

IV. Other Decisions and Changes to the IPPS for Operating Costs and Graduate Medical Education (GME) Costs

A. Hospital Readmissions Reduction Program

1. Statutory Basis for the Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act, as amended by section 10309 of the Affordable Care Act, added a new subsection (q) to section 1886 of the Act. Section 1886(q) of the Act establishes the “Hospital Readmissions Reduction Program,” effective for discharges from an “applicable hospital” beginning on or after October 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions.

Section 1886(q)(1) of the Act sets forth the methodology by which payments to “applicable hospitals” will be adjusted to account for excess readmissions. Pursuant to section 1886(q)(1) of the Act, payments for discharges from an “applicable hospital” will be an amount equal to the product of the “base operating DRG payment amount” and the adjustment factor for the hospital for the fiscal year. That is, “base operating DRG payments” are reduced by an adjustment factor that accounts for excess readmissions. Section 1886(q)(2) of the Act defines the base operating DRG payment amount as “the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o) [the Hospital VBP Program]) for a discharge if this subsection did not apply; reduced by . . . any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).”

Paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection(d) refer to outlier payments, IME payments, DSH payments, and payments for low-volume hospitals, respectively.

Furthermore, section 1886(q)(2)(B) of the Act specifies special rules for defining “the payment amount that would otherwise be made under subsection (d)” for certain hospitals. Specifically, section 1886(q)(2)(B) of the Act states that “[i]n the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital . . . the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).” We are finalizing policies to implement the statutory provisions related to the definition of “base operating DRG payment amount” in this FY 2013 IPPS/LTCH PPS final rule.

Section 1886(q)(3)(A) of the Act defines the “adjustment factor” for an applicable hospital for a fiscal year as equal to the greater of “(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or (ii) the floor adjustment factor specified in subparagraph (C).”

Section 1886(q)(3)(B) of the Act, in turn, describes the ratio used to calculate the adjustment factor. It states that the ratio is “equal to 1 minus the ratio of – (i) the aggregate payments for excess readmissions...; and (ii) the aggregate payments for all discharges....” Section 1886(q)(3)(C) of the Act describes the floor adjustment factor, which is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

Section 1886(q)(4) of the Act sets forth the definitions of “aggregate payments for excess readmissions” and “aggregate payments for all discharges” for an applicable hospital for the applicable period. The term “aggregate payments for excess readmissions” is defined in section 1886(q)(4)(A) of the Act as “the sum, for applicable conditions . . . of the product, for each applicable condition, of (i) the base operating DRG payment amount for such hospital for such applicable period for such condition; (ii) the number of admissions for such condition for such hospital for such applicable period; and (iii) the “Excess Readmission Ratio... for such hospital for such applicable period minus 1.” The “excess readmission ratio” is a hospital-specific ratio based on each applicable condition. Specifically, section 1886(q)(4)(C) of the Act defines the excess readmission ratio as the ratio of “risk-adjusted readmissions based on actual readmissions” for an applicable hospital for each applicable condition, to the “risk-adjusted expected readmissions” for the applicable hospital for the applicable condition.

Section 1886(q)(5) of the Act provides definitions of “applicable condition,” “expansion of applicable conditions,” “applicable hospital,” “applicable period,” and “readmission.” The term “applicable condition,” this is addressed in detail in section IV.C.3.a. of the FY 2012 IPPS/LTCH PPS final rule (76 FR 51665 through 51666), is defined as a “condition or procedure selected by the Secretary among conditions and procedures for which: (i) readmissions... represent conditions or procedures that are high volume or high expenditures...and (ii) measures of such readmissions . . . have been endorsed by the entity with a contract under section 1890(a)...and such endorsed

measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).” Section 1886(q)(5)(B) of the Act also requires the Secretary, beginning in FY 2015, “to the extent practicable, [to] expand the applicable conditions beyond the 3 conditions for which measures have been endorsed...to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary.”

Section 1886(q)(5)(C) of the Act defines “applicable hospital,” that is, a hospital subject to the Hospital Readmissions Reduction Program, as a “subsection (d) hospital or a hospital that is paid under section 1814(b)(3) [of the Act], as the case may be.” The term “applicable period,” as defined under section 1886(q)(5)(D) of the Act, “means, with respect to a fiscal year, such period as the Secretary shall specify.” As explained in the FY 2012 IPPS/LTCH PPS final rule, the “applicable period” is the period from which data are collected in order to calculate various ratios and adjustments under the Hospital Readmissions Reduction Program.

Section 1886(q)(6) of the Act sets forth the public reporting requirements for hospital-specific readmission rates. Section 1886(q)(7) of the Act limits administrative and judicial review of certain determinations made pursuant to section 1886(q) of the Act. Finally, section 1886(q)(8) of the Act requires the Secretary to collect data on readmission rates for all hospital inpatients for “specified hospitals” in order to calculate the hospital-specific readmission rates for all hospital inpatients and to publicly report these readmission rates.

2. Overview

As we stated in the FY 2012 IPPS/LTCH PPS final rule, we intend to implement the requirements of the Hospital Readmissions Reduction Program in the FY 2012, FY 2013, and future IPPS/LTCH PPS rulemaking cycles.

As explained above, the payment adjustment factor set forth in section 1886(q) of the Act does not apply to discharges until FY 2013. Therefore, we elected to implement the Hospital Readmissions Reduction Program over a 2-year period, beginning in FY 2012. In the FY 2012 IPPS/LTCH PPS final rule, we addressed the issues of the selection of readmission measures and the calculation of the excess readmission ratio, which will be used, in part, to calculate the readmission adjustment factor. Specifically, in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51660 through 51676), we addressed portions of section 1886(q) of the Act related to the following provisions:

- Selection of applicable conditions;
- Definition of “readmission;”
- Measures for the applicable conditions chosen for readmission;
- Methodology for calculating the excess readmission ratio; and
- Definition of “applicable period.”

With respect to the topics of “measures for readmission” for the applicable conditions, and “methodology for calculating the excess readmission ratio,” we specifically addressed the following:

- Index hospitalizations;
- Risk adjustment;

- Risk standardized readmission rate;
- Data sources; and
- Exclusion of certain readmissions.

We are providing below a summary of the provisions of section 1886(q) of the Act that were finalized in the FY 2012 IPPS/LTCH PPS final rule.

Applicable conditions: In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51665 through 51666), we finalized the applicable conditions for the FY 2013 Hospital Readmissions Reduction Program as heart failure (HF), acute myocardial infarction (AMI), and pneumonia (PN). Section 1886(q)(5)(A) of the Act requires that the “applicable conditions” be conditions or procedures for which readmissions are “high volume or high expenditure” and that “measures of such readmissions” have been endorsed by the entity with a contract under section 1890(a) of the Act (currently National Quality Forum (NQF)) and such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge. In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27956), we proposed to codify this definition of “applicable conditions” in the regulations we proposed at 42 CFR 412.152.

Comment: One commenter stated that the Hospital Readmissions Reduction Program measures were not reviewed by the Measure Application Partnership (MAP) in 2011. The commenter urged CMS to coordinate MAP review of the Hospital Readmissions Reduction Program and related measures.

Response: We thank the commenter for the suggestion. The three measures to be used in the Hospital Readmissions Reduction Program were finalized in the FY 2012

IPPS/LTCH Final Rule posted at the Office of the Federal Register on August 1, 2011, which pre-dated the requirement and establishment of the pre-rulemaking process as described under section 3014(b) of the Affordable Care Act, which amended section 1890A of the Act. This provision of the Affordable Care Act requires the Secretary to submit measures to a multi-stakeholder group, currently the Measure Application Partnership (MAP) for pre-rulemaking review. CMS established this pre-rulemaking process in December 2011. Because the statutory language at section 1886(q)(1) of the Act, as amended by section 3025 of the Affordable Care Act, refers to FY 2013 “and subsequent Fiscal Years” but authorizes expansion of the conditions (and hence measures) to be used in the program beginning with FY 2015, we believe the statute implies that the measures adopted for use in FY 2013 would also be used in FY 2014. In the future, if we consider proposing any new measures for future expansion of the Hospital Readmissions Reduction Program beyond these three measures, which we have the authority to do beginning with in FY 2015, we plan to submit them to the MAP for pre-rulemaking review.

Comment: Several commenters expressed concerns that the Hospital Readmissions Reduction Program may induce unintended consequences of overcrowding hospital emergency departments, as hospitals may believe they are compelled to avoid readmitting patients.

Response: We recognize that performance-based payment penalty or incentive programs may have the potential for unintended consequences. We are committed to monitoring the measures and assessing unintended consequences over time, such as the

inappropriate shifting of care, increased patient morbidity and mortality, and other negative unintended consequences for patients.

After consideration of the public comments we received, we are finalizing our proposal to codify the definition of “applicable condition” at 42 CFR 412.152 without modification.

In the FY 2012 IPPS/LTCH PPS final rule, we discussed how each of the finalized “applicable conditions” for FY 2013 meets these statutory requirements. We noted that section 1886(q)(5)(B) of the Act allows for the Secretary to expand the conditions for the Hospital Readmissions Reduction Program starting in FY 2015.

Comment: Several commenters addressed the expansion of conditions to be included in the program. Some commenters urged that CMS not include the hospital-wide readmission measure, currently proposed for the Hospital IQR program, in future HRRP program expansion. Commenters believed it would result in double counting of AMI, HF, and PN patients, and that condition-specific measures were more actionable and understandable for hospitals subject to this provision. Other commenters encouraged CMS to include the following conditions in future program expansions: atrial fibrillation (as one of other vascular conditions); chronic obstructive pulmonary disease; coronary artery bypass grafting; and percutaneous transluminal angioplasty. One commenter suggested that CMS delay the expansion of the program until such time as hospitals gain familiarity with the first three conditions used in the program.

Response: We thank the commenters for these suggestions and will take them into consideration when we address the expansion of the applicable conditions in future rulemaking.

Readmission: In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51666), we finalized a definition of “readmission” as occurring when a patient is discharged from an applicable hospital and then admitted to the same or another acute care hospital, that is, another applicable hospital, within a specified time period (30 days) from the date of discharge from the initial index hospitalization. In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27956), we proposed to codify this definition of “readmission” under the regulations we proposed at 42 CFR 412.152. As we also discussed in the FY 2012 IPPS/LTCH PPS final rule, only one readmission during the 30 days following the discharge from the initial hospitalization will count as a readmission for purposes of calculating the ratios set forth in section 1886(q)(3) of the Act. For any given patient, none of the subsequent readmissions he or she experiences within 30 days after discharge would be counted as a new “index” admission (that is, an admission evaluated for a subsequent readmission).

Comment: Several commenters did not believe that the readmissions measures adequately measures quality. Commenters noted that it is difficult to determine which readmissions are preventable, and questioned whether reducing readmissions is a desirable outcome because increased mortality could lead to decreased readmission rates. One commenter cited research that higher readmission rates occur in communities with more physicians and hospital beds and in areas with high poverty and large minority or

older populations to demonstrate that it is unclear whether readmissions always reflect poor quality.

Response: We believe that risk-standardized readmission rates provide an important quality indicator to hospitals, CMS, patients, policymakers, and insurers. Readmission of patients who were recently discharged after hospitalization with AMI, HF, or pneumonia represents an important, expensive, and often avoidable adverse outcome. The risk of readmission can be avoided by improving the quality and type of care provided to these patients. There is ample evidence^{50,51,52} that hospitals can reduce their readmission rates through such efforts as ensuring patients are clinically ready at discharge, reducing risk of infection, reconciling medications, improving communication with community providers participating in transitions of care, educating patients adequately upon discharge, and assuring patients understand follow-up care upon discharge. These interventions are aligned with efforts to improve mortality and are not at odds with the goal of survival. Moreover, the results of public reporting of the measures indicate that hospitals can do well on both mortality and readmission rates.

Comment: One commenter recommended a 7-day to 15-day readmission timeframe instead of 30 days, stating that a 30-day measure may be appropriate for assessing a community's ability to work together to provide the best care and services for

⁵⁰ Jack BW, Chetty VK, Anthony D et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med.* Feb 3, 2009;150(3):178-187.

⁵¹ Coleman EA, Perry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med.* Sep 25 2006;166(17):1822-1828.

⁵² Hernandez AF, Greiner MA, Fonarow GC, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. *JAMA,* May 5 2010;303(17):1716-1722.

patients, but may attribute more responsibility to the hospital than might otherwise be warranted.

Response: In the FY 2012 IPPS/LTCH PPS final rule, we finalized 30 days as the time period specified from the date of discharge for the purpose of defining readmission for the Hospital Readmissions Reduction Program. The 30-day time period meets the requirement set forth in section 1886(q)(5)(E) of the Act that the time period specified by the Secretary for defining a readmission be consistent with the time period specified for the endorsed measures. Furthermore, the timeframe of 30 days is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions.

Comment: One commenter expressed specific concerns that the list of planned readmissions in the AMI measure does not account for all planned readmissions. Specifically, the commenter recommended the inclusion of AMI codes with “0” in the fifth digit, indicating “episode of care unspecified.” The commenter noted that if the episode of care is unspecified, it could be outside the 30-day readmission timeframe. The commenter added that under the ICD-9-CM guidelines, the ICD-9-CM codes 410.XX for AMI are used for “acute” condition for up to 8 weeks duration.

Response: We thank the commenter for the suggestion. However, the AMI ICD-9-CM codes described by the commenter are used to identify index hospitalizations, not readmissions. The measures only identify the index admissions based on the use of the principal discharge diagnosis, which should represent the reason the patient was admitted to the hospital. Therefore, despite the use of the word “unspecified,” in most

cases the AMI will have been the primary reason for admission and appropriately included as an index case.

Comment: One commenter stated the 30-day timeframe may be appropriate for assessing a community's ability to collaborate and provide the best care and services for discharged patients, but 30 days is too long a timeframe to fairly assess the attribution of the hospital's direct care of a patient.

Response: The 30-day time period that we finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51666) meets the requirement set forth in section 1886(q)(5)(E) of the Act that the time period specified by the Secretary for defining a readmission be consistent with the time period specified for the endorsed measures. We disagree with the commenter that a much shorter timeframe is fairer, and believe that the timeframe of 30 days is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions. This approach would ensure patients are clinically ready at discharge, reducing risk of infection, reconciling medications, improving communication with community providers participating in transitions of care, educating patients adequately upon discharge, and assuring patients understand follow-up care upon discharge.

Comment: One commenter requested clarification whether transfers from short-term acute care hospitals to LTCHs are excluded from the definition of readmissions.

Response: As defined in section 1886(q)(5)(E) of the Act, and finalized in the FY 2012 IPPS/LTCH PPS final rule, only readmissions to a subsection (d) hospital or a

hospital that is paid under section 1814(b)(3) [of the Act] will be counted as readmissions. Readmissions to LTCHs will not be counted as readmissions.

After consideration of the public comments we received, we are finalizing our proposal to codify the definition of “readmission” at 42 CFR 412.152 without modification.

Measures for applicable conditions: As finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51666 and 51667), we will use three NQF-endorsed, hospital risk-standardized readmission measures for FY 2013, which are currently in the Hospital IQR Program: Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF #0505); Heart Failure 30-Day Risk Standardized Readmission Measure (NQF #0330); and Pneumonia 30-day Risk Standardized Readmission Measure (NQF #0506). The measures, as endorsed by the NQF, include the 30-day time window, risk-adjustment methodology, and exclusions for certain readmissions.

As finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51673), we will use the risk-standardized readmission ratio of the NQF-endorsed readmission measures as the excess readmission ratio. The ratio is a measure of relative performance. If a hospital performs better than an average hospital that admitted similar patients (that is, patients with the same risk factors for readmission such as age and comorbidities), the ratio will be less than 1.0. If a hospital performs worse than average, the ratio will be greater than 1.0.

Measure methodology: In the FY 2012 IPPS/ LTCH PPS final rule (76 FR 51668 through 51669), we finalized the methodology of the measures and are summarizing it briefly below.

Index hospitalizations included in the measure calculation: We finalized the definition of “index hospitalization” consistent with the NQF-endorsed definition. The measures define an index hospitalization as a hospitalization evaluated in the measure for a possible readmission within 30 days after discharge (that is, a hospitalization included in the measure calculation). The measures exclude as index hospitalizations patients who died during the first admission, patients who have not spent at least 30 days post-discharge enrolled in Medicare fee-for-service (FFS), patients who are discharged against medical advice, and patients who are under the age of 65.

Comment: Several commenters suggested exclusions from the index hospitalizations included in the measures, which included exclusions for patients under “extreme circumstances” such as transplants, end-stage renal disease, burn, trauma, psychosis and substance abuse.

Response: We appreciate the concern expressed by the commenters that patients of these “extreme circumstances” clinically could be sicker and more likely to be readmitted. The measures address clinical differences in hospitals’ case-mix through risk adjustment rather than through excluding patients from the measure as suggested by the commenter. The goal in developing outcomes measures is to create a clinically cohesive cohort that includes as many patients as possible admitted with the given condition. Greatly expanding our list of exclusions would result in a measure that was less useful

and meaningful, because it would reflect the care of fewer patients. In addition, we believe that by excluding patients with significant comorbidities, the measure would not assess of the quality of care for those patients. To fairly profile hospitals' performance, it is critical to place hospitals on a level playing field and account for their differences in the patients that present for care. This is accomplished through adequate risk-adjustment for patients' clinical presentation rather than exclusion of patients.

Risk adjustment: The three measures, as endorsed by the NQF and finalized in the FY 2012 IPPS/LTCH PPS final rule, adjust for key factors that are clinically relevant and have strong relationships with the outcome (for example, patient demographic factors, patient coexisting medical conditions, and indicators of patient frailty). Under the current NQF-endorsed methodology, these covariates are obtained from Medicare claims extending 12 months prior to, and including, the index admission. This risk-adjustment approach adjusts for differences in the clinical status of the patient at the time of the index admission as well as for demographic variables. A complete list of the variables used for risk adjustment and the clinical and statistical process for selecting the variables for each NQF-endorsed measure, as proposed, is available at the Web site:

<http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPPage%2FQnetTier4&cid=1219069855841>.

