate in both programs. We believe this process would satisfy the requirement in section 1886(o)(10)(A)(ii) of the Act to allow hospitals to review and submit corrections for one of the pieces of information that will be made public with respect to each hospital—the measure rates for chart-abstracted measures. For hospitals that do not participate in the Hospital IQR Program but do participate in the Hospital VBP Program, such as Maryland hospitals, we intend to make proposals regarding how those hospitals will be able to review and correct their Hospital VBP data in future rulemaking.

Under the Hospital IQR Program, hospitals currently have an opportunity to submit, review, and correct any of the chart-abstracted information submitted to the QIO Clinical Warehouse for the full 4½ months following the last discharge date in a calendar quarter. (We note that in the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25915), we proposed to reduce the submission period from 4½ months to 104 days.) Hospitals can begin submitting data on the first discharge day of any reporting quarter. Hospitals are encouraged to submit data early in the submission schedule so that they can identify errors and resubmit data before the quarterly submission deadline. Users are able to view and make corrections to the data that they submit within 24 hours of submission. The data are populated into reports that are updated nightly with all data that have been submitted and successfully processed for the previous day. Hospitals are able to view a report each quarter which shows the numerator, denominator and percentage of total for each Clinical Measure Set and Strata. That report contains the hospital's performance on each measure set/strata submitted to the QIO Clinical Warehouse. The numerator is the number of cases that satisfies the conditions of the performance measure, and a denominator is the number of successfully accepted cases in the measure population evaluated by the performance measure. The percentage of total is calculated by using the numerator divided by the denominator multiplied by 100. This measure rate is the same as the Hospital VBP measure rate.

We believe that 4½ months is sufficient time for hospitals to be able to submit, review data, make corrections to the data, and view their percentage of total, or measure rate, on each Clinical Measure Set/Strata for use in both the

Hospital IQR and Hospital VBP Programs. Additionally, because this process is familiar to most hospitals, use of this existing framework reduces the burden that could have been placed on hospitals that participate in the Hospital IQR Program if they had to learn a new process for submitting data for the Hospital VBP Program. Following the period in which hospitals can review and correct data and measure rates for chart-abstracted measures as specified above, we propose that hospitals will have no further opportunity to correct such data or measure rates.

We are proposing that once the hospital has an opportunity to review and correct data related to chart-abstracted measures submitted in the Hospital IQR Program, we will consider that the hospital has been given the opportunity to review and correct this data and measure rates for purposes of the Hospital VBP Program, and these measure rates will be used to calculate domain, condition, and Total Performance Scores for the Hospital VBP Program without further review and correction. We invite public comment on this proposal.

3. Proposed Review and Correction Process for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Data

We are proposing a “two-phase” process for the review and correction of HCAHPS data. Under this proposed process, hospitals would have the opportunity to review and correct data they submitted on all HCAHPS Hospital IQR Program items in the first phase, whether or not such items or combination of items are adopted as HCAHPS dimensions for the Hospital VBP Program. In the second phase, hospitals would have the opportunity to review the patient-mix and mode adjusted HCAHPS scores (details on the HCAHPS adjustment process may be found at: <http://www.hcahponline.org/files/Final%20Draft%20Description%20of%20HCAHPS%20Mode%20and%20PMA%20with%20bottom%20box%20modedoc%20April%2030,%202008.pdf>) on dimensions that we will use to score hospitals under the Hospital VBP Program to determine whether they believe CMS calculated their scores on these dimensions correctly. We believe that this proposal for a two-phase review process will expedite hospital review and correction of data. We also believe that this proposal will improve quality of care because hospitals will be able to timely review their HCAHPS scores and respond efficiently in improving patient care to address areas of weakness

reflected in their scores. We are not proposing to release any patient level data to the public. This proposed review process would only grant each hospital the authority to review and correct the hospital's patient-level data.

a. Phase One: Review and Correction of HCAHPS Data Submitted to the QIO Clinical Warehouse

For the first phase of the HCAHPS review and correction process, we proposed to reduce the HCAHPS submission deadline under the Hospital IQR Program by one week in order to create a 1-week period for hospitals to review and correct their HCAHPS data. We included this proposal to reduce the submission deadline in the FY 2012 IPPS/LTCH PPS proposed rule (76 FR 25916). Currently, hospitals have approximately 14 weeks after the end of a calendar quarter to submit HCAHPS data for that quarter to the QIO Clinical Warehouse. Under this proposal, hospitals would have approximately 13 weeks after the end of a calendar quarter to submit HCAHPS data for that quarter to the QIO Clinical Warehouse and a 1-week period to review and correct that data. During the 13-week submission period, hospitals would be able to resubmit their data to make corrections to the patient-level records. The 1-week review and correction period would occur immediately after the 13-week data submission deadline.

