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Details for: NEW PROVISIONS TO STRENGTHEN TIE BETWEEN MEDICARE PAYMENT AND QUALITY FOR INPATIENT

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NEW PROVISIONS TO STRENGTHEN TIE BETWEEN MEDICARE PAYMENT AND QUALITY FOR INPATIENT
STAYS IN ACUTE CARE HOSPITALS IN FISCAL YEAR 2011 AND BEYOND

OVERVIEW: On July 30, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes revisions to policies and payment rates for general acute care hospitals that are paid for inpatient services under the Inpatient Prospective Payment System (IPPS). The provisions of this rule are generally effective for discharges in fiscal (FY) 2011 – that is, on or after Oct. 1, 2010. In addition to promoting accurate payment for inpatient services to Medicare beneficiaries, the rule strengthens the relationship between payment and quality of service by expanding the quality measures that hospitals must report in order to receive the full market basket update in fiscal year 2012. Under the Medicare law, hospitals that choose not to participate in the voluntary reporting program or do not participate successfully will receive an inflation update less two percentage points. The final rule sets the FY 2011 market basket update at 2.6 percent. This update is reduced by 0.25 percentage points – to 2.35 percent – in accordance with the Affordable Care Act, and, therefore, hospitals that do not successfully report the quality measures will receive updates currently projected to be 0.35 percent.

The final rule does not change the list of hospital-acquired conditions (HACs) in FY 2011, but it does discuss the findings from a HHS sponsored evaluation of the impact of the existing policy.

This Fact Sheet discusses only the quality provisions of the IPPS FY 2011 final rule; separate fact sheets also issued today provide more detail on the payment and policy changes.

REPORTING HOSPITAL QUALITY DATA FOR ANNUAL PAYMENT UPDATE:

BACKGROUND: The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and HACs initiatives represent significant steps toward implementing value-based

purchasing (VBP) in Medicare. VBP is intended to transform Medicare from a passive payer for services to a prudent purchaser of services, paying not just for quantity of services but for quality as well.

The RHQDAPU Program grew out of the Hospital Quality Initiative developed by CMS in consultation with hospital groups. Participation in the program is voluntary, but after initial levels of participation proved disappointing, Congress added a financial incentive to the program in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Under the MMA, hospitals that chose not to participate or failed to meet the criteria for successful reporting in a given year received the annual payment update (APU) reduced by 0.4 percentage points. The Deficit Reduction Act of 2005 increased this reduction to 2.0 percentage points. Since the implementation of the financial incentive, hospital participation has increased to 99 percent and, of participating hospitals, 96 percent are receiving the full APU in FY 2010.

In the meantime, the RHQDAPU measure set has grown from a starter set of 10 quality measures in 2004 to the current set of 46 quality measures. The 46 measures include 27 chart-abstracted measures (heart attack, heart failure, pneumonia, surgical care improvement), 15 claims-based measures (mortality and readmissions measures for heart attack, heart failure, pneumonia; AHRQ Patient Safety Indicators and Inpatient Quality Indicators; nursing sensitive care), 1 survey-based measure (patient satisfaction), and 3 structural measures (participation in a cardiac surgery, stroke care, and nursing sensitive care registry).

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CHANGES TO THE RHQDAPU PROGRAM FOR THE FY 2012 FULL APPLICABLE PERCENTAGE UPDATE: In this final rule for FY 2011, CMS will retire one of these RHQDAPU measures – Mortality for selected surgical procedures (composite) – for the FY 2011 payment determination and for subsequent payment determinations.

CMS will add 10 new measures, bringing the total number of measures in the RHQDAPU measure set to 55 for the FY 2012 market basket update. Specifically, CMS is adding the following eight categories of conditions included on the HAC list:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Falls and trauma (including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock)
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection (UTI)
- Manifestations of poor glycemic control

The other two measures are two additional Patient Safety Indicators developed by the Agency for Healthcare Research and Quality – post-operative respiratory failure and post-operative pulmonary embolism or deep vein thrombosis.

ADDITIONAL REPORTING PROVISIONS IN THE FY 2011 FINAL RULE:
Currently when CMS adds a new measure for reporting, it may only have data for one-quarter's worth of discharges to use in determining the ensuing year's annual payment update. CMS believes that it would facilitate more accurate data analysis if there were at least one full year's worth of discharge data for each of the quality measures. Therefore in the IPPS/LTCH Final Rule for FY 2011, CMS is adopting the use of one full calendar year or four quarters of calendar year discharge data to make the ensuing year's annual payment update.