Comment: Several commenters suggested that the readmission measures include adjustments for socioeconomic status and other factors that are either outside the hospitals' immediate control or that may adversely affect certain types of hospitals more than others. Suggestions for variables to include in either the patient level or the hospital-

level model included: patient race, ethnicity, language, income, lifestyle, health literacy, dual-eligible status (that is, eligibility for both Medicare and Medicaid), insurance status, functional status, cognitive impairment, post-discharge care support structure, and access to primary care. Two commenters suggested stratification of the hospital calculations by the percentage of dual-eligible patients. Other commenters suggested accounting for societal factors such as housing stability, food scarcity, and chronic unemployment.

Response: We have continued to consider and evaluate stakeholder concerns regarding the influence of patient socioeconomic status on readmission rates. In our analyses (<http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalChartBook2011.pdf>), we consistently find that hospitals that care for large proportions of patients of low socioeconomic status are capable of performing well on readmission measures. Many safety-net providers and teaching hospitals do as well or better on the measures than hospitals without substantial numbers of patients of low socioeconomic status. The measures include rigorous risk-adjustment for differences in patient illness, and this likely incorporates some of the patient differences due to socioeconomic status (to the extent that patients of low socioeconomic status present to the hospital with greater level of disease). The risk adjustment for clinical factors likely captures much of the variation due to socioeconomic status, thus leading to more modest impact of socioeconomic status on hospital readmissions than stakeholders expect. We note that the goal of risk adjustment is to account for factors that are inherent to the patient at the time of admission, such as severity of disease, so as to put hospitals on a level playing field. The

measures should not be risk-adjusted to account for differences in practice patterns that lead to lower or higher risk for patients to be readmitted. The measures aim to reveal differences related to the patterns of care. Furthermore, the statutory language in section 1886(q)(5)(A)(ii)(I) of the Act requires that the measures included in the Hospital Readmissions Reduction Program be consistent with measures that are NQF-endorsed. A change in the risk-adjustment methodology of the measures as they are currently endorsed by the NQF would take time and necessitate additional rulemaking to adopt such measures. The measures also do not adjust for socioeconomic status because the association between socioeconomic status and health outcomes can be due, in part, to differences in the quality of health care received by groups of patients with varying socioeconomic status. The measures do not adjust for socioeconomic status, or other patient factors such as race, both because we do not want to hold hospitals to different standards for the outcomes of their patients of low socioeconomic status (which would definitely occur if calculations were stratified by percent dual-eligible patients as suggested by two of the commenters), and because our analyses demonstrate that patient socioeconomic status does not determine hospital performance on the readmission measures. Finally, we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. This approach is also consistent with the guidance from the NQF, which states that risk models should not obscure disparities by adjusting for factors associated with inequality in care (such as race or socioeconomic status) as well as with the methodology finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51660 through 51676). However, we are committed

to tracking this issue and will continue to evaluate disparities in care and the impact of the Hospital Readmissions Reduction Program on providers of vulnerable populations, including teaching and safety-net hospitals.

Comment: Two commenters supported CMS' decisions not to risk-adjust for socioeconomic status and urged CMS to resist making any changes to the Hospital Readmissions Reduction Program based on socioeconomic status, because the same care protocols that work with a different population may also work with patients of lower socioeconomic circumstances. One commenter appreciated the justification for the continued exclusion of patient-level socioeconomic status covariates—that doing so would impose different performance expectations based on the income distribution of patients and would also result in overfitting the risk adjustment models, in that it would result in an overly complex and possibly multicollinear model that yields inaccurate predictions.

Response: We thank the commenters for their support of our approach to risk-adjustment.

Comment: One commenter believed that the risk adjustment variables used to calculate readmission rates are not transparent to hospitals and urged CMS to ensure they are publicly and easily accessible.

Response: The risk adjustment variables that will be used to calculate readmission rates can be found in the readmission measure methodology reports found on the Web site at:

<http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQn>

[etTier4&cid=1219069855841](#). Some of the patient risk factors are grouped using the CMS Condition Categories (CC) classification. A crosswalk of CCs to ICD-9-CM codes is available at:

<http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069856694>.

Comment: One commenter stated that the comorbidities included in the risk-adjustment variables may not all be consistently coded at the present time.

Response: We have validated the 30-day readmission measures with models that use medical record-abstracted data for risk adjustment. This validation supported the use of the administrative claims data on comorbidities and demonstrated that the estimates of hospitals' risk-standardized readmission rates (RSRRs) based on administrative data are very similar to the rates estimated by models based on medical record data. This high level of agreement in the results based on the two different approaches supports the use of the administrative claims-based models for public reporting. Our approach to gathering risk factors for patients also mitigates the potential limitations of claims data. Because not every diagnosis is coded at every visit, we use inpatient, outpatient, and physician claims data for the 12 months prior to admission, and secondary diagnosis codes during the index admission, for risk adjustment.

Data sources: The finalized measures use Medicare inpatient claims data for Medicare FFS patients 65 years and older to identify index hospitalizations and readmissions. For risk adjustment, the measures use Part A and Part B claims for the 12 months prior to the index hospitalization as well as index hospitalization claims.

Exclusion of certain readmissions: The NQF-endorsed measures of readmissions finalized in the FY 2012 IPPS/LTCH PPS final rule include exclusions of readmissions consistent with the statutory requirement that all measures exclude certain readmissions that are unrelated to the prior discharge, such as transfers to other acute care facilities and planned readmissions.

Comment: Some commenters urged CMS to identify and exclude planned readmissions for the AMI, HF, and PN readmission measures. The commenters stated that failure to do so may encourage providers to delay necessary follow-up procedures. Two commenters urged CMS to explore common reasons for planned readmissions, bring them to the NQF for review for continued endorsement for the AMI, HF, and PN measures, and use these planned readmissions for the measures in subsequent rulemaking. A few commenters recommended that CMS also consider implementing codes that hospitals can use to designate when a readmission is planned so that these cases can be excluded from the readmission measure, and recommended using the NUBC Committee's proposed discharge status codes to identify planned readmissions.

Response: Our contractor engaged multiple clinical experts to develop a list of planned readmissions which was made part of a hospital-wide readmission measure that recently obtained NQF endorsement. During the development of this hospital-wide readmission measure, there was a 2-week informal public comment period in order to receive feedback on the measure and its planned readmission algorithm. The list of planned readmissions also underwent a 2-week informal public comment period when the hospital-wide readmission measure was evaluated at the NQF.

We maintain the measures annually and submit the updates to NQF for review. In response to stakeholder input, we intend to update the condition-specific measures to permit more planned readmissions for the condition-specific measures, which would not be counted as readmissions. Any NQF-approved changes to the measures will then be proposed for the Hospital Readmissions Reduction Program through future rulemaking. We are aware of the NUBC's intention to propose discharge status code on claims to identify planned readmissions. We would analyze its reliability, validity, and usability for identifying planned readmissions prior to considering the adoption of such a code for use in the readmission measures in the future.

Comment: Some commenters suggested that CMS exclude readmissions that occur for reasons such as transplants and device implantation, trauma, psychoses, substance use, end-stage renal disease, maternity and neonatal readmissions, rehabilitation, sepsis, natural disease or treatment progression, acute decompensated heart failure, the result of nonhospital community factors, and disaster relief.

Response: We thank the commenters for these suggestions. Many of these suggestions are among the planned readmission updates we intend to submit for the AMI, HF and PN measures as part of annual maintenance review by NQF. We perform measure maintenance reviews which include consideration of public comments, exploration and identification of any other exclusions for the measures; in this case, other types of readmissions, that would be excluded from the measures as planned readmissions would be considered during the maintenance review. If we determine certain readmissions should be excluded from the measures, we will revise the measures,

present them to NQF for endorsement, and update the Hospital Readmissions Reduction Program in future rulemaking.

Comment: Several commenters urged CMS to differentiate between related and unrelated readmissions. One suggestion to define “related readmissions” as any readmission for which the patient’s primary diagnosis falls within the same MS-DRG or as the diagnosis for the initial admission, or to use the AHRQ CCs as a way to group diagnoses and procedure codes into clinically meaningful groups.

Response: We do not seek to differentiate between related and unrelated readmissions, or to identify preventable readmissions or “necessary” readmissions for several reasons. First, from the patient perspective, an unplanned readmission for any reason is likely to be an undesirable outcome of care after an acute hospitalization. Second, readmissions not directly related to the index condition may still be a result of the care received during the index hospitalization. For example, a patient hospitalized for heart failure who develops a hospital-acquired infection may ultimately be readmitted for sepsis. It would be inappropriate to treat this readmission as unrelated to the care the patient received during the index hospitalization. Furthermore, the range of potentially avoidable readmissions also includes those not directly related to the initial hospitalization, such as those resulting from poor communication at discharge or inadequate follow-up. As such, creating a comprehensive list of potential complications related to the index hospitalization would be arbitrary, incomplete, and, ultimately, impossible to implement. The measures are not meant to suggest that the appropriate

readmission rate is zero, but rather to identify hospitals that have a higher rate of readmissions than would be expected given their case mix.

Minimum number of discharges for applicable conditions: Section 1886(q)(4)(C)(ii) of the Act allows the Secretary discretion to determine the minimum number of discharges for the applicable condition. We finalized a policy in the FY 2012 IPPS/LTCH PPS final rule that the minimum number of discharges for applicable conditions is 25 for each condition for the FY 2013 Hospital Readmissions Reduction Program.

Comment: Several commenters urged CMS to raise the minimum case threshold to qualify for the Hospital Readmissions Reduction Program to improve the reliability of the measures.

Response: We determined the 25-case threshold for public reporting based on a reliability statistic that is calculated from the intercluster correlation, a parameter of the model. We are maintaining the minimum 25-case threshold that we adopted through rulemaking last year.

Applicable period: Under section 1886(q)(5)(D) of the Act, the Secretary has the authority to specify the applicable period with respect to a fiscal year. In the FY 2012 IPPS/LTCH PPS final rule, we finalized our policy to use 3 years of claims data to calculate the proposed readmission measures. Specifically, we finalized the policy to use claims data from July 1, 2008, to June 30, 2011, to calculate the excess readmission ratios and to calculate the FY 2013 Hospital Readmissions Reduction Program payment adjustment. As we discussed in section IV.A.3.d. of the preamble of the FY 2013

IPPS/LTCH PPS proposed rule (77 FR 27957), the excess readmission ratios used to model our proposed methodology to calculate the Hospital Readmissions Reduction Program payment adjustment were based on the 3-year time period of July 1, 2007 to June 30, 2010. However, we indicated that, for the final rule, we intended to use excess readmission ratios based on the applicable period of July 1, 2008 to June 30, 2011, as finalized in the FY 2012 IPPS/LTCH PPS final rule. In the FY 2013 IPPS/LTCH PPS proposed rule, we proposed to codify the definition of “applicable period” at 42 CFR 412.152 as the 3-year period from which data are collected in order to calculate excess readmission ratios and adjustments for the fiscal year.

Comment: Several commenters urged CMS to consider a shorter timeframe for measuring performance for readmissions such as a 1-year or 2-year period. The commenters believed that hospitals should not be assessed on readmissions that occurred during 2008, long before the policy addressing this provision was passed in the Affordable Care Act.

Response: In the FY 2012 IPPS/LTCH PPS final rule, we finalized 3 years as the applicable period for the FY 2013 payment adjustment. We use a 3-year period of index admissions to increase the number of cases per hospital used for measure calculation, which improves the precision of each hospital’s readmission estimate. Although this approach utilizes older data, it also identifies more variation in hospital performance and still allows for improvement from one year of reporting to the next. We are maintaining the 3-year period as previously adopted.

Comment: One commenter stated that, although data from across a 3-year period helps to identify significant improvements over time, there is a huge lag in the end of the 3-year period and the commencements of penalties (approximately 15 months).

Response: We decided to use the current timeframe because it balances the needs for the most recent claims and for sufficient time to process the claims data and calculate the measures to meet the program implementation timeline. We will continue to explore the feasibility of using more up-to-date data sources.

After consideration of the public comments we received, we are finalizing our proposal to codify our definition of “applicable period” under the regulations at 42 CFR 412.152 without modification.

Excess Readmission Ratio Calculation: In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51673 through 51676), we finalized the excess readmission ratio pursuant to section 1886(q)(4)(C) of the Act. We established the excess readmission ratio as the risk-adjusted readmission ratio from the NQF-endorsed measures. The ratio is calculated using hierarchical logistic regression. The method adjusts for variation across hospitals in how sick their patients are when admitted to the hospital (and therefore variation in hospital patients’ readmission risk) as well as the variation in the number of patients that a hospital treats to reveal difference in quality. The method produces an adjusted actual (or “predicted”) number in the numerator and an “expected” number in the denominator. The expected calculation is similar to that for logistic regression--it is the sum of all patients’ expected probabilities of readmission, given their risk factors and the risk of readmission at an average hospital.

For each hospital, the numerator of the ratio used in the NQF-endorsed methodology (actual adjusted readmissions) is calculated by estimating the probability of readmission for each patient at that hospital and summing up over all the hospital's patients to get the actual adjusted number of readmissions for that hospital.

Mathematically, the numerator equation can be expressed as:

Numerator: Adjusted Actual Readmissions

Step 1:

Calculate each patient's predicted probability of readmission = $\frac{1}{1 + e^{-Z_a}}$

$Z_a = \text{hospital-specific effect} + X\beta$

intercept + risk-adjustment coefficients

Step 2:

To get the numerator result, add all patients' predicted probabilities of readmission

The denominator of the risk-standardized ratio (excess readmission ratio) under this NQF-endorsed methodology sums the probability of readmission for each patient at an average hospital. This can be expressed mathematically as:

Denominator: Expected ReadmissionsStep 1:

Calculate each patient's expected probability of readmission = $\frac{1}{1 + e^{-Z_e}}$

$$Z_e = X\beta$$



intercept + risk-adjustment coefficients

Step 2:

To get the denominator result, add all patients' expected probabilities of readmission

Thus, the ratio compares the total adjusted actual readmissions at the hospital to the number that would be expected if the hospital's patients were treated at an average hospital with similar patients. Hospitals with more adjusted actual readmissions than expected readmissions will have a risk-standardized ratio (excess admission ratio) greater than one. In summary, in the FY 2012 IPPS/LTCH PPS final rule, we defined the "excess admission ratio" as the risk-standardized admission ratio of the NQF-endorsed admission measures. More in-depth detail surrounding the methodology of excess admission ratio calculation can be accessed on the Web site at: <http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841>.

In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27958), we proposed to codify the definition of "excess admission ratio" under the regulations we proposed at 42 CFR 412.152 as a hospital-specific ratio for each applicable condition for an

applicable period, which is the ratio (but not less than 1.0) of (1) risk-adjusted readmissions based on actual readmissions for an applicable hospital for each applicable condition to (2) the risk-adjusted expected readmissions for the applicable hospital for the applicable condition.

Comment: Two commenters indicated that almost no hospitals are statistically significantly different from the U.S. average because the hierarchical logistic regression model shrinks the coefficients of small hospitals towards the mean. One commenter expressed concern that the methodology relies excessively on the ability of the model to correct for hospital-specific characteristics and may be at odds with the observed rate. Another commenter suggested that alternatives to the current method could include looking at more conditions over several years which would increase the sample size, reduce random variation, and reduce the need to shrink estimates toward the national mean.

Response: The modeling of the readmission rates takes into account hospitals' case-mix as well as the sample size of the hospital. For both of these reasons, the risk-standardized rate may appropriately differ from the observed rates. These differences are important in leveling the playing field for hospitals and accounting for uncertainty in small volume estimates. The hierarchical logistic regression model that we use to calculate the 30-day measures allows the inclusion of hospitals with relatively few observations but takes into account the uncertainty associated with sample size.

Comment: One commenter believed that the statute requires that CMS calculate an Observed-to-Expected (O/E) ratio for each readmission condition by hospital and to

use that ratio to determine the payment penalty. The commenter requested that CMS revise its methodology so that it calculates hospital-specific observed and expected readmission rates and reports them on Hospital Compare.

Response: We disagree with the commenter's assessment that the statute requires that we use an observed to expected ratio. Rather, the statute at section 1886(q)(4)(C) of the Act defines the excess readmission ratio as the ratio of "the risk adjusted readmissions based on actual readmissions," and "the risk adjusted expected readmissions" as "determined consistent with a readmission methodology that has been endorsed" by an entity with a contract under section 1890(a) of the Act (currently the NQF). The readmission measures that we are using for the Hospital Readmissions Reduction Program have numerators and denominators consistent with these definitions. The measures have been endorsed by the NQF, and we finalized use of these NQF-endorsed readmission measures in the FY 2012 IPPS LTCH PPS final rule.

Comment: One commenter asked for clarification on the calculation of the readmission rates for multiple readmissions, particularly where one or more readmissions might be unrelated to the index admission.

Response: As finalized in the FY 2012 IPPS/LTCH PPS final rule, the readmissions measures are designed to measure whether a patient experienced at least one readmission within 30 days of an initial (or "index") discharge as a single binary (yes/no) event, rather than counting the number of readmissions experienced within 30 days of discharge as a separate readmissions. For any given patient, only one readmission during the 30 days following the discharge from the initial hospitalization

will count as a readmission for purposes of calculating the ratios set forth in section 1886(q) of the Act. For any given patient, none of the subsequent readmissions he or she experiences within 30 days after discharge would be counted as a new “index” admission within the same measure (that is, an admission evaluated in the measure for a subsequent readmission). Any eligible admission after the 30-day time period will be considered a new index admission. For example, if a patient’s index admission was for heart failure and the patient was readmitted with a primary diagnosis of pneumonia, that hospitalization could count as both a readmission for the health failure measure and an index admission for the pneumonia measure.

