DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

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CMS Proposals to Improve Quality of Care during Hospital Inpatient Stays

OVERVIEW: On April 30, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospitals Prospective Payment System (LTCH PPS) in Fiscal Year (FY) 2015.

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, would affect discharges occurring on or after October 1, 2014.

In addition to setting the standards for payment for Medicare-covered inpatient services, the proposed rule will update the measures and financial incentives in the Hospital Acquired Condition Reduction, Hospital Value-Based Purchasing and Hospital Readmissions Reduction programs, as well as the Hospital Inpatient Quality Reporting (IQR) Program and Electronic Health Records Incentive Program. It would also revise measures for the Long-Term Care Hospital (LTCH) Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting Program.

This fact sheet discusses major quality-related provisions of the proposed rule. A separate fact sheet on proposed payment changes is available on the CMS Web page at: www.cms.gov/newsroom.

Hospital-Acquired Condition Reduction Program

Section 3008 of the Affordable Care Act requires CMS to establish a financial incentive program for IPPS hospitals to improve patient safety by applying a one percent payment reduction to hospitals that rank in the lowest performing quartile of all subsection (d) hospitals relative to a national average of HACs acquired during an applicable hospital stay. HACs are conditions that patients did not have upon admission to a hospital, but that developed during the hospital stay.

In the FY 2014 IPPS/LTCH PPS final rule, CMS finalized a scoring methodology to calculate a Total HAC Score for each hospital. Under the scoring methodology, hospitals are given a score for each measure within two domains. Domain 1 comprises the Patient Safety Indicator (PSI) 90 measure, an administrative claims based measure developed by the Agency for Healthcare Research and Quality

(AHRQ). PSI-90 is a composite of 8 measures: 1) PSI-03 Pressure Ulcer; 2) PSI-06 Iatrogenic Pneumothorax; 3) PSI-07 Central Venous Catheter-related bloodstream infections; 4) PSI-08 Postoperative Hip fracture; 5) PSI-12 Postoperative Pulmonary Embolism or Deep Venous Thrombosis; 6) PSI-13 Postoperative Sepsis; 7) PSI-14 Postoperative Wound Dehiscence; and 8) PSI-15 Accidental Puncture or Laceration.

Domain 2 measures include two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (CDC NHSN): Central Line-Associated Blood Stream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI). A score is calculated for each domain and the two domains are weighted to determine a Total HAC Score. Hospitals with a Total HAC Score in the lowest performing quartile are subject to a one percent payment penalty.

All measures are risk adjusted and endorsed by the National Quality Foundation. Risk factors such as the patient's age, gender, and comorbidities are considered in the calculation of the measure rates so that hospitals serving a large proportion of sicker patients are not unfairly penalized. In accordance with the statute, a review and correction process allows hospitals to review their measure, domain and Total HAC scores. For FY 2016 a third CDC NHSN-developed healthcare associated infection measure, Surgical Site Infections (SSI), will be added to the program in domain 2.

In order to better assess hospital performance on these measures, CMS is proposing refinements of the scoring methodology finalized in the FY 2014 IPPS/LTCH PPS final rule.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction program began on October 1, 2012. The maximum reduction under this program, which was one percent of payment amounts in FY 2013 and two percent of payment amounts in FY 2014, will increase to three percent of payment amounts in FY 2015, as specified under section 3025 of the Affordable Care Act.

For FY 2015, CMS proposes to continue to assess hospitals' readmission penalties using five readmissions measures endorsed by the National Qualify Forum (NQF): heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip/knee arthroplasty. CMS also proposes an updated methodology to take into account planned readmissions for these five existing readmissions measures, as well as refinement in the hip/knee arthroplasty readmission measure methodology. CMS also proposes to add another new readmission measure beginning in FY 2017: readmissions for coronary artery bypass graft (CABG) surgical procedures.

Proposed Changes to the Hospital Inpatient Quality Reporting (IQR) Program and the EHR Incentive Program

The Hospital IQR Program grew out of the Hospital Quality Initiative developed by CMS in consultation with hospital groups. Previously, hospitals that do not participate successfully in the Hospital IQR Program have their annual payment update reduced by two percentage points. Since the implementation of this financial penalty, hospital participation has increased to well over 99 percent of Medicare-participating hospitals that are paid under the IPPS. Starting for the FY 2015 payment determination, however, that reduction will be one quarter of the applicable IPPS market basket update.

Measures reported under the Hospital IQR Program are published on the *Hospital Compare* Web site (http://www.medicare.gov/hospitalcompare/search.html), and may later be adopted for use in the Hospital VBP Program.

The Hospital IQR Program measure set has grown from a starter set of 10 quality measures in 2004 to the set of 57 quality measures for the FY 2016 payment determination. These measures include chart-abstracted measures, such as heart attack and surgical care improvement measures; claims-based measures such as mortality and readmissions; healthcare-associated infections measures; survey-based measures, such as patient experience of care; and structural measures that assess features of hospitals to assess their capacity to improve quality of care.

CMS is proposing to reduce the number of Hospital IQR Program measures to 46 measures in FY 2017, down from 57 measures in FY 2016. We are removing 15 topped-out chart-abstracted measures and 1 structural measure that is also topped out. We are adding 1 chart-abstracted measure and 4 claims-based measures. We are retaining 10 of the topped-out chart abstracted measures as voluntary electronic clinical quality measures. Outcome and cost measures are among the measures being proposed for FY 2017.

