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Office of Media Affairs

MEDICARE FACT SHEET

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Proposals to improve quality of care furnished during inpatient hospital stays

OVERVIEW: On Apr. 19, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would revise policies and payment rates for general acute care hospitals that are paid for inpatient services under the Inpatient Prospective Payment System (IPPS), effective for discharges in fiscal (FY) 2012 – that is, on or after Oct. 1, 2011. The proposed rule would also update payment policies and rates for Long-term Care Hospitals (LTCHs) under the LTCH Prospective Payment System (LTCH PPS).

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 420 LTCHs, would generally be effective for discharges occurring on or after Oct. 1, 2011. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 would decrease by a projected $498 million or 0.5 percent between FY 2011 and FY 2012. This reflects a proposed hospital update of 1.5 percent (based on a projected increase of 2.8 percent for inflation in hospital costs, reduced by a multi-factor productivity adjustment of 1.2 percent and an additional 0.1 percent in accordance with the Affordable Care Act), increased by 1.1 percent in response to litigation, as well as a -3.15 percent documentation and coding adjustment. This documentation and coding adjustment is consistent with a statutory provision that requires CMS to adjust payments to remove the effect of increased aggregate payments due to changes in documentation and coding that did not reflect increases in patients' severity of illness after adoption of the MS-DRGs. Medicare payments to LTCHs in FY 2012 are projected to increase by $95 million or 1.9 percent.

In addition to promoting accurate payment for inpatient services to Medicare beneficiaries, the proposed rule would strengthen the relationship between payment and quality of service in a number of ways. First, the proposed rule includes proposals that are part of a new Readmissions Reduction Program required by the Affordable Care Act. Second, it would expand the quality measures that hospitals must report under the Hospital Inpatient Quality Reporting (IQR)

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Program – formerly called the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program - in order to receive the full update to the standardized amount in FYs 2014 and 2015. Under the Medicare law, the update for hospitals that choose not to participate in the voluntary reporting program or that do not meet program requirements includes (until FY 2015) a two percentage point reduction. As detailed above, the proposed rule proposed an update of -1.5 percent. Therefore, CMS is proposing that hospitals that do not successfully report the quality measures will receive updates currently projected to be -0.5 percent (that is, the projected increase of 2.8 percent for inflation in hospital costs, reduced by two percentage points for non-compliance with the IQR program, and further reduced by a multi-factor productivity adjustment of 1.2 percent and the additional required 0.1 percent).

Finally, the proposed rule would add one category of conditions to the list of hospital-acquired conditions (HACs) in FY 2012 for purposes of the HACs payment policy. This policy prevents hospitals from being paid at an enhanced rate for treating a beneficiary if the sole reason for the higher payment is the occurrence, during the beneficiary's hospital stay, of one of conditions on the HACs list. The proposed HAC is Acute Renal Failure after Contrast Administration (also known as contrast-induced acute kidney injury, or CI-AKI0), which is an abrupt deterioration in renal function that can be associated with the use of iodinated contrast medium.

The proposed rule also contains a proposal to create a new quality reporting program, as authorized by the Affordable Care Act, that would apply to hospitals that are paid under the LTCH PPS.

This year, CMS expects to build on these quality efforts by implementing a new Hospital Value-Based Purchasing (HVBP) program, authorized by the Affordable Care Act, that will provide additional incentives to hospitals to improve the way care is delivered. CMS issued a proposed rule for the HVBP program in January and plans to issue a final rule in the near future. The IPPS proposed rule being issued today contains additional proposals related to the HVBP program.

This fact sheet discusses the provisions in the proposed rule that are intended to promote continued improvement in the quality and safety of care that beneficiaries receive during inpatient hospital stays. Other policy and payment proposals included in the proposed rule are addressed in a separate fact sheet that is available on the CMS Web page at:

www.cms.gov/apps/media/fact_sheets.asp.

READMISSIONS REDUCTION PROGRAM REQUIRED BY THE AFFORDABLE CARE ACT:

Section 3025 of the Affordable Care Act established a new Hospital Readmissions Reduction Program, under which payments to certain hospitals will be reduced to account for excess

readmissions. These payment adjustments will apply to discharges on or after Oct. 1, 2012 (FY 2013). This year, CMS is proposing a number of policies as part of the new program, including a proposal to select three "measures of readmission" for the first year of the program: acute myocardial infarction (AMI) or heart attack, heart failure, and pneumonia. In addition, CMS is also proposing a methodology for calculating excess readmissions. CMS plans to continue implementation of this program in future rulemaking.