We do not seek to differentiate between related and unrelated readmissions, or to identify preventable readmissions or “necessary” readmissions for several reasons. First, from the patient perspective, a readmission for any reason is likely to be an undesirable outcome of care after an acute hospitalization. Second, readmissions not directly related to the index condition may still be a result of the care received during the index hospitalization.

After consideration of the public comments we received, we are finalizing our proposal to codify the definition of “excess readmission ratio” under the regulations at 42 CFR 412.152 without modification.

3. FY 2013 Proposed and Final Policies for the Hospital Readmissions Reduction Program

a. Overview

In this final rule, we are addressing the provisions in section 1886(q) of the Act that are related to the Hospital Readmissions Reduction Program payment adjustment, as well as any other provisions in section 1886(q) of the Act that were not addressed in the FY 2012 IPPS/LTCH PPS final rule that are effective for discharges beginning on or after October 1, 2012. Specifically, in this final rule (as we did in the FY 2013 IPPS/LTCH PPS proposed rule), we are addressing section 1886(q) of the Act related to the following provisions:

- Base operating DRG payment amount, including policies for SCHs and MDHs and hospitals paid under section 1814(b) of the Act;
- Adjustment factor (both the ratio and floor adjustment factor);
- Aggregate payments for excess readmissions and aggregate payments for all discharges;
- Applicable hospital;
- Limitations on review;
- Reporting of hospital-specific information, including the process for hospitals to review and submit corrections.

b. Base Operating DRG Payment Amount, Including Special Rules for SCHs and MDHs and Hospitals Paid under Section 1814 of the Act

(1) Definition of Base Operating DRG Payment Amount (§ 412.152)

Under the Hospital Readmissions Reduction Program at section 1886(q) of the Act, payments for discharges from an “applicable hospital” will be an amount equal to the product of the “base operating DRG payment amount” and an “adjustment factor” that accounts for excess readmissions for the hospital for the fiscal year, for discharges beginning on or after October 1, 2012. Specifically, section 1886(q)(1) of the Act requires the Secretary to base payments for a discharge on an amount equal to the product of “the base operating DRG payment amount” and “the adjustment factor” for the hospital in a given fiscal year. The “base operating DRG payment amount” is defined under section 1886(q)(2) of the Act as “the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o) [the Hospital VBP Program]) for a discharge if this subsection did not apply; reduced by . . . any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).” Paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d) of section 1886 of the Act refer to outlier payments, indirect medical education (IME) payments, disproportionate share (DSH) payments, and low-volume hospital payments, respectively.

In general, “the payment amount that would otherwise be made under subsection (d) . . . for a discharge” (that is, the discharge payment amount made under section 1886(d) of the Act) determined without consideration of the adjustments to payments made under the Hospital VBP Program (section 1886(o) of the Act) or under the Hospital Readmissions Reduction Program (section 1886(q) of the Act) is the applicable average standardized amount adjusted for resource utilization by the

applicable MS-DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment (COLA) for hospitals located in Alaska and Hawaii), which is often referred to as the “wage-adjusted DRG operating payment.” This payment amount may then be further adjusted if the hospital qualifies for an IME adjustment (under section 1886(d)(5)(B) of the Act), a DSH payment adjustment (under section 1886(d)(5)(F) of the Act), and/or a low-volume payment adjustment (under section 1886(d)(12) of the Act), or if the discharge qualifies for an outlier payment (under section 1886(d)(5)(A) of the Act). Furthermore, certain discharges may qualify for an additional payment for new medical services or technologies under section 1886(d)(5)(K) of the Act (often referred to as a “new technology add-on payment”).

Consistent with section 1886(q)(2) of the Act, in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27959), under the regulations we proposed at 42 CFR 412.152, we proposed to define the “base operating DRG payment amount” under the Hospital Readmissions Reduction Program as the wage-adjusted DRG operating payment plus any applicable new technology add-on payments. As required by the statute, we stated that the proposed definition of “base operating DRG payment amount” does not include adjustments or add-on payments for IME, DSH, outliers and low-volume hospitals provided for under sections 1886(d)(5)(B), (d)(5)(F), (d)(5)(A), and (d)(12) of the Act, respectively. Section 1886(q)(2) of the Act does not exclude new technology payments made under section 1886(d)(5)(K) of the Act in the definition of “base operating DRG payment amount”; therefore, any payments made under section 1886(d)(5)(K) of the Act

are included in the definition of “base operating DRG payment amount.” In addition, under the regulations we proposed at 42 CFR 412.152, we proposed to define “wage-adjusted DRG operating payment” as the applicable average standardized amount adjusted for resource utilization by the applicable MS-DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable COLA for hospitals located in Alaska and Hawaii). We proposed that, under § 412.154(b)(1), to account for excess readmissions, an applicable hospital’s base operating DRG payment amount would be adjusted for each discharge occurring during the fiscal year. The payment adjustment for each discharge is determined by subtracting the product of the base operating DRG payment amount for such discharge and the hospital’s readmission payment adjustment factor for the fiscal year from the base operating DRG payment amount for such discharge.

Under this proposal, consistent with section 1886(q)(2)(B)(i) of the Act and proposed § 412.154(b)(2), for SCHs that receive payments based on their hospital-specific payment rate, we also proposed to exclude the difference between the hospital’s applicable hospital-specific payment rate and the Federal payment rate from the definition of “base operating DRG payment amount.” We noted that, under the Hospital Readmissions Reduction Program at section 1886(q) of the Act, the proposed definition of “base operating DRG payment amount” would be used to calculate both the “aggregate payments for excess readmissions” and “aggregate payments for all discharges” under sections 1886(q)(4)(A) and (B) of the Act, which would then be used to determine the readmission adjustment factor that accounts for excess readmissions

under section 1886(q)(3) of the Act (as discussed in greater detail in section IV.A.3.c. of the preamble of the proposed rule and this final rule), and would also be used to determine which payment amounts will be adjusted to account for excess readmissions. (We note that, as discussed in section IV.G. of the preamble of the proposed rule and this final rule, under current law, the MDH program expires at the end of FY 2012 (that is, the MDH program is currently only applicable to discharges occurring before October 1, 2012). Therefore, due to the expiration of the MDH program beginning with FY 2013, we did not include MDHs in the discussion of our proposals regarding the base operating DRG payment amount in the proposed rule.)

Comment: Commenters supported the proposed definition of the base operating DRG payment amount. Commenters also supported our proposal to exclude IME, DSH, outliers, low-volume adjustment, and additional payments made due to status as an SCH from the definition of the base operating DRG payment amount.

Commenters both supported and opposed our proposed inclusion of new technology payments in the definition of the base operating DRG payment amount. Commenters recommended that CMS exclude the new technology payment from the definition of “base operating DRG payment amount” because, like payment adjustments for IME and DSH, it is extrinsic to the base rate. In addition, without any known association between the use of new technology and the quality and efficiency of care provided by a hospital, one commenter did not believe there was justification to incorporate the use of new technology into the structure of a quality program. Some commenters asserted that the inclusion of the new technology payments in the base DRG

operating payment definition for the determination of payment reduction adjustments conflicts with the primary principle of identifying and ensuring adequate payment for new medical services and technologies for a brief 2- to 3-year period and should not be altered by our other required initiatives.

Response: We believe the statute is specific with regards to the definition of base operating DRG payment amount at section 1886(q)(2) of the Act, which explicitly specifies that any additional payments for IME, DSH, outliers, and low-volume hospitals provided for under sections 1886(d)(5)(B), (d)(5)(F), (d)(5)(A), and (d)(12) of the Act, respectively, are to be excluded. Section 1886(q)(2) of the Act does not specify an exclusion for new technology payments made under section 1886(d)(5)(K) of the Act, and therefore, we do not believe we have the flexibility to exclude new technology payments in the definition of base operating DRG payment amount under the Hospital Readmissions Reduction Program. We are finalizing our definition of “base operating DRG payment,” as proposed, without modification.

Comment: One commenter stated that cases that receive transfer adjustments when determining their payment should be accounted for in the proposed definition of base operating DRG payment amount. The commenter specified that the base operating DRG payment amount should also include any payment reductions for patients covered under the transfer policy as it applies to both post-acute and short-stay acute hospitals.

Response: We are clarifying that the base operating DRG payment amount accounts for any applicable transfer adjustment for cases that are paid under as either an acute care transfer or post-acute care transfer. In other words, if a case is paid as a

transfer in accordance with our transfer payment policy at 42 CFR 412.4(f), resulting in a reduced IPPS payment, the reduced transfer-adjusted payment amount is also reflected in the base operating DRG payment amount. For the FY 2013 IPPS/LTCH PPS proposed rule, the data used to model the proposed readmission payment adjustment factors actually reflected transfer adjusted base operating DRG payment amounts, where applicable. As discussed earlier, the “base operating DRG payment amount” would be used to calculate both the “aggregate payments for excess readmissions” and “aggregate payments for all discharges” under sections 1886(q)(4)(A) and (q)(4)(B) of the Act, which would then be used to determine the readmissions payment adjustment, and would also be used to determine which payment amounts will be adjusted to account for excess readmissions. We are finalizing that the definition of “base operating DRG payment amount” includes any applicable payment adjustments for transfer cases under 42 CFR 412.4(f). In addition, in this final rule, we are revising the definition of “wage-adjusted DRG operating payment” in the regulations we proposed at 42 CFR 412.152 to specify that any applicable payment adjustment for transfers under § 412.4(f) is included. Accordingly, we are finalizing the definition of “wage adjusted DRG operating payment” as the applicable average standardized amount adjusted for resource utilization by the applicable MS-DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable COLA for hospitals located in Alaska and Hawaii). This amount includes an applicable payment adjustment for transfers under § 412.4(f).

Comment: Commenters recommended that the proposed definition of base operating DRG payment should be refined to account for the special payment status of MDHs that are paid under the hospital-specific rate should the MDH payment status be extended under legislation. In addition, commenters suggested that CMS make a proposal to exclude the difference between the hospital's applicable hospital-specific payment rate and the Federal payment rate from its definition of "base operating DRG amount" for MDHs, similar to our proposal made for SCHs, which can also be paid under the hospital-specific payment rate.

Response: As stated earlier, under current law, the MDH program expires at the end of FY 2012 (that is, the MDH program is currently only applicable to discharges occurring before October 1, 2012). MDHs are paid the sum of the Federal payment amount plus 75 percent of the amount by which their hospital-specific rate exceeds the Federal payment amount. As discussed later in this section, we had proposed to exclude hospital-specific payments from the definition of base operating DRG payments in the calculation of a hospital's readmission payment adjustment factor. Specifically, we stated that because we are using historical data to determine the base operating DRG payments to calculate the adjustment factor, we proposed to model their base operating DRG payment amount as they would have been paid under the Federal standardized amount, rather than using the information on the claim (which may represent a payment either made under the hospital-specific rate or the Federal rate) so that their payments are consistent with our proposed definition of "base operating DRG payment."

For MDHs, the payment difference between the payment made under the hospital-specific rate and the payment made under the Federal rate is not included in the base operating DRG payment amount to determine the readmissions adjustment factor; that is, it is neither included in the numerator of the aggregate dollars for excess readmissions nor in the denominator of the aggregate dollars for all discharges.

Furthermore, we are clarifying that the difference between the applicable hospital-specific payment rate and the Federal payment rate for both SCHs and for MDHs, should the MDH provision be extended beyond FY 2012, is excluded from base operating DRG payment amount for these hospitals. This means that, for an SCH or an MDH, the readmissions payment adjustment under Hospital Readmissions Reduction Program for each discharge will be calculated by multiplying the SCH's or MDH's readmission payment adjustment factor by the base-operating DRG payment amount that is exclusive of the amount by which the hospital-specific rate payment exceeds the Federal payment rate, where applicable. The resulting payment adjustment will then be subtracted from the hospital's payment for the discharge, regardless of whether the hospital is paid based on the Federal rate or its hospital-specific rate.

After consideration of the public comments we received, we are finalizing the proposed definition of "base operating DRG payment amount" at 42 CFR 412.152, noting that it includes any applicable payment adjustments for transfer cases under 42 CFR 412.4(f). In addition, we are revising the definition of "wage-adjusted DRG operating payment" in the regulations we proposed at 42 CFR 412.152 to specify that any applicable payment adjustment for transfers under § 412.4(f) is included.

(2) Special Rules for Certain Hospitals: Hospitals Paid under Section 1814(b)(3) of the Act (§ 412.154(d))

Although the definition of “applicable hospital” under section 1886(q)(5)(C) of the Act also includes hospitals paid under section 1814(b)(3) of the Act (that is, certain Maryland hospitals), section 1886(q)(2)(B)(ii) of the Act allows the Secretary to exempt such hospitals from the Hospital Readmissions Reduction Program, provided that the State submits an annual report to the Secretary describing how a similar program to reduce hospital readmissions in that State achieves or surpasses the measured results in terms of health outcomes and cost savings established by Congress for the program as applied to “subsection (d) hospitals.” Accordingly, a program established by the State of Maryland that could serve to exempt the State from the Hospital Readmissions Reduction program would focus on those “applicable” Maryland hospitals operating under the “waiver” provided by section 1814(b)(3) of the Act, that is, those hospitals that would otherwise have been paid by Medicare under the IPPS, absent the provision.

In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27960), we proposed to establish criteria for evaluation of an annual report to CMS to determine whether Maryland should be exempted from the program each year. Accordingly, we proposed to evaluate a report submitted by the State of Maryland documenting how its program (described below) meets those criteria. Based on the information in the report, we proposed to determine whether or not Maryland’s readmission program met our criteria to be exempt from the Hospital Readmissions Reduction Program for FY 2013. We noted that our proposed criteria to evaluate Maryland’s program is for FY 2013, the first

year of the program, and our evaluation criteria may change through notice-and-comment rulemaking as the Hospital Readmissions Reduction Program evolves. We proposed to codify this requirement at § 412.154(d) of the regulations.

Based on preliminary discussions with the State, we understand that, effective July 1, 2011, Maryland has established the Admission-Readmission Revenue (ARR) Program. The State has described its program as a voluntary program for acute care hospitals, of which 30 out of the 46 acute care hospitals in the State are currently enrolled. Under the program, the State pays hospitals under a case-mix adjusted bundled payment per episode of care, where the episode of care is defined as the initial admission and any subsequent readmissions to the same hospital or linked hospital system that occur within 30 days of the original discharge. According to the State, an initial admission with no readmissions provides the hospital with the same weight as an initial admission with multiple readmissions. Therefore, hospitals receive a financial reward for decreased readmissions (as determined through the case mix adjusted, episode of care weights). Unlike the Hospital Readmissions Reduction Program under section 1886(q) of the Act, which is currently based on measures for three conditions (HF, AMI, and PN) for the Medicare FFS population and only adjusts the IPPS operating payments, Maryland's program applies to all conditions for all patients. In addition, while the Hospital Readmissions Reduction Program considers a readmission to be a subsequent admission to either the original acute care hospital from where the patient was initially discharged or an admission to another acute care hospital, currently Maryland only tracks readmissions to the same acute care hospital (or linked hospital system) from which the patient was

originally discharged. The State had noted that, under its ARR program, the readmission rates for the hospitals participating in the ARR program for the first quarter of its fiscal year compared to the first quarter of its previous fiscal year decreased from 9.86 percent to 8.96 percent.

In the FY 2013 IPPS/LTCH PPS proposed rule, we proposed to evaluate Maryland's ARR program based on whether the State could demonstrate that cost savings under its program achieved or exceeded the savings to the Medicare program due to the Hospital Readmissions Reduction Program under section 1886(q) of the Act. We also proposed to evaluate whether Maryland's program could demonstrate similar results in reducing unnecessary readmissions among hospitals in the State, as described in more detail below. With specific regard to Maryland's demonstration of cost savings, we proposed to evaluate whether Maryland's ARR program could demonstrate savings to the Medicare program that are at least similar to those expected under the Hospital Readmissions Reduction Program. As discussed in this proposed rule, we estimated that, under the Hospital Readmissions Reduction Program, for FY 2013, Medicare IPPS operating payments would decrease by approximately \$300 million (or 0.3 percent) of total Medicare IPPS operating payments. Maryland has indicated that it believes it can achieve comparable savings because it intends to reduce the rate update factor for all hospitals by 0.3 percent, regardless of a hospital's performance on readmissions.

In addition, we indicated in the proposed rule that we plan to propose, in future rulemaking, to evaluate whether Maryland's ARR program can meet or exceed health outcomes that we expect to improve under the Hospital Readmissions Reduction

Program. Because the Hospital Readmissions Reduction Program is not effective until October 1, 2012, we indicated that we do not yet have measured health outcomes against which we can evaluate Maryland's ARR program. However, we intend to have outcomes data in the future with which to evaluate Maryland's ARR program. We anticipate that, under the Hospital Readmissions Reduction Program, hospitals will experience a reduction in unnecessary readmissions. Therefore, in future rulemaking, we intend to propose to evaluate whether Maryland's ARR program can demonstrate similar decreases in potential preventable readmissions among hospitals in the State. Furthermore, in the FY 2013 IPPS/LTCH PPS proposed rule, we proposed that the State's annual report and request for exemption from the Hospital Readmissions Reduction Program must be resubmitted and reconsidered annually in accordance with the statute and as proposed at § 412.154(d)(2).

Based on preliminary information provided by Maryland, the State believes that its program can meet our evaluation criteria and demonstrate that its program achieves or surpasses the measured results in terms of health outcomes and cost savings. We indicated in the proposed rule that we are reviewing whether the Maryland's ARR program, which currently cannot monitor readmissions to other hospitals and provide a financial reward for hospitals that reduce within-hospital readmissions, but provides for an across-the-board 0.3 percent reduction to the annual rate update to account for comparable savings to the Hospital Readmissions Reduction Program, meets the criteria to exempt Maryland hospitals from the Hospital Readmissions Reduction Program. We welcomed public comments on whether the Maryland ARR program meets the

requirements for exemption from the Hospital Readmissions Reduction Program set forth in section 1886(q)(2)(B)(ii) of the Act.