The proposed 1-week review and correction period would allow hospitals to provide missing data or replace incorrect data in the data files they have submitted to the QIO Clinical Warehouse. The 1-week review and correction period will allow hospitals to identify any issues with the data they had submitted in the 13-week submission period. Hospitals will have the opportunity to review frequency distributions of all of their submitted data items, which include hospital summary information, patient administrative data, and patient survey responses, and resubmit their HCAHPS data files to correct identified issues during the 1-week review and correction period. We define the term “review and correct” to mean that hospitals can correct their existing data records, but not add new data records. Accordingly, hospitals would not be allowed to add new patient-level records or remove existing patient-level records during the review and correction period. Following the conclusion of the 1-week review and correction period, hospitals would not be allowed to review, correct, or submit additional HCAHPS data for the applicable calendar quarter.

b. Phase Two: Review and Correction of HCAHPS Scores for the Hospital VBP Program

In the second phase of the proposed HCAHPS review and correction process, hospitals would be given the opportunity to review their scores on the HCAHPS items that will be used in the Hospital VBP Program. These HCAHPS scores are constructed after the data that hospitals had submitted have been analyzed to identify and remove incomplete surveys and after adjustments for the effects of patient-mix and survey mode have been applied. (Details on the HCAHPS adjustment process may be found at: <http://www.hcahponline.org/files/Final%20Draft%20Description%20of%20HCAHPS%20Mode%20and%20PMA%20with%20bottom%20box%20modedoc%20April%2030,%202008.pdf>.) Hospitals would have approximately 1 week to examine their HCAHPS dimension scores for the applicable Hospital VBP Program performance period. A participating hospital would have the opportunity to question CMS if the hospital believes its scores were miscalculated. We would respond to a hospital's inquiries by checking the calculation and, if necessary, recalculating the hospital's HCAHPS scores. In this proposed second phase of the HCAHPS review and correction process, hospitals would not be allowed to change or submit new HCAHPS data or delete existing data. Their right to correct information during this period would be limited to reviewing their HCAHPS dimension scores and notifying CMS of any errors in its calculation of those scores. We intend to propose the procedural aspects of the second phase of the proposed HCAHPS review and correction process in the FY 2013 IPPS/LTCH PPS proposed rule. In summary, for the chart-abstracted and patient experience of care measures, we are proposing that existing procedures for submission, review, and correction related to chart-abstracted measures under the Hospital IQR Program, coupled with the proposed two phase review of HCAHPS scores discussed above, would constitute an opportunity for review and correction of measure data and measure rates under the Hospital VBP Program. Because these procedures give hospitals the opportunity to review and correct the data and/or measure rates, such data and measure rates may be used to calculate domain, condition, and Total Performance Scores for the Hospital VBP Program. We intend to make proposals related to making this

information publicly available, and to make additional proposals regarding the review and correction of outcome measures, efficiency measures, and domain, condition, and Total Performance Scores in future rulemaking. We invite public comment on these proposals.

XVII. Files Available to the Public via the Internet

In the past, a majority of the Addenda to which we referred throughout the preamble of the OPSS/ASC proposed and final rules appeared in the printed version of the **Federal Register** as part of the annual rulemakings. However, beginning with this CY 2012 proposed rule, the Addenda of the proposed and final rules will be published and available only via the Internet on the CMS Web site. We note that our existing regulations at §§ 416.166(b), 416.171(b), and 416.173 provide for the annual publication of the covered surgical procedures and the payment rates under the ASC payment system in the **Federal Register**. In this proposed rule, we are proposing to revise these three regulations to reflect the option of annually publishing the Addenda containing the covered surgical procedures and payment rates under the ASC payment system via the Internet on the CMS Web site.

To view the Addenda of the CY 2012 OPSS/ASC proposed rule pertaining to the CY 2012 proposed payments under the OPSS, go to the CMS Web site at: <http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD> and select "1525-P" from the list of regulations. All Addenda for this proposed rule are contained in the zipped folder entitled "2012 OPSS NPRM Addenda" at the bottom of the page.