INPATIENT QUALITY REPORTING PROGRAM FOR ACUTE CARE HOSPITALS:

BACKGROUND: The Hospital Inpatient Quality Reporting (IQR) Program (formerly, the Reporting Hospital Quality Data for Annual Payment Update Program or RHQDAPU) and HACs initiatives represent significant steps toward implementing value-based purchasing (VBP) in Medicare. VBP is intended to promote high quality, safe, patient-centered care, while reducing costs through efficient provision of care and avoidance of preventable adverse events that not only increases the burden of illness on the patient and his or her caregivers, but also greatly increases health care spending.

The IQR 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 (MMA) of 2003. Under the MMA, hospitals that chose not to participate or failed to meet the criteria for successful reporting received a 0.4 percentage point reduction to the applicable percentage increase. 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, 97 percent are receiving the full update to the standardized amount in FY 2011.

In the meantime, the IQR measure set has grown from a starter set of 10 quality measures in 2004 to the current set of 60 measures. The 60 measures include chart-abstracted measures (heart attack, heart failure, pneumonia, surgical care improvement), claims-based measures (mortality and readmissions measures for heart attack, heart failure, pneumonia; AHRQ Patient Safety Indicators and Inpatient Quality Indicators; nursing sensitive care), a survey-based measure (patient satisfaction), and structural measures (participation in a cardiac surgery, stroke care, and nursing sensitive care registry).

QUALITY AND MEASUREMENT STRATEGY: The proposals in the proposed rule focus on several fundamental CMS and Administration priorities:

- Implementing Affordable Care Act provisions
- Eliminating redundant Federal data systems and inefficiencies through Departmental and Federal-private collaboration and system process redesign
- Eliminating preventable healthcare associated infections (HAIs) and other adverse events
- Reducing provider burden by retiring eight measures that are collected through chart abstraction and adopting more claims-based outcome measures
- Aligning the IQR with the Administration's National Quality Strategy goals.

The IPPS proposed rule makes additional proposals related to the Hospital VBP program. CMS issued a proposed rule that proposed to implement a Hospital VBP program in January 2011, and plans to issue a final rule in the near future.

With respect to the Hospital IQR Program, the IPPS proposed rule proposes to improve the alignment of the validation process with Health and Human Services (HHS) and Administration priorities by adding to the validation sample the Central Line Associated Blood Stream Infection (CLABSI) measure that it adopted for the FY 2013 Hospital IQR measure set last year. CMS is also proposing to add outcome, cost and efficiency, and HAI measures to the Hospital IQR Program. These proposals also align with the Administration's National Quality Strategy in measure proposals and priorities.

The IPPS proposed rule also proposes to expand the list of proposed measures that CMS has proposed to adopt for the FY 2014 Hospital VBP program. Specifically, the proposed rule proposes to adopt a Medicare Spending per Beneficiary measure for that program. CMS made other proposals related to the implementation of a Hospital VBP Program in a separate proposed rule issued on Jan. 7, 2011, and CMS plans to issue a final rule with respect to those proposals in the near future.

SUMMARY OF PROPOSED CHANGES TO IPPS IQR:

Proposed Improvements to Program Administration - In the FY 2012 IPPS/LTCH proposed rule, CMS is proposing a number of changes to improve how the Hospital IQR Program operates and to reduce burden on participating hospitals. Specifically, , CMS is proposing to align the deadlines for submitting different types of data, and to reduce the time in which hospitals must submit requested records as part of the validation process in order to improve the accuracy of that process. CMS is also proposing to allow Quality Improvement Organizations to expedite

medical record requests for cases involving "serious reportable events" or other circumstances that have been identified during the course of a QIO quality of care review.

Proposed Changes to IQR Measure Set - The proposed rule would also make proposed changes to the measures to be reported for the FY 2014 and FY 2015 payment updates. Specifically, CMS is proposing to:

- Retire 8 measures for FY 2014 that CMS has proposed not to select for Hospital Value Based Purchasing
- Add 3 HAI measures over a 2 year period (2 for FY 2014, 1 for FY 2015)
- Add 1 claims-based efficiency measure for FY 2014
- Add 1 structural measure of participation in a registry for general surgery for FY 2014.
- Add Stroke and Venous Thromboembolism (VTE) chart abstracted measures for FY 2015.

These changes would increase the IQR measure set to 73 measures, streamline IQR processes and align submission requirements, which will make the IQR process less burdensome and more transparent to hospitals and QIOs. A list of all of the proposed measures to be reported is attached as Appendix A. A list of topics and measures under consideration in future years' reporting are attached as Appendix B. A complete list of the current categories of conditions that are subject to the HAC payment policy is attached as Appendix B.