Comment: Commenters requested that Maryland hospitals be exempt from the Hospital Readmissions Reduction Program. Commenters contended that Maryland's readmissions program meets the criteria for Maryland hospitals to be waived from the Hospital Readmissions Reduction Program. One commenter stated that Maryland has already demonstrated successful reductions in readmissions as a result of the Admission-Readmission Revenue (ARR) and Total Patient Revenue (TPR) programs. The commenter described the TPR program as a global budget payment program, designed to reduce overall volumes and, thus, reduce readmissions. ARR hospitals have seen a 7.1 percent reduction in Medicare readmissions since the inception of the program; TPR hospitals have experienced a 6.4 percent decline in readmissions from FY 2009 to FY 2011. The commenter sought more information on how CMS plans to measure Maryland's performance relative to the nation prior to implementation in order to ensure that Maryland's hospitals are prepared to meet our expectations, and can make the appropriate adjustments in advance of submitting an exemption request.

Commenters acknowledged that the ARR program provides a financial incentive for hospitals to reduce readmissions and improve the quality of care and that the ARR program established a 30-day episode of care payment instead of a payment per admission, so a hospital that reduces readmissions keeps the same revenue and increases profits by reducing costs. However, one commenter suggested that savings are generated by reducing inter-hospital readmissions and outpatient visits. The commenter stated that

the TPR program generates savings by restricting revenues and, therefore, providing an incentive for hospitals to reduce volumes. The commenter stated that this mechanism allows participating hospitals to focus on patient care and improved outcomes, rather than generating volume. Furthermore, the commenter pointed out that Maryland's Health Services Cost Review Commission reduced hospitals' FY 2013 rate update by 0.58 percentage points to guarantee readmissions savings.

Finally, the State of Maryland also commented that, in future years, it will work with us to demonstrate cost savings and improved outcomes, over a multiyear period.

Response: We appreciate the commenters' requests to exempt Maryland from the Hospital Readmissions Reduction Program for FY 2013. In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27959), we proposed to establish an annual process by which to evaluate Maryland's readmission program to determine whether the State's program meets or exceeds measured results in terms of health outcomes and cost savings as compared to the Hospital Readmissions Reduction Program. For FY 2013, we indicated that the Hospital Readmissions Reduction Program would result in an estimated savings of \$300 million (-0.3 percent), and we proposed to evaluate whether Maryland's program could have comparable savings. As commenters acknowledged, Maryland's readmissions program provides a financial incentive, not penalty, to hospitals that reduce their readmissions. Furthermore, commenters acknowledged that the State has guaranteed savings by reducing the FY 2013 rate by 0.58 percent. We understand that this is a uniform rate reduction for all hospitals, regardless of an individual hospital's performance on readmissions. We understand that the acute care hospitals in Maryland

are included either in the ARR program or the TPR program, which provides incentives for hospitals to reduce readmissions.

With respect to health outcomes, we proposed that since this is the first year of the Hospital Readmissions Reduction Program, we do not have a measured health outcomes by which to evaluate Maryland against. Thus, for the first year, we would not evaluate Maryland's program with respect to health outcomes. In the future, we intend to have national outcomes data to evaluate Maryland's program, and we will work with the State to measure those outcomes. Similarly, after considering the commenters' comments, we believe it would be premature to evaluate Maryland's readmissions program on cost savings, as it is the first year of the Hospital Readmissions Reduction Program, and Maryland's ARR Program just completed its first year. As such, we are finalizing to not evaluate Maryland's ARR Program on measureable health outcomes and cost savings for the first year. For FY 2013, we are exempting hospitals paid under section 1814(b)(3) of the Act from the Hospital Readmissions Reduction Program under our authority under section 1886(q)(2)(B)(ii) of the Act. We are finalizing, as proposed, our plan to evaluate whether Maryland's readmissions program can demonstrate similar decreases in potential preventable readmissions and similar cost savings on an annual basis. However, that evaluation will not begin until FY 2014. We intend to work with Maryland next year as the State develops its readmissions programs to be able to measure health outcomes and to have demonstrable savings. We are finalizing, as proposed, our requirement that the State's annual report and request for exemption from the Hospital Readmissions

Reduction Program be resubmitted and reconsidered annually in accordance with the statute, as finalized at § 412.154(d)(2).

Comment: Commenters sought clarification as to whether an exemption for Maryland hospitals from the payment requirements under the Hospital Readmissions Reduction Program would apply to all section 1814(b) hospitals in Maryland or all of Maryland's acute care hospitals. The commenters requested that the waiver be applied to all Maryland acute care hospitals.

Response: Section 1886(q)(2)(B)(ii) of the Act allows the Secretary to exempt hospitals paid under the "waiver" provided by section 1814(b)(3) of the Act, that is, those hospitals that would otherwise have been paid by Medicare under the IPPS, absent the provision. Accordingly, we are finalizing that, for FY 2013, all acute care hospitals in Maryland, which are the hospitals that are paid under the waiver at section 1814(b)(3) of the Act, that otherwise would have been paid under the IPPS, are exempt from the Hospital Readmissions Reduction Program.

Comment: One commenter asked for a definition of base operating DRG payment for Maryland hospitals, considering that Maryland hospitals paid under section 1814(b)(3) of the Act are paid at 94 percent of their charges.

Response: In the FY 2013 IPPS/LTCH PPS proposed rule, we did not make a proposal regarding the definition of base operating DRG payment amount with regard to Maryland hospitals. Because we are finalizing our proposal to exempt Maryland hospitals from the Hospital Readmissions Reduction Program for FY 2013, we intend to

revisit the definition of base operating DRG payment amount for Maryland hospitals in future rulemaking.

Comment: Commenters asked that there be a combined exemption request for Maryland hospitals for the Hospital Readmissions Reduction Program, the HAC program, and the Hospital VBP Programs in order to be more efficient and to reduce the administrative burden at the State and Federal level.

Response: The Hospital Readmissions Reduction Program and the Hospital VBP Program, effective in FY 2013, are separate hospital payment programs with different purposes and policy goals. For example, the Hospital Readmissions Reduction Program reduces payments to hospitals for excess readmissions, while the Hospital VBP Program redistributes reductions made to the base operating DRG payment amount, based on certain performance measures. Because of the varying nature of these two programs, at this time, we do not believe it is appropriate for the State to submit one exemption request to determine whether certain Maryland hospitals should be waived from the requirements under both the Hospital Readmissions Reduction Program and the Hospital VBP Program. Because the HAC Program, established under section 1886(p) of the Act, is not effective until FY 2015, we believe it is premature to consider the process by which the State can request an exemption from the requirements of this Program.

For the purposes of modeling the impacts of our proposal, we modeled under the assumption that Maryland hospitals will not have Hospital Readmissions Reduction Program adjustment factors applied to them. Although the adjustment factors do not apply to these hospitals under our models, Maryland hospitals have excess admission

ratios, consistent with the definition of excess readmission ratio. Any readmission to a Maryland hospital from a subsection(d) hospital in another State is still considered a readmission for purposes of the original hospital in another State. This is consistent with the definition of readmissions in section 1886(q)(5)(E) of the Act, which includes admissions to the same or another “applicable hospital.” As discussed above, we interpret the definition of “applicable hospital” under section 1886(q)(5)(C) of the Act to include both subsection (d) hospitals and hospitals paid under section 1814(b)(3) of the Act that would, absent the provisions of section 1814(b)(3) of the Act, be paid under subsection (d).

Although we are exempting Maryland hospitals from the Hospital Readmissions Reduction Program, Maryland hospitals are still considered an “applicable hospital.” As such, we are finalizing, as proposed, that we are calculating excess readmission ratios for Maryland hospitals, consistent with the definition of excess readmission ratio. In addition, any readmission to a Maryland hospital from a subsection(d) hospital in another State is still considered a readmission for purposes of the original hospital in another State, and we are finalizing, as proposed, to include data from Maryland hospitals in the calculation of the excess readmission ratios for all applicable hospitals.

c. Adjustment Factor (Both the Ratio and Floor Adjustment Factor) (§ 412.154(c))

Section 1886(q)(3)(A) of the Act defines the “adjustment factor” for an applicable hospital for a fiscal year as equal to the greater of “(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or (ii) the floor adjustment factor specified in subparagraph (C).”

Section 1886(q)(3)(B) of the Act in turn describes the ratio used to calculate the adjustment factor. Specifically, it states that the ratio is “equal to 1 minus the ratio of – (i) the aggregate payments for excess readmissions...; and (ii) the aggregate payments for all discharges...” In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27960), we proposed to codify the calculation of this ratio at § 412.154(c)(1) of the regulations.

Section 1886(q)(3)(C) of the Act specifies the floor adjustment factor, which is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years. We proposed to codify the floor adjustment factor at § 412.154(c)(2) of the regulations.

For FY 2013, under proposed §412.154(c), we proposed that an applicable hospital would receive an adjustment factor that is either the greater of the ratio described in section IV.A.3.d. of the preamble of the proposed rule or a floor adjustment factor of 0.99. We proposed that the ratio would be rounded to the fourth decimal place, consistent with the calculation of other IPPS payment adjustments such as the wage index, DSH adjustment, and the IME adjustment. In other words, a hospital included in this program can have an adjustment factor that is between 1.0 and 0.9900 for FY 2013. Consistent with section 1886(q)(3) of the Act , under proposed § 412.154(c), we proposed that, for FY 2013, the hospital will receive an adjustment factor under the Hospital Readmissions Reduction Program that is the greater of the ratio or the floor of 0.99. Consistent with this proposal, under the regulations we proposed at 42 CFR 412.152, we proposed to define the “floor adjustment factor” as the value that the readmissions adjustment factor cannot be less than for a given fiscal year. As noted

above, the floor adjustment factor is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

Comment: Commenters supported our proposed calculation of the adjustment factor as 1 minus the ratio of the hospital's aggregate payments for excess readmissions for applicable conditions to the hospital's aggregate payments for all discharges for applicable conditions. Commenters also supported our proposal to determine a hospital's actual payment adjustment factor as the higher of its calculated factor or 0.99, resulting in a maximum reduction of 1 percent of base operating DRG payments for FY 2013.

Response: We thank the commenters for their support of these proposals.

In this final rule, we are finalizing our proposal to establish an applicable hospital's adjustment factor as the higher of a ratio or the floor adjustment factor of 0.99 for FY 2013. We are finalizing, as proposed, that the ratio will be rounded to the fourth decimal place. We also are finalizing our proposal to codify these policies in regulation at § 412.154(c) without modification.

d. Aggregate Payments for Excess Readmissions and Aggregate Payments for All Discharges (§ 412.152)

As discussed earlier, section 1886(q)(3)(B) of the Act specifies the ratio used to calculate the adjustment factor under the Hospital Readmissions Reduction Program. It states that the ratio is "equal to 1 minus the ratio of – (i) the aggregate payments for excess readmissions...; and (ii) the aggregate payments for all discharges..." In the FY 2013 IPPS LTCH PPS proposed rule (77 FR 27961), we set forth proposals to define aggregate payments for excess readmissions and aggregate payments for all discharges,

as well as a methodology for calculating the numerator of the ratio (aggregate payments for excess readmissions) and the denominator of the ratio (aggregate payments for all discharges).

Section 1886(q)(4) of the Act sets forth the definitions of “aggregate payments for excess readmissions” and “aggregate payments for all discharges” for an applicable hospital for the applicable period. The term “aggregate payments for excess readmissions” is defined in section 1886(q)(4)(A) of the Act as “for a hospital for an applicable period, the sum, for applicable conditions . . . of the product, for each applicable condition, of (i) the base operating DRG payment amount for such hospital for such applicable period for such condition; (ii) the number of admissions for such condition for such hospital for such applicable period; and (iii) the ‘Excess Readmission Ratio’ . . . for such hospital for such applicable period minus 1.” We proposed to include this definition of “aggregate payments for excess readmissions” under the regulations we proposed at 42 CFR 412.152.

We did not receive any public comments on the proposed definition of “aggregate payments for excess readmissions” and are finalizing our definition as proposed under the regulations at 42 CFR 412.152 without modification.

The “excess readmission ratio” is a hospital-specific ratio calculated for each applicable condition. Specifically, section 1886(q)(4)(C) of the Act defines the excess readmission ratio as the ratio of “risk-adjusted readmissions based on actual readmissions” for an applicable hospital for each applicable condition, to the “risk-adjusted expected readmissions” for the applicable hospital for the applicable

condition. The methodology for the calculation of the excess readmission ratio was finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51673). “Aggregate payments for excess readmissions” is the numerator of the ratio used to calculate the adjustment factor under the Hospital Readmissions Reduction Program.

The term “aggregate payments for all discharges” is defined at section 1886(q)(4)(B) of the Act as “for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.” “Aggregate payments for all discharges” is the denominator of the ratio used to calculate the adjustment factor under the Hospital Readmissions Reduction Program. In the proposed rule, we proposed to include this definition of “aggregate payments for all discharges” under the regulations we proposed at § 412.152.

We did not receive any public comments on the proposed definition of “aggregate payments for all discharges” and are finalizing our definition as proposed under the regulations at 42 CFR 412.152 without modification.

As discussed above, when calculating the numerator (aggregate payments for excess readmissions), we determined the base operating DRG payments for the applicable period. “Aggregate payments for excess readmissions” (the numerator) is defined as “the sum, for applicable conditions . . . of the product, for each applicable condition, of (i) the base operating DRG payment amount for such hospital for such applicable period for such condition; (ii) the number of admissions for such condition for such hospital for such applicable period; and (iii) the ‘Excess Readmission Ratio’ . . . for such hospital for such applicable period minus 1.”

We discussed above our proposed definition of “base operating DRG payment amount.” When determining the base operating DRG payment amount for an individual hospital for such applicable period for such condition, we proposed to use Medicare inpatient claims from the MedPAR file with discharge dates that are within the same applicable period that was finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51671) to calculate the excess readmission ratio. We proposed to use MedPAR claims data as our data source for determining aggregate payments for excess readmissions and aggregate payments for all discharges, as this data source is consistent with the claims data source used in IPPS rulemaking to determine IPPS rates. For FY 2013, we proposed to use data from MedPAR claims with discharge dates that are on or after July 1, 2008, and no later than June 30, 2011, the applicable period finalized in the FY 2012 IPPS/LTCH PPS final rule. We proposed to use the update of the MedPAR file for each Federal fiscal year, which is updated 6 months after the end of each Federal fiscal year within the applicable period, as our data source (that is, the March updates of the respective Federal fiscal year MedPAR files for the final rules, as described in greater detail below). These are the same MedPAR files that are used in the annual IPPS rulemaking for each Federal fiscal year.

In the FY 2013 IPPS/LTCH PPS proposed rule, for FY 2013, we proposed to use the March 2009 update of the FY 2008 MedPAR file to identify claims within FY 2008 with discharge dates that are on or after July 1, 2008, the March 2010 update of the FY 2009 MedPAR file to identify claims within FY 2009, the March 2011 update of the FY 2010 MedPAR file to identify claims within FY 2010, and the December 2011 update

of the FY 2011 MedPAR file to identify claims within FY 2011 with discharge dates no later than June 30, 2011. For the FY 2013 IPPS/LTCH PPS final rule, we proposed to use the March 2012 update of the FY 2011 MedPAR file to identify claims within FY 2011, as these would be the most recently available FY 2011 claims data used for FY 2013 rulemaking. These MedPAR data files are used each year in other areas of the IPPS, including calculating the IPPS relative weights, budget neutrality factors, outlier thresholds, and the standardized amount. Accordingly, we believe it is appropriate to use these same data files for the purpose of calculating the readmission adjustment factors. The FY 2008 through FY 2011 MedPAR data files can be purchased from CMS. Use of these files will allow the public to verify the readmission adjustment factors. Interested individuals may order these files through the Web site at:

<http://www.cms.hhs.gov/LimitedDataSets/> by clicking on the MedPAR Limited Data Set (LDS)-Hospital (National). This Web page describes the files and provides directions and further detailed instructions for how to order the data sets. Persons placing an order must send the following: a Letter of Request, the LDS Data Use Agreement and Research Protocol (refer to the Web site for further instructions), the LDS Form, and a check for \$3,655 to:

Mailing address if using the U.S. Postal Service: Centers for Medicare and Medicaid Services, RDDC Account, Accounting Division, P.O Box 7520, Baltimore, MD 21207-0520.

Mailing address if using express mail: Centers for Medicare and Medicaid Services, OFM/Division of Accounting- RDDC, Mailstop C#-07-11, 7500 Security Boulevard, Baltimore, MD 21244-1850.

In the proposed rule, we proposed to determine aggregate payments for excess readmissions and aggregate payments for all discharges using data from MedPAR claims with discharge dates that are on or after July 1, 2008, and no later than June 30, 2011, which is the applicable period finalized in the FY 2012 IPPS/LTCH PPS final rule. However, we noted in the proposed rule, that for the purposes of modeling, we used excess readmission ratios based on an older performance period of July 1, 2007 to June 30, 2010. As we stated in the proposed rule, for this final rule, we are using both the excess readmission ratios and MedPAR claims data to calculate aggregate payments for excess readmissions and aggregate payments for all discharges based on the applicable period finalized in the FY 2012 IPPS/LTCH PPS final rule (July 1, 2008 to June 30, 2011).

Comment: Commenters supported the use of MedPAR claims data to determine base operating DRG payment amounts. However, several commenters opposed CMS' proposal to use 3 years of data from the period July 1, 2008 through June 30, 2011, for calculating hospital readmissions adjustment factors for FY 2013. The commenters stated that using older data did not reflect current practices of a hospital, and recommended that CMS use a 1-year period from July 1, 2010 to June 30, 2011, to accurately reflect a hospital's performance on readmissions.