For the FY 2017 payment determination and subsequent years, CMS is proposing to add a total of eleven measures to the Hospital IQR measure set: nine new measures (episode of care payment measures for pneumonia and heart failure; a sepsis reduction bundle; breast feeding; hearing screening; readmissions for CABG and vascular access; home management plan of care document, and mortality for CABG), and two measures that were previously removed from the program (aspirin prescribed at discharge for AMI and statin prescribed at discharge – both electronically specified). Outcome and cost measures are among the measures being proposed for FY 2017. CMS is proposing to remove a total of twenty measures: sixteen "topped out" measures showing hospitals have generally achieved these measures with little remaining variation and four previously suspended clinical process-of-care measures. CMS is retaining 10 of the topped-out chart abstracted measures as voluntary electronic clinical quality measures.

Providers participating in the Hospital IQR Program have the option to voluntarily report a minimum of 16 electronically specified measures over three domains from 28 available measures. The proposals would increase the number of electronic measures in the Hospital IQR Program.

CMS also proposes to align for 2015 and 2016 the reporting and submission timelines for clinical quality measures for the Medicare Electronic Health Record (EHR) Incentive Program with the reporting and submission timelines of the Hospital IQR Program. In order to match data collection periods between the EHR Incentive Program and the Hospital IQR Program, hospitals would voluntarily submit electronically a full year's worth of patient level data for the Hospital IQR Program as well as three-quarters of a year's worth of data for the EHR Incentive Program.

Proposed Changes in the Hospital VBP Program:

Payment Details for FY 2015. The proposed rule outlines the Hospital VBP Program payment details for FY 2015, including an increase in the applicable percent reduction to 1.5 percent of base operating

DRG payment amounts to all participating hospitals. The total estimated amount available for value-based incentive payments in FY 2015 is approximately $1.4 billion.

Proposed Program Requirements for FY 2017. The proposed rule would update the FY 2017 measure set by adding two new safety measures and one new clinical care - process measure, re-adopting the current version of the CLABSI measure, and removing six "topped out" clinical process measures. Over 80 percent of the measures in the Hospital VBP Program would assess health outcomes, patient experience and cost.

FY 2017 Proposed New Measures. CMS is proposing to adopt two new outcome measures for the new Safety domain: hospital-onset methicillin-resistant staphylococcus aureas (MRSA) bacteremia and clostridium difficile infection; and a clinical care - process measure: early elective deliveries. CMS is also seeking comment on the possible future adoption of new items from the HCAHPS survey once those items become eligible for measure selection.

FY 2017 Domain Weighting. CMS adopted new quality domains based on the National Quality Strategy in the FY 2014 IPPS/LTCH final rule, and also adopted domain weighting for FY 2017. Due to the large number of "topped out" measures that CMS is now proposing to remove from the FY 2017 measure set, CMS is now proposing to revise the finalized FY 2017 domain weighting by reducing the weight of the clinical care – process subdomain to 5 percent and increasing the weight of the safety domain to 20 percent.

FY 2019/2020 Measure. CMS is proposing to adopt one new hospital-level risk-standardized complication rate following elective hip and knee arthroplasty measure with a 30 month performance period for FY 2019, and a 36 month performance period for FY 2020.

More information about the Hospital VBP program is available online at: http://www.cms.gov/hospital-value-based-purchasing.

Proposed Changes to the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP):

Section 3004(a) of the Affordable Care Act established the LTCHQR Program. Beginning in FY 2014, the applicable annual increase factor for any LTCH that did not submit the required quality data to CMS was reduced by two percentage points. To date, CMS has finalized 9 measures for inclusion in the LTCH QRP. In the FY 2015 IPPS/LTCH PPS NPRM, we are proposing to include 3 additional quality measures, for a total of 12.

Proposed Quality Measures: For the FY 2018 payment determination and subsequent years, we are proposing to add three additional quality measures: National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure; Functional Outcome Measure: Change in Mobility among LTCH Patients Requiring Ventilator Support; and Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.

Proposed Policies: We are proposing a mandatory Reconsideration procedure for the LTCH QRP, which proposes to require that LTCH providers follow specific procedures when submitting a request for CMS' reconsideration of an initial LTCH QRP provider compliance determination. Our proposal

would also expand the exception and extension process to allow LTCH providers to request exceptions or extensions for circumstances beyond their control, including those that are not classified as natural disasters. Finally, we are proposing to implement a new Data Validation process, which will require randomly selected LTCH providers to meet a proposed 90% data reliability score for required LTCH CARE Data Set items.

Proposals for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The proposed rule proposes to adopt a new measure beginning with the FY 2017 PCHQR Program. The addition of this measure, external beam radiotherapy for bone metastases, would increase the number of measures beginning with the FY 2017 program to a total of 19. Additionally, CMS is also proposing to adopt a number of other reporting updates

CMS will accept comments on the proposed rule until June 30, 2014, and will respond to all comments in a final rule to be issued by August 1, 2014. The proposed rule, which includes tables for the proposed and previously adopted measures referenced in this fact sheet, can be downloaded from the *Federal Register* at:
http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

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