FISCAL YEAR 2009 QUALITY MEASURE REPORTING FOR 2010 PAYMENT UPDATE

OVERVIEW:

On August 1, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a final regulation that would update payment policies and rates under the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2009, beginning for discharges on or after October 1, 2008. The final rule continues to build on recent efforts by CMS to transform the Medicare program into a prudent purchaser of health care services, paying not just for quantity of services but also for quality.

These efforts include:

- Requiring hospitals to report quality measures in order to receive the full update to payment rates in the ensuing year – the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program; and
- Revising coverage and payment policies to give hospitals financial incentives to take steps to reduce the incidence of serious adverse events during inpatient stays that should never occur (Never Events) or that are reasonably preventable through adherence to evidence-based guidelines.

This fact sheet focuses on changes to the quality measures hospitals will have to report to receive the full payment update in FY 2010. Additional fact sheets, summarizing the provisions of the IPPS FY 2009 final rule, and describing the efforts to reduce the occurrence of hospital-acquired conditions and Never Events, can be found at: www.cms.hhs.gov/apps/media/fact_sheets.asp

BACKGROUND:

The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points.

In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care. Some of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website at: www.hospitalcompare.hhs.gov.

In FY 2007, nearly 95 percent of hospitals participated successfully in the reporting program and received the full market basket update for FY 2008.

NEW MEASURES FOR REPORTING FOR FY 2010 UPDATE

CMS is adding 13 new measures for the FY 2010 program, and retiring one existing measure. For some of these new measures, the hospitals will not have to affirmatively report data to CMS. Instead, CMS will calculate the measures using Medicare claims data. The total number of measures that are included in the FY 2010 payment update is 42.

The inclusion of these additional measures will encourage hospitals to take steps to make care safer for patients. Heart failure, pneumonia, and heart attack—three conditions that are included in the 42 measures for FY 2010—rank among the ten most common diagnoses for Medicare inpatient care, and therefore have the greatest impacts on costs to the Medicare program. The processes of care represented by quality measures for these three conditions are known to improve the quality of care patients receive during inpatient visits to the hospital.

In addition, the measures for the FY 2010 payment determination will include a measure to track readmissions for heart failure. Re-admissions have a significant impact on beneficiaries and their families. According to MedPAC, re-admissions cost the program $15 billion annually, and potentially $12 billion of those costs are preventable. Almost 18 percent of Medicare patients are re-admitted to the hospital within 30 days of discharge. CMS believes that reporting these measures will encourage better coordination of care among the hospitals where the inpatient services are provided and other post acute settings.

The new measures are:

A. Surgical Care Improvement Project (SCIP) Measure:

- SCIP Cardiovascular 2, surgery patients on a beta blocker prior to arrival who received a beta blocker during the peri-operative period

B. Re-admission Measure:

 Heart failure (HF) 30-day risk standardized re-admission measure (Medicare patients)

C. Nursing Sensitive Measure:

 Failure to rescue (Medicare patients)

D. AHRQ Patient Safety and Inpatient Quality Indicator Measures (9):

 Patient Safety Indicators (PSIs)
 Death among surgical patients with treatable serious complications
 Iatrogenic pneumothorax, adult
 Postoperative wound dehiscence
 Accidental puncture or laceration
 Inpatient Quality Indicator Measures
 Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
 Hip fracture mortality rate
 Mortality for selected medical conditions (composite)
 Mortality for selected surgical procedures (composite)
 Complication/patient safety for selected indicators (composite)

E. Cardiac Surgery Measure:

 Participation in a systematic database for cardiac surgery

PREVIOUSLY ADOPTED MEASURES FOR REPORTING FOR FY 2010 UPDATE

 Heart Attack (Acute Myocardial Infarction)
 Aspirin at arrival
 Aspirin prescribed at discharge
 ACE inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
 Beta blocker at arrival
 Beta blocker prescribed at discharge
 Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
 Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
 Adult smoking cessation advice/counseling
 Heart Failure (HF)
 Left ventricular function assessment
 ACE inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
 Discharge instructions
 Adult smoking cessation advice/counseling
 Pneumonia (PNE)
 Timing of receipt of initial antibiotic following hospital arrival
 Pneumococcal vaccination status
 Blood culture performed before first antibiotic received in hospital
 Adult smoking cessation advice/counseling
 Appropriate initial antibiotic selection
 Influenza vaccination status
 Surgical Care Improvement Project (SCIP) – (Previously SIP)
 Prophylactic antibiotic received within 1 hour prior to surgical incision
 Prophylactic antibiotics discontinued within 24 hours after surgery end time
 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
 Mortality Measures
 Acute Myocardial Infarction 30-day mortality (Medicare patients)

 Heart Failure 30-day mortality (Medicare patients)
 Pneumonia 30-day mortality (Medicare patients)
 Patients' Experience of Care
 HCAHPS Patient Survey
The final rule will appear in the August 19 *Federal Register* and will generally be effective for discharges on or after October 1, 2008.
For more information, see: www.cms.hhs.gov/AcuteInpatientPPS/

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. The IPPS FY 2009 Final Rule is available in the **Statute/Regulations/Program Instructions** section, accessible through the navigation menu at left.

The 10 categories of HACs include:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burns
    - Electric Shock
6. Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following:
    - Coronary Artery Bypass Graft (CABG) - Mediastinitis
    - Bariatric Surgery
        - Laparoscopic Gastric Bypass
        - Gastroenterostomy

        - Laparoscopic Gastric Restrictive Surgery
    - Orthopedic Procedures
        - Spine
        - Neck
        - Shoulder
        - Elbow

10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)

- Total Knee Replacement
- Hip Replacement

Payment implications will begin October 1, 2008, for these 10 categories of HACs.