Response: We appreciate the commenters' support for using the MedPAR data to determine base operating DRG payment amounts to calculate the readmission payment adjustment factors.

In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27961), we proposed to calculate the readmission payment adjustment factor using the same applicable period that is used to calculate the excess readmission ratios, as finalized in the FY 2012 IPPS/LTCH PPS final rule. The statute references "applicable period" in both the calculation of the readmissions measures and the readmission payment adjustment factor, such that it requires that the same time period be used for both the calculation of the measures and the adjustment factor. As finalized in the FY 2012 IPPS/LTCH PPS final rule, we use 3 years of data to calculate the readmissions measures (that is, for FY 2013, we are using discharge data from July 1, 2008 through June 30, 2011), and therefore, we are using data from the same time period to calculate the aggregate payments for excess readmissions and aggregate payments for all discharges. Using 3 years of claims data increases precision for the calculation of excess readmission ratios and the calculation of the readmissions payment adjustment factors.

In this final rule, we are finalizing our proposal to use MedPAR data from July 1, 2008 through June 30, 2011, and we are finalizing our proposal to use the March 2009 update of the FY 2008 MedPAR file to identify claims within FY 2008 with discharges dates that are on or after July 1, 2008, the March 2010 update of the FY 2009 MedPAR file to identify claims within FY 2009, the March 2011 update of the FY 2010 MedPAR file to identify claims within FY 2010, and the March 2012 update of the

FY 2011 MedPAR file to identify claims within FY 2011 with discharge dates no later than June 30, 2011.

Comment: One commenter asked CMS to ensure that outlier payments are correctly excluded from the base operating DRG amount using the MedPAR data source.

Response: We have ensured that we are correctly excluding outlier payments in the calculation of the base operating DRG amount using our MedPAR data source.

In order to identify the admissions for each condition for an individual hospital for calculating the aggregate payments for excess readmissions, we proposed to identify each applicable condition using the same ICD-9-CM codes used to identify applicable conditions to calculate the excess readmission ratios. In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51669), in our discussion of the methodology of the readmissions measures, we stated that we identify eligible hospitalizations and readmissions of Medicare patients discharged from an applicable hospital having a principal diagnosis for the measured condition in an applicable period. The discharge diagnoses for each applicable condition are based on a list of specific ICD-9-CM codes for that condition. These codes are listed in the [2010 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures](#). They also are posted on the Web site at: <http://www.QualityNet.org> > Hospital-Inpatient > Readmission Measures >methodologies.

In order to identify the applicable conditions to calculate the aggregate payments for excess readmissions, we proposed to identify the claim as an applicable condition if

the ICD-9-CM code for that condition is listed as the principal diagnosis on the claim, consistent with the methodology to identify conditions to calculate the excess readmission ratio. Furthermore, we proposed to only identify Medicare FFS claims that meet the criteria (that is, claims paid for under Part C, Medicare Advantage, would not be included in this calculation), consistent with the methodology to calculate excess readmission ratios based on readmissions for Medicare FFS patients. The tables below list the ICD-9-CM codes we proposed to use to identify each applicable condition to calculate the aggregate payments for excess readmissions under this proposal. These ICD-9-CM codes will also be used to identify the applicable conditions to calculate the excess readmission ratios, consistent with our policy finalized in the FY 2012 IPPS/LTCH PPS final rule.

ICD-9-CM CODES TO IDENTIFY PNEUMONIA CASES

ICD-9-CM Code	Description of Code
480.0	Pneumonia due to adenovirus
480.1	Pneumonia due to respiratory syncytial virus
480.2	Pneumonia due to parainfluenza virus
480.3	Pneumonia due to SARS-associated coronavirus
480.8	Viral pneumonia: pneumonia due to other virus not elsewhere classified
480.9	Viral pneumonia unspecified
481	Pneumococcal pneumonia [streptococcus pneumoniae pneumonia]
482.0	Pneumonia due to klebsiella pneumoniae
482.1	Pneumonia due to pseudomonas
482.2	Pneumonia due to hemophilus influenzae [h. influenzae]
482.30	Pneumonia due to streptococcus unspecified
482.31	Pneumonia due to streptococcus group a
482.32	Pneumonia due to streptococcus group b
482.39	Pneumonia due to other streptococcus
482.40	Pneumonia due to staphylococcus unspecified
482.41	Pneumonia due to staphylococcus aureus
482.42	Methicillin Resistant Pneumonia due to Staphylococcus Aureus
482.49	Other staphylococcus pneumonia
482.81	Pneumonia due to anaerobes
482.82	Pneumonia due to escherichia coli [e.coli]
482.83	Pneumonia due to other gram-negative bacteria
482.84	Pneumonia due to legionnaires' disease
482.89	Pneumonia due to other specified bacteria
482.9	Bacterial pneumonia unspecified
483.0	Pneumonia due to mycoplasma pneumoniae
483.1	Pneumonia due to chlamydia
483.8	Pneumonia due to other specified organism
485	Bronchopneumonia organism unspecified
486	Pneumonia organism unspecified
487.0	Influenza with pneumonia
488.11	Influenza due to identified novel H1N1 influenza virus with pneumonia

ICD-9-CM CODES TO IDENTIFY HEART FAILURE CASES

ICD-9-CM Code	Code Description
402.01	Hypertensive heart disease, malignant, with heart failure
402.11	Hypertensive heart disease, benign, with heart failure
402.91	Hypertensive heart disease, unspecified, with heart failure
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified failure and chronic kidney disease stage V or end stage renal disease
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease heart failure and with chronic kidney disease stage I through stage IV, or unspecified
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
428.xx	Heart Failure

ICD-9-CM CODES TO IDENTIFY ACUTE MYOCARDIAL INFARCTION CASES

ICD-9-CM Code	Description of Code
410.00	AMI (anterolateral wall) – episode of care unspecified
410.01	AMI (anterolateral wall) – initial episode of care
410.10	AMI (other anterior wall) – episode of care unspecified
410.11	AMI (other anterior wall) – initial episode of care
410.20	AMI (inferolateral wall) – episode of care unspecified
410.21	AMI (inferolateral wall) – initial episode of care
410.30	AMI (inferoposterior wall) – episode of care unspecified

ICD-9-CM Code	Description of Code
410.31	AMI (inferoposterior wall) – initial episode of care
410.40	AMI (other inferior wall) – episode of care unspecified
410.41	AMI (other inferior wall) – initial episode of care
410.50	AMI (other lateral wall) – episode of care unspecified
410.51	AMI (other lateral wall) – initial episode of care
410.60	AMI (true posterior wall) – episode of care unspecified
410.61	AMI (true posterior wall) – initial episode of care
410.70	AMI (subendocardial) – episode of care unspecified
410.71	AMI (subendocardial) – initial episode of care
410.80	AMI (other specified site) – episode of care unspecified
410.81	AMI (other specified site) – initial episode of care
410.90	AMI (unspecified site) – episode of care unspecified
410.91	AMI (unspecified site) – initial episode of care

Comment: Several commenters requested that, in the calculation of aggregate payments for excess readmissions, CMS remove admissions for the applicable conditions that were not considered admissions for the purposes of the calculation of the excess readmission ratio. Specifically, commenters requested that CMS remove admissions for (1) index admissions for beneficiaries who die in the hospital; (2) admissions for beneficiaries who were transferred to another acute care hospital; (3) admissions for beneficiaries who were discharged against medical advice; (4) admissions for beneficiaries without at least 30 days post-discharge enrollment in Medicare Part A fee-for-service; and (5) multiple admissions within 30 days of a prior index admission. Commenters argued that these trims are made for the readmissions measures, and accordingly, they should also be made when determining which admissions are included in the calculation of aggregate payments for excess readmissions. One commenter

recognized that not all of these trims can be identified in our proposed data source, MedPAR, so the commenter requested that CMS estimate an “additional exclusions factor” for the exclusions that we cannot account for based on data from the Measures Maintenance Technical Report, which lists the percentage of admissions that are removed by exclusion. The commenter suggested that the “additional exclusions factor” for each exclusion that cannot be accounted for in our proposed data source be removed for every hospital. By not excluding these admissions, the commenters believed that CMS is erroneously inflating the calculation of aggregate payments for excess readmissions.

Response: In our proposal to calculate the excess payments for readmissions, we proposed to identify admissions for each condition for an individual hospital for calculating the aggregate payments for readmissions by using the same ICD-9-CM codes used to identify the applicable conditions to calculate the excess readmissions ratios. We proposed to identify the claim as an applicable condition if the ICD-9-CM code for that condition is listed as the principal diagnosis on the claim, consistent with the calculation of the excess readmission ratios. Similarly, we proposed to limit our admissions to Medicare FFS claims, consistent with the methodology to calculate the excess readmission ratios.

As finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51669), the readmissions conditions of AMI, HF, and PN account for certain exclusions of admissions from being considered as an index admission. The NQF-endorsed readmission measures exclude from the group of index admission: (1) hospitalizations for patients with an in-hospital death; (2) hospitalizations for patients without at least 30

days post discharge enrollment in Medicare FFS; (3) hospitalizations for patients discharged against medical advice; (4) transfers; and (5) multiple admissions within 30 days of a prior index admission. In addition, for AMI, same day discharges are excluded as an index admission. Furthermore, we limit admissions to include Medicare Part A FFS enrollees who are 65 years or older.

We agree with the commenters that the index admissions that are not considered admissions for the purpose of the readmissions measures, thus excluded from the calculation of the excess readmission ratio, should also not be considered admissions for the purposes of determining a hospital's aggregate payments for excess readmissions. Accordingly, we are modifying our methodology to identify the admissions included in the calculation of "aggregate payments for excess readmissions." For this final rule, using our MedPAR data source, we will identify admissions for the purposes of calculating aggregate payments for excess readmissions as follows:

- We will exclude admissions that are identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis, but where the patient had died, as identified by the discharge status code on the MedPAR claim.
- We will exclude admissions identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis, but where the patient was transferred to another applicable hospital, as identified by the discharge status code on the MedPAR claim.

- We will eliminate admissions identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis, but where the patient was discharged against medical advice as identified by the discharge status code on the MedPAR claim.
- We will exclude admissions identified as an applicable condition based on the ICD-9-CM code listed as the primary diagnosis for patients who are under the age of 65, as identified on the MedPAR claim.
- For conditions identified as AMI, we will exclude claims that are same day discharges, as identified by the admission date and discharge date on the MedPAR claim.

As the commenters acknowledged, the MedPAR proposed data set that we are using to calculate the aggregate payments for excess readmissions cannot identify all of the exclusions included in the readmissions measures. Specifically, at this time, we cannot identify directly multiple admissions within 30 days of a prior index admission and patients without at least 30 days post discharge enrollment in Medicare FFS in the MedPAR data. However, the suggestion that we develop an “additional exclusions factor” to apply to the calculation of the readmissions payment adjustment factor is not within the statutory authority under section 1886(q) of the Act. We do not believe we have the authority to calculate an “additional exclusions factor,” which would be in lieu of the exclusion of admissions from the calculation of the aggregate payments for excess readmissions, and then uniformly applied that amount to all applicable hospitals. We believe that with the exclusions to the data for the scenarios discussed earlier, we will have accounted for nearly all of the admissions excluded in the calculation of the excess readmission ratios. We intend to work towards modifying our systems to identify these

claims for the two additional scenarios, and we will propose in future rulemaking to what extent we can include those exclusions from the calculation of the aggregate payments for excess readmissions.

For FY 2013, we are finalizing a methodology to calculate aggregate payments for excess readmissions, using MedPAR claims from July 1, 2008 to June 30, 2011, to identify applicable conditions based on same ICD-9CM codes used to identify the conditions for the readmissions measures and to apply the exclusions for the types of admissions discussed above, which are currently identifiable on the claim in MedPAR.

Comment: One commenter stated that a claim that the Recovery Audit Contractor (RAC) determines should have been provided in the outpatient setting and subsequently is denied as an inpatient should not be included in the calculation of a hospital's readmissions adjustment. The commenter sought clarification on whether the Common Working File (CWF) has been updated for RAC denials. The commenter stated that if a claim was subsequently denied for inpatient status, it should be removed from inpatient claims data set used to calculation of a hospital's readmission adjustment.

Response: In the FY 2013 IPPS/LTCH PPS proposed rule, we proposed to use the MedPAR claims data as our data source to calculate the excess payments for readmissions and payments for all discharges. Specifically, we proposed to use MedPAR data for discharges from July 1, 2008 through June 30, 2011, and we proposed to use the March 2009 update of the FY 2008 MedPAR file to identify claims within FY 2008 with discharges dates that are on or after July 1, 2008, the March 2010 update of the FY 2009 MedPAR file to identify claims within FY 2009, the March 2011 update of the FY 2010

MedPAR file to identify claims within FY 2010, and the March 2012 update of the FY 2011 MedPAR file to identify claims within FY 2011. We proposed to use these MedPAR updates, as it is consistent with the inpatient claims data set used in IPPS ratesetting.

The RACs have up to 3 years to review claims to determine whether a claim was inappropriately billed as inpatient when it should have been an outpatient claim. If a claim is denied as an inpatient stay, the claim is adjusted through the standard Medicare claims processing systems, going through the CWF and MedPAR. However, given the timing of the RAC audits and the updates of the MedPAR used to calculate the readmissions payment adjustments, it is not certain that all denied claims will be reflected in MedPAR at the time of our analysis. To the extent that those RAC determinations are made within the timeframe of the updates of MedPAR, those denied inpatient claims will not be included the MedPAR or in the calculation of the readmissions payment adjustment. We believe that using the updates of the MedPAR used in annual IPPS rate setting allows for us to use a complete inpatient claims data set and allows for transparency for the public to obtain this dataset to replicate our calculations.

In this final rule, we are finalizing our proposal to use MedPAR to calculate the readmissions payment adjustment factors without modification.

Section 1886(q)(2) of the Act defines the base operating DRG payment amount as “the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o) [the Hospital VBP Program]) for a discharge if this subsection did not apply; reduced by . . . any portion of such payment amount that is

attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).” Paragraphs (d)(5)(A), (d)(5)(B), (d)(5)(F), and (d)(12) of section 1886 refer to outlier payments, IME payments, DSH payments, and payments for low-volume hospitals, respectively.

As discussed earlier in section IV.A.3.b.(1) of the preamble of the proposed rule, we proposed to define “base operating DRG payment amount” under the Hospital Readmissions Reduction Program as the wage-adjusted DRG operating payment plus any new technology add-on payments. Thus, in order to calculate the base operating DRG payment amount for such condition for such hospital, we proposed to identify the base operating DRG payment amount for such conditions based on the payment amounts in the MedPAR files on the claims identified to meet those conditions based on their ICD-9-CM code.

As discussed in section IV.A.3.b. of the preamble of the proposed rule, applicable hospitals in the Hospital Readmissions Reduction Program include SCHs and current MDHs (whose status is set to expire at the end of FY 2012), as these hospitals meet the definition of subsection (d) hospitals. SCHs are paid in the interim (prior to cost report settlement) on a claim-by-claim basis at the amount that is the higher of the payment based on the hospital-specific rate or the IPPS Federal rate based on the standardized amount. At cost report settlement, the fiscal intermediary or MAC determines whether the hospital would receive higher IPPS payments in the aggregate using the hospital-specific rate (on all claims) or the Federal rate (on all claims). MDHs are paid the sum of the Federal payment amount plus 75 percent of the amount by which their hospital-

specific rate exceeds the Federal payment amount. Although MDH status is set to expire at the end of FY 2012, because we are using historical data to determine the base operating DRG payments to calculate adjustment factor, the payments reflected on claims for current MDHs may be based on the hospital-specific rate. For SCHs and current MDHs, we proposed to model their base operating DRG payment amount as they would have been paid under the Federal standardized amount, rather than using the information on the claim (which may represent a payment either made under the hospital-specific rate or the Federal rate) so that their payments are consistent with our proposed definition of base operating DRG payment. As such, the payment difference between the payment made under the hospital-specific rate and the payment made under the Federal rate is not included in the base operating DRG amount to determine the readmission adjustment factor; that is, it is neither included in the numerator of the aggregate dollars for excess readmissions nor in the denominator of the aggregate dollars for all discharges.

We did not receive public comments on our proposal for current MDHs and SCHs to model the “base operating DRG payments” as they would have been paid under the Federal standardized amount, rather than using the information on the claim in MedPAR (which may represent a payment either made under the hospital-specific rate or the Federal rate) to calculate their “aggregate payments for excess readmissions, so that their payments are consistent with our definition of base operating DRG payment.

As discussed earlier, we proposed to use data from the MedPAR files that contain claims from the 3-year applicable period of July 1, 2008, to June 30, 2011, for FY 2013 to calculate aggregate payments for excess readmissions (the numerator of the ratio). To

calculate aggregate payments for excess readmissions, we proposed to calculate the base operating DRG payment amounts for all the claims in the 3-year applicable period that list each applicable condition as the principal diagnosis (as described above). Once we have calculated the base operating DRG payment amounts for all the claims that list each condition as the principal diagnosis, we proposed to sum the base operating DRG payment amounts by each condition, resulting in three summed amounts, one amount for each of the three applicable conditions. We then proposed to multiply each amount for each condition by their respective excess readmission ratio minus 1. The methodology for the calculation of the excess readmission ratio was finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51673). We proposed that the excess readmission ratios for each condition used to calculate the numerator of this ratio are excess readmission ratios that had gone through the proposed review and correction process described in the FY 2013 IPPS/LTCH PPS proposed rule. Each product in this computation represents the payment for excess readmissions for that condition. We proposed to then sum the resulting products, which represent a hospital's proposed "aggregate payments for excess readmissions" (the numerator of the ratio).