PROPOSALS FOR LTCH QUALITY REPORTING PROGRAM

The Affordable Care Act requires CMS to establish a new quality reporting program that would apply to hospitals paid under the LTCH PPS. The law requires that CMS apply a 2% reduction, beginning in FY 2014, to the annual payment update for LTCHs that fail to successfully report quality data to the Secretary. The law also requires CMS to publish, by no later than 10/01/2012, the quality measures selected for submission by LTCHs for FY 2014.

CMS is proposing to select quality measures for the LTCH quality reporting program that:

- Align with CMS' aims for better care for the individual, better population health, and lower cost through better quality.
- Promote improved quality for priorities most relevant to LTCHs, including patient safety, avoidance of HAIs, and well-coordinated person-and-family-centered care.
- Cover important domains of care that are considered important by patients, national experts, and stakeholder input made via a number of existing outreach methods, including one or more Special Open Door Forums and Listening Sessions.

The proposed rule solicits public comment on a multi-year approach to expanding the LTCH quality reporting program. Under this proposal, CMS would collect data from Oct. 1 through Dec. 31, 2012 for the LTCH's payment determination in FY 2014 on the following proposed quality measures that focus on patient safety:

- Catheter Associated Urinary Tract Infection (CAUTI) rate per 1000 Urinary Catheter Days for Intensive Care Unit Patients.
- Central Line Associated Blood Stream Infection (CLABSI) rate per 1000 Central Line Days.
- Pressure Ulcers that are New or Have Worsened. This is the percentage of patients who have one or more stage 2-4 pressure ulcers that are new or worsened from a previous assessment.

For future years, CMS plans to consider implementing additional quality measurements using the standardized assessment instrument CARE (Continuity Assessment Record & Evaluation), as a primary data source, that could be used across all post-acute care sites to support the calculation and comparison of key quality measures related to priorities such as patient safety, patient care goals, functional outcomes, HACs, acute care hospitalization, care coordination and bundled care processes. It is also planning to consider additional measures aligning with National Quality Strategy for safer, better coordinated, affordable, person-centered care, healthy people and healthy communities, such as avoidable adverse events, prevention, patient preferences, patient/family experience of care, symptom management, coordination of care and care transitions). The proposed rule specifically identifies the following measures for possible future inclusion in the LTCH quality reporting program:

Possible Measures and Measure Topics for the LTCH Quality Reporting Program Under Consideration for Future Years	
Overarching Goal: Safety and Healthcare Acquired Conditions -- HAIs	
	HAI reporting for: ● Ventilator-associated Pneumonia ● Surgical site infection rate ● Multi-drug resistant organism infection

Possible Measures and Measure Topics for the LTCH Quality Reporting Program Under Consideration for Future Years (cont.)	
Overarching Goal: Safety and Healthcare Acquired Conditions: Avoidable Adverse Events and Serious Reportable Events	
	• Unplanned acute care hospitalizations • Mortality • Blood Incompatibility • Foreign object retained after surgery • Manifestation of poor glycemic control • Air Embolism • Falls and trauma • Venous Thromboembolism • Injuries secondary to Poly-pharmacy • Injuries related restraint use • Medication errors • Stage III and IV Pressure Ulcer
Overarching Goal: Safety and Improvement Practices for Adverse Event Reduction	
	• Central line bundle • Ventilator bundle • Patient Immunization for Influenza • Patient Immunization for Pneumonia • Staff immunization
Overarching Goal: Safety -- NQF Endorsed Nursing Sensitive Care Measures	
	• Patient Fall Rate • Falls with Injury • Pressure Ulcer Prevalence • Restraint Prevalence (vest and limb only) • Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract) Nursing care hours per patient day (RN, LPN, UAP) • Voluntary turnover for RN, APN, LPN, UAP • Practice Environment Scale-Nursing Work Index

The proposed rule can be downloaded from the *Federal Register* at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

CMS will accept comments on the proposed rule until June 20, 2011, and will respond to them in a final rule to be issued by Aug. 1, 2011.