To view the Addenda of the CY 2012 OPSS/ASC proposed rule pertaining to the CY 2012 proposed payments under the ASC payment system, go to the CMS Web site at: <http://www.cms.gov/ASCPayment/ASCRN/> and select "1525-P" from the list of regulations. All Addenda for this proposed rule are contained in the zipped folder entitled "Addendum AA, BB, DD1, and DD2" at the bottom of the page.

A. Information in Addenda Related to the Proposed CY 2012 Hospital OPSS

Addenda A and B provide various data pertaining to the proposed CY 2012 payment for items and services under the OPSS. Specifically, Addendum A includes a list of all proposed APCs to be payable under the OPSS, including the proposed scaled relative weights, the proposed national unadjusted

payment rates, the proposed national unadjusted copayments, and the proposed minimum unadjusted copayments for each APC that we are proposing for CY 2012. Addendum B includes a list of all active HCPCS codes, including the proposed APC assignments, the proposed scaled relative weights, the proposed national unadjusted payment rates, the proposed national unadjusted copayments, the proposed minimum unadjusted copayments, and the proposed payment status indicators and proposed comment indicators for CY 2012 OPSS.

For the convenience of the public, we also are including on the CMS Web site a table that displays the HCPCS code data in Addendum B sorted by APC assignment, identified as Addendum C.

Addendum D1 defines the proposed payment status indicators that we are proposing to use in Addenda A and B. Addendum D2 defines the proposed comment indicators that are used in Addendum B. Addendum E lists the HCPCS codes that are proposed to be only payable to hospitals as inpatient procedures and that are not payable under the OPSS for CY 2012. Addendum L contains the proposed out-migration wage adjustment for CY 2012. Addendum M lists the HCPCS codes that are proposed to be members of a composite APC and identifies the proposed composite APC to which each is assigned. This addendum also identifies the proposed status indicator for each HCPCS code and a proposed comment indicator if there is a proposed change in the code's status with regard to its membership in the composite APC. Each of the HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it is assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific I/OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.2.e. of this proposed rule for a complete description of the proposed composite APCs.

Addendum N, "Proposed Bypass Codes for Creating 'Pseudo' Single Procedure Claims for CY 2012 OPSS," contains a list of the HCPCS codes that we are proposing to use to create "pseudo" single claims from multiple procedure claims so that the most claims data can be used to set median costs for the CY 2012 OPSS. We refer readers to section II.A.1.b. of this

proposed rule for a full discussion of the use of this file in the proposed 2012 OPSS ratesetting process. Addendum N contains the following elements for the proposed CY 2012 bypass codes: (1) HCPCS code; (2) short descriptor; (3) overall bypass indicator; and (4) an indicator if the code was not used as a bypass code in ratesetting activities prior to this CY 2012 proposed rule. The addendum was previously issued as a table (usually Table 1) in the preamble of the applicable proposed or final rule. We are issuing it as an addendum in this proposed rule because it is lengthy and users can better analyze the file if it is furnished in Excel format on the CMS Web site.

B. Information in Addenda Related to the Proposed CY 2012 ASC Payment System

Addenda AA and BB provide various data pertaining to the proposed CY 2012 payment for the covered surgical procedures and covered ancillary services for which ASCs may receive separate payment. Addendum AA lists, for CY 2012, the proposed ASC covered surgical procedures, whether the procedure is proposed to be subject to multiple procedure discounting, the proposed comment and payment indicators for each procedure, and the proposed payment weights and rates for each procedure. Addendum BB displays, for CY 2012, the proposed ASC covered ancillary services, the proposed comment and payment indicators for each service, and the proposed payment weights and rates for each service.

Addendum DD1 defines the proposed payment indicators that are used in Addenda AA and BB. Addendum DD2 defines the proposed comment indicators that are used in Addenda AA and BB.

To view the Addenda that pertain to the list of proposed surgical procedures to be excluded from Medicare payment if furnished in ASCs, go to the CMS Web site at: <http://www.cms.gov/ASCPayment/ASCRN/> and select "1525-P" from the list of regulations. The proposed excluded ASC procedures are contained in the zipped folder titled "Addendum EE" at the bottom of the page. The proposed excluded procedures listed in Addendum EE are surgical procedures that are assigned to the OPSS inpatient list, are not covered by Medicare, are reported using a CPT unlisted code, or have been determined to pose a significant safety risk to a Medicare beneficiary when performed in an ASC or for which standard medical practice dictates that the beneficiary typically requires active