If a hospital has an excess readmission ratio that is greater than 1 for a condition, that hospital has performed, with respect to readmissions for that applicable condition, worse than the average hospital with similar patients. As such, it will have aggregate payments for excess readmissions. If a hospital has an excess readmission ratio that is less than (or equal) to one, that hospital has performed better (or on average), with respect to readmissions for that applicable condition, than an average hospital with

similar patients. As such, that hospital would not be considered to have “aggregate payments” for excess readmissions, and its payments would not be reduced under section 1886(q) of the Act. As described in section 1886(q)(4)(C) of the Act, and finalized in the FY 2012 IPPS/LTCH PPS final rule, the excess readmission ratio used cannot be less than 1 because the hospital will not have aggregate payments for excess readmissions and will not be subject to a readmission payment adjustment, as the hospital will have performed equal to or better than average. Because this calculation is performed separately for the three conditions, a hospital’s excess readmission ratio must be less than or equal to 1 on each measure to avoid aggregate payments for excess readmissions.

Section 1886(q)(4)(B) of the Act defines “aggregate payments for all discharges” (the denominator of the ratio) as “for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.” In the FY 2013 IPPS/LTCH PPS proposed rule, we proposed to use the same MedPAR files to calculate the denominator as we proposed to use to calculate the numerator, for the 3-year applicable period of July 1, 2008 to June 30, 2011, for FY 2013. We proposed to calculate base operating DRG payments in the same manner as we calculate base operating DRG payments for the numerator. We proposed to sum the base operating DRG payment amounts for all Medicare FFS claims for such hospital during the 3-year applicable period. We also proposed that we would model base operating DRG payment amount for SCHs and current MDHs as they would have been paid under the Federal standardized amount, rather than using the information on the claim (as described above).

We did not receive any public comments regarding our proposed calculation of “aggregate payments for all discharges” and we are finalizing it as proposed without modification.

We proposed that the ratio described in section 1886(q)(3)(B) of the Act is 1 minus the ratio of the numerator and denominator described above. In addition, we proposed that the readmission adjustment for an applicable hospital is the higher of this ratio under section 1886(q)(3)(B) of the Act or the floor of 0.99 for FY 2013. Consistent with this proposal, under the regulations we proposed at 42 CFR 412.152, we proposed to define “readmissions adjustment factor” as equal to the greater of: (i) 1 minus the ratio of the aggregate payments for excess readmissions to aggregate payments for all discharges or (ii) the floor adjustment factor.

For the proposed rule, for the purpose of modeling the proposed aggregate payments for excess readmissions and the proposed readmissions adjustment factors, we used excess readmission ratios for the applicable hospitals from the 3-year period of July 1, 2007 to June 30, 2010, because the underlying data from this period had already been available to the public on the [Hospital Compare](#) Web site (as of July 2011). The data from the 3-year applicable period for FY 2013 of July 1, 2008 to June 30, 2011, had not been through the review and correct process required by section 1886(q)(6) of the Act (as discussed below). As we stated in the proposed rule, for this final rule, we are using excess readmission ratios based on discharges for the finalized applicable period of July 1, 2008 to June 30, 2011, to calculate the aggregate payments for excess readmissions and, ultimately, to calculate the readmission adjustment factors. Applicable

hospitals had the opportunity to review and correct these data before they were made public under our proposal set forth below regarding the reporting of hospital-specific readmission rates, consistent with section 1886(q)(6) of the Act.

Formulas to Calculate the Readmission Adjustment Factor

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmission Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmission Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmission Ratio for PN-1)].

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = 1-(Aggregate payments for excess readmissions/Aggregate payments for all discharges).

Readmissions Adjustment Factor for FY 2013 is the higher of the ratio or 0.99.

*Based on claims data from July 1, 2008 to June 30, 2011 for FY 2013.

Comment: Several commenters supported our methodology to calculate the readmissions payment adjustment factor. Commenters supported calculating the adjustment factor as 1 minus the ratio of the hospital's aggregate payments for excess readmissions for applicable conditions to the hospital's aggregate payments for all discharges for applicable conditions. Commenters supported determining the hospital's aggregate payments for all discharges for applicable conditions based on our proposed definition of the base operating DRG payment amount, and commenters supported our proposal to determine the hospital's aggregate payments for excess readmissions by multiplying the hospital's aggregate payments for all discharges for an applicable condition by 1, minus the hospital's excess readmissions ratio.

Some commenters stated that it is unclear why the proposed numerator of the readmission payment adjustment factor, or the calculation of the excess payments for readmissions, is based on total admissions for each condition, when the purpose of the Hospital Readmissions Reduction Program is to reduce only preventable readmissions. Commenters stated that our proposed methodology to calculate the readmission payment adjustment factor should amend the legislative language in the formula for calculating the readmissions adjustment factor. The formula as proposed stipulated that the amount of aggregate payments due to excess readmission is calculated by multiplying the number of admissions for the condition times the average base DRG payment for the condition and the “excess readmission ratio.” The excess readmissions ratio is defined as the ratio of the number of actual readmissions as compared to the number of expected readmissions for the clinical condition. However, commenters contended that the formula should specify that the calculation should be based on the number of expected readmissions in each condition, not the total number of admissions. They urged that we replace the words “number of admissions” with “number of expected readmissions” so that the formula for the aggregate payments for excess readmissions calculates the number of expected readmissions for each condition and not the total number of admissions.

One commenter believed that the proposed formula produces penalties that are higher than Medicare payments for excess readmissions, although the full impact is mitigated because of the proposed maximum penalty for FY 2013 of 1 percent of base operating DRG payments. The commenter believed that our proposed methodology to calculate the readmissions payment adjustment factors conforms to the statute. However,

the commenter suggested long-term changes to the formula to be more proportionate to the cost of readmissions, such as examining the issue of shrinking excess readmission computations towards the national mean and appropriate changes to account for excess payments for readmissions.

Commenters believe that our proposed methodology to calculate the readmissions payment adjustment over estimates the excess payments for readmissions resulting in an excessive readmission payment adjustment and is not consistent with Congressional intent. Commenters believed our proposed readmissions payment adjustments are excessive as evident by the Congressional Budget Office (CBO) score for the provision at \$100 million while our estimates of the Hospital Readmissions Reduction Program published in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28172) was approximately \$300 million.

Response: We believe that the statute is prescriptive with respect to the calculation of “aggregate payments for excess readmissions” where the statute specifies that the “aggregate payments for excess readmissions” is the sum for each condition of the product of “the operating DRG payment amount for such hospital for such applicable period for such condition” and “the number of admissions for such condition” and “the excess readmission ratio” minus one. We believe that section 1886(q)(4)(A) of the Act requires us to include all admissions for a condition in the calculation of “aggregate payments for excess readmissions.”

Our estimate of \$300 million in savings associated with the Hospital Readmissions Reduction Program published in the FY 2013 IPPS/LTCH PPS proposed

rule was based on different data that were not available to the CBO at the time of the CBO estimate. Furthermore, we potentially used different assumptions in our methodology to estimate the savings of this Hospital Readmissions Reduction Program as compared to CBO. Our proposed readmission payment adjustment factors were calculated using excess readmission ratios based on hospitals' readmissions performance from July 1, 2007 to June 30, 2010, which was not available at the time of the CBO estimate. In addition, our calculation for "aggregate payments for excess readmissions" and "aggregate payments for all discharges" were based on MedPAR claims data from July 1, 2007 to June 30, 2010, which was also not available at the time of the CBO estimate. Finally, we applied the proposed readmission payment adjustment factor to our estimated FY 2013 IPPS base operating DRG payments to determine the savings associated with the Hospital Readmissions Reduction Program and our FY 2013 IPPS base operating DRG payments were likely based on different assumptions than the CBO's estimate published in 2010. Therefore, it is difficult to assess the precise differences between our estimate of this provision and the CBO's estimate. Nonetheless, we believe that we are implementing the provision as required by law.

Comment: Several commenters requested that CMS make additional adjustments to the calculation of the readmissions payment adjustment factor to account for differences in the readmissions payment adjustment factors for hospitals that treat a high proportion of patients of low socioeconomic status. Commenters made a number of suggestions as to how to modify the readmissions payment adjustment factors. One commenter suggested that CMS and Congress could apply a uniform percentage

reduction to all hospitals' expected readmission rates, which the commenter believed would be a budget neutral change. The commenter urged CMS and Congress to intervene somehow to correct an inequity affecting the nation's most vulnerable hospitals and Medicare beneficiaries.

Another commenter suggested that CMS offer a one-time opportunity to waive the payment reduction for safety net and other hospitals that serve a higher-than-average proportion of patients of low socioeconomic status and are found to be at risk of experiencing a payment reduction. In return, the commenter suggested that these hospitals would be required to submit a comprehensive and aggressive preventable readmission rate improvement plan that centers on collaboratively engaging with the patients, their families, consumer organizations and community supports, to address the various factors that are causing preventable readmissions in their local community. The commenter stated that this approach should have a time limit (for example, 6 months) on how long the hospital would have for submitting and implementing the plan and another well-defined (for example 6 months) timeframe for monitoring and reporting results to CMS.

Some commenters requested that CMS postpone implementation of the Hospital Readmissions Reduction Program until it has made adjustments to the measures to account for socioeconomic status. One commenter requested postponing the application of the readmissions payment reduction to safety net hospitals that serve a vulnerable population while these hospitals develop programs to reduce readmissions.

Commenters suggested that CMS make an adjustment to the readmission payment adjustment factors to account for a hospital's proportion of dual-eligible patients.

Commenters contended that dual-eligible status is a better predictor of readmission rates because it reflects Medicare beneficiaries, which is what the readmissions measures are based on.

In addition, commenters suggested that CMS make a hospital-level adjustment based on DSH. Commenters asserted that because the number of hospitals that will receive the maximum penalty in the first year jumps sharply between the sixth and seventh deciles for hospital's DSH Patient Percentage, the commenters suggested that any hospital-level adjustment based on DSH be applied to the top four deciles.

Response: We thank the commenters for their suggestions on modifying the readmission payment adjustment to account for differences in the socioeconomic status of patients treated by hospitals. As stated earlier, we continue to believe that we need to examine the relationship of patient socioeconomic status and readmissions as it applies to the readmissions measures. As we have stated earlier, the readmissions measures, as endorsed by the NQF, do not include risk adjustments for socioeconomic status. Currently, the NQF does not support risk adjustments based on socioeconomic status, as the NQF believes it can create different standards of quality for hospitals that treat a higher proportion of patients with low socioeconomic status. Risk adjusting the readmissions measures for socioeconomic status can obscure differences in the quality of health care. Similarly, applying an adjustment to the readmissions payment adjustment factors can also create different standards of quality for hospitals based on the

socioeconomic status of the patients treated. Applying an adjustment to the readmissions payment adjustment factors at this point to account for socioeconomic status rather than determining whether a risk adjustment for socioeconomic status would be appropriate for the readmissions measures could appear as circumventing the NQF's position on the application of a risk adjustment for socioeconomic status on the readmissions measures. We note that, to the extent that dual eligible patients or patients of low socioeconomic status have higher readmission rates because they are sicker or have more comorbidities, we already account for comorbidities in the risk adjustment for the excess readmission rates. Since, we believe that all hospitals should be working towards the goal of reducing readmissions, on an ongoing basis, regardless of their patient population, we believe that we do not need to postpone the implementation of the readmission payment adjustments in order to provide additional time to hospitals to implement readmission reduction programs. While we are not incorporating any special adjustments for SES in the readmissions reduction program at this time, we remain concerned about the impact of this provision on hospitals that serve a high proportion of low income patients. We will continue to monitor the issue of the relationship of a patient's socioeconomic status and a hospital's readmission performance, and how it affects payments to hospitals.

Comment: One commenter recommended that CMS apply the readmissions adjustment in a manner that norms the calculation of the adjustment factor on the risk-adjusted readmission rate that is achieved by at least 25 percent of hospitals rather than on the average readmission rate.

Response: The excess readmission ratio, finalized in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51673), measures a hospital's performance on readmissions for a specified condition relative to the national average. The methodology to calculate the excess readmission ratio is endorsed by the NQF, as required at section 1886(q)(5)(C) of the Act. We did not propose any changes to the methodology to calculate the excess readmission ratio. Accordingly, we are not modifying the methodology to calculate the excess readmission ratio to compare a hospital's performance on readmissions relative to the 25th percentile of national performance, as opposed to the average.

Comment: One commenter questioned the statistical difference in the excess readmission ratio for a hospital that has an excess readmission ratio slightly above 1 and thus, subject to the payment penalty, versus a hospital that has an excess readmission ratio slightly below 1, and not subject to the penalty. The commenter asked that CMS consider the equitability of this policy approach and recommended the remunerative framework account for the confidence intervals surrounding the estimated Risk Standardized Readmission Rates and Ratios in determining future penalties for excess readmissions. The commenters believed that omitting a control for statistical significance exposes a large number of hospitals to financial penalties based on random variation. They recommended that CMS account for the confidence intervals surrounding the estimated Risk Standardized Readmission Rates and Ratios in determining future penalties for excess readmissions.

Response: We thank the commenter for raising the issue of statistical reliability of the excess readmission ratio and for recommending the use of confidence intervals in

determining whether or not to use a hospital's excess readmission ratio in the calculation of a hospital's readmission payment adjustment factor. We finalized our methodology of the calculation of the excess readmission ratio in the FY 2012 IPPS/LTCH PPS final rule, which results in the use of the point estimate as a hospital's excess readmission ratio.

We will consider the role, if any, of confidence intervals in determining a hospital's excess readmission ratio. We recognize that because the excess readmission ratio is a statistical measure, there may be some degree of variation. However, there are other Medicare programs, not limited to the Hospital Readmissions Reduction Program, that use statistical measures as part of their program, so any consideration to confidence intervals made with respect to the Hospital Readmissions Reduction Program may have implications for other programs. We will evaluate this concern and address it in future rulemaking, if needed.

Comment: Several commenters suggested that CMS take into consideration a hospital's improvement on readmissions in the calculation of the readmissions payment adjustment factor. One commenter noted that because measurement is based on 3 years' worth of data, it will be difficult for low performing hospitals to move out of being penalized, and the Hospital Readmissions Reduction Program does not reward for improvement as the Hospital VBP Program does, but only measures achievement. The commenter noted that this could result in low performing hospitals being unable to ever get out of the penalty phase.

Response: We appreciate the concerns raised by the commenters. The Hospital Readmissions Reduction Program is structured to apply a payment reduction to hospitals

with excess readmissions, as measured by having worse performance on readmissions for certain conditions compared to the average hospital. The readmission payment adjustment under section 1886(q)(1) of the Act does not allow for us to provide a reward for quality improvement, which is allowed under section 1886(p) of the Act for the Hospital VBP Program. We believe that hospitals do have the opportunity to not be subject to a reduction to payments due to excess readmissions if they can perform better than the average hospital in the future. We update the data annually with the most recently available 3 years of data, and we use 3 years of data in order to have sufficient data to reliably measure a hospital's performance.

Comment: Commenters sought clarification on how the readmissions payment adjustment factors would be applied to a hospital's base operating DRG payment amount. Commenters asked whether the readmissions payment adjustment factors would be applied on a per claim basis or at cost report settlement. Commenters asked how the IME, DSH, and outlier payments would not be affected by the readmissions payment adjustment factor when the IME, DSH and outlier payments are adjustments are currently determined from the base operating DRG payment amount, and the readmissions payment adjustment factor reduces the base operating DRG payment amount. Commenters asked if there would be changes to the cost report and to the PS&R to account for the implementation of the payment adjustment for excess readmissions. In addition, commenters noted that the effective date of the Hospital Readmissions Reduction Program is October 1, 2012, which straddles the cost reporting period for

many hospitals, and asked for clarification on how that would be accounted for with respect to the Medicare hospital cost report.

Commenters also stated that the statutory intent of the readmissions payment adjustment factor is that the factor should not be applied to payments for all admissions, but rather to payments for initial admissions with at least one readmission. Commenters requested clarification whether the readmissions payment adjustment factors will apply to only Medicare discharges for AMI, PN or HF; or whether the readmissions payment adjustment factor will apply to all discharges. The commenters believed that the readmissions payment adjustment factor should only be applicable to the specific populations included in the program rather than the entire Medicare population.

Response: We are clarifying that, for FY 2013, a hospital's payments will be reduced by the amount of the product of the readmissions payment adjustment factor and the base operating DRG payment amount (as defined as the wage-adjusted DRG payment amount), on a per-claim basis for all Medicare FFS discharges occurring on or after October 1, 2012. In other words, the payment amount the hospital would otherwise receive in FY 2013 in absence of the Hospital Readmission Reduction Program will be reduced by the an amount for excess readmissions (determined as the product of the readmissions payment adjustment factor and the base operating DRG payment amount). Section 1886(q)(1) of the Act specifies that "the Secretary shall make payments . . . in an amount equal to the product of (A) the base operating DRG payment amount for the discharge; and (B) the adjustment factor..." Therefore, it requires us to apply the readmissions payment adjustment factor to all discharges, not just discharges for initial

admissions with a readmission or admissions for the applicable conditions. We note that the readmissions payment adjustment factor is inversely proportional to the aggregate payments for all discharges (in the formula determining the excess readmissions ratio) so the adjustment factor appropriately reflects the relation between payments for excess readmissions and aggregate payments for all discharges.

In addition, we intend to modify the Medicare hospital cost report and the corresponding cost reporting instructions, effective for FY 2013, to account for the reductions to payments under the Hospital Readmission Reduction Program required by section 1886(q) of the Act (that is, the payment adjustment for excess readmissions). The current calculation of the additional payments for IME, DSH, outliers, and low-volume hospitals will remain unchanged consistent with the statutory requirement that payments for outliers, IME, DSH, and low-volume adjustments are not affected by the adjustments made under the Hospital Readmissions Reduction Program.