APPENDIX A

PROPOSED MEASURES FOR REPORTING IN 2013 FOR FY 2014 AND 2015 PAYMENT UPDATES

Topic	HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 and Jan. 1, 2013)
Acute MyocardiaI Infarction	
	AMI-2 Aspirin Prescribed At Discharge
	AMI-7a Fibrinolytic Agent Received Within 30 Minutes Of Hospital Arrival
	AMI-8a Primary PCI Received Within 90 Minutes Of Hospital Arrival
	AMI-10 Statin Prescribed at discharge
Heart Failure	
	HF-1 Discharge Instructions
	HF-2 Evaluation of LVS Function
	HF-3 ACEI or ARB for LVSD
Pneumonia	
	PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
	PN-6 Appropriate initial antibiotic selection
Surgical Care Improvement Program	
	SCIP INF-1 Prophylactic Antibiotic Received Within One Hour prior to Surgical Incision
	SCIP INF-2 Prophylactic Antibiotic Selection for Surgical Patients
	SCIP INF-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (48 hours for cardiac surgery)
	SCIP INF-4 Cardiac Surgery Patients With Controlled 6am Postoperative Blood Glucose
	SCIP INF-9 Urinary Catheter Removed On Postoperative Day 1 Or Postoperative Day 2 With Day Of Surgery Being Day Zero.
	SCIP INF 10- Surgery Patients with Perioperative Temperature Management
	SCIP CARD 2- Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period
	SCIP VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
	SCIP VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours after Surgery

Topic (Cont.)	**HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 (Cont.)**
Patients' Experience of Care	
	HCAHPS Survey
Mortality Measures	
	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
	Heart Failure (HF) 30-Day Mortality Rate
	Pneumonia (PN) 30-Day Mortality Rate
Readmission Measures	
	30-Day All-Cause Risk Standardized Readmission Rate (RSRR) Following AMI
	30-Day All-Cause RSRR Following HF Hospitalization
	30-Day All-Cause RSRR Following PN Hospitalization
AHRQ Patient Safety Indicators, Inpatient Quality Indicators and Composite Measures	
	PSI-4 Death Among Surgical Inpatients with Serious Treatable Complications
	PSI-6 Iatrogenic Pneumothorax, adult
	PSI-11 Postoperative Respiratory Failure
	PSI-12 Postoperative PE or DVT
	PSI-14 Postoperative Wound Dehiscence
	PSI-15 Accidental Puncture or Laceration
	IQI-11 Abdominal Aortic Aneurysm (AAA) Mortality Rate
	IQI-19 Hip Fracture Mortality Rate
	Complication/Patient Safety for Selected Indicators (Composite)
	Mortality for Selected Medical Conditions (Composite)
Healthcare Associated Infections (CDC/NHSN)	
	Central Line Associated Blood Stream Infection
	*Surgical Site Infection
	**Central Line Insertion Practices Adherence Percentage
	** Catheter Associated Urinary Tract Infection
	*** Healthcare Provider Influenza Vaccination
	***Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia
	***C. Difficile Standardized Infection Ratio (SIR)
Hospital Acquired Conditions	
	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)

Topic (Cont.)	HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 (Cont.)
	Manifestations Of Poor Glycemic Control
Emergency Department Throughput	
	*ED-1 Median Time from ED arrival to Time of Departure from the ED for Patients Admitted to the Hospital
	*ED-2 Median Time from Admit Decision to Time of Departure from the ED for ED Patients Admitted to Inpatient Status
Prevention	
	*Immunization for Influenza
	*Immunization for Pneumonia
Structural Measures	
	Participation in a Systematic Database for Cardiac Surgery
	Participation in a Systematic Clinical Database Registry for Stroke Care
	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
	**Participation in a Systematic Database Registry for General Surgery
Medicare Spending per Beneficiary	
	**Medicare Spending per Beneficiary
Stroke	
	***STK-1 VTE Prophylaxis
	***STK-2 Antithrombotic Therapy for Ischemic Stroke
	***STK-3 Anticoagulation Therapy for A-fib/flutter
	***STK-4 Thrombolytic Therapy for Acute Ischemic Stroke
	***STK-5 Antithrombotic Therapy by the end of Hospital Day 2
	***STK-6 Discharged on Statin
	***STK-8 Stroke Education
	***STK-10 Assessed for Rehab
Venous Thromboembolism (VTE)	
	***VTE-1 VTE Prophylaxis
	***VTE-2 ICU VTE Prophylaxis
	***VTE-3 VTE Patients with Anticoagulation Overlap Therapy
	***VTE-4 Unfractionated Heparin with Dose/Labs Monitored by a Protocol
	***VTE-5 VTE Discharge Instructions
	***VTE-6 Incidence of Potentially Preventable VTE

* Measures Adopted for FY 2014 Payment Determination in FY 2011 IPPS Final Rule
** Measures Proposed for FY 2014 Payment Determination in FY 2012 IPPS Proposed Rule
*** Measures Proposed for FY 2015 Payment Determination in FY 2012 IPPS Proposed Rule

APPENDIX B

PROPOSED LIST OF HOSPITAL ACQUIRED CONDITIONS FOR FY 2012
(Items listed in *italics* represent changes from FY 2011)

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)

Selected HAC	CC/MCC (ICD-9-CM Codes)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis – 278.01 998.59 9 (CC) And one of the following procedure codes: 44.38, 44.39, 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, 81.54

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