CMS is adopting two additional quality measures – Acute Myocardial Infarction (AMI) - Statin at discharge, and Catheter Associated Blood Stream Infection (CABSI) - for reporting in FY 2011 that will be used to determine the FY 2013 APU. CMS is also adopting five quality measures - 2 emergency department (ED) throughput measures, 2 global immunization measures, and Surgical Site Infection - for reporting in 2012 that will be used in determining the FY 2014 APU.

Over the three-year period, CMS is retiring 2 measures from the measurement set (Pneumonia (PN-2 and PN-7)) and adding 17 new measures to the measure set, for a total of 60 measures. (See Appendix A for complete list of current and new measures.)

Collection of the measures for the FY 2013 payment determination will begin in 2011, and collection of the measures for the FY 2014 payment determination will begin in 2012. The Central Line Associated Blood Stream Infection (CLABSI) and Surgical Site Infection (SSI) measures will be collected via the National Healthcare Safety Network (NHSN), a secure, Internet-based surveillance system administered by the Centers for Disease Control & Prevention.

Finally, the rule identifies additional measures for possible inclusion in future rulemaking cycles. (See Appendix B.)

HOSPITAL-ACQUIRED CONDITIONS UPDATE

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As required by the Deficit Reduction Act of 2005, CMS has implemented a payment policy to reduce Medicare payments in the event certain hospital-acquired conditions (HACs) occur

during a Medicare beneficiary's inpatient stay. These HACs are conditions that the agency has determined are reasonably preventable through adherence to evidence-based guidelines, are high cost and/or high volume, and result in higher payment when present as a secondary diagnosis. CMS has aggressively sought public input and worked with the Centers for Disease Control and Prevention on evaluating and selecting these conditions. Beginning for discharges on or after Oct. 1, 2008, CMS no longer pays at the higher MS-DRG if the only secondary diagnoses on a claim are on the HAC list and were not reported as present at admission. To date, there are ten categories of conditions that are subject to the HAC payment provision.

For FY 2010, CMS did not select any conditions for addition to the list, while it began a process to conduct a comprehensive evaluation of the policy's impact, working with other agencies within the Department of Health and Human Services - the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Public Health and Science (OPHS).

The rule for FY 2011 does not add any new conditions to the HAC list, but includes a discussion of the progress to date of the comprehensive evaluation, based on FY 2009 data. According to the analysis - updated since the proposed rule to include 12 months of claims data - the HAC policy resulted in payment adjustments for 3,416 discharges out of a total of approximately 9.3 million discharges for the 10 categories of conditions currently on the HAC list. These adjustments yielded a net savings of about $18.8 million.

The analysis also reviewed seven conditions that have been considered previously as possible candidates for inclusion on the HACs list, and found 3,527 cases that would have been subject to the HACs policy - that is, the presence of the condition as a secondary diagnosis was the sole reason for payment at the higher rate. However, CMS does not believe that there is additional information at this time that would require a change to previous determinations regarding either current HACs or previously considered candidate HACs.

CMS continues to believe that this policy plays an integral role in promoting quality of care and considers it to be part of an array of Medicare VBP tools that CMS believes will promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through Quality Improvement Organization (QIO)

activities. The application of VBP tools, such as this HAC provision, is transforming Medicare from a passive payer to an active purchaser of higher value health care services.

The final rule was placed on display at the *Federal Register* today, and can be found under Special Filings at:

www.ofr.gov/inspection.aspx#special.

For more information, please see:

www.cms.gov/AcuteInpatientPPS/01_overview.asp.