Currently, the cost report includes the base operating DRG payment for the cost reporting period and we use that line to determine add-on payments including payments for indirect medical education and disproportionate share hospital payments. This line will remain unchanged and will continue to be used to determine IPPS add-on payments, consistent with our policy that add-on payments for outliers, IME, DSH, and low-volume adjustments are not affected by the adjustments made under the Hospital Readmissions Reduction Program. We intend to modify the Medicare hospital cost report to include lines for base operating DRG payments by Federal fiscal year. For example, we will have a line that represents base operating DRG payments prior to October 1, 2012 and a

line that represents base operating DRG payments after October 1, 2012. In addition, we intend to modify the Medicare hospital cost report with lines for the readmissions payment adjustment factor by Federal fiscal year and lines with the readmissions payment amount by Federal fiscal year that would be deducted from a hospital's Medicare payments. The readmissions payment amounts would be determined by applying the readmission payment adjustment factor to the base operating DRG payment amount by Federal fiscal year. We intend to modify the cost reporting instructions to account for these new calculations. In addition, for FY 2013, we will ensure that the cost reporting instructions account for the readmissions adjustment to only be made to base operating DRG payments for discharges on or after October 1, 2012. We intend to modify the PS&R to account for these changes as well.

Comment: One commenter sought clarification as to whether the Hospital Readmissions Reduction Program is intended to replace the existing readmission review at Internet Only Manual (IOM) 100-04, Chapter. 3, Section 40.2.5, or if both policies will exist together.

Response: The Hospital Readmissions Reduction Program is not intended to replace the existing readmission review under IOM 100-04, Chapter 3, Section 40.2.5. IOM 100-04, Chapter 3, Section 40.2.5 of the Inpatient Claims Processing Manual provides guidance on appropriate billing practices for repeat admissions. In accordance with the manual, "a patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence. Hospitals may place a patient on a leave of absence when readmission is expected... and providers may not use the leave of absence billing procedure when the second admission is unexpected." If a hospital

uses the leave of absence billing code, two inpatient stay claims for the original admission and the repeat admissions are bundled as one inpatient claim with one DRG payment. These claims can be reviewed by a fiscal intermediary or MAC and referred to the QIOs. This is a separate billing procedure from the Hospital Readmissions Reduction Program and will continue to exist.

During the FY 2012 IPPS rulemaking cycle, we received public comments expressing concern that hospitals that treat a larger proportion of patients of lower socioeconomic circumstances may have higher readmission rates and could be unfairly penalized under the Hospital Readmissions Reduction Program. The table below shows, based on the excess readmission ratios and the proposed methodology to calculate the readmissions adjustment factor discussed in the proposed rule, the estimated distribution of the readmission adjustment factors among hospitals ranked by their DSH patient percentage (DPP). The DPP is used as a proxy for low-income patients and is the sum of the hospital's Medicare fraction and Medicaid fraction. The Medicare fraction is computed by dividing the number of a hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days. The DPP is used to determine a hospital's Medicare DSH payment adjustment. Thus, hospitals with higher percentages of Medicare patients entitled to SSI and higher percentages of Medicaid patients have higher

DPPs. In the table, the hospitals are ranked by their estimated DPP and categorized into deciles. The table shows the number of hospitals within each decile that are subject to no proposed readmission payment adjustment, the -1 percent floor readmission payment adjustment, and a readmission payment adjustment that is less than the -1 percent floor. We invited public comment on this analysis.

**DISTRIBUTION OF HOSPITALS READMISSION ADJUSTMENT FACTOR BY
DSH PATIENT PERCENTAGE (DPP)**

Decile	Number of Hospitals	Payment Adjustment of less than -1 percent	-1 Percent Floor Adjustment	No Readmission Adjustment Factor
Lowest DPP	339	156	38	145
Second	339	164	57	118
Third	339	168	44	127
Fourth	339	170	48	121
Fifth	339	182	42	115
Sixth	339	171	43	125
Seventh	339	187	44	108
Eighth	339	182	43	114
Ninth	339	179	58	102
Highest DPP	342	185	61	96
Total	3,393	1,744	478	1,171

In addition, we examined the estimated distribution of the proposed readmissions adjustment factor based on the excess readmission ratios in this proposed rule (determined using the 2007-2010 data discussed above). The table below shows the number and percentage of hospitals ranked by the percent reduction received under the Hospital Readmissions Reduction Program. The table shows that about 71 percent of

hospitals would receive either no adjustment or a readmission adjustment factor that would reduce their base operating DRG payments by less than 0.5 percent.

DISTRIBUTION OF READMISSION ADJUSTMENT FACTORS

Percent Reduction	Number of Hospitals	Percent of Hospitals
No Adjustment	1,171	34.5%
Up to -.09 Percent	347	10.2%
-0.1 Percent to -0.19 Percent	280	8.3%
-0.20 Percent to -0.29 Percent	228	6.7%
-0.30 Percent to -0.39 Percent	196	5.8%
-0.40 Percent to -0.49 Percent	180	5.3%
-0.50 Percent to -0.59 Percent	129	3.8%
-0.60 Percent to -0.69 Percent	118	3.5%
-0.70 Percent to -0.79 Percent	110	3.2%
-0.80 Percent to -0.89 Percent	77	2.3%
-0.90 Percent to -0.99 Percent	76	2.2%
-1.0 Percent	481	14.2%
Total	3,393	100.0%

Comment: Several commenters addressed the Medicare DSH analysis that was presented in the proposed rule. Several commenters could not replicate the DSH analysis and produce the same results presented in the proposed rule. Some commenters presented different results where they found that high DSH hospitals are, in fact, subject to higher readmission penalties. In addition, several commenters contended that DSH was not a good proxy to determine socioeconomic status. Commenters indicated that it is not uncommon for hospitals in areas with relatively affluent Medicare beneficiaries to qualify for DSH reimbursement due to the high volume of labor and delivery services provided to non-resident aliens. One commenter asked why CMS did not present a comparison table of the impacts to the DSH hospitals (approximately 1,882 hospitals) instead of the entire hospital population.

Commenters indicated that hospitals with high disproportionate share patient percentages have higher excess readmission ratios. Commenters presented other analyses showing that hospitals with high DSH have higher readmission penalties. Commenters provided analyses where the results indicate that high DSH hospitals (defined as hospitals in the top 25th percentile for the DSH percentage) and hospitals located in large urban areas (defined as those Metropolitan Statistical Areas with more than one million population) are much more likely to receive a readmission penalty under the CMS proposal. The commenter found that high DSH hospitals located in large urban areas are 1.9954 times more likely to be penalized for heart attack than other hospitals, 2.5849 times more likely for heart failure, and 2.1915 times more likely for pneumonia.

Response: In the proposed rule, we used the proposed readmissions payment adjustment factors and the DSH disproportionate patient percentage (DPP) reported in the FY 2012 IPPS/LTCH PPS final rule Impact file, as it was the most recently available data at the time of our analysis. We note that, for hospitals that have a missing DPP, we assigned them a DPP of zero. We believe that may have been one potential source for differences in the results.

We understand that there are several ways to measure socioeconomic status of a hospital's patient population and as we continue to monitor the issue of the relationship of a patient's socioeconomic status and a hospital's readmission performance, and how it affects payments to hospitals, we also can explore different measures of socioeconomic status, such as dual-eligible status. To the extent differences in readmission rates among hospitals treating a significant number of patients with low socioeconomic status are

determined to inappropriately affect their readmission payment adjustment, we can work with NQF to explore options for improving the readmissions measures to promote high quality care, as appropriate.

We understand that there have been different conclusions drawn from review of these data, and we will continue to work with MedPAC and other stakeholders to complete a more sophisticated analysis.

Comment: One commenter suggested that CMS provide a level of statistical significance for our DSH analysis, as well as correlation factors between hospitals' actual DSH patient percentage (as opposed their national decile) and the likeliness of receiving a readmissions adjustment, the magnitude of a readmissions adjustment, and the likeliness of reaching the maximum readmissions penalty.

Response: At this time, we are unable to produce a rigorous analysis showing the relationship of a hospital's actual DSH patient percentage and their likeliness of receiving a readmissions adjustment, the magnitude of a readmissions adjustment, and the likeliness of receiving the maximum adjustment of -1.0 percent. However, we will research these issues in the upcoming year and, if significant, we will present our findings in future rulemaking.

e. Applicable Hospitals

An "applicable hospital," is defined at section 1886(q)(5)(C) of the Act as (1) "a subsection(d) hospital or (2) a hospital that is paid under section 1814(b)(3)." Specifically, hospitals subject to the Hospital Readmissions Reduction Program are hospitals paid under the IPPS and hospitals paid under the authority of section 1814(b)(3)

of the Act. We are interpreting this reference to section 1814(b)(3) of the Act to mean those Maryland hospitals that are paid under section 1814(b)(3) of the Act and that, absent the “waiver” specified by section 1814(b)(3) of the Act, would have been paid under the IPPS. A subsection (d) hospital is defined in section 1886(d)(1)(B) of the Act, in part, as a “hospital located in one of the fifty States or the District of Columbia.” The term subsection (d) hospital does not include hospitals located in the Territories or hospitals located in Puerto Rico. Section 1886(d)(9)(A) of the Act separately defines a “subsection (d) Puerto Rico hospital” as a hospital that is located in Puerto Rico and that “would be a subsection(d) hospital . . . if it were located in one of the 50 States.” Therefore, Puerto Rico hospitals are not considered applicable hospitals under the Hospital Readmissions Reduction Program. An Indian Health Services hospital enrolled as a Medicare provider meets the definition of a subsection (d) hospital and, therefore, is considered an applicable hospital under the Hospital Readmissions Reduction Program, even if it is not paid under the IPPS. In addition, hospitals that are SCHs and current MDHs, although they may be paid under a hospital-specific rate instead of under the Federal rate under the IPPS, are subsection (d) hospitals and, therefore, are included in the definition of an applicable hospital under the Hospital Readmissions Reduction Program.

A subsection (d) hospital as defined in section 1886(d)(1)(B) of the Act does not include hospitals and hospital units excluded from the IPPS, such as LTCHs, cancer hospitals, children's hospitals, IRFs, and IPFs, and, therefore, these hospitals are not considered “applicable hospitals.” CAHs are not “applicable hospitals” because they do

not meet the definition of a “subsection (d) hospital,” as they are separately defined under section 1886(mm) of the Act and are paid under a reasonable cost methodology under section 1814(l) of the Act. Therefore, in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27966), consistent with the statute, we proposed to define “applicable hospital” under the regulations at 42 CFR 412.152 to include both (1) subsection (d) hospitals, that is, hospitals paid under the IPPS and (2) hospitals in Maryland that are paid under section 1814(b)(3) of the Act and that, absent the “waiver” specified by section 1814(b)(3) of the Act, would have been paid under the IPPS.

The term “applicable hospital” is also referenced in the definition of readmission in section 1886(q)(5)(E) of the Act, which defines “readmission” as “in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge.” In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51666), we finalized the definition of readmission as “occurring when a patient is discharged from the applicable hospital and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the index hospitalization.” Furthermore, we finalized the time period specified for these readmission measures as 30 days. With our proposal to define an applicable hospital as a subsection (d) hospital or certain Maryland hospitals described above, we also proposed to refine the definition of readmission to only include admissions and readmissions occurring from an applicable hospital (that is, a subsection (d) hospital or certain Maryland hospitals) to the same or another applicable hospital (again, a subsection (d)

hospital or certain Maryland hospitals) (proposed § 412.152). Accordingly, excess readmission ratios calculated for the purpose of the Hospital Readmissions Reduction Program would include only admissions and readmissions to “applicable hospitals.”

We note that because the Hospital Readmissions Reduction Program only includes admissions and readmissions to “applicable hospitals” to calculate the excess readmission ratios used under section 1886(q) of the Act, these excess readmission ratios will differ from the readmission rates reported on [Hospital Compare](#) for the purpose of the Hospital IQR Program. The excess readmission ratios for the purpose of the Hospital IQR Program were determined based on admissions and readmissions to all hospitals, not just hospitals specified in sections 1886(d) and 1814(b)(3) of the Act. Therefore, as discussed above, the excess readmission ratios used in the proposed rule used a subset of the claims used to calculate the readmission rates reported on [Hospital Compare](#) for the purpose of the Hospital IQR Program and are limited to admissions and readmissions to “applicable hospitals” and are based on the period of June 30, 2007 to July 1, 2010. In the proposed rule, we used these excess readmission ratios, as they were based on the most recent data available and would allow the public to replicate our methodology to understand how the readmission adjustment factor is calculated. We believe that the differences between these proposed excess readmission ratios and those excess readmission ratios currently published on [Hospital Compare](#) under the Hospital IQR Program are minimal, and it was helpful for hospitals to see the impact of our proposed methodology to calculate the readmission adjustment using excess readmission ratios calculated under our methodology finalized in the FY 2012 IPPS/LTCH PPS final rule.

As we stated in the proposed rule, for this final rule, we are using excess readmission ratios based on the applicable period of June 30, 2008 to July 1, 2011, as finalized in the FY 2012 IPPS/ LTCH PPS final rule, and hospitals have had the opportunity to review and correct their data related to their excess readmission ratios prior to the publication of those excess readmission ratios.

We specifically invited public comment on our readmissions proposal, including our proposed definition of base operating DRG payment, our proposed methodology to calculate the readmission adjustment factor, the minimum number of cases, and our proposed definition of applicable hospital.

Comment: Commenters urged CMS to align the Hospital Readmissions Reduction Program with the clinical quality measure requirements of the Hospital IQR Program.

Response: As discussed above, the excess readmission ratios for the purpose of the Hospital IQR Program were determined based on admissions and readmissions to all hospitals, not just hospitals specified in sections 1886(d) and 1814(b)(3) of the Act. Therefore, the excess readmission ratios used in the final rule use a subset of the claims used to calculate the readmission rates reported on [Hospital Compare](#) for the purpose of the Hospital IQR Program and would be limited to admissions and readmissions to “applicable hospitals.” We have aligned the methodology for readmission measures in the Hospital IQR Program and the Hospital Readmissions Reduction Program as much as is allowed by statutory requirements.

Comment: Some commenters supported our proposal to include subsection (d) hospitals and Maryland hospitals in our definition of “applicable hospital” for the Hospital Readmissions Reduction Program. One commenter asked CMS to waive the requirements of the Hospital Readmissions Reduction Program for hospitals that participate in an accountable care organization (ACO) under the Medicare Shared Savings Program or the Pioneer ACO Model. The commenter argued that hospitals that participate in ACOs are already subject to incentives to reduce hospital readmissions, are already measured for their performance on all conditions for readmissions; therefore, to include these hospitals in the Hospital Readmissions Reduction Program is redundant. The commenter argued that CMS has the authority to waive Title XVIII requirements, including the requirements of the Hospital Readmission Reduction Program, for these hospitals under the waivers provided under sections 1115A(d)(1) and 1899(f) of the Act.

Response: We appreciate the suggestion submitted by the commenters to exempt hospitals from the Hospital Readmissions Reduction Program if they already participate in an ACO under the Medicare Shared Savings Program or the Pioneer ACO Model. We agree that ACOs are encouraged to improve quality of care and reduce the rate of growth in expenditures. We also agree that avoidable readmissions is an area in which we believe an ACO’s coordination of care and accountability can have a significant impact in improving patient care. To that end, we finalized an all-condition readmission quality measure in the Medicare Shared Savings Program Final Rule. This measure is also used to assess quality of care furnished by ACOs participating in the Pioneer ACO Model. However, the waivers under sections 3021 and 3022 of the Affordable Care Act permit us

to waive provisions of Title XVIII only to the extent that such a waiver may be “necessary” in order to carry out those sections. In this case, because the incentives of the Hospital Readmissions Reduction Program and the Medicare ACO initiatives are aligned, we see no need to waive the requirements of the Hospital Readmissions Reduction Program in order to carry out either the Medicare Shared Savings Program or to test the Pioneer ACO Model.

Indeed, because the incentives of the two programs are aligned, we believe that hospitals successful in reducing avoidable readmissions could be important allies for ACOs who share similar goals. Because it is unlikely that the beneficiaries assigned to ACO will use only a single inpatient facility, ACOs will need to work effectively with all local hospitals that their Medicare FFS beneficiaries choose to use.

Finally, as we gain experience with the Shared Savings Program and other new payment incentives in the Medicare FFS program, we will monitor their interactions with the Hospital Readmissions Reduction Program and continue our efforts to align measures and incentives to achieve the best outcomes for our patients and the program.

Comment: One commenter requested clarification regarding how hospitals participating in the Rural Hospital Community Demonstration Program will be impacted by the Hospital Readmissions Reduction Program.

Response: As described, the applicable hospital is defined as a subsection (d) hospital or certain Maryland hospitals. Hospitals participating in the Rural Hospital Community Demonstration Program are subsection (d) hospitals and, thus, will be included in the Hospital Readmissions Reduction Program. Accordingly, we have

calculated excess readmission ratios and readmissions payment adjustment factor for hospitals in the Rural Hospital Community Demonstration Program. If hospitals in the Rural Hospital Community Demonstration Program are subject to a readmissions payment reduction, the reduction will be applied to their base operating DRG amount as if they were paid under the IPPS. At cost report settlement, the readmissions payment amount subtracted from the hospital's base operating DRG amount will be reduced from the payments received under the demonstration.

We are finalizing as proposed our definition of applicable hospitals under the regulations at 42 CFR 412.152 to include both (1) subsection (d) hospitals, that is, hospitals paid under the IPPS and (2) hospitals in Maryland that are paid under section 1814(b)(3) of the Act and that, absent the "waiver" specified by section 1814(b)(3) of the Act, would have been paid under the IPPS. Furthermore, we note that the Hospital Readmissions Reduction Program only includes admissions and readmissions to "applicable hospitals" to calculate the excess readmission ratios used under section 1886(q) of the Act.

4. Limitations on Review (§ 412.154(e))

Section 1886(q)(7) of the Act provides that there will be no administrative or judicial review under section 1869 of the Act, under section 1878 of the Act, or otherwise for any of the following:

- The determination of base operating DRG payment amounts.

- The methodology for determining the adjustment factor, including the excess readmissions ratio, aggregate payments for excess readmissions, and aggregate payments for all discharges, and applicable periods and applicable conditions.

In the FY 2013 IPPS/LTCH PPS proposed rule (77 FR27966), we proposed to include under proposed § 412.154(e) that the provisions listed above will not be subject to administrative or judicial review, consistent with section 1886(q)(7) of the Act. We note that section 1886(q)(6) of the Act requires that the Secretary “make information available to the public regarding readmissions rates of each subsection (d) hospital under the [Hospital Readmissions Reduction Program]” and also requires the Secretary to “ensure that a subsection (d) hospital has the opportunity to review and submit corrections for, the information to be made public.” Our proposal for reporting hospital-specific information, including a hospital’s opportunity to review and submit corrections, consistent with section 1886(q)(7) of the Act, is discussed below.

We did not receive any public comments on our proposals regarding the Limitations for Review; therefore, we are finalizing our proposals without modification, including the regulatory text at § 412.154(e).

5. Reporting Hospital-Specific Information, Including Opportunity to Review and Submit Corrections (§ 412.154(f))

Section 1886(q)(6)(A) of the Act requires the Secretary to “make information available to the public regarding readmissions rates of each subsection (d) hospital under the [Hospital Readmissions Reduction Program]”. Section 1886(q)(6)(B) of the Act also requires the Secretary to “ensure that a subsection (d) hospital has the opportunity to

review, and submit corrections for, the information to be made public with respect to the hospital.” In addition, section 1886(q)(6)(C) of the Act requires the Secretary to post the hospital-specific readmission information for each subsection (d) hospital on the [Hospital Compare](#) Web site in an easily understood format.

As we stated in the proposed rule, for purposes of the Hospital Readmissions Reduction Program for FY 2013, we will calculate excess readmission ratios for each of the three conditions, AMI, HF, and PN, using the previously finalized 3-year applicable period for the FY 2013 payment determination that spans from July 1, 2008 through June 30, 2011 (76 FR 51671), data sources, and the minimum number of discharges previously finalized in the FY 2012 IPPS/LTCH PPS final rule for each applicable hospital (76 FR 51671 through 51672). We stated that we intended to make these excess readmission ratios available to the public, consistent with the requirements of section 1886(q)(6)(B) of the Act, as part of the FY 2013 rulemaking process, in addition to posting this information on the [Hospital Compare](#) Web site in a subsequent release.

In the FY 2012 IPPS/LTCH PPS final rule, we indicated that we would provide hospitals an opportunity to review and submit corrections using a process similar to what is currently used for posting results on [Hospital Compare](#). We currently provide hospitals with the data elements necessary to verify the accuracy of their readmission rates for the Hospital IQR Program prior to posting their rates on [Hospital Compare](#). Because we believe it is important to provide hospitals with relevant information available to hospitals for assessing payment impacts for purposes of the Hospital Readmissions Reduction Program, as we stated in the proposed rule, we plan to make the excess

readmission ratios used for the Hospital Readmissions Reduction Program adjustment factor calculation available during the rulemaking cycle. As a result, the timeline and details of this process must accommodate the rulemaking timeline in addition to posting on [Hospital Compare](#). In the proposed rule, we set forth the following details regarding the process for hospitals to review and submit corrections to their excess readmission ratios prior to making this information available to the public in rulemaking and on [Hospital Compare](#).

For FY 2013, we proposed to deliver confidential reports and accompanying confidential discharge-level information to applicable hospitals as defined in section IV.A.2. of this preamble, which contain their excess readmission ratios for the three applicable conditions by June 20, 2012. These reports will be delivered in hospitals' secure [QualityNet](#) accounts. The information in the confidential reports and accompanying confidential discharge-level information would be calculated using the claims information we had available approximately 90 days after the last discharge date in the applicable period, which is when we would create the data extract for the calculations (we discuss this practice in more detail later).

The discharge-level information accompanying the excess readmission ratios would include the risk-factors for the discharges that factor into the calculation of the excess readmission ratio, as well as information about the readmissions associated with these discharges (such as dates, provider numbers, and diagnosis upon readmission). Our intent in providing this information is twofold: (1) to facilitate hospitals' verification of the excess readmission ratio calculations we provide during the review and correction

period based upon the information CMS had available at the time our data extract was created; and (2) to facilitate hospitals' quality improvement efforts with respect to readmissions.

We proposed to provide hospitals with a period of 30 days to review and submit corrections for their excess readmission ratios for the Hospital Readmissions Reduction Program. This 30-day period would begin the day hospitals' confidential reports and accompanying discharge-level information are posted to their [QualityNet](#) accounts. Based on previous experience with public reporting of measures under the Hospital IQR program, including the 30-day risk standardized readmission rates, we believe this 30-day period would allow enough time for hospitals to review their data and notify CMS of calculation errors, and for CMS to incorporate appropriate corrections to the excess readmission ratio calculations prior to the publication of the final rule, at which time the excess readmission ratios would be made available to the public in a table to be cited in the final rule and available via the Internet on the CMS Web site. During the review and correction period, hospitals should notify CMS of suspected errors in their excess readmission ratio calculations using the technical assistance contact information provided in their confidential reports. In order to meet the timelines for this program, we delivered these confidential reports and discharge-level data files to hospitals for the review and correction period on June 20, 2012.

The review and correction process we proposed for the excess readmission ratios above would not allow hospitals to submit additional corrections related to the underlying claims data we used to calculate the ratios, or allow hospitals to add new claims to the

data extract we used to calculate the ratios. This is because it is necessary to take a static “snapshot” of the claims in order to perform the calculations. For purposes of this program, we would calculate the excess readmission ratios using a static snapshot (data extract) taken at the conclusion of the 90 day period following the last date of discharge used in the applicable period. We recognize that under our current timely claims filing policy, hospitals have up to 1 year from the date of discharge to submit a claim to CMS. However, in using claims data to calculate measures for this program, we proposed to create data extracts using claims in CMS’ Common Working File (CWF) 90 days after the last discharge date in the applicable period which we will use for the calculations. For example, if the last discharge date in the applicable period for a measure is June 30, 2011, we would create the data extract on September 30, 2011 (90 days later), and use that data to calculate the ratios for that applicable period. Hospitals would then receive the excess readmission ratio calculations in their confidential reports and accompanying discharge-level information and they would have an opportunity to review and submit corrections for the calculations. As we stated above, hospitals would not be able to submit corrections to the underlying data that were extracted on September 30, 2011, and would also not be able to add claims to the data set. Therefore, we would consider hospitals’ claims data to be complete for purposes of calculating the excess readmission ratios for the Hospital Readmissions Reduction Program at the conclusion of the 90-day period following the last date of discharge used in the applicable period.

We considered a number of factors in determining that a 90-day “run-out” period is appropriate for purposes of calculating claims based measures. First, we seek to provide timely quality data to hospitals for the purpose of quality improvement and to the public for the purpose of transparency. Next, we seek to make payment adjustments to hospitals based on their performance on measures as close in time to the performance period as possible. Finally, with respect to claims-based measures, we seek to have as complete a data set as possible, recognizing that hospitals have up to one year from the date of discharge to submit a claim under CMS’ timely claims filing policy.

After the data extract is created, it takes several months to incorporate other data needed for the calculations (particularly in the case of risk-adjusted, and/or episode-based measures). We then need to generate and check the calculations, as well as program, populate, and deliver the confidential reports and accompanying data to be delivered to hospitals. We also are aware that hospitals would prefer to receive the calculations to be used for the Hospital Readmissions Reduction Program as soon as possible. Because several months lead time is necessary after acquiring the data to generate these claims-based calculations, if we were to delay our data extraction point to 12 months after the last date of the last discharge in the applicable period, we would not be able to deliver the calculations to hospitals sooner than 18 to 24 months after the last discharge date. We believe this would create an unacceptably long delay both for hospitals and for CMS to deliver timely calculations to hospitals for quality improvement and transparency, and ultimately timely readmission adjustment factors for purposes of this program. Therefore, we proposed to extract the data needed to calculate the excess

readmission ratios for this program 90 days after the last date of discharge for the applicable period so that we can balance the need to provide timely program information to hospitals with the need to calculate the claims-based measures using as complete a data set as possible.

During the 30-day review and correction process for the excess readmission ratios, if a subsection (d) hospital suspects that such discrepancies exist in the CMS application of the measures' methodology, it should notify CMS during the review and correction period using the technical support contacts provided in the hospital's confidential report. We would investigate the validity of each submitted correction and notify hospitals of the results. If we confirm that we made an error in creating the data extract or in calculating the excess readmission ratios, we would strive to correct the calculations, issue new confidential reports to subsection (d) hospitals, and then publicly report the corrected excess readmission ratios through the rulemaking process, and subsequently on [Hospital Compare](#). However, if the errors take more time than anticipated to correct, not allowing for publication of the corrected ratios in the final rule, we would notify hospitals in the final rule that corrected ratios will be made available after the final rule through delivery of confidential reports followed by a second 30-day review and correction period, subsequent publication, and posting on [Hospital Compare](#). In addition, we proposed that any corrections to a hospital's excess readmission ratios would then be used to recalculate a hospital's ratio under section 1886(q)(4)(B) of the Act in order to determine the hospital's adjustment factor in accordance with section 1886(q)(3) of the Act.

We believe that this proposed process would fulfill the statutory requirements at section 1886(q)(6)(A), section 1886(q)(6)(B), and section 1886(q)(6)(C) of the Act. We further believe that the proposed process would allow hospitals to review and correct their excess readmission ratios. We note that, under the proposed process, hospitals would retain the ability to submit new claims and corrections to submitted claims for payment purposes in line with CMS' timely claims filing policies. However, we emphasize that the administrative claims data used to calculate the excess readmission ratios reflect the state of the claims at the time of extraction from CMS' Common Working File. Under the proposed process, a hospital's opportunity to submit corrections to the calculation of the excess readmission ratios ends at the conclusion of the review and correction period. We welcomed public comments on the proposed review and corrections process for the Hospital Readmissions Reduction Program.

Comment: One commenter disagreed with the use of the Common Working File (CWF) to calculate the readmission measures, stating that it does not contain final-action claims for all of the discharges eligible to be used to calculate excess readmission ratios:

Response: The excess readmission ratios are calculated using only the final action claims (that is, we do not include canceled/edited claims) from the CWF available as of September 30, which are published in the Inpatient Standard Analytic File (SAF). Calculations include claims processed by CMS as of the following dates: June 26, 2009 for July 1, 2007 through June 30, 2008 claims; June 25, 2010 for July 1, 2008 through June 30, 2009 claims; June 24, 2011 for July 1, 2009 through June 30, 2010 claims; and September 30, 2011 for July 1, 2010 through June 30, 2011 claims. Claims and

corrections processed after these dates are not reflected in the calculations. Thus data between 2008 and 2010 include more than 6 months of run-out period, and 2011 data contain a 3-month run-out period to allow as many corrected and final-action claims to be incorporated. These are the most recent final action data that can be used to meet the timeline of the program need. We encourage hospitals to submit claim corrections as early as possible and to ensure the quality of the data they submitted for reimbursements. If CMS waits for final-action claims for all eligible discharges to be included in the data, then the excess readmission ratios will be based on old data, which will limit its usefulness for hospitals to review and improve their care delivery processes. Therefore, we have encouraged hospitals to submit claim corrections as early as possible and to ensure the quality of the data they submitted for reimbursements. We will continue to research and seek public comments on alternative data sources that might provide measure results that are as accurate and are more timely than the CWF. The CWF will be used for the calculation of excess readmission ratios for the Hospital Readmissions Reduction Program as finalized in the FY 2012 IPPS/LTCH final rule (76 FR 51671 through 51672).

Comment: One commenter appreciated the release of additional hospital specific data and “excess readmission rates” data prior to the implementation of the program, as well as the readmission information and patient’s risk factors.

Response: We thank the commenter for the recognition and we are committed to foster transparency, provide accurate data to hospitals for quality improvement, and,

ultimately, timely calculate readmission adjustment factors for base operating DRG payments.

Comment: One commenter thanked CMS for the 30-day review and correction period while one commenter requested the review and correction period be extended to 60 days.

Response: We appreciate the commenter's support of the 30-day review period. We note that, in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51672 through 51673), we adopt the same preview and correction process and timeframe used for subsection (d) hospitals for the rates calculated for the Hospital Readmissions Reduction Program. That is, we provide hospitals with an opportunity to preview their readmission rates for 30 days prior to posting on the Hospital Compare webs site. This process meets the statutory requirement in section 1886(q)(6)(B) of the Act which requires the Secretary to ensure that a subsection (d) hospital has the opportunity to review and submit corrections before the information to be made public with respect to the hospital*** prior to such information being made public.

Aside from the statutory requirements, we also considered hospital experience with the measure and data production timeline in proposing the 30-day preview period. In terms of hospital experience with the measures, while the Hospital Readmissions Reduction Program is new, subsection (d) hospitals are already familiar with the three 30-day risk-standardized readmission measures that the Program uses to determine payment adjustment. In particular, these three measures were first publicly reported by the former Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program

(currently known as the Hospital IQR Program), back in 2009. The measure results have been reported annually since then and have recently been updated in July 2012. To help hospitals understand the methodology for these measures and the calculation and interpretation of measure results, we have made publicly available the latest version of the methodology reports, a Frequently-Asked-Question list, a mock hospital-specific report, and a mock discharge-level data file for these measures on the *QualityNet* website. The measures methodology for the Hospital Readmissions Reduction Program is the same as that for the Hospital IQR Program. Because hospitals are working with measures in which they have prior experience from the Hospital IQR Program, we believe that a 30-day preview period is sufficient for hospitals to review and correct their excess readmission ratios.

In terms of data production timeline, due to the complexity of these measures and the need for bootstrapping in measure calculations, a significant amount of programming resources is needed. It took several months to complete the production and extensive quality assurance procedures for the results for more than 3,500 hospitals. As a result, we will not be able to begin the preview period earlier than late June. Also, we will not be able to extend the preview period to more than 30 days. This is because if hospitals find data problems that we determine to be attributable to our calculation or programming errors, we will need adequate time between mid-July and the end of September to:

- (1) recalculate the excess readmission ratios;
- (2) regenerate and disseminate corrected results to hospitals in time for payment adjustment in early October (the beginning of the subsequent fiscal year); and
- (3) publicly report the excess readmission ratios on the

Hospital Compare website in mid-October to meet the statutory reporting requirements under section 1886(q)(6) of the Act. Based on the above reasons, we cannot change the review and correction timeframe to 60 days.

Comment: One commenter requested that, for self-validation purposes, CMS provide each hospital with a downloadable database containing all of the claims data used to calculate the hospital's readmission rates. One commenter recommended that CMS provide hospitals with additional claim information documenting the first physician/licensed independent practitioner visit post index discharge and prior to readmit (days from discharge to first visit). The commenter stated that the first follow-up provider information is critical to decreasing readmissions. Another commenter was concerned that limited access to the claims data will impair hospitals' ability self-validate our results.

Response: We considered several factors in deciding the amount of information that CMS provides to hospitals for the review and correction process. These factors are: confidentiality of information, our resources, and feasibility for hospital providers to process the data.

For the purposes of the Hospital Readmissions Reduction Program data, we have decided to provide as much of the claims-based information that is pertinent to the calculation of the excess readmission ratio so that hospitals can verify the accuracy of these calculations and engage in outreach and coordination with readmitting hospitals. Providing the entire raw claims history for index admissions and for subsequent services after discharge would provide more information than would be necessary in hospitals'

effort to review their excess readmission ratios. To protect sensitive patient information, and to avoid burden and confusion to hospitals, we are careful not to include data elements that are not relevant for the review and correction process.

Furthermore, providing all subsection (d) and Maryland hospitals with all the claims data will require a large amount of resources, infrastructure changes and exert significant financial burden on these hospitals and on taxpayers. We have already provided supplemental discharge-level data to hospital providers to review qualified individual readmissions, including primary diagnosis at index and readmission stays, where the patient was readmitted, dates of index and readmission stays, and individual risk factors, and instructions for replicating their excess readmission ratios.

Additionally, we have also set up a Help Desk for hospitals to inquire about their results. This Help Desk has access to all the claims data used for the calculation of the hospitals' excess readmission ratios, and is highly experienced in assisting hospitals with the results of the 30-day risk-standardized readmission measures. Therefore, we believe that the proposed review correction policies are adequate. We are working to identify new methods to provide hospitals with accurate and timely data to improve their care delivery processes to reduce readmission rates. We encourage hospitals and other healthcare providers to provide us with recommendations for this effort.

After consideration of the public comments received, for the review and correction process, we are finalizing the policies of providing applicable hospitals with: (1) a period of 30 days to review and submit corrections for their excess readmission ratios for the Hospital Readmissions Reduction Program; and (2) confidential reports and

accompanying confidential discharge-level information (this includes the excess readmission ratios, the risk-factors for the discharges that factor into the calculation of the excess readmission ratio, as well as information about the readmissions associated with these discharges).

B. Sole Community Hospitals (SCHs) (§ 412.92)

1. Background

Section 1886(d)(5)(D)(iii) of the Act defines a sole community hospital (SCH) generally as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations at 42 CFR 412.92 set forth the criteria that a hospital must meet to be classified as a SCH. For more information on SCHs, we refer readers to the FY 2009 IPPS/LTCH PPS final rule (74 FR 43894 through 463897).

2. Reporting Requirement and Clarification for Duration of Classification for Hospitals Incorrectly Classified as Sole Community Hospitals (§ 412.92(b)(3)(iv))

The regulations at § 412.92(b)(2) and (b)(3) address the effective dates of a classification as an SCH and the duration of this classification. Currently, a hospital's SCH classification status remains in effect without the need for reapproval unless there is a change in the circumstances under which the classification was approved. Section 412.92(b)(3) requires a hospital to notify the fiscal intermediary or Medicare administrative contractor (MAC) within 30 days of a change that could affect its