Appendix A

RHQDAPU PROGRAM QUALITY MEASURES

FY 2012 – FY 2014 Payment Determinations

RHQDAPU Program Quality Measures

Topic

Acute Myocardial Infarction (AMI)

- AMI-1 Aspirin at arrival
- AMI-2 Aspirin prescribed at discharge
- AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
- AMI-4 Adult smoking cessation advice/counseling
- AMI-5 Beta blocker prescribed at discharge

Topic	RHQDAPU Program Quality Measures
	· AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	· AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
	· AMI Statin at Discharge **
Heart Failure (HF)	
	· HF-1 Discharge instructions
	· HF-2 Left ventricular function assessment
	· HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	· HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	· PN-3b Blood culture performed before first antibiotic received in hospital
	· PN-4 Adult smoking cessation advice/counseling
	· PN-5c Timing of receipt of initial antibiotic following hospital arrival
	· PN-6 Appropriate initial antibiotic selection
Surgical Care Improvement Project (SCIP)	
	· SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	· SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time

Topic	RHQDAPU Program Quality Measures
	· SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	· SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	· SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	· SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	· SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	· SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	· SCIP-Infection-10: Perioperative Temperature Management
	· SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	· MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients
	· MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	· MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	· HCAHPS survey
Readmission Measure (Medicare Patients)	
	· READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)

Topic	RHQDAPU Program Quality Measures
	· READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	· READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	· PSI 06: Iatrogenic pneumothorax, adult
	· PSI 11: Post Operative Respiratory Failure *
	· PSI 12: Post Operative PE or DVT *
	· PSI 14: Postoperative wound dehiscence

Topic	RHQDAPU Program Quality Measures
	· PSI 15: Accidental puncture or laceration
	· IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	· IQI 19: Hip fracture mortality rate
	· Complication/patient safety for selected indicators (composite)
	· Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	· Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	

Topic	RHQDAPU Program Quality Measures
	· Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	· Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	· Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Healthcare Associated Infections	
	· Central Line Associated Bloodstream Infection**
	· Surgical Site Infection***
HAC Prevalence Measures	
	· Foreign Object Retained After Surgery *
	· Air Embolism *
	· Blood Incompatibility *
	· Pressure Ulcer Stages III & IV *
	· Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	· Vascular Catheter-Associated Infection*
	· Catheter-Associated Urinary Tract Infection (UTI) *
	· Manifestations of Poor Glycemic Control*
Emergency Department Throughput	

Topic	RHQDAPU Program Quality Measures
	· Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. ***

Topic	RHQDAPU Program Quality Measures
	· Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ***

Global Immunization Measures

· Immunization for Influenza ***

· Immunization for Pneumonia ***

MEASURES RETIRED FROM RHQDAPU PROGRAM IN FY 2011 RULE

· AHRQ Mortality for Selected Procedures Composite (beginning with FY 2011 payment determination measure set)

· PN-2 Pneumococcal vaccination status (beginning with FY 2014 payment determination measure set)

· PN-7 Influenza vaccination status (beginning with FY 2014 payment determination measure set)

KEY

***New for FY 2012 payment determination.**

****New for FY 2013 payment determination.**

***** New for FY 2014 payment determination.**

Appendix B

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Surgical Safety	Surgical checklist use for surgical procedures
Complications	Lower Extremity Bypass Complications
PCI Readmission	30-day risk-standardized readmission rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older.
PCI Mortality	30-day risk-standardized mortality rate following PCI for STEMI/shock patients.
PCI Mortality	30-day risk-standardized mortality rate following PCI for non-STEMI/non-shock patients.
VTE	VTE-1: Venous Thromboembolism Prophylaxis
VTE	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
VTE	VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
VTE	VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
VTE	VTE-5: Venous Thromboembolism Discharge Instructions
VTE	VTE-6: Incidence of Potentially-Preventable Venous Thromboembolism.
SCIP	Short Half-Life prophylactic administered preoperatively redosed within 4 hours after preoperative dose

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge ED Visit Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Evaluation and Management Service Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge ED Visit Rate
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Evaluation and Management Service Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Care Transition Composite Measure
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge ED Visit Rate
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Evaluation and Management Service Measure

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Care Transition Composite Measure
Healthcare Associated Infections	Ventilator Associated Pneumonia
Healthcare Associated	Multidrug-resistant organism (MDRO) infection

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Infections	
Healthcare Associated Infections	Clostridium Difficile Associated Diseases (CDAD)
Health Care Personnel Immunization	Influenza Vaccination for Healthcare Personnel
Cardiac Rehabilitation Referral	Cardiac Rehabilitation Referral for AMI, HF, Cardiac Surgery
End of Life Care	Appropriate Pain Management
Serious Reportable Events	NQF approved Serious Reportable